THE IMPACT OF A

RECOVERY ORIENTED SYSTEM OF CARE (ROSC)

IN HANCOCK COUNTY, OHIO

A Behavioral Health System Transformation

A COMMUNITY REPORT BY THE HANCOCK COUNTY ADAMHS BOARD • MARCH 2022

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Given today's need for improved population health, transforming any system of care is daunting, urgent and necessary - but is doable. Access and retention in behavioral health and primary health, provided by competent workers and healthy programs that service and represent the community values and needs are where local policy meets science and healing can begin. Hancock County took such a challenge. Begun by educating and empowering it's citizens and providers to define and seek their own sought health outcomes, they built the system-community inter-relationships necessary to achieve that Vision. Faced with an ever growing opioid epidemic and a COVID-19 pandemic, they were still able to improve the behavioral health of their community.

- Michael T. Flaherty, Ph.D., ROSC Consultant to Hancock County

The Impact of a Recovery Oriented System of Care (ROSC) in Hancock County, Ohio

December 2021

In the fall of 2013, Hancock County ADAMHS, launched a system analysis for improvement and transformation of its behavioral health services. This analysis included an exploration of the relevance of establishing a Recovery Oriented System of Care (ROSC) model for the community. During this process, a full assessment of Hancock County's existing mental health and substance use disorder treatment service continuum was conducted which included identification of service gaps; recommendations to increase and expand services; aligning systems, programs, practices, and policies in such a manner that uses best science; and unifying a vision of recovery as an opportunity for each person, family, and the community.

This process was guided by the following two principles:

1. ROSC provides ongoing monitoring and feedback with assertive outreach efforts to promote continual participation, re-motivation, and reengagement.
2. ROSC will be guided by recovery-based processes and outcome measures. Outcome measures will be developed in collaboration with individuals in recovery. Outcome measures will reflect the long-term global effects of the recovery process on the individual, family and community, not just the remission of biomedical symptoms. Outcomes will be measurable and include benchmarks of quality-of-life changes.

ROSC also seeks to build recovery capital. Recovery capital is the measure of assets needed for recovery in an individual, family, and community. Recovery capital is measured at the beginning of a person's journey into recovery and shows strengths or needs for success. As recovery capital grows, so does the health and resilience of the individual, family, and community.

Finally, ROSC, provides a natural trajectory into population health. The purpose of population health is to improve the health of individuals and the community by advising where to invest resources to address social determinant of health. By having ROSC focused on the health, wellness and recovery of the entire community, Hancock County will ultimately link the values of the community to service delivery, resulting in optimal health outcomes for all.

What follows is a visual representation of the increasing scope of services, programs, and supports that have expanded during the development, implementation, and sustainment of ROSC in Hancock County.

Hancock Co. Mental Health & Substance Use Disorder Services

Fiscal Year	2013	2014	2015	2016	2017	2018	2019	2020	2021
EXISTING SERVICES PRIOR TO TRANSFORMATION									
Diagnostic Assessment	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outpatient Counseling	✓	✓	✓	✓	✓	✓	✓	✓	✓
Case Management	✓	✓	✓	✓	✓	✓	✓	✓	✓
Peer Support (paid)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Peer Drop-In Center	✓	✓	✓	✓	✓	✓	✓	✓	✓
Robost Mental Health System	✓	✓	✓	✓	✓	✓	✓	✓	✓
NEW INTERVENTION/TREATMENT SERVICES SINCE TRANSFORMATION									
Residential Detox		✓	✓	✓	✓	✓	✓	✓	✓
MAT (Medication Assisted Treatment)		✓	✓	✓	✓	✓	✓	✓	✓
Naloxone (Narcan) **/ Project DAWN** (Deaths Avoided with Naloxone)			✓	✓	✓	✓	✓	✓	✓
SBIRT (Screening, Brief Intervention and Referral to Treatment)			✓	✓	✓	✓	✓	✓	✓
Recovery Guides (volunteer)			✓	✓	✓	✓	✓	✓	✓
Recovery Support Center (FOCUS)			✓	✓	✓	✓	✓	✓	✓
Recovery Housing (2)			✓	✓	✓	✓	✓	✓	✓
Residential Detox (Purchased on case by case basis from Arrowhead)			✓	✓	✓	✓	✓	✓	✓
Recovery Check-Ups				✓	✓	✓	✓	✓	✓
Intensive Outpatient Treatment				✓	✓	✓	✓	✓	✓
Ambulatory Detox				✓	✓	✓	✓	✓	✓
QRT (Quick Response Team)					✓	✓	✓	✓	✓
Inpatient Withdrawal Management (Blanchard Valley Hospital)						✓	✓	✓	✓
MAT for Youth						✓	✓	✓	✓
ICD Home-Based Services for Youth (integrated Co-occuring Disorders)						✓	✓	✓	✓
MRSS for Youth (Mobile Response - Stabilization Services)							✓	✓	✓
Recovery Housing for Pregnant Women							✓	✓	✓

Fiscal Year	2013	2014	2015	2016	2017	2018	2019	2020	2021
EXISTING SERVICES PRIOR TO TRANSFORMATION									
On-site Services at Probation Dept. (4 FTEs)	✓	✓	✓	✓	✓	✓	✓	✓	✓
On-site Services at the Justice Center (4 FTEs)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Physician Continuing Education Opportunities	✓	✓	✓	✓	✓	✓	✓	✓	✓
PROGRAM CHANGES/ENHANCEMENTS/ADDITIONS SINCE TRANSFORMATION									
***You're Not Alone* Family Support Group**		✓	✓	✓	✓	✓	✓	✓	✓
Trauma-Informed Care Learning Community		✓	✓	✓	✓	✓	✓	✓	✓
Opiate Treatment Protocol Ratified		✓	✓	✓	✓	✓	✓	✓	✓
Mental Health FIrst Aid		✓	✓	✓	✓	✓	✓	✓	✓
Drug Court (2)			✓	✓	✓	✓	✓	✓	✓
Vivitrol Protocol			✓	✓	✓	✓	✓	✓	✓
Overdose Fatalities Review Board			✓	✓	✓	✓	✓	✓	✓
211 Helpline				✓	✓	✓	✓		
Addictions Minor Established at the University of Findlay				✓	✓	✓	✓	✓	✓
Crisis Text Line				✓	✓	✓	✓	✓	✓
Recovery Resources Guide				✓	✓	✓	✓	✓	✓
Drug Free Workforce Community Initiative				✓	✓	✓	✓	✓	✓
CRAFT Program (Community Reinforcement and Family Training)				✓	✓	✓	✓	✓	✓
Zero Suicide Initiative				✓	✓	✓	✓	✓	✓
Family Dependency Court				✓	✓	✓	✓	✓	✓
MOMS Program (Maternal Opiate Medical Support)						✓	✓	✓	✓
Motivational Interviewing (Youth staff)						✓	✓	✓	✓
AYG - The Loft (Alternative Youth Group)							✓	✓	✓
Universal Screening in the Jail							✓	✓	✓
Matrix Model Implemented							✓	✓	✓
Harm Reduction BIPPP (Bloodborne Infectious Disease Prevention Program, syringe service program)							✓	✓	✓
Hancock Helps								✓	✓
Youth Thrive Initiative									✓

What ROSC has done in Hancock County makes me think of one of my favorite poems, "Awaken" by Lawrence Tribble:

One man awake,
Awakens another.
The second awakens
His next door brother.
The three awake can rouse a town
By turning
the whole place
Upside down.

The many awake
Can cause such a fuss
It finally awakens the rest of us.
One man up,
With dawn in his eyes
Surely then
Multiplies.

The ROSC Leadership Committee of leaders has done exactly that for those in recovery and for those who want to be in recovery.

– Nichole Coleman,
Executive Director, Hancock County Veterans Services Office

Beginning in the fall of 2013,

Hancock County, under the authority of the Hancock County Board of Alcohol, Drug Addiction and Mental Health Services (ADAMHS), launched a system analysis for improvement and transformation of its behavioral health services. Included in this analysis was a simultaneous exploration of the relevance of a Recovery Oriented System of Care (ROSC) model. At its beginning, the intent was to do an assessment of Hancock County's existing service continuum, identify gaps in that system, and, while seeking to fill those gaps, align the community and all services to best science and practice within a unifying vision of recovery for each person, family, and the community.

Year 1 (SFY 2014)

was spent identifying system gaps and developing Principles and Objectives of a ROSC for the community and its providers. The focus was largely to 1) build a unified vision of recovery with healthcare leadership, 2) educate the community about ROSC, 3) invite the community to assist in defining recovery for Hancock County, and 4) encourage the community to participate in the implementation of ROSC.

A ROSC Leadership Committee was established to develop principles and objectives derived and aligned from people in recovery, oversee implementation, and offer guidance to all services. An ADAMHS staff position was designated as the ROSC Liaison within ADAMHS. A four-year ROSC Strategic Plan was developed.

While supporting the ROSC Leadership Committee, ADAMHS continued to educate providers while identifying local prevention, intervention and treatment gaps based on the American Society of Addiction Medicine Guidelines (2013) continuum of care for substance use treatment. An overarching "Preamble for Care" for Hancock County was designed and promulgated by the community, people in recovery, service providers, and community leaders. Hancock County contracted with the National Council on Behavioral Health (now the National Council for Mental Wellbeing) to engage twenty-one local stakeholders, representing various community sectors, in a year-long Trauma-Informed Care Learning Community to help identify the root causes of addiction, mental illness and potential relapse for people seeking recovery.

Year 2 (SFY 2015)

focused on continuing community and service provider awareness, implementing ROSC principles and objectives, and promoting the "Preamble for Care" for Hancock County. ROSC measures were established (e.g., accessibility of treatment; hours of counseling provided; numbers in treatment; length of treatment, number of trained peer supports; number of connections to peer support made by providers) and monitored by ADAMHS and the ROSC Leadership Committee. National experts on ROSC (Michael Flaherty (year 01), William White, Lonnetta Albright, Beverly Haberle) were brought to the community to offer guidance as well as to establish linkage to the National Substance Abuse and Mental Health Services Association's (SAMHSA) Addiction Technology Transfer Centers support.

The ROSC Leadership Committee maintained on-going needs assessments of existing services which resulted in identifying gaps and deficiencies in Hancock's continuum of care. The following list demonstrates the services expanded because of needs assessments:

An overarching community "Preamble of Care" for Hancock County was drafted and

As someone personally in recovery, I can confidently say that traditional treatment methods were ineffective, until I was ready. Despite the fact that I wanted "recovery," or a life that included happiness and meaning without substances, the reality is that it wasn't a speedy or easy process. When working with clients, I have found that walking alongside the clients, as they decide what their "recovery" looks like, is crucial to reaching their individual life goal. At the end of the day, it's important to remember that the person working towards "recovery" is the author of their story and only they can fill in the content on these pages.

– Heidi Barilla, Peer, Person in Recovery

adopted by the community and all providers.

Screening, Brief Intervention and Referral to Treatment (SBIRT) was begun county wide.

A "Shared Opioid Treatment Philosophy," based on best science, was adopted system-wide that would establish a local best practice for initiating Medication Assisted Treatment (MAT) for people seeking recovery.

The local recovery support center, FOCUS, drop-in center, expanded its services for all populations seeking to sustain personal recovery.

The Hancock County Opioid & Addictions Task Force developed and published the Recovery Resources Guide, which provides resource listings and educational materials.

Clinical staff for substance use and recovery were added to the jail.

Efforts were launched within the Common Pleas Court to reduce jail overcrowding by establishing the first Drug Court in Hancock County.

A local provider was sought to fill the community need for a substance use residential treatment program (ASAM Level III-5).

The need and value of recovery housing was also established and locations for such residences were identified. Community resistance to recovery housing locations emerged, and increased board and community involvement ensued, educating all involved to modified for success.

Implementing ROSC in Hancock County meant they had committed to align and build best science and practice with a determination that there was an opportunity for recovery in every episode of care provided.

– Michael Flaherty, PhD, ROSC Consultant

ROSC offers those with substance use disorders a way to find their own pathways to recovery including detox, inpatient treatment, and residential treatment and housing. Organizations participating in ROSC provide those with criminal records as a result of addiction and opportunity to find employment, income, and housing.

– Don Illif, PhD, Community Member

Project DAWN (Deaths Avoided with Naloxone) started through a grant awarded to Hancock Public Health. Project DAWN provides free naloxone kits and training to any Hancock County resident or employee.

Year 3 (SFY 2016)

ADAMHS consulted with national ROSC experts, adding depth to the existing Hancock County ROSC system design. The following is a partial listing of accomplishments from Year 3:

Initiatives to increase access to treatment and use of best practice (e.g., SBIRT, MAT, incarceration and post-incarceration support, drug court, peer worker development) were launched, monitored, and grew consistently.

Drug Court was strengthened by the addition of a specific Family Court. The need for outpatient services such as Withdrawal Management was identified and brought to two providers, Blanchard Valley Health System and A Renewed Mind, for assistance.

National expert Sabato Stile, M.D. key noted a Blanchard Valley Health System Conference on the assessment and treatment of substance use with an emphasis on medications and pharmacology.

Obtaining physical locations (real estate) for needed recovery housing services was completed and the first local residential recovery housing (ASAM Level III-X) opened to meet the local need for residential care.

Extensive community education (e.g. Rotary presentations, community-at-large forums, meetings with press and local corporations/employers/police) and assessment occurred that added further awareness of needs in general and specifically, such as: general housing; transportation; increased access to medication and medical (physician) expertise in Mental Health (MH) and Substance Use in the community; more residential recovery housing (locations

were proposed). A new workforce development challenge emerged within the provider population to fill new vacancies to meet increased demand for workers offered more than a job but a career. Workers were specifically sought from those in recovery and families with lived experience (peer recovery supports).

Specific linkage was made with the University of Findlay to assist in developing the increasingly needed workforce pipeline; and to the local Veteran Services and churches to reach vulnerable populations through internal peers.

The Ohio Association of County Behavioral Health Authorities (OACBHA) sought collaboration and consultation with Hancock County ADAMHS for (subsequent) replication of their ROSC model at a statewide level; consultation was provided, and presentations were made at the state provider conference. State ROSC efforts (Recovery Is Beautiful) grew.

The Opiate Task Force, established in 2010, continued to address the emerging opioid overdose epidemic, developing, and distributing the Recovery Resources Guide Packet containing information regarding overdose recognition, intervention, and local recovery services.

In collaboration with Hancock Public Health Department and local leaders, it was agreed that every overdose death would be reviewed for root cause understanding and system improvement.

"A Community Position on the Value of a Life in Hancock County" was adopted in collaboration with all stakeholders to affirm the value each life in Hancock County ("…no life is expendable") and to establish levels of evidence- based prevention from the then growing overdose epidemic for each person, family, and the community.

Overdose and overdose deaths were added to the community measures to be monitored as well as number of individuals receiving MAT and Family Peer Support.

Dr. Robert Myers traveled to Hancock County to facilitate the Community Reinforcement and Family Training (CRAFT) with thirty-three community members and professionals.

Community resistance to recovery housing locations emerged, and increased board and community involvement ensued. Again, modifications for success were attained.

Hancock County ADAMHS received subsequent strong community support by strongly renewing a local levy.

Two local recovery homes were opened.

Year 4 (SFY 2017)

saw the oncoming opioid epidemic reach Hancock County's ROSC development and growing services. The following is a partial history of accomplishments from Year 4:

To address and reduce stigma, a community awareness outreach program "We All Know Someone" was launched, built upon the principles outlined in the 2016 "A Community Position on the Value of Life in Hancock County," Hancock's Preamble for Care and ROSC principles.

Special efforts were started to reach further into under-represented community members (e.g., families of substance user; LGBTQ+; veterans (Battle Buddies), post incarceration individuals, drug court (revised policies/initial evaluation), women who are pregnant and have substance use disorder and their newborns; youth,

ROSC has made a dramatic difference in my life and my personal recovery. It has also changed the way I train and lead the staff in the county veterans office. The Ohio veterans service offices were created to ensure that veterans have a way to understand and connect with their state and federal benefits. And, while we continue to do an excellent job of providing that service, we now also evaluate the veterans' wellness as a whole person. In 2021, we added a Resiliency Operations Manager with 5 programs to offer resiliency building tools. We have normalized seeking mental health services by sharing our stories publicly and with our clients.

– Nichole Coleman, Executive Director, Hancock County Veterans Services Office

racial minorities; those needing housing).

CRAFT classes began to offer families a hopeful, positive and more effective alternative to addressing a loved one's substance use disorder.

The University of Findlay's College of Health Professions launched their Minor in Substance Use Disorder that also expanded the university's enrollment.

Trauma and mental health services were elevated as priorities within Hancock's ROSC model.

SBIRT was added to the electronic record of hospital patients while implementing warm handoffs became the accepted method for transferring a person from one level of treatment to another.

The community recovery center, FOCUS, received a three-year SAMHSA award to further develop its recovery support services.

Brandeis University/Heller School visited Hancock for prospective collaboration/ evaluation.

A community health assessment, in collaboration with community partners, was completed.

A grant was awarded from the Findlay Hancock County Community Foundation to create, in collaboration with Blanchard Valley Hospital and A Renewed Mind (provider), a local Maternal Opiate Medical Supports (MOMs) Program for women who are pregnant and have substance use disorder - and their newborns.

ROSC widens community awareness of the needs, stigma, and effectiveness of sustained interventions for those in recovery. The local collaboration of many and diverse organizations has been instrumental in the progress seen, especially in the context of the Covid pandemic.

– Dr. William Kose, Director of Special Projects, Blanchard Valley Health System

Efforts to distribute Narcan (overdose revival medication) were increased in collaboration with the Hancock Public Health Department.

Permanent unused medication collection boxes were installed, and ongoing community medication collection events garnered more than 1300 pounds of unused pills.

The state of Ohio reported an across state average of 21.4 opioid deaths for every 100,000 citizens; Hancock County reported 10.2/100,000.
An updated strategic plan was adopted.

Transformation efforts were presented at the National Behavioral Health Council Conference.

Year 5 (SFY 2018)

continued focus on completing a full continuum of care for mental health and substance use disorder services with specific efforts to find a partner to open a community crisis center. The following is a partial list of accomplishments in Year 5:

Opioid overdose was further addressed via Emergency Room and First Responder training, opening of the local MOMs Program, expanded MAT services (Buprenorphine, Vivitrol and NARCAN) and the launch of inpatient Withdrawal Management services at Blanchard Valley Hospital that included Risk Assessment for future overdose.

Community and professional education occurred on Harm Reduction and its potential role in Hancock's service and population health.

Acupuncture was formally added to Hancock County's "A Shared Opioid Treatment Philosophy."

US Senator Rob Portman visited Hancock County and sought information to assist in his national efforts directed at overdose prevention and legislation.

Hancock County was asked to present on ROSC at the Opiate Conference in Columbus, Ohio, sponsored by the Ohio Association of Community Behavioral Health Authorities.

Hancock County's ROSC was featured in Psychiatric Services, a journal of the American Psychiatric Association (October 2018), as a model for addressing opioids in rural America.

For me, one of the best programs started under ROSC in my time on the Board is the MOMS program. I joined the Board to help those dealing with mental health and addiction issues and to lower the stigma associated with them. No one is more looked down upon in our society than a mother who endangers her child. Mothers with addiction issues are treated and viewed very harshly and many times fear seeking help because they could lose their children. The MOMS program offers help to mothers who suffer from addiction and offers them hope to better themselves and the lives of their children. I can't think of a better program.

– Mark Rimelspach, ADAMHS Board Chair, FY21-22

Measures of ROSC services were gathered monthly and reviewed quarterly by the ADAMHS Board and the ROSC Leadership Committee.

Access to treatment doubled with a system average of more than 51% remaining in treatment for at least 90 days, which is the target goal of sustained treatment for obtaining long-term recovery.(The national measure of remaining in treatment for 90 days is less than 10%.)

The concept of using ROSC to build individual, family and community recovery capital was introduced as long term measures leading to improved overall population health of the community.

In collaboration with the Hancock Public Health and local leadership, harm reduction strategies were introduced into Hancock County with a specific three-tiered intervention model designed to better access individuals and families both in and not in treatment. BIDPP (Bloodborne Infectious Disease Prevention Program) was introduced to provide syringe services, prevention services, and access to treatment resources

Brandeis University (Massachusetts) and the Harvard Business School sought to collaborate with Hancock County and/or evaluate the county's work.

With services expanding, issues of worker shortage began to emerge and hamper service development. Further collaboration with University of Findlay occurred seeking to address these workforce needs.

Year 6 (SFY 2019)

continued using the developing ROSC system to face off the opioid epidemic in Ohio and nationally. The following is a listing of accomplishments from Year 6:

To meet increased demands, Brandeis University partnered with ADAMHS and specific providers to build unique programs for families (SAMHSA's System of Care grant awarded) and criminal justice populations (SAMHSA's LEAD grant awarded).

Universal screening for mental health and substance use was implemented at the Justice Center.

Specific guidelines for providers and the MOMs program were designed to refine its clinical services and roles with the Courts.

National recovery leaders (White, Flaherty, Stuby) and ADAMHS produced a model comprehensive summary for screening tools for Children, Adolescents, Transitional Age Youth and Families (CATYF) seeking substance use or behavioral health services. This tool funded by the ROSC-based System of Care grant and seeks to identify early childhood risks in SU families.

A second paper titled "Heritability of Substance Use Disorder" was produced by Dr. Ralph Tarter to foster community understanding of intergenerational effects of substance use.

Continued modification and analyses of Tree Line, Hancock County's residential substance use treatment facility, occurred suggesting potential changes in programming to help patients at the facility both survive and thrive via a more appropriate level of care.

By monitoring attained recovery goals, population health measurement began to emerge as a potential long-term model for Hancock County with a concept paper and proposal submitted to local business (e.g., Marathon Petroleum Corporation).

Overdose deaths dropped 30% from 2017 to 2019 in Hancock County (23% drop in Ohio).

"We Haven't Won the War Yet" editorial article, authored by Dr. Michael Flaherty, ROSC consultant, was printed in the "The Courier", the community's local newspaper.

Outpatient methadone services were considered as a potential MAT service to reach deeper into the population with severe substance use disorder.

The continued development of harm reduction strategies as both a clinical health prevention strategy for entire community (led by Hancock Public Health Department), and an attempt to reach and serve high-risk individuals and families, was collaboratively designed and implemented.

Additional barriers and disparities were identified in the most abject populations to accessing care (stigma, population diversity, despair, gender, race, etc.).

The opening of a third residential recovery home for pregnant women with substance use disorders.

Year 7 (SFY 2020)

began with a targeted goal to further engage and strengthen families in solving the full manifestation and reach of substance use for the individual, the family and the community, while continuing to improve mental health services. The following is a partial listing of accomplishments from Year 7:

Early 2020 sought specific research and guidance legal substances, resulting in a guiding document titled "A Community Position on Legal Substances." An additional document, "Primer on Harm Reduction" was also developed and shared across Hancock County.

Federal grants were awarded to Hancock County including SAMHSA's Certified Community Behavioral Health grant, and SAMHSA's Adult Suicide Prevention. These system augmentation and focus grants (now totaling approximately $10 million) were all built upon the ROSC model already underlying all of Hancock County's mental health and substance use disorder work.

Through the System of Care grant, Family Resource Center, in collaboration with the Findlay-Hancock County Center for Civic Engagement and the Hancock ADAMHS Board declared in March, a week dedicated to empowering families in Hancock County. The week was highlighted by a very successful "Thriving Families" community conference that addressed the barriers identified in Year 06. National experts Ralph Tarter, Ph.D. and Dennis Daley, Ph.D. and others presented on the intergenerational nature of addiction, research on the impact of drug use on families, and 21st century approaches to strengthen and empower families and the community.

Additional state grants further augmented service development. However, all of this grant funding success severely strained the historical workforce shortage and the need to identify, train, and place skilled workers in new grant funded positions while facing the coronavirus (COVID-19) pandemic. The SUD Residential facility, Tree Line, was closed due to financing and COVID.

In response to COVID, telehealth services become universally available and access to care was sustained.

In 2020, an article about Han-

Serving on the ADAMHS Board was one the most enlightening and fulfilling experiences of my life. Working together, with like-minded people, attempting to create a system of recovery support for our friends and neighbors, was extremely rewarding. With Dr. Flaherty's guidance, the Board continued to develop our ROSC programs, and establish recovery housing for our community. While my term ended in 2018, the services have continued.

– John Kissh, ADAMHS Board Chair, FY17-18

ADAMHS had concluded that by building a ROSC, reaching those most in need was the best way to help the entire community.

– Michael Flaherty, PhD, ROSC Consultant

cock's ROSC efforts published in 2019 was selected by the American Psychiatric Association Journal, Psychiatric Services, as the "editor's choice" Frontline Report for its description of culturally relevant, person-centered services built on community led model of care in a rural area (1).

Year 8 (SFY 2021)

COVID and the workforce shortage continue to negatively impact the community.

A BJA federal grant was awarded to reopen the SUD residential treatment facility as a residential crisis stabilization facility.

State Opiate Response (SOR) funds awarded to increase capacity in existing services and add mobile outreach to pregnant women and access to employment services. Investments were made in the local financial opportunity center.

Youth Thrive Initiative started which works with youth-serving systems and its partners to change policies, programs, and practices so that they build on what we know about adolescent development, value young people's perspectives, and give youth opportunities to succeed (protective and promotive factors).

Year 9 (SFY 2022 YTD)

All services were sustained either in person or via telehealth during Covid-19.

Methadone services began (12/30/21) in Findlay (Pinnacle Treatment).

Overdose deaths are continuing to trend **down**, with 12 as of 12/30/2021. This reduction is partly contributed to harm reduction strategies (BIDPP) which focuses on addressing the challenges of "third floor" individuals struggling with substance use and addiction. Harm reduction strategies such as these focus on addressing three primary areas of ROSC, health, wellness, and recovery by giving people connection and access to tools and resources, Since the inception of BIDPP, 12 participants have entered treatment.

Since the start of Project DAWN (Deaths Avoided with Naloxone), 4024 kits have been distributed in Hancock County, 1895 persons have been train on how to reverse and overdose using naloxone, and 770 overdose reversals have been reported. Additionally, through Hancock Public Health's BIDPP (harm reduction) an additional 336 overdose reversals have been reported since the program began in October 2020.

Having a recovery oriented system of care in Hancock County has brought comprehensive supports and services into the community. I can see how this cohesive work is measurably improving the lives of all involved and how this work promotes the overall health, wellness, and recovery.

– Angela DeBoskey, Executive Director, United Way of Hancock County

Guiding Principles

Recovery-oriented systems of care provide ongoing monitoring and feedback with assertive outreach efforts to promote continual participation, re-motivation and reengagement (2).

Recovery-oriented systems of care will be guided by recovery-based process and outcome measures. These measures will be developed in collaboration with individuals in recovery. Outcome measures will reflect the long-term global effects of the recovery process on the individual, family and community, not just the remission of biomedical symptoms. Outcomes will be measurable and include benchmarks of quality-of-life changes (2).

Beyond many specific or priority measures of progress, a ROSC suggests a few initial overarching core measures to be monitored annually:

1. **Access**. Access or engagement in treatment by year by agency (number of individuals entering treatment; time from request for services to intake; outreach to and inclusion of potential clients/families). There has been a 284% increase in individuals served in Hancock from 2014 to 2020.

2. **Retention**. Percent of retention of individuals in treatment by agency or across agencies (e.g., percent of clients, families etc. reaching 90 days of continuous care, by agency; treatment culturally and spiritually relevant to population). 51% of all served, achieved a 90-day sustained continuum of care, with recovery support.

3. **Outcome**. Outcome (e.g., percent of clients by agency connected to peer support; complete treatment successfully; percent of individuals and families connected to continuing care; percent involved in post-treatment recovery check-ups for one year). 85% report maintaining recovery at 90-day follow-up.

For referenced data and documents please see Supporting Documents (page 20).

These overarching measures represent the initial and core measures for both system and person ROSC care (3). Within these quantitative numbers specific population measures can exist (e.g., drug court referrals/completers; referrals to recovery housing; referrals to withdrawal-management, overdose death rates; healthy babies born (MOMs), access to Veteran supports, etc.). These sub-group measures are established and monitored regularly by the ROSC Leadership Team, ADAMHS Board, and the broader community. In establishing a quantitative analysis of ROSC, the core measures come first with the population and system need and linkage measures second. The longevity of this data should reflect system change and progress to both establish recovery principles (core) in all treatment while still addressing, from within those same principles, measures of progress while addressing continual community challenges and needs, e.g., opioid epidemic, Covid-19, workforce shortage. Hancock County's ROSC is a dynamic and continuing process of system and person growth adaptable to all services and grants based on the principles and elements that seek to ensure an opportunity for recovery is afforded in each episode of care and all services provided.

From the beginning of Hancock County's ROSC implementation, monthly and yearly data has been gathered to mark progress, address emerging local needs, and identify areas of concern while being accountable to the community. Select measures were regularly posted and open to all in the ADAMHS Board Room and would be the basis to measure achievements and challenges.

Advanced Quantitative Analytics: Next Steps

As ROSC evolves and becomes more adopted into the system and community, the above three core measures open to a more detailed assessment of attained and sustained recovery and gained individual, family and community health and wellness. While an array of measures and screening tools of recovery exist, few are held universally applicable (4). The three measures above sought to use well accepted specific factors to measure improvement and gained recovery capital (3,5). This capital serves both as an initial assessment and as a measure of strength or gained resilience, progress and growth overtime for individuals, families and the community itself. Simplistically stated, recovery capital is the measure of assets versus challenges needed for recovery of an individual, a family or a community. Recovery capital is established at intake and measured over time. It establishes a person's or family's strengths or needs for successful treatment (e.g., type of treatment, level of care, support needed, level of medical intervention, personal resources, etc.) As it grows, so does the health and developed **resilience** of the individual, family, and community i.e. population health.

To measure recovery capital, one must measure both personal assets and weakness. Recovery is attained by intention and progress toward a series of measures vs any one achievement (e.g., abstinence alone). White (3) offers examples of system, agency, and personal recovery measures as does SAMHSA (2) and others (6). Increasing recovery measures builds recovery. SAMHSA now encourages recovery measures in most new federal grant applications and has placed them in the existing federal block grants awarded to the states. For example, using White's (3) recovery measures an individual's recovery capital is assessed and measured with progress in:

- Alcohol or drug use reduction and abstinence; mental health stability
- Living environment
- Physical health or reduced health costs
- Emotional health
- Family relationships and family care
- Citizenship (legal issues, employment, education, community service)
- Quality of life (spirituality, life purpose or meaning)

A family also brings their recovery capital to each experience, and it too can be assessed and grow along these same and other measures (e.g., is the family actively involved in recovery of member; is family getting help themselves; is treatment reaching other family members needing help; is biological and cultural predisposition or vulnerability assessed, etc.)

Community recovery capital is the measure of resources a community brings to improve the health, wellness and recovery for all in the community. By addressing and building individual and family recovery capital, community health is fortified (e.g., building strong prevention programs based on local found solutions for behavioral issues or diverse populations; building support and outreach programs for all families through community resources (i.e. churches, jails, courts, press, community leader awareness, outreach to high risk or underserved populations, etc.); having a timely access to the needed levels of care; having an adequate, skilled workforce, etc.). Community recovery capital measures a community's resilience to illness.

In behavioral health, (e.g., mental health and substance use science), measuring core elements of system development and progress with individual, family and community capital as measures of health can become behavioral health's measure within local population health. Addressing and improving population health is the 21st Century goal for all health care.

Next Steps cont.

Before further discussing "population health," there are three specific areas within Hancock County's ROSC development that need to be discussed and noted as critical in any evaluation of their adjudged outcomes.

From Hancock's system transformation the value of a robust and skilled workforce became quickly obvious. A skilled and available **workforce** is a critical element in the development and success of behavioral or any health delivery system. In behavioral health, in particular, the greatest asset remains the worker. Science and technology need understanding by skilled, trained, and educated workers to become best practice. The workforce remains the critical starting point for disseminating and implementing best science and practice. Throughout this ROSC project, professional worker and peer development remained a constant challenge, impacting each component of the system and its ultimate outcomes of this ROSC. The University of Findlay joined to help by developing specific clinical programs (an addictions minor/certificate program) with potential career tracks that could remain a **recruitment** opportunity for Hancock County's continued behavioral health workforce needs. Still, needs related to demand, and growth remain, such as needed opportunities for behavioral specialist training of Nurse Practitioners and Physician Assistants as well further training and acceptance of peers, families as peers, behavioral health counselors and across discipline (public and private) collaboration. Also, the specific recruitment of a diverse workforce to match with parity the community population, the recruitment of addiction certified specialist medical staff, and the increased integration of behavioral services in primary care, to name a few, still exist.

In addition to specific recruitment, enhanced **retention** planning that includes strengthening more open, interprofessional collaboration, career path development for all workers and volunteers, pay equity and a system embracing new technologies (e.g., telehealth) are potential new avenues for recruitment, retention, and service growth. Such potential is currently exemplified by the ADAMHS Board led Hancock County Cultural Humility & Health Equity Delegation who, in their work, seeks to ensure the voice and inclusion of **all** in the community, potentially addressing workforce recruitment and retention and improving health equity and policy. A specific recruitment and retention plan could be an asset. The bottom line, any measure of ROSC success or challenge must be reported within the context of a measure of community involvement and a description and understanding of the strength, nature, and impact of the workforce involved.

Research also plays a critical role now that ROSC has developed in Hancock County. Research within Hancock County's ROSC was a sign of a flourishing, externally respected system bringing national attention and independent evaluation of its services. Research builds science. Research changes foundations. Within a ROSC, research takes on a whole new dimension. Behavioral health becomes more than addressing pathology. ROSC based research wants to know how recovery was locally attained and sustained – and build on that. ROSC based research studies what is successful, how and why. It wants to know why less than a third of those needing help ever seek help. Can medication be used to achieve, more than compliance, but recovery? ROSC research starts with the person, family, community, and studies how they benefit – or not – from locally applied science and practice. Each person, each family and the community's health are the measure of success to be measured and understood by research.

Beyond broad system studies that ROSC research might build a science or improved practice, many other forms of recovery research emerge. What are the effectiveness and costs of ROSC compared to treatment as usual? What are the savings or cost off-sets to the community? How is recovery from mental illness or substance use similar or different to recovery from other chronic illnesses? Are there unique pathways (8) to recovery in distinct populations, (e.g., teens, racial minorities, pregnant and addicted women, and their newborns, LGTBQA+, veterans, men, women, elderly). Does involvement

in a Fellowship help? Does ROSC effect overdose trends? Can we intervene earlier in inter-generational consequences of addiction or mental illness (7,8)?

As Hancock's ROSC advances, it finds that the scientific study of their ROSC is more than a measure of outcomes or even population health. As it studies itself, through the eyes of objective science, it must hold true to its being an example beyond treatment as usual. It is a study of complete system transformation within a recovery-based focus, principles and objectives that enhances treatment as usual. ROSC research is a study of a community driven effort to heal itself. It's not research as usual.

The final factor needing to be mentioned in measuring Hancock County's ROSC establishment, development, and continuance is perhaps the most important yet overlooked – **leadership**. To its credit, Hancock County's ADAMHS Board has a most exceptional leader who from day one pioneered and believed in a vision of enhanced service and recovery for Hancock County. While surrounded by an equally dedicated team of professionals and with the undaunting support of her Board and many ROSC committees and citizens, Mrs. Precia Stuby believed in this effort, while initiating and facing each challenge and obstacle found to transform the entire behavioral health system of Hancock County into becoming a ROSC. For her distinctive leadership she was justifiably recognized both nationally and locally. Mrs. Stuby typifies the essential role and need for a dedicated, courageous leader, the kind needed for such meaningful system change and improved community health. Visionary leadership, more than anything else, was and is the key for a Hancock's successful ROSC. It will be so anywhere for such transformation to be successful.

Population Health

Health care in this 21st century is focusing on measuring and improving the population health of each community. Population health is increasingly important for leaders and managers of health systems (8). Typically, when spoken of, population health goes beyond behavioral or even medical concerns to matters that assure general health and welfare (i.e., water and sewage systems, public sanitation quality, pollution guidelines, vaccinations, air quality, employment, transportation, etc.). Population health incorporates local analysis and research into the widest possible number of determinants that influence the health of the local population and its citizens. The ultimate purpose of population health is to improve the health of individuals and the community while advising the community and its leaders where it to invest its resources to improve the determinants of local health.

ROSC provides a natural formula and entry for Hancock County into population health for behavioral health. In this, as in many other ways, Hancock County remains ahead of its time. By having its ROSC focus on the health, wellness, and recovery of its citizens, Hancock County is transcending measures of service and agency performance by linking that performance to the values of the community and its best outcomes for each person, family, and the community. This is a 21st century model of care.

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Michael Flaherty, Ph.D.
12/30/21

Supporting Documents

Scan the QR code on this page to access all the documents referenced below. If viewing digitally, simply click on each title.

A Preamble for Building Recovery in Hancock County: Core Definitions
ADAMHS Board Approved August 27, 2013

An Approach to Further Improve and Integrate Community Health in Hancock County: A Shared Prevention and Treatment Philosophy for Recovery
Ratified November 2014. Updated August 26, 2020.

A Community Position on the Value of Life in Hancock County
Adopted February 21, 2017

Cultural Awareness Guiding Document
Drafted December 2017

A Community Position on the Value of Life in Hancock County: Supporting Document
Revised September 15, 2020

Becoming a Community of Belonging: Milestones
June 2020

ROSC Score Card
SFY21, Q4

Hancock County Opioid & Addictions Task Force Composite Database Report
December 15, 2021

ROSC Selected Outcomes Trends
December 2021

Community Leaders

Hancock County Community Members Engaged in the Development and Implementation of ROSC:

Clara Ames
Elaine Ashley
Patricia Bakies
Dennis Bash
Susan Berry
John Bindas
Sharona Bishop
Thom Bissell
Michael Brand
KevinBreen
Jonnna Brendle
Gary Bright
Julie Brown
Maggie Brown
Thomas Buis
Susan Bunn
Kimberly Butler
Carla Etta Capes
Brian Clark
Michelle Clinger
Todd Coffman
Nichole Coleman
Carolyn Copus
Lisa Cross
Brandon Daniels
Jill Darnell
Jim Darrach
Sunny Davis-McNeil
Angela DeBoskey
Mary Beth Dillon
Steve Dillon
John Drymon
Matt Dysinger
Rick Eakin
Joshua Eberle
Steve Edmiston
Karen Eubanks
Jodie Firsdon
Wayne Ford
Cayla Fortman
Gregg Fox
Brian Guerriero
Pat Hardy
Heather Heilman
Rachael Helms
Jane Hemminger
Mike Hiller
Mark Hollinger
Diana Hoover
Jeff Howell
Michelle Huff
Nancy Hutchinson
Julie Kato
Kathryn Kelly

Bailey Kerr
Ryan Kidwell
Rosalie King
John Kissh
Jodi Knoff
Andrea Koepke
William Kose
Mark Kowalski
Gene Lauck
Cheryl Lentz
Scott Lewis
Rick Lofgren
Jim Martin
Meagan McBride-Klein
Robert McEvoy
Michelle McGraw
Eric McKee
Greg Meyers
Mark Miller
Susan Pancake
Ron Pfeiffer
Tina Pine
Cheryl Preston
Beth Richards
Mark Rimelspach
Matt Rizzo
Ellyn Schmiesing
Jim Schultz
David Scruggs
Angy Shaferly
Stacy Shaw
Sarah Sisser
James Stahl
Richard States
Jenny Sterling
Precia Stuby
Jennifer Swartzlander
Kim Switzer
Shanna Taylor
Zach Thomas
Deb Twining
John Urbanski
Tricia Valasek
Rob Verhoff
Tina Verhoff
Sara Wagner
Rachel Walter
Dale Warnecke
Karyn Westrick
Steve Wiechart
Ginny Williams
Amber Wolfrom
Ann Woolum

The Board's efforts to inform the community regarding mental health and substance use areon-going. I am proud to state that the citizens of Findlay and Hancock County showed theirsupport in 2018 when they approved the last Operating Levy by the largest margin of any in our history. Community financial support is essential to the continuation of these recovery services.

– John Kissh, ADAMHS Board Chair, FY17-18

Hancock County ADAMHS Board
438 Carnahan Ave.
Findlay, OH 45840
419-424-1985
www.yourpathtohealth.org
@hancockadamhs

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Family involvement in treatment and recovery for substance use disorders among transition-age youth: Research bedrocks and opportunities

Aaron Hogue [a,*,1], Sara J. Becker [b], Kevin Wenzel [c], Craig E. Henderson [d], Molly Bobek [a], Sharon Levy [e], Marc Fishman [c]

[a] Partnership to End Addiction, United States of America
[b] Center for Alcohol and Addictions Studies, Brown University School of Public Health, United States of America
[c] Maryland Treatment Centers, United States of America
[d] Sam Houston State University, United States of America
[e] Boston Children's Hospital, Harvard Medical School, United States of America

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ABSTRACT

This article presents a narrative review and conceptual framework for research on family involvement across the continuum of substance use disorder (SUD) services for transition-age youth (ages 15–26). Though families are powerful resources for enhancing treatment and recovery success among youth with SUDs, they are not routinely included in clinical practice. This article summarizes youth SUD prevalence and service utilization rates and presents developmental and empirical rationale for increasing family involvement in services. It then describes key research issues on family involvement across the SUD services continuum: Problem Identification, Treatment Engagement, Active Treatment, Recovery Support. Within each phase, it highlights bedrock research findings and suggests promising opportunities for advancing the scientific knowledge base on family involvement. The main goals are to endorse family-oriented practices for immediate adoption in routine care and identify areas of research innovation that could significantly enhance the quality of youth SUD services.

Improving the quality of treatment and recovery support services for transition-age youth (ages 15–26) with substance use disorder (SUD) remains an urgent national health priority. Both empirical and developmental research indicate that families are powerful resources for enhancing treatment and recovery success among youth with SUD. Yet, families are not routinely targeted or systematically included in common clinical practice. To address this critical shortcoming, we present a narrative review and conceptual framework for research on family involvement across the continuum of SUD services for transition-age youth. We first summarize youth SUD prevalence and service utilization rates and describe developmental and empirical rationale for increasing family involvement in services. We then discuss key research issues on family involvement within four phases of the SUD services continuum: Problem Identification, Treatment Engagement, Active Treatment, and Recovery Support. Within each phase we highlight bedrock research findings and suggest promising opportunities for advancing the scientific knowledge base on family involvement. We contend that such advances across the full continuum of services can help upgrade the quality of youth SUD care.

1. Substance use prevalence and service utilization among transition-age youth

In recent years, transition-age youth have experienced unprecedented levels of substance-related consequences in general and opioid-related consequences in particular. According to the latest national data (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020a), about 6.4 million youth under the age of 26 meet diagnostic criteria for a SUD and over 300,000 youth meet criteria specifically for an opioid use disorder. Nearly 1800 youth initiate heroin or pain reliever misuse each day (SAMHSA, 2020a), and 8–12% of those who engage in opioid misuse develop opioid use disorder (Vowles et al., 2015). Most alarmingly, the rate of lethal overdoses attributable to opioids has increased markedly in this age cohort, from 3.4 deaths to 5.3 deaths per 100,000 between 2006 and 2015 (Ali et al., 2019).

When left untreated or ineffectively treated, risky substance use in

* Corresponding author at: Partnership to End Addiction, 485 Lexington Avenue, 3rd floor, NY, NY 10017, United States of America.
E-mail address: ahogue@toendaddiction.org (A. Hogue).
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youth often persists and contributes to an array of lifetime sequalae, including mental health disorders, sexually transmitted infections, unwanted pregnancy, accidents, and violent crime (National Center on Addiction and Substance Abuse, 2011). This developmental vulnerability highlights the critical importance of effective intervention for this age group. Unfortunately, rates of service utilization among this age group remain poor. In 2019, less than 9% of transition-age youth who met full diagnostic criteria for a SUD received any substance use treatment, and even fewer (7.2%) received treatment at a specialty SU treatment facility (SAMHSA, 2020a). Reasons reported for not receiving SU treatment despite perceived need included: not ready to stop using (39.9%), not knowing where to go for treatment (23.8%), and lacking healthcare coverage or other means to afford treatment (20.9%) (SAMHSA, 2020a). Utilization rates are even more alarming among those youth with an opioid use disorder, for whom early intervention with medication for opioid use disorder (MOUD), consisting of opioid agonist or antagonist medication (buprenorphine, naltrexone, or methadone) is the only evidence-based treatment to reduce risk of lethal overdose (Volkow, Jones, Einstein, & Wargo, 2019). A retrospective cohort analysis of 9.7 million transition-age youth found that fewer than 1 in 4 insured clients with an opioid use disorder received front-line MOUD services (Hadland et al., 2017). Of even greater concern, there were marked disparities: Youth who were younger, female, Black, and/or Hispanic had lower odds of receiving MOUD. Thus, in addition to a need for evidence-based intervention services, there is vital need for effective, equitable treatment identification and engagement strategies.

2. Rationale for increasing family involvement in youth SUD services

2.1. Healthy youth outcomes are grounded in supportive family relations

Developmental science indisputably asserts that supportive family relationships are a vital predictor of healthy development for youth. Among the truisms of positive parenting is that caregivers cannot exhibit too much love or support for their adolescents, and that the royal road to psychological autonomy and well-being is caregiver involvement and responsiveness (L. Steinberg & Levine, 1997). A consistent and involved familial network is also a potent resource for countervailing individual-level developmental processes that predispose youth to SU and other risky behavior, including normative escalations in sensation seeking, reward sensitivity, and delay discounting, with overall difficulties in executive inhibitory control including postponement of gratification (Christakou et al., 2013; L. Steinberg et al., 2009). Developmental science also confirms that the maturational processes governing risky behavior—a neurodevelopmental balance between motivation/reward and cognitive control systems—continue to reconfigure and refine from early teenage years through the mid-20s (Casey, Jones, & Somerville, 2011; L. Steinberg, 2014). At the social level, barometers of youth independence signal a generational change in the functional period of youth reliance on families: Compared to just fifty years ago, among youth 25 years of age, twice as many are still students, half as many are married, 50% more are living with their parents, and nearly 50% total receive financial support from caregivers (L. Steinberg, 2014). This dynamic of extended family interdependence begets an emerging truism of contemporary parenting: Supportive family relations remain critical for healthy development throughout emerging adulthood as young adults finalize the developmental negotiation between autonomy and connectedness.

2.2. Empirical support for involving families in youth SUD treatment is extensive

In the past decade several literature reviews and meta-analytic studies have emphasized the top-shelf effectiveness of family-based treatment for SUD across the lifespan. Family-based treatment addresses family skills (e.g., communication, coping, problem-solving), family relationships and processes, and family member relations with key extrafamilial persons and systems (Hogue et al., in press). Tanner-Smith, Wilson, and Lipsey (2013) completed a meta-analysis that sampled 45 randomized and quasi-experimental adolescent studies reporting on 73 treatment-comparison group pairs to test the comparative effectiveness of treatment approaches; family-based models prevailed in almost every comparison, including tests against other empirically supported models. A. Hogue, Henderson, Becker, and Knight (2018) concluded in a systematic literature review that family therapy is a well-established outpatient approach for adolescent SU that has accumulated the largest evidence base compared to all other approaches. Ariss and Fairbairn (2020) completed a meta-analysis of family-involved treatments that condensed data from 2115 adolescents and adults across 16 independent trials. They calculated a small effect size that endured up to 12–18 months post-treatment and translated to a 5.7% reduction in SU frequency—the equivalent of approximately three fewer weeks per year of SU. They also found that family-involved treatment showed consistent impacts across client age, other characteristics, and treatment models. Moreover, both family and couple therapy produce benefits for SUD whether they are delivered as the exclusive treatment or as part of a multicomponent SUD treatment program (Hogue et al., in press).

2.3. Family involvement can be calibrated to meet the unique developmental needs of transition-age youth

To involve families effectively in SUD services, it is essential to account for the unique developmental challenges of transition-age youth. The prevailing framework is elaborated by Arnett and colleagues, whose work synthesizes developmental science for this age group (aka emerging adults) to delineate the normative psychosocial challenges pervading their beliefs and behaviors (see J.J. Arnett, 2000; J.J. Arnett, 2015) as well as how these challenges intersect with SU and SUD service delivery (e.g., Bergman, Kelly, Nargiso, & McKowen, 2016; D.C. Smith, Bahar, Cleeland, & Davis, 2014; Sussman & Arnett, 2014). This framework casts the overarching developmental theme for transition-age youth as *independence seeking*, a meta-label for the five psychosocial challenges: personal identity exploration, familial and societal role instability, self-focus, feeling in-between childhood and adulthood, and future possibilities (J.J. Arnett, 2000). Independence factors that impact SU risk across the youth developmental span include those associated with individual characteristics (e.g., severity and peer norms of SU habits, problem-solving and self-regulation capacity, extrinsic versus intrinsic motivation, treatment stigma) and those associated with social capital (e.g., family and social network relations, educational and work achievement, housing and financial stability, general self-sufficiency) (Bergman et al., 2016; Stone, Becker, Huber, & Catalano, 2012; Sussman & Arnett, 2014).

Youth independence factors must play a large role in efforts to design strategies for involving family members in all aspects of youth SUD care. To be sure, even within the 15–26 age range, such strategies must account for developmental variation in the interaction between youth independence and expression of SUD risk and protective factors. For example, as youth age from middle adolescence to the cusp of adulthood, autonomy in decision-making and self-definition of values increase as well; accordingly, family involvement that is viewed by youth as supportive is much more influential on youth motivation for SU treatment than involvement viewed as coercive (Goodman, Peterson-Badali, & Henderson, 2011).

3. Articulating family involvement across the youth SUD services continuum

Behavioral health services for youth with SUD can be conceptualized as a continuum (sometimes called a “services cascade”; see Belenko

et al., 2017) consisting of the routine sequence of SUD-focused activities experienced by any given youth as they progress through the care system. For heuristic purposes we have previously described this continuum as a client flow chart anchored by four overlapping phases (A. Hogue, Becker, Fishman, Henderson, & Levy, 2021). In the *Problem Identification* phase, youth are identified as having serious SU and/or SU-related problems that warrant consideration for treatment. Identification can be triggered via SUD screening by youth-involved professionals (e.g., physicians, school counselors, justice system personnel) or via voluntary referral by the client. In the *Treatment Engagement* phase, SUD treatment providers endeavor to contact identified clients and enroll them in services. In the *Active Treatment* phase, providers complete clinical needs assessments with enrolled clients and proceed as indicated with treatment planning and intervention delivery. In the *Recovery Support* phase, clients participate in post-treatment activities intended to support sobriety and/or SUD improvement and relapse prevention goals, strengthen personal and social supports, and enable progression toward a rewarding and civically productive lifestyle.

Fig. 1 depicts an articulated version of the youth SUD services continuum. In each of the four phases, the figure differentiates activities that are primarily youth-focused from those that are family-focused; the latter, being the subject matter of current interest, are highlighted. In the remainder of this article we present bedrock empirical knowledge and promising opportunities for research on family involvement in each phase: family-focused problem identification, family engagement strategies, family assessment methods, family-based behavioral treatments and medication services, and family-focused recovery planning. Our intent is not to drill deeply into each area, which is well beyond the scope of this review. Instead, we endorse research-based family-oriented practices that can be immediately prioritized for adoption in routine care and identify areas primed for research innovation that we believe could significantly enhance the quality of youth SUD services moving forward.

Two related points bear mention. First, the basic structure of the services continuum is conceptualized as similar at all levels of SUD care: outpatient, residential, inpatient. Second, as with adults, youth who enter the SUD treatment system typically experience episodic increases and decreases in use—that is, a chronic "course of disorder" marked by regular use, remission, and recurrence—over a given time span (Buckheit, Moskal, Spinola, & Maisto, 2018; McLellan, Lewis, O'brien, & Kleber, 2000). For this reason movement along the continuum is not expected to be linear, in that many youth transition both forward and backward (i.e., re-entering earlier in the continuum following a recurrence of problems) across stages.

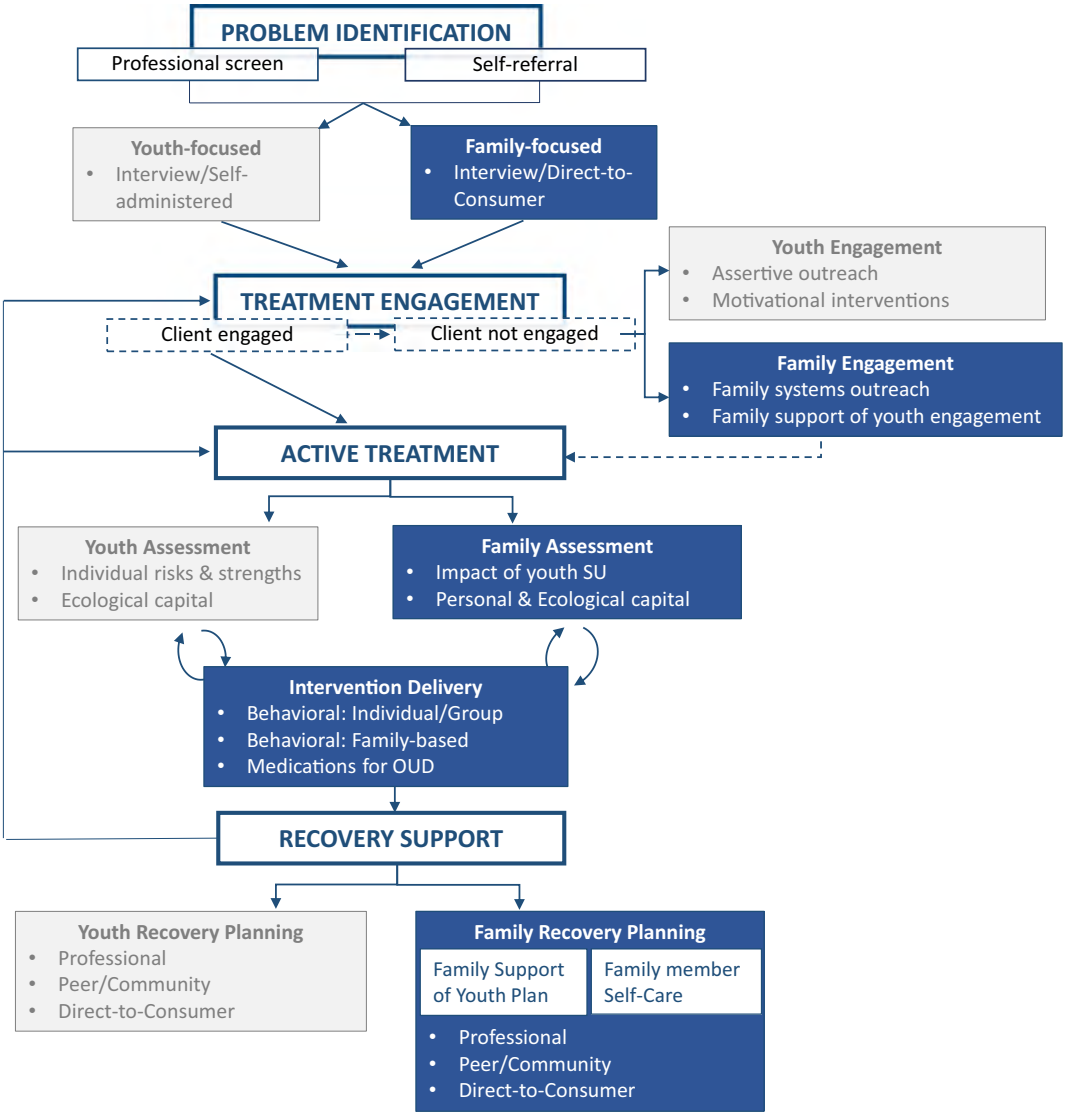

Fig. 1. Family involvement across youth SUD services continuum: articulated client flow.

4. Problem identification

Routine SU screening is recommended as a part of routine healthcare for all youth (S. Levy & Williams, 2016), and evidence suggests that youth-facing healthcare providers are increasingly adopting this practice (S. Levy et al., 2017). However, many providers forgo validated screening tools that facilitate SUD identification and rely instead on clinical instincts, which are notably poor for detecting SU problems (Harris et al., 2012). Even when validated tools are used, rates of SU disclosure by youth in primary care remain low, in part due to ineffective implementation practices and concerns about confidentiality (Brener, Billy, & Grady, 2003). Though self-administration of screening tools via electronic tablets has been advocated as a strategy to avert need for direct disclosure and potentially improve case finding (S. Levy et al., 2014), some youth choose not to disclose use even when use is suspected or has been identified by others. It is well-established that utilizing multiple sources of information to detect youth SU is more accurate than relying on any single source (K.C. Winters, 1999). Recommendations for youth screening also encourage practitioners to ask youth about family substance use, as this is a significant risk factor for youth (K.C. Winters & Kaminer, 2008).

4.1. Professional family screening

4.1.1. Bedrock

To our knowledge there are no evidence-based screening approaches in which family members are systematically recruited to serve as sources of information on youth SU problems.

4.1.2. Opportunity

Providing an opportunity for family members and other knowledgeable adults to report their observations or concerns regarding SU and related problems could enhance screening and also set the stage for a facilitated conversation that engages the family unit. Ozechowski, Becker, and Hogue (2016) advocate for the *no missed opportunities* paradigm, in which practitioners aim to have family members complete a brief screening instrument during every youth clinical encounter. Ideally, such screening instruments are administered in parallel to youth screening tools. The goal of this conjoint approach to screening is to increase the likelihood of case detection and set the stage for family involvement in subsequent stages of the continuum. Evidence suggests that parental reports are fair-to-good proxy measures of youth substance use behavior (McGillicuddy, Rychtarik, Morsheimer, & Bruke-Storer, 2012), though they typically underestimate to some degree (S.L. Fisher et al., 2006). Parental report may be particularly useful when youth have minimized self-report of use or impairment. Ideally, family screening tools could help to triage youth more accurately into risk categories and increase early identification of youth who have initiated SU. Given the paucity of well-validated family screening tools, identifying and validating such measures is a priority to promote family involvement in the screening stage of the continuum.

4.2. Family self-referral

4.2.1. Bedrock

To our knowledge there are no evidence-based strategies to guide family members toward referring their youth to SU screening and other treatment services.

4.2.2. Opportunity

A potential strategy for increasing identification of youth SU problems is applying direct-to-consumer (DTC) marketing strategies to encourage families to request SU screening and associated intervention services, akin to strategies used to market psychiatric medication (S.J. Becker, 2015; Santucci, McHugh, & Barlow, 2012). The most commonly reported barriers to seeking SU treatment include beliefs that treatment isn't needed and lack of knowledge about how to access care (SAMHSA, 2020a). Marketing that directly targets families (e.g., websites, TV commercials, brochures displayed in primary care offices and schools) can increase family awareness of substance-related problems and thereby potentially increase their willingness to seek screening and intervention. In the same manner that DTC marketing for pharmaceuticals encourage people to "ask their doctor about a specific medication," DTC marketing for SU interventions could specifically encourage families to ask their primary care doctor (or school counselor or other allied health professional) for a SU or general behavioral health screening. Recent research suggests that DTC marketing targeted toward parents is useful for promoting intentions to obtain SU treatment for their youth as long as the messaging is customized for the target population (S.J. Becker et al., 2020). National organizations such as the National Institute on Drug Abuse (https://teens.drugabuse.gov/parents) and Division of Child and Adolescent Psychology of the American Psychological Association (http://www.effective childtherapy.com) have employed DTC marketing to disseminate information about youth SU symptoms and treatment options to caregivers. Additional work is needed to improve the tailoring of these outreach efforts by soliciting feedback from families about their communication preferences (S.J. Becker, Spirito, & Vanmali, 2016).

5. Treatment engagement

As seen in Fig. 1, treatment engagement in youth behavioral services begins with first contact between client and provider, usually termed *outreach* (K.D. Becker et al., 2015). Successful outreach for youth clients requires provider commitment to promoting service accessibility and addressing potential barriers to treatment participation. Common barriers include both logistical (e.g., insufficient time, lack of resources, agency wait list) and attitudinal (e.g., perceived and actual costs versus benefits of treatment, prior unhelpful treatment experiences) obstacles experienced by both individual youth and their families (McKay & Bannon Jr, 2004). Broadly speaking, outreach concludes when a client completes enrollment procedures and attends a first treatment session. From there, engagement interventions are used to encourage attendance and enhance readiness and motivation to participate actively (K.D. Becker et al., 2015). Research-based family engagement interventions for an array of behavioral services, derived primarily from studies on childhood populations, include emphasizing the role of family involvement in services, anticipating how family resources and dynamics could impact participation, building therapeutic alliances with multiple family members, and adroitly managing family interactions during initial clinical encounters (K.D. Becker, Boustani, Gellatly, & Chorpita, 2018; Haine-Schlagel & Walsh, 2015; Lindsey et al., 2014). These factors appear to be similar in the limited research on transition-age youth (Kim, Munson, & McKay, 2012).

5.1. Bedrock

In some cases, youth with SUD exhibit minimal or no readiness to enter treatment, whereas family members are motivated to assist them in doing so. A research-supported approach to boost engagement in this scenario is Community Reinforcement and Family Training (CRAFT; J.E. Smith & Meyers, 2007). A main component of CRAFT for transition-age youth is treatment entry training, which focuses on training caregivers to recognize appropriate times for them to suggest treatment, employ effective motivational strategies to endorse entry, and have treatment options available at the time a decision is made to enter (K.C. Kirby et al., 2015). CRAFT has proven superior to usual care in promoting enrollment in SUD services among both youth (K.C. Kirby et al., 2017; Waldron, Kern-Jones, Turner, Peterson, & Ozechowski, 2007) and adults (see Archer, Harwood, Stevelink, Rafferty, & Greenberg, 2020), with more intensive family training producing better engagement rates (Archer et al., 2020).

In other cases, neither youth nor caregivers successfully engage with a provider during routine outreach procedures for SUD services. One evidence-based model for enhancing engagement in this scenario is Strategic Structural Systems Engagement (Szapocznik et al., 1988), which was developed on samples of high-risk youth. It teaches clinicians to recognize incompatible agendas of family members, and how this reduces the likelihood of the family attending conjointly; identify who can act as a reliable family messenger, and who has power to influence other members to attend; and provide rationale for treatment that accounts for the specific concerns of key members (Coatsworth, Santisteban, McBride, & Szapocznik, 2001; Santisteban et al., 1996).

5.2. Opportunity

In the mental health field, family peer advocates (aka family navigators), a non-professional workforce of caregivers who connect with treatment-seeking families to provide education and help navigate enrollment barriers, have proven effective at boosting the health service literacy and self-efficacy of caregivers (see Hoagwood et al., 2018). This engagement approach has not yet been formally tested for youth with SUD (Gagne, Finch, Myrick, & Davis, 2018).

Another promising opportunity for advancing family-oriented engagement in youth SUD services is tele-intervention (A. Hogue, Becker, et al., 2021). Given the near-ubiquity of smartphones (A. Smith & Page, 2015) and widespread use of the internet among youth and adults (Pew Research Center, 2020) in the US, providers can employ a comprehensive range of tele-engagement strategies. Tele-intervention's low-cost remote delivery allows increased reach to groups with traditionally limited access to SUD services, which can reduce troubling disparities for underserved areas and populations (Gros et al., 2013). Tele-engagement also creates opportunities to counter traditional barriers to family involvement in care (see Baker-Ericzén, Jenkins, & Haine-Schlagel, 2013) that can be protocolized and tested. For example, it offers features that protect family confidentiality, which could soften stigma-related barriers that dampen trust in providers (Livingston & Boyd, 2010). It permits family members to join "on the spot" for parts of tele-sessions, alleviating time and commuting burdens. Other engagement benefits include allowing coordinated participation of family members who live apart (Wrape & McGinn, 2019), creating direct access to home environments (Burgoyne & Cohn, 2020), and facilitating conjoint sessions with other practitioners involved in a youth's treatment (e.g., physicians, case managers, peer counselors), which could further promote comprehensive and integrated care. As a caution, providers should take stock of functional limitations in telehealth options for those families with unreliable access to required technology platforms.

6. Active treatment

Active treatment for youth SUD (see Fig. 1) routinely begins with clinical assessment activities that take stock of treatment-salient youth characteristics (e.g., individual risk and strengths; ecological capital) and also family characteristics (e.g., impact of youth SUD on family members; members' personal and ecological capital). Clinical assessment is meant to inform treatment planning and intervention delivery for each client. Intervention delivery for youth SUD typically involves individual/group behavioral services aimed at youth, family-based behavioral services, and/or OUD medication services; these types of interventions are delivered either standalone or in combination.

6.1. Clinical family assessment

6.1.1. Bedrock

Despite longstanding evidence of the negative consequences of youth SUD on family member wellness (Schneider Institute for Health Policy, 2001), and the establishment of families as a critical resource for sustaining youth recovery (i.e., "recovery capital"; E.A. Hennessy, Cristello, & Kelly, 2019), there are few validated, comprehensive tools for assessing family functioning and relations with targeted youth as a routine function of SUD treatment planning. One option is the Significant Other Survey (Benishek et al., 2012), which assesses problems experienced by family members in seven domains: emotional, relationship, family, financial, physical violence, legal, and health. More generally, several instruments are available to assess family stress and coping (e.g., Orford, Templeton, Velleman, & Copello, 2005), caregiver strain and well-being (e.g., O'Malley & Qualls, 2017), and family climate (e.g., Moos & Moos, 1986), though little has been applied specifically to youth SUD treatment.

6.1.2. Opportunity

As discussed above, families are lodestone sources of instrumental support and other kinds of recovery capital for transition-age youth in SUD treatment. As a starting point, clinical assessments should aim to capture the independence status (discussed above) of individual youth, focusing on factors such as education and work aspirations, financial and insurance support, family involvement and other social capital, and plans for independent living (Bergman et al., 2016; Schwartz et al., 2011; D.C. Smith et al., 2014; Stone et al., 2012; Sussman & Arnett, 2014). In addition, following E.A. Hennessy et al.' (2019) model, a comprehensive measure of youth social capital would focus on four domains, each involving some aspect of family support: *financial* resources that enable access to recovery support and buffer youth from life stressors (e.g., stable living situation, health insurance, reliable transportation); *human recovery* resources used to achieve individual goals (e.g., self-efficacy and motivation, mental and physical health, religious/spiritual resources); *social* resources generated through an individuals' relationship with others, especially family involvement and awareness of youths' online connections (Anderson, Jiang, & Center, 2018); and *community* resources that includes formal and informal treatment and recovery supports as well as community attitudes such as addiction-related stigma and injunctive social norms. Holistic measures would also assess how youth recovery impacts the family as a system (e.g., Edwards, Best, Irving, & Andersson, 2018).

Another opportunity to upgrade clinical family assessment can be found in adapting existing models for assessing family involvement in child behavioral health services. A prime example is the REACH model (K.D. Becker et al., 2015; K.D. Becker et al., 2018; Lindsey et al., 2014), which provides a framework for conceptualizing and measuring use of evidence-based strategies to promote family involvement in five domains: Relationship, Expectancy, Attendance, Clarity, Homework. REACH could be leveraged to operationalize assessment of family involvement in youth SUD services, with scales and items adapted as needed for transition-age youth. Further, the model could be expanded to assess family involvement as it relates to youth recovery capital.

6.2. Intervention delivery

6.2.1. Bedrock

The extensive dossier of empirical support for involving family members in active treatment for youth SUD is summarized in the Introduction as well as in a plethora of systematic reviews and meta-analyses (e.g., A. Hogue et al., 2018; Hogue et al., in press; Tanner-Smith et al., 2013).

6.2.2. Opportunity

SUD providers currently use various technology platforms to deliver behavioral interventions, particularly phone and video conferencing (Lin et al., 2019), and reliance on tele-intervention has skyrocketed since the outbreak of COVID-19 (US Dept Health and Human Services, 2020). Because addiction is a chronic and relapsing disorder (McLellan et al., 2000), self-management during daily routines is critical for treatment success. Yet, in conventional practice little support outside of formal

treatment settings is provided to families affected by SUD, which contributes to high rates of treatment failure and relapse (Quanbeck, Chih, Isham, Johnson, & Gustafson, 2014). Tele-intervention's capacity for rapid or automated response to emergent family needs via adaptive intervention software could be transformative for the field of youth SUD services, given that tele-intervention can occur when families are situated in the immediate daily environments where clients' cravings and use most often occur (Campbell, Muench, & Nunes, 2015).

Efforts to revamp youth treatment services by increasing family involvement need to be informed by the developmental needs of transition-age youth. These include independence-related factors that are especially salient for effective SUD interventions with this age group: conceptualize SUD as a chronic medical illness with ongoing recovery, acknowledge the normalcy of autonomy-seeking and how this is a healthy developmental trope, emphasize treatment investment rather than rote compliance, support SU goals other than abstinence, address wide social network change, and employ youth-friendly communication methods (Bergman et al., 2016). The normative developmental challenge of "feeling in-between" (J.J. Arnett, 2000) corresponds to a regrettable fault line in the SUD research base, whereby transition-age youth fall between the cracks in research on family-involved treatment: They are underrepresented in samples of both family therapy studies with adolescents (A. Hogue et al., 2018) and couple therapy studies with adults (Hogue et al., in press). Growing a new generation of SUD treatment strategies designed to leverage the diverse family networks of transition-age youth—caregivers, extended family members, mentors, romantic partners, interdependent peers, other family-of-choice configurations—is a top clinical and research priority.

Because of the high risk of overdose among youth who misuse opioids, along with well-documented barriers to engaging youth in MOUD services (A. Hogue, Becker, et al., 2021), it is important to develop novel strategies for involving families in MOUD. One promising family-oriented innovation is the Youth Opioid Recovery Support (YORS) intervention (Fishman, Wenzel, Vo, Wildberger, & Burgower, 2020; Wenzel & Fishman, 2020). YORS is an assertive, multi-component behavioral intervention that aims to enhance MOUD adherence and decrease opioid relapse among youth. YORS mobilizes practical parenting strategies for guiding service utilization for a young person not yet fully capable of sustaining the effort alone, while promoting youth autonomy as it strengthens with gradual maturation and healing of illness. Family involvement strategies include family member role induction, MOUD education, and collaborative treatment planning that includes stipulating contingencies and back-up plans for various course-of-treatment scenarios. When youth drop out of MOUD services, YORS increases family involvement via phone calls, text messaging, linkage to peer support, and family-focused behavioral treatment sessions to support families in leveraging their relationships and resources to bolster treatment success. In a pilot trial YORS improved treatment and relapse outcomes compared to standard treatment (Fishman et al., 2020).

Two related behavioral interventions are primed to enhance youth MOUD services are family psychoeducation and shared decision-making. Family OUD education can provide structured information about OUD symptoms, disease course, impacts on multiple domains of functioning, individual differences, and MOUD practices. Family psychoeducation has been shown to increase medication and behavioral treatment adherence and outcomes (e.g., Cummings & Fristad, 2007; Lincoln, Wilhelm, & Nestoriuc, 2007) and improve prosocial functioning (e.g., Ferrin et al., 2014) for clients with a variety of disorders. Family psychoeducation can be paired with family-based decision-coaching (Langer & Jensen-Doss, 2018) to enhance MOUD enrollment, retention, and adherence by helping clients prioritize their healthcare values, collaboratively process youth and family attitudes about MOUD in the context of benefit-cost decisions about MOUD services, and formulate client-centered decisions about medication use (see Davis, Claudius, Palinkas, Wong, & Leslie, 2012; A. Hogue et al., 2020).

7. Recovery support

Recovery support services (RSS) for SUD comprise a range of services intended to promote sustained efforts to eschew or reduce SU and improve wellness (R.D. Ashford et al., 2019; Laudet & Humphreys, 2013). Over the last decade-plus, shifts in policy and insurance practices have vastly expanded the availability, accessibility, and diversity of RSS (Laudet & Humphreys, 2013), making such services a mainstay of the treatment continuum. For heuristic purposes we organize RSS into three broad categories: (1) *Professional*: services offered by licensed clinicians in the context of a provider-client relationship. Professional RSS are typically adjuncts to or extensions of active treatment, in line with continuing care models, in an ongoing monitoring and maintenance phase of treatment. (2) *Peer/Community*: support offered by persons who have similar lived experiences in the context of a peer-to-peer relationship. These include peer recovery coaching, sober educational settings, recovery community centers, and mutual help groups, which combine peer support via shared recovery experiences during group meetings and mentoring relationships with senior peers (aka sponsors) outside meetings. (3) *DTC*: supports offered by social media or other information brokers that are accessed directly by affected persons. These include standardized (e.g., self-help books, website bulletins) and tailored (e.g., phone or digital helplines) educational and motivational materials. When individuals use direct-to-consumer (DTC) supports without intercession from an external agent, this is considered an "unassisted" or "natural" pathway to recovery (J.F. Kelly, Bergman, Hoeppner, Vilsaint, & White, 2017). It bears emphasizing that the RSS marketplace is dominated by services aimed at individual youth rather than families (J.F. Kelly, Bergman, & Fallah-Sohy, 2018).

7.1. Family support of youth recovery

7.1.1. Bedrock

Evidence-based models of assertive continuing care (see S.H. Godley et al., 2010, 2014) stipulate that when youth transition from acute treatment to recovery maintenance, providers make strong efforts to include family members in recovery-oriented booster sessions and clinical management procedures, either intermittently or as-needed. Beyond family participation in booster sessions, there is optimism that family involvement in youth recovery management can be facilitated by digital communication with family members and technology-based family-focused recovery supports (e.g., Dennis, Scott, & Laudet, 2014). However, currently there are no empirically supported RSS approaches or programs in which families are systematically recruited to serve as instrumental supports for ongoing youth-focused recovery activities.

7.1.2. Opportunity

Professionals can avail several robust youth-focused recovery management strategies to monitor youth during aftercare, encourage linkage to peer/community RSS, and re-engage them in active treatment when warranted (E.A. Fisher, 2014). The effectiveness of these youth-focused strategies could be substantially enhanced by directly involving families. In accord with a family collaboration approach (Hornberger & Smith, 2011), providers can adapt family engagement interventions (described above) with the intent of cultivating RSS management partnerships with family members. This would facilitate providers and families sharing information about promoting youth recovery, as well as providers enlisting family members to become resource advocates who actively assist youth in linking to peer/community and DTC services, thereby reducing gaps in youth aftercare (Ventura & Bagley, 2017). As needed, providers can also select evidence-based family interventions (described above) as the focal approach or a featured component of booster treatment activities scheduled during recovery periods. A similar option, but with a thin evidence base, is family recovery programs that convene groups of affected family members to explore family change and wellness processes (Buckley-Walker, Crowe, & Caputi, 2017; Toumbourou &

Bamberg, 2008). Another professional RSS option, with mixed evidence, is working with a caregiver to design and administer home-based contingency management plans whereby youth adhere to a consensually determined reward system for progressing toward SU reduction goals or other recovery objectives (e.g., M.D. Godley et al., 2014; Letourneau, McCart, Sheidow, & Mauro, 2017). And there is clearly a market for, but scant research on, DTC resources designed to improve parenting habits as a facet of SUD recovery management (see S.J. Becker, Hernandez, Spirito, & Conrad, 2017). Recent surveys conducted in outpatient (Ryan-Pettes, Lange, & Magnuson, 2019) and justice settings (Folk, Harrison, Rodriguez, Wallace, & Tolou-Shams, 2020) found that most caregivers desired ongoing DTC support on parenting during aftercare.

The effectiveness of peer/community and DTC supports for youth could be bolstered if those approaches intensified their commitment to helping youth augment the strength of their familial networks. Supportive personal connections with family members are themselves a critical source of social recovery capital; moreover, positive relations with family members can open access to recovery capital of other kinds (e.g., financial, community), engendering a synergistic interaction among capital domains (E.A. Hennessy et al., 2019). This may be especially salient for young adults who are estranged from their families of origin but remain connected with other concerned adults in their family-of-choice circle. Research is needed to evaluate the potential benefits of infusing peer/community and DTC services with family-oriented programming that scaffolds youth to pursue healthy (re) connection with family and (re)investment in familial goals.

7.2. Family member self-care

7.2.1. Bedrock

To our knowledge there are no empirically supported RSS approaches or programs that reliably enhance self-care behaviors or well-being among family members for youth with SUD.

7.2.2. Opportunity

CRAFT (discussed above; J.E. Smith & Meyers, 2007) is a provider-delivered intervention sometimes advertised as effective for improving the personal well-being of parents of youth, or spouses of adults, with SUD. However, few studies have rigorously examined CRAFT impacts on the wellness of significant others (Archer et al., 2020), and findings to date are mixed (e.g., Bischof, Iwen, Freyer-Adam, & Rumpf, 2016; K.C. Kirby et al., 2017). The field would benefit from additional research on CRAFT and other professional approaches for addressing stress and coping mechanisms, behavioral health problems, and general wellness among family members affected by youth SUD.

Regarding peer/community RSS, there is solid evidence in the mental health field for family-to-family group psychoeducation (e.g., Dixon et al., 2011), and there is a growing workforce of credentialed family-to-family (aka family-peer) advocates, many with lived experience as SUD-affected caregivers, whose focus includes helping caregivers access self-care resources (Gagne et al., 2018). However, research on peer-based RSS for SUD is quite limited in both quantity and quality (Bassuk, Hanson, Greene, Richard, & Laudet, 2016; Eddie et al., 2019), with virtually no studies testing impacts on CSO wellness specifically (but see Carpenter, Foote, Hedrick, Collins, & Clarkin, 2020). Controlled research on family-to-family parent coaching models and mutual aid groups for youth SUD would contribute enormously to understanding whether and how such services work.

For persons with SUD, mutual help groups are the most utilized peer/community RSS in the United States (Bekkering, Mariën, Parylo, & Hannes, 2016; J.F. Kelly et al., 2018), and comprehensive reviews have found that group attendance has positive effects on recovery among both adults (Bassuk et al., 2016; J.F. Kelly, Abry, Ferri, & Humphreys, 2020) and, based on a handful of studies with limited rigor, adolescents (Bekkering et al., 2016; E.A. Hennessy & Fisher, 2015). Mutual help groups are also widely available to aid family members of persons with SUD (e.g., Al-Anon), and a few studies based on member surveys have reported gains in member self-care (e.g., Timko, Laudet, & Moos, 2016). This area of recovery practice appears poised to host rigorous studies of family member service access and outcomes among families of youth with SUD.

Arguably, DTC telehealth represents the great frontier for research on supporting family member self-care. Examples of widely available DTC tele-resources that target family members include *synchronous* supports (i.e., real-time communication with support persons) such as helplines, peer-to-peer coaching, networking forums, and online professional- and peer-led education and mutual aid groups; and *asynchronous* supports (i.e., archived or posted communication) such as automated text messaging, self-directed web-based programs, and digital web support (including social media platforms) (see Molfenter, Brown, O'Neill, Kopetsky, & Toy, 2018; Muench, Vitale, & Potenza, 2020). Despite this abundance, little is known about which DTC RSS tele-resources produce measurable recovery benefits among persons with SUD (R.D. Ashford, Bergman, Kelly, & Curtis, 2020; Nesvåg & McKay, 2018), and still less about possible benefits to family member well-being. Whereas proliferation of such resources (e.g., drugfree.org) can be deemed a benefit in itself, their value would multiply to the degree they are proven effective.

8. Conclusions

Advancing research, practice, and policy agendae to increase family involvement in treatment and recovery for SUD among transition-age youth remains an arduous path. Prominent gaps and barriers to involving families in youth SUD services exist at multiple levels. Practitioners often harbor biases against families as having a role in causing or sustaining ("enabling") SU, lack skills or motivation to pursue family involvement, believe that most or all youth with SUD need unilateral individuation from their families (Hornberger & Smith, 2011), and may rigidly apply concerns about confidentiality at the expense of consensual collaboration. Agencies frequently do not prioritize family-centered outreach or treatment planning (SAMHSA, 2020b). And families themselves experience lack of resources, low confidence, and stigma-related reticence to engage with SUD systems of care (England-Kennedy & Horton, 2011).

These and other barriers have made family involvement in SUD services the exception rather than the rule. Yet, active family involvement is developmentally crucial for effecting positive outcomes and sustaining long-term recovery among youth. If properly recruited and integrated into the SUD service continuum, families could shift the balance toward efficient problem identification and treatment engagement, help consolidate active treatment gains, and facilitate routine access to youth- and family-oriented RSS. As described above, three areas of the service continuum contain little or no evidence base on involving families in SUD care: Professional Family Screening (Problem Identification), Family Self-referral (Problem Identification), and Family Member Self-Care (Recovery Support). For these areas it is all the more important to advance promising opportunities for generating an evidence base that can subsequently function as bedrock for both researchers and practitioners.

Comprehensive roadmaps of evidence-based practice for involving families in SUD treatment and recovery exist (e.g., SAMHSA, 2020b). Discovering how to put those practices to work—achieving adoption and implementation success with counselors, provider organizations, regulatory agencies, and families—is the challenge before us. We contend that to address this challenge successfully, three foundational shifts in business-as-usual SUD services must occur. First, there needs to be dynamic reconciliation of false or misleading distinctions that pervade SUD treatment and recovery practice and research: professional versus non-professional versus DTC service options; families as impediments versus allies versus affected persons needing self-care support; and youth- versus family-focused recovery planning, to name a few. The

research bedrocks and opportunities described above are offered as one means to speed this process.

Second, the national SUD treatment system needs to take sober account of the myriad mechanisms by which it may inflict negative impacts on youth and families in service contexts predicated on social control, including mandated treatment that can be overly punitive, and carceral consequences for disapproved SU behaviors (e.g., Wild, 2006). Without such accounting, initiatives to increase family involvement in those contexts are as likely to pile-up harms as to promote recovery. Congruent with system changes, individual providers can take measures to counter potentially iatrogenic treatment effects by helping youth and families recognize societal constraints on personal agency, identify strengths and resiliencies, and especially for families in oppressive contexts, acts as allies for clients aiming to resist internalized oppression and navigate systems constraints (McDowell, Knudson-Martin, & Bermudez, 2017). Providers should also be attuned to potential harms, but also conditional benefits, of involving family members in contexts of child abuse/neglect, family violence, and other family-related trauma.

Third, the youth SUD service system needs to become rigorously relationship-oriented. The most recent annual survey of SUD provider practices (SAMHSA, 2019) does not list any clinical or therapeutic approach that is fundamentally family-based. This omission acknowledges that although most providers purport to involve families in routine programming, evidence-based family approaches are not widely practiced. Moreover, whereas a primary goal of youth recovery support is to enhance the quality of personal and family/social life, the current landscape of behavioral services offers little in terms of a framework for what optimal family relationships can or should look like during recovery (R.D. Ashford et al., 2019). To be fair, SAMHSA 's (2020b) comprehensive roadmap makes extensive recommendations for involving families in SUD treatment. Beyond aspiration, actually transforming SUD systems of care to become relationship-oriented will require greater system-wide attunement to familial relationships and to cultural context characteristics that shape user experiences of SUD services (Kirmayer, Bennegadi, & Kastrup, 2016). It will also require a shift toward relational conceptualizations of problems and solutions, more fluid and flexible roles for youth and CSO, thicker and more complex narratives of youth and family lives, and from "alone" to "together" in SUD treatment. This shift can be greatly facilitated by training providers to recognize and address stigma and unconscious biases about youth SU, and by fostering provider comfort in speaking with families openly about SU. In doing so, providers will inevitably come to understand family involvement as routinely beneficial rather than detrimental to recovery, a premise from which more effective interventions and supports are likely to emerge (Heru, 2015).

Declaration of competing interest

None.

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EVIDENCE-BASED RESOURCE GUIDE SERIES

Community Engagement: An Essential Component of an Effective and Equitable Substance Use Prevention System

SAMHSA
Substance Abuse and Mental Health Services Administration

Community Engagement: An Essential Component of an Effective and Equitable Substance Use Prevention System

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Abstract

By engaging community members, prevention systems learn firsthand from individuals and community systems about substance use problems and social determinants that influence behavioral health. Community engagement brings together the skills, knowledge, and experiences of diverse groups to create and/or implement solutions that work for all members of the community. This guide focuses on how community engagement can play a critical role in the equitable scale-up of evidence-based programs and policies within the substance use prevention system. The guide presents what we know about community engagement from research studies, reporting on common community engagement activities and outcomes. It also discusses practical considerations drawn from on-the-ground experience regarding how to participate effectively in community engagement.

MESSAGE FROM THE ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

As the Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the head of the Substance Abuse and Mental Health Services Administration (SAMHSA), I am pleased to present this new resource—*Community Engagement: An Essential Component of an Effective and Equitable Substance Use Prevention System.*

SAMHSA is committed to improving prevention, treatment, and recovery support services for individuals with mental illnesses and substance use disorders. SAMHSA's National Mental Health and Substance Use Policy Lab developed the Evidence-Based Resource Guide Series to provide communities, clinicians, policymakers, and others with the information and tools to incorporate evidence-based practices into their communities or clinical settings. As part of the series, this guide shares practical considerations for state, community, and tribal leadership in using community engagement to create and/or implement solutions that work for all members of the community.

This guide and others in the series address SAMHSA's commitment to behavioral health equity, including providing equal access for all people to evidence-based prevention, treatment, and recovery support services regardless of race, ethnicity, religion, income, geography, gender identity, sexual orientation, and disability. Each guide recognizes that substance use disorders and mental illnesses are often rooted in structural inequities and influenced by the social determinants of health. Behavioral health practitioners and community stakeholders must give attention to health equity to improve individual and population health.

Community engagement plays a pivotal role in the equitable scale-up of evidence-based practices, programs, and policies within the substance use prevention system. I encourage you to use this guide, as meaningful participation of community members ensures accountability to those most affected by problems related to substance use.

Miriam E. Delphin-Rittmon, PhD
Assistant Secretary for Mental Health and Substance Use
U.S. Department of Health and Human Services

FOREWORD

Evidence-Based Resource Guide Series Overview

The Substance Abuse and Mental Health Services Administration (SAMHSA), and specifically, its National Mental Health and Substance Use Policy Laboratory (Policy Lab), is pleased to fulfill the charge of the 21st Century Cures Act. This charge is to disseminate information on evidence-based practices and service delivery models.

The Evidence-Based Resource Guide Series is a comprehensive set of modules with resources to improve health outcomes for people at risk for, experiencing, or recovering from mental health and/or substance use disorders. It is designed for practitioners, administrators, community leaders, health professions educators, and others considering an intervention for their organization or community.

Expert panels of federal, state, and non-governmental participants provided input for each guide in this series. The panels include accomplished researchers, educators, service providers, community members with lived experience (including families), community administrators, and federal and state policymakers. Members provide input based on their lived expertise and knowledge of healthcare systems, implementation strategies, evidence-based practices (EBPs), provision of services, and policies that foster change.

A priority for SAMHSA is ensuring that behavioral health services reach under-resourced populations for prevention, treatment, and recovery supports. Implementation of evidence-based practices, policies, and programs can reduce mental health and substance use problems for individuals and communities. However, implementation and uptake of EBPs can be challenging, and only a small percentage of communities have implemented them. Even when communities implement EBPs, not all populations experience their benefits equally, including those in greatest need. Health disparities may worsen as a result, despite the goal of equity.

Prevention researchers have identified community engagement as a critical factor that influences the equitable scale-up of EBPs and subsequently contributes to improvements in population health.[1] This guide reviews research on community engagement in substance use prevention, outlining common community engagement activities and outcomes. It is one piece of an overall approach to implement and sustain change. Readers are encouraged to review the SAMHSA website for additional tools and technical assistance opportunities.

[1] Cooper, B., Hill, L., Parker, L., Jenkins, G., Taylor, G., & Graham, P. (2019). *Prevention works: A call to action for the behavioral health system.* Society for Prevention Research. https://www.preventionresearch.org/wp-content/uploads/2019/06/SPR-Behavioral-Health-Brief_FINAL.pdf

Behavioral health equity is the right to access high-quality and affordable healthcare services and supports for all populations, including Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders, and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, queer/questioning and intersex (LGBTQI+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. As population demographics continue to evolve, behavioral healthcare systems will need to expand their ability to fluidly meet the growing needs of a diverse population. By improving access to behavioral health care, promoting quality behavioral health programs and practice, and reducing persistent disparities in mental health and substance use services for under-resourced populations and communities, recipients can ensure that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with promoting access to high-quality services, behavioral health disparities can be further mitigated by addressing social determinants of health, such as social exclusion, unemployment, adverse childhood experiences, and food and housing insecurity. In all areas, including community engagement, SAMHSA is committed to behavioral health equity.

Content of the Guide

This guide contains a foreword (FW) and five chapters (1-5). Each chapter is designed to be brief and accessible to practitioners, administrators, community leaders, health professions educators, and others considering community engagement strategies and activities to support the equitable scale-up of evidence-based practices, programs, and policies.

FOCUS OF THE GUIDE

For years, practitioners and researchers in the prevention field have widely recognized community engagement as important and necessary. By engaging community members, prevention systems learn firsthand from individuals and community systems about substance use problems and social determinants that influence behavioral health.

This guide highlights research on community engagement in substance use prevention and provides practical guidance for implementing and evaluating community engagement strategies and activities.

The guide does not focus on specific evidence-based practices, programs, or policies, but instead provides an overview of how community engagement can play a pivotal role in the uptake of EBPs broadly across the substance use prevention system.

CHAPTER

1

Issue Brief

The World Health Organization (WHO) defines community engagement as "a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes."[1] Community engagement brings together the skills, knowledge, and experiences of diverse groups to create and/or implement solutions that work for all members of the community. Practitioners and researchers in the prevention field have recognized community engagement as important and necessary for years. However, researchers have not systematically studied community engagement in ways that have yielded the practical guidance necessary to promote more widespread use. This guide presents what we know about community engagement from research studies. It also discusses practical considerations drawn from on-the-ground experience regarding how to effectively participate in community engagement.

Preventing Substance Use Disorders Depends on Expansion of Evidence-Based Programs and Policies

Substance use disorders (SUDs) are among the most common disabling conditions in the United States.[2] They have the potential to impair a person's ability to work, engage in relationships, maintain mental health, connect with community, and carry out activities of daily life. Substance use affects all Americans and all communities—the young and old, all racial and ethnic groups, people of all abilities, and people of all sexual orientations, gender identities, or sex characteristics.[3-7] Substance use affects both under-resourced and affluent neighborhoods. It impacts all community sectors: business, education, health care, law enforcement, social services, and more.[8]

Prevention systems aim to:

- Protect community members across lifespans from substance use and SUDs
- Minimize the negative consequences of substance use on individuals and society
- Advance equity and population health

Achievement of these goals depends on scaling up evidence-based practices (EBPs). Dozens of prevention-focused EBPs have been developed for community settings with various populations and conditions.[9] The Substance Abuse and Mental Health Services Administration (SAMHSA) provides guidance in determining what EBPs could be applied or adapted to a community.[10] However, only a small percentage of communities have implemented EBPs.[9] Even when communities implement EBPs, the benefits are often not experienced by all populations equally, especially those in greatest need.[11] Health disparities may worsen as a result, despite the goal of equity.

Community engagement is a critical factor that influences the equitable scale-up of EBPs and contributes to improvements in population health.[12] As stated in the White House Office of National Drug Control Policy's (ONDCP's) 2022 National Drug Control Strategy, "implementing evidence-based policies, environmental strategies, and programs requires an understanding of a community's challenges and knowing which strategies will effectively address a community's specific challenge."[13] By engaging community members, prevention systems learn firsthand from affected individuals and community systems about substance use problems and the social determinants that affect behavioral health. Within prevention systems, community engagement often consists of:

- Engaging community members with needs assessments and prevention planning
- Building community capacity
- Selecting and implementing EBPs
- Evaluating EBPs' effectiveness over time

Community engagement within prevention systems integrates meaningful participation of community members who have diverse experiences, values, cultures, and perspectives. Community engagement also ensures accountability to those most affected by problems related to substance use.

Effective Scale-Up Efforts Are Informed and Executed at the Community Level

Developing an effective community-based prevention strategy to address substance use depends on assessment and engagement at the community level. It requires:

- Community voice concerning how substance use affects individuals, families, neighborhoods, and community sectors (e.g., child welfare, health care, law enforcement)
- Assessment of historical trauma and neighborhood-level risk and protective factors for substance use, as well as other social determinants of health
- Capacity building to enable SUD prevention systems, partner organizations, prevention professionals, and others to deliver EBPs successfully
- Collaboration among community partners to identify EBPs that can effectively address problems the community experiences
- Implementation and evaluation of EBPs to measure improvements in community conditions and behavioral health
- Assessment of the community engagement process to ensure it is equitable, meaningful, and continual
- Obtaining feedback from community members to ensure outcomes from EBPs are consistent with community priorities, expectations, and lived experiences

Community Engagement Requires Trust

Community engagement begins by "gathering the community," or assembling a group of community members. Relationships and the trust upon which they are built need to be in place. Authentic community engagement efforts recognize that there may be distrust in the community.

Structural racism is a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity.[14] It remains a root cause of persistent health disparities in the United States.

Historical trauma is collective, multigenerational trauma experienced over time by a group of people who share an identity, affiliation, or circumstance; it is frequently linked to health disparities.

The process of establishing trust starts with dispelling myths and honestly acknowledging community members' shared traumatic history, structural racism that perpetuates inequities, and other trauma experienced by communities, including the LGBTQI+ community. When distrust exists, communities need to promote healing and reconciliation, so that meaningful, trusting relationships can develop. This process involves actively seeking information, visualizing what needs to change, and engaging in shared learning.

Formally acknowledging a community's shared traumatic history is a fundamental step in preparing for and planning community engagement efforts that address health inequities.

Community Engagement Is Based on Core Principles but May Differ in Implementation

Community engagement can take many forms, and has several core principles.[15, 16]

Transparency and trust. Community engagement creates an environment in which all ideas are respected and considered; discussions and input of participants are documented and shared; and there is mutual understanding of stakeholders' and community members' needs, capacities, and goals.

Careful planning and preparation. Community engagement is a strategic process of planning around an issue of interest. Those involved continually reflect on the best ways to engage community members, stakeholders, and the needs of participants.

Inclusion and demographic diversity. Community engagement involves leaders from different sectors of the community, as well as community members at large. Individuals and sectors participating in community engagement represent the community's diversity and bring various perspectives and expertise.

Collaboration and shared purpose. Community engagement brings organizations and individuals together around a shared purpose, such as prevention of substance use. Community engagement involves shared decision-making and equity among participants.

Openness and learning. Participants in the community engagement process are open to data, information, and ideas from all relevant sources. They listen to others' views and experiences, to develop an informed, data-driven plan for addressing community issues.

Impact and action. Community engagement focuses on making a difference in the community and having an impact on the identified problem. Community engagement is intended to move communities toward desired outcomes.

Sustained engagement and participatory culture. Community engagement is ongoing. All participants are valued for their contributions. Information and resources are shared among community members and stakeholders to advance outcomes and build community capacity.

Community Stakeholder Examples

- Youth
- Parents and family members
- People in recovery
- Businesses (e.g., barbershops, salons, gyms)
- Media
- Schools and other educational institutions
- Youth-serving organizations
- Public safety and law enforcement
- Faith-based organizations
- Fraternal organizations
- Civic and volunteer organizations
- Health care (e.g., pharmacists, veterinarians, dentists, physicians, nurses, other prescribers)
- State, local, and tribal governments
- Other organizations involved in reducing substance use (e.g., philanthropic organizations, community gatekeepers or champions)

Multiple community engagement frameworks are available, using various terminologies and outlining areas of emphasis, such as level of engagement.

- The Active Community Engagement (ACE) Continuum[17] identifies three levels of engagement—consultative, cooperative, and collaborative—and five types of engagement: community involvement in assessment; access to information; inclusion in decision-making; local capacity to advocate to institutions and governing structures; and accountability of institutions to the public.
- The WHO proposes four engagement approaches: community-oriented, community-based, community-managed, and community-owned.[1]

- The Community Engagement Continuum identifies five levels of engagement: outreach, consultation, involvement, collaboration, and shared leadership. Each level represents an increasing degree of community involvement, trust, participation in decision-making, impact, and bi-directional communication flow.[18]

Community engagement efforts often evolve over time. For example, partnerships may change from having a single focus (e.g., opioid overdoses in a specific neighborhood) to addressing a range of social, economic, and environmental concerns affecting the community.[18, 19] Coalitions also may go through phases of development, confronting external factors within the community that affect coalition operation.[20]

Infrastructure to Support Community Engagement and Scale-Up of Evidence-Based Programs and Policies

State and community prevention systems often have an infrastructure to support community engagement, capacity building, and scale-up of EBPs. SAMHSA provides funding for prevention through the Substance Abuse Prevention and Treatment (SAPT) Block Grant and through its discretionary grant programs. ONDCP funds the Drug-Free Communities (DFC) Support Program to support mobilization of communities in preventing and reducing substance use among youth and adults. SAMHSA also offers training and technical assistance to communities through its Technology Transfer Center Network and partners such as the Community Anti-Drug Coalitions of America (CADCA).

SAMHSA grant programs, as well as the DFC program, require collaboration with community partners and community engagement, often through formation of new coalitions or advisory councils or the expansion of existing ones.

Aligning Current Infrastructure With Needed Supports to Ensure Equitable Care

The degree to which available infrastructure is accessible to all communities remains a concern, as many communities lack the capacity to access and/or leverage available systems and resources. A critical opportunity exists to infuse the current system with the support needed for truly equitable care.

Several models support the scale-up of EBPs and community engagement, including:

- Strategic Prevention Framework (SPF): A structured, data-driven approach that supports community-led efforts to address substance use problems and implement EBPs (discussed in more detail below).[21]
- Communities That Care (CTC): A structure for engaging community stakeholders, assessing risk and protective factors related to adolescent health and behavior problems, and selecting and implementing EBPs with fidelity. CTC guides community coalitions in monitoring program outcomes and periodically reevaluating community levels of risk and protection, informing adjustments in prevention programming.[22]
- Promoting School-Community-University Partnerships to Enhance Resilience (PROSPER): A program delivery system in which universities partner with practitioners and community teams to implement EBPs for preventing youth substance use and other problem behaviors. The model involves completing a needs assessment, selecting EBPs, implementing EBPs, receiving ongoing technical assistance in program implementation, monitoring implementation quality and partnership functions, and evaluating intervention outcomes. PROSPER supports implementation of EBPs in school settings.[23]

The above models incorporate the following common elements:

- Ongoing needs assessment
- Capacity building
- Prevention planning
- Review, selection, and possible cultural adaptation of EBPs to improve program fit
- EBP implementation
- Program monitoring (e.g., implementation quality, fidelity)
- Evaluation of health and other related outcomes

While complex, these elements provide a roadmap for communities seeking more tactical guidance and insight for those implementing more nimble or responsive community engagement approaches.

Strategic Prevention Framework (SPF)

SAMHSA's SPF supports engagement of prevention professionals and community stakeholders in a data-driven assessment process and provides a comprehensive approach to understanding and addressing substance use and related problems that states and communities face.[21] The SPF has five steps:

1. Community assessment of epidemiological and other data
2. Capacity building
3. Planning
4. Implementation of effective prevention policies, programs, and practices
5. Evaluation of these efforts

Two cross-cutting principles—cultural competence and sustainability—are integral to each step of the SPF process. In addition, prevention planning using SPF should be dynamic, iterative, data-driven, and reliant on community engagement. SPF is supported by a disparity impact statement, consisting of the proposed number of individuals to be served during a specific time period and all identified under-resourced populations in the service area. The SPF process aims for equitable EBP implementation to address substance use problems and improve substance use outcomes and associated risk and protective factors.

How Community Engagement Benefits the Prevention System

Community engagement is a critical factor in the scale-up of EBPs, improvements in population health, and equity.[9] Therefore, it is important to identify and communicate its benefits and outcomes and provide guidance on best practices. Outcomes associated with community engagement occur at implementation, service, and individual levels,[24] and include:

- Coalition functioning
- Acceptability of EBPs and/or prevention strategies
- Adoption of EBPs and/or prevention strategies
- Feasibility
- Sustainability
- Behavioral health functioning

Attributing outcomes to community engagement broadly or to specific community engagement activities is difficult.[25] However, researchers have documented outcomes associated with community engagement at multiple levels (see Chapter 2).

CHAPTER

2

What Research Tells Us

Community engagement is "a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes."[1] By building community trust and relationships, community engagement may benefit substance use prevention by promoting implementation of evidence-based practices (EBPs);[9, 12] selecting EBPs to meet community needs and adapting them, as needed; and increasing EBPs' sustainability.[15, 16]

This chapter discusses research on how community engagement supports substance use prevention, intervention, treatment, harm reduction, and recovery support services. Results of this literature review indicate the following:

- **Community engagement starts with an organizing group, such as a coalition or community advisory board**. The first step reported in reviewed community engagement efforts was gathering local stakeholders from diverse sectors in the community. Coalitions were by far the most common structure for accomplishing this organization. Most coalitions included stakeholders from three or more sectors, often including community members at large who are not paid staff of local organizations.
- **Community engagement typically involves a set of activities**. Most studies engaged community members and stakeholders in multiple ways. Community engagement activities occurred at every stage of prevention planning and programming—assessment, capacity building, planning, implementation, and evaluation.
- **Many community engagement activities are ongoing, extending over several years or for the duration of the substance use prevention intervention.** Once a community engagement process is in place, it will ideally continue for the duration of a particular prevention intervention, and preferably beyond. Several studies involved coalitions that existed prior to the specific intervention of focus, and many described ongoing engagement of community stakeholders.
- **Community engagement is an important component of many behavioral health programs.** Research on these programs indicates positive outcomes associated with community-driven interventions, although research designs in the existing research literature preclude linking outcomes to community engagement specifically. Many communities have used community engagement to plan, implement, and evaluate evidence-based prevention interventions.
- **Research-based evidence is currently not the best source material for practitioners seeking guidance on how to operationalize or translate community engagement principles into practice.** The available research literature lacks rich, practicable detail. This information is more likely to be found in grey literature

(i.e., work that is not formally published), other products developed from practice-based data, or directly from communities doing the work.

This chapter documents the available research evidence on community engagement and provides examples of outcomes. The reviewed studies examined implementation outcomes (e.g., coalition functioning, intervention acceptability), service outcomes (e.g., provider prescribing behavior), and individual outcomes (e.g., substance use). The chapter also discusses gaps in the literature and opportunities for future research.

Evidence Review

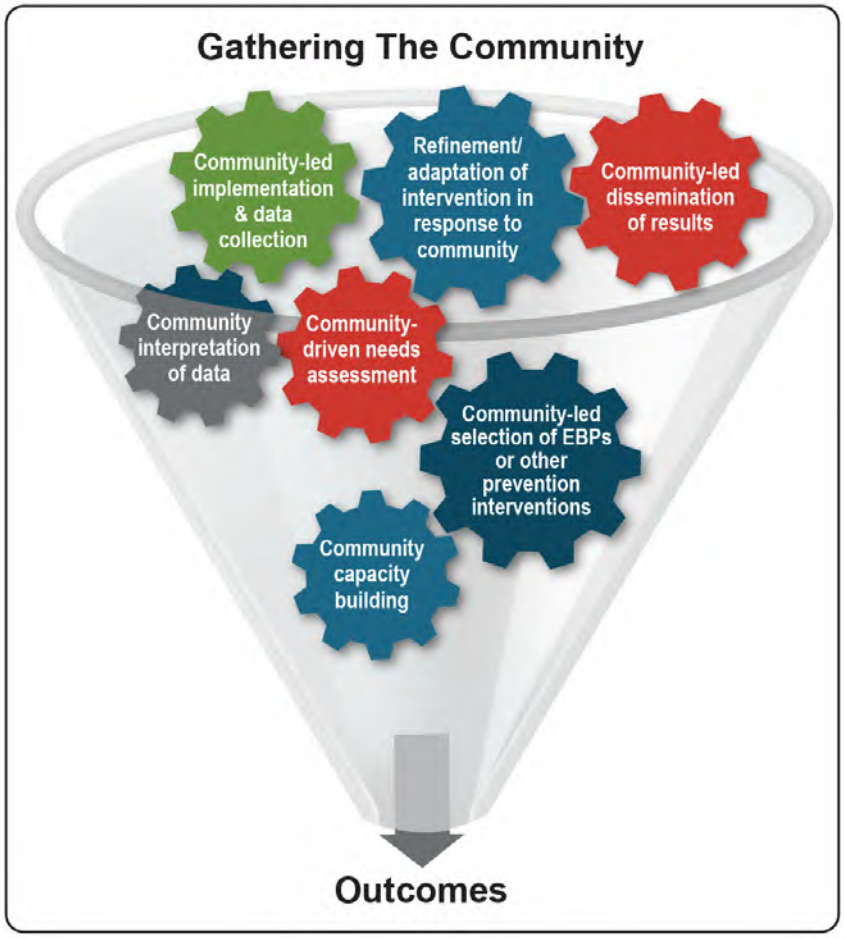
Forty-one articles examined communities implementing community engagement as part of a substance use prevention, intervention, treatment, harm reduction, or recovery support services strategy or intervention. We identified studies through discussions with a panel of experts and a systematic literature search (see Appendix 2 for details on the literature search process and a complete list of publications with the community engagement activities and outcomes examined). These articles studied a wide range of communities and populations, including but not limited to individuals living in a variety of locations—tribal, urban, suburban, and rural—and individuals of different races—American Indian or Alaska Native, Asian and Pacific Islander, Native Hawaiian, Black or African American, Latino/Latina, and White—and demographic factors—income levels, ages, and gender identities. Several strategies, practices, and outcomes emerged from this systematic literature search.

Gathering the Community

Gathering community stakeholders is the first step in community engagement. Most commonly, community engagement starts with coalitions. A coalition is a formal, voluntary collaboration among community groups, to work together for a common goal.[26] Other less common structures referenced in the literature include community organizing bases,[27, 28] community advisory boards,[29] and community planning groups.[30, 31] Once community stakeholders are engaged, the coalition or other advisory body plans and organizes the community engagement activities and provides overall direction.

Community Engagement Organizing Structures

Unlike coalitions, individuals participating in community organizing bases do not represent systems or organizations. Instead, they are community members united by a shared prevention goal, which they pursue by challenging rather than partnering with local organizations. In the literature, community advisory boards and community planning groups are similar to coalitions in structure and function.



Coalition Engagement

Communities may form a new coalition or expand the scope of an existing one, to take on a newly identified or emerging issue. Thirty studies discussed programs that used coalitions of community stakeholders to coordinate community engagement.[25, 32-60] Coalition members represented diverse community stakeholders, including, but not limited to:

- Community members representing affected populations, such as people who use drugs or individuals who are in recovery
- Community-based organizations and advocacy groups
- Faith-based organizations
- Law enforcement
- Local and state governments
- Medical facilities and behavioral health and primary care practices
- Public health organizations
- Schools
- Universities

The division of responsibilities, including levels of involvement during assessment, capacity building, planning, implementation, and evaluation, varied among coalition members, depending on their expertise and knowledge. Coalitions represented geographies of varying size, such as:

- One neighborhood
- One town
- Multiple communities within a tribe
- An entire state

Ongoing Engagement During Implementation and Evaluation

Once a community organizational structure was in place, it typically continued for the duration of the particular intervention and, in some cases, beyond. One benefit of ongoing engagement is that it can demonstrate that all participants are valued for their contributions to community well-being and health. Engagement can also provide opportunities to share information and resources among community stakeholders for the purpose of advancing outcomes, building capacity, and keeping interventions responsive to current community needs.

Twelve studies discussed maintaining community engagement throughout implementation of the intervention and evaluation.[25, 31, 33-36, 52, 54, 57, 61-63] Community structures used engagement techniques, such as regular coalition meetings and focus groups with community members, to inform program delivery improvements.

Implementation Examples from the Literature

- A large university formed a coalition to address high-risk drinking on campus. The coalition developed guiding principles, and the members viewed the reduction of high-risk drinking as a shared responsibility of the campus and the community. The diverse coalition included representation from campus and town police, neighboring town governments, community chambers of commerce, student residence life, Greek life, campus health services, the dean of students, athletics, campus transit, and the university's department of community relations. The full coalition met monthly to share information, discuss successes and challenges, learn from experts in the field, and strengthen relationships. The coalition also convened sub-committees dedicated to implementing different environmental changes. To build and sustain leadership over time, the coalition hosted leadership events to celebrate successes and increase the visibility of campus and community outcomes. Coalition membership remained largely consistent over the five years of its existence.[54]
- Four Alaskan communities implemented a community organizing model, as part of a feasibility study called the *Alaska Harmful Legal Products Prevention Study*. The community mobilization component involved seven steps: 1) assess the community; 2) build a base; 3) expand the base; 4) develop a plan of action; 5) implement the plan of action; 6) seek feedback and disseminate results; and 7) sustain the effort. The mobilization strategy involved coalitions consisting of key leaders and representatives of community agencies and organizations. A part-time local community prevention organizer (CPO), hired for the project, followed a work plan organized by tasks and due dates, to mobilize community members at large. With the CPO's support, each coalition developed a prevention action plan with concrete steps and strategies. Media advocacy was an essential aspect of the plan to motivate community members to become involved with community prevention interventions.[28]

Community Engagement Activities

The literature review revealed a common set of activities that occurred once the community had been gathered for engagement. Most efforts engaged community stakeholders in multiple activities, occurring at every stage of the intervention.

Community-Driven Needs Assessment

Involving the community in needs assessments both opens access to new sources of information and builds community capacity to plan and manage its own programs affecting health. Twelve studies investigated interventions that used community-driven needs assessments to identify issues and priorities for change.[28, 30-31, 33-34, 40, 44, 53-54, 62-64] Prevention professionals in the community often led needs assessments or conducted them in close partnership with community members. Programs conducted targeted needs assessments built on clear understanding of the prevention goals and communities to engage.

Communities identified and analyzed existing data and collected new data using various methods, including neighborhood forums, focus groups, and surveys. The data captured information about substance use behaviors and key implementation considerations, such as cultural context, trusted settings for implementation, and community perceptions of needs.

Implementation Examples from the Literature

- The *Tampa Practice Improvement Collaborative*, a **coalition** in the Tampa Bay area, tasked a subset of coalition members to develop and conduct a **needs assessment**. This workgroup included university faculty, court and law enforcement personnel, service providers, government agencies, and consumers. Its goals were to identify community needs for substance use treatment and engage community members who would later help implement EBPs. Over one year, needs assessment activities included **focus groups** with treatment providers, law enforcement personnel, policymakers, researchers, and consumers; **key informant interviews** with consumers, justice-based service providers, substance use treatment providers, policymakers, and researchers; and a **survey** of substance use treatment providers.[40]
- ʻImi Hale, a community-based organization in Hawaiʻi, collaborated with five Native Hawaiian Health Centers (NHHCs) to conduct and analyze **two statewide surveys** of Native Hawaiian smokers' attitudes toward cessation and preferences for programs; take **inventory of tobacco services** on each island; and partner with the Hawaiʻi State Department of Health to **analyze preexisting, population-specific data** on Native Hawaiian tobacco use. These data showed that prevention initiatives were not reaching Native Hawaiians. This finding led NHHC staff to agree on the need for a cessation program developed and provided by Native Hawaiians for Native Hawaiians.[63]

Community Capacity Building to Deliver the Intervention

Thirteen studies examined initiatives that involved training or technical assistance (T/TA) to build community capacity for planning, delivering, and sustaining an intervention.[25, 28, 32, 34-36, 43, 44, 47-48, 52, 57, 65] Public health professionals and lay coalition members delivered T/TA to community members by phone or in person. The trainings varied from a one-time event to multiple sessions of varying lengths. Topics included planning, implementation, and evaluation.

Implementation Examples from the Literature

- Over a three-year period, 11 community **coalitions** received T/TA to plan and implement strategies to prevent teen drinking parties. **Coalition members with specific expertise delivered trainings**. A retired police captain developed and implemented trainings for **members of other coalitions** on how to engage law enforcement representatives in the intervention. Another coalition member with experience in media advocacy trained intervention sites on the **production and dissemination of social media messages** about the moral and legal liability associated with hosting underage drinking parties.[47]
- The Health Extension: Advocacy, Research, and Teaching (HEART) intervention brought academic resources into nine counties in Utah with high opioid overdose deaths. At a **community-wide summit**, faculty presented to rural healthcare providers about community members' concerns with opioid use in their communities. Faculty also provided **training to providers and community members**, to reduce stigma associated with opioid use disorder, because stigma in the community and among providers had impeded efforts to increase medication prescribing for opioid use disorder. Faculty helped counties **build capacity** for opioid-monitoring programs by **providing TA** in building a digital repository of personal opioid narratives and by **training** community members in harm reduction education and naloxone use.[48]

Community-Led Selection of EBPs or Other Prevention Interventions

Community selection of intervention components operates on the understanding that communities are in the best position to choose activities that fit their needs and cultural and linguistic contexts. Twenty-three studies described prevention initiatives that involved community members in selecting EBPs or other interventions.[25, 29-30, 32-36, 38, 42-43, 46-47, 49, 54-55, 57, 61-66]

In many of these studies, researchers used a community-based participatory research (CBPR) approach to partner with community members in selecting interventions. Some communities selected from interventions that had been identified by researchers. Others led or participated in the development of their own intervention. In yet other cases, communities consulted with outside experts.

Implementation Examples from the Literature

- The *Methamphetamine Action Coalition (MAC)*, which included nursing faculty from a university, the county health department, a school district, and the sheriff's department, used CBPR to implement and measure a school-based intervention to decrease methamphetamine use and production in the county. The **steering team**, composed of representatives from these organizations, collaborated to **identify potential curriculum** subject matter for health education on substance use. The team also brought in a **substance use prevention expert** to assess the team's progress. The team presented the proposed curriculum to a **focus group** of local school personnel and discussed how to **adapt the curriculum** to meet the schools' needs. The coalition **used focus group feedback to finalize selection** of the curriculum for the pilot intervention.[36]
- Fourteen rural communities across Iowa and Pennsylvania implemented the Promoting School-Community-University Partnerships to Enhance Resilience (PROSPER) model to address adolescent substance use. Each community formed a **stakeholder group** which included a local team leader, public school co-leader, representatives of local human service agencies, parents, and youth. Each group **selected two interventions from a list of EBPs**: a family-focused intervention (Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14)) and a school-based intervention (four groups chose Life Skills Training, four chose Project Alert, and six chose the All Stars curriculum).[43]

Refinement or Adaptation of Interventions in Response to Community Input

Among communities actively involved in selecting interventions, some had to adapt or develop new interventions following community feedback around appropriateness and fit. Communities are in the best position to ensure interventions are culturally responsive. Sixteen studies described how communities adapted an intervention to reflect the unique cultural context in which it would be implemented.[29-30, 32-33, 35, 36, 38, 46-47, 54-55, 61-64, 66]

Some communities adapted interventions to include local languages or reflect kinship structure and social dynamics.[31, 46, 61] Other communities created entirely new interventions tailored to cultural contexts, often in response to a lack of culturally appropriate EBPs.[29, 33, 38, 62-64] For a detailed discussion on the process of cultural adaptation of existing EBPs, please see the Substance Abuse and Mental Health Services Administration's Evidence-Based Resource Guide, *Adapting Evidence-Based Practices for Under-Resourced Populations*.[67]

Implementation Examples from the Literature

- A rural Alaska Native community created the Elluam Tungiinun *(Toward Wellness)* prevention program in partnership with university researchers. The **community planning group** used **focus groups with local community experts** to create and adapt program elements. The community planning group developed and compiled activities in the Qungasvik, a community-designed toolbox that outlines a **process for adapting activities** to reflect local customs and circumstances, the current season, and the advice of Elders. Focus groups' input and researchers' previous work informed **cultural and linguistic adaptations** to the evaluation interview protocol, including revising wording and shortening interview length.[30]
- Responding to feedback from participants in a previous phase of a smoking cessation program, a **community-university partnership** adapted its *Communities Engaged and Advocating for a Smoke-Free Environment* intervention so it could be **delivered by peer motivators** who had successfully quit smoking and in **trusted community venues**, including nonprofit organizations, churches, and schools, rather than in medical facilities by health professionals who may have never smoked.[61]

Community-Led Implementation and Data Collection

Partnering with community members to implement interventions and collect data redistributes power and responsibilities traditionally held by government, academics, and health professionals. It also empowers and builds the capacity of community members to measure and interpret an intervention's effects on community well-being and health. Twenty studies described community involvement in an intervention's implementation and/or data collection, including design of data collection processes.[32-36, 43, 46-48, 52-55, 57, 59, 61-63, 65-66]

Some coalitions led implementation efforts, while others relied on community members, such as community health workers, to deliver interventions and collect participant data. Several initiatives used a CBPR approach, in which researchers partnered with community members to deliver the intervention, identify ways to measure impact, and collect data.

Implementation Examples from the Literature

- **Coalitions** in five northern California municipalities worked with county health department staff to **design, implement, and document a media campaign** to reduce underage drinking. The campaign focused on increasing awareness of social host ordinances, which impose fines on owners of residences used for underage drinking. Coalition members sent press releases when a social host ordinance violation occurred, handed out social host ordinance informational cards for parents and adults at school events, conducted paid media campaigns in local print and online media sources, sent letters to parents from school principals, posted information about social host ordinances on school websites, launched paid Facebook ads, and pinned posters at bus shelters.[59]
- Arizona tribal communities selected a medication lockbox from several options for safe medication storage and to prevent opioid poisoning. **Community partners led** implementation and data collection efforts. Housing staff installed lockboxes in participant homes. Community health workers reviewed the user guide with participants and **conducted initial surveys for baseline data**. Community partners and health workers collaboratively scheduled, conducted, and documented 30- and 60-day follow-up visits.[66]

Community Interpretation of Data Collected

Data often drives decisions, so engaging the community in interpreting data with openness and transparency is a pivotal element of community engagement. Community members may also help identify what data are missing and who is not included in the data. Four studies reported that community members participated in interpreting data collected on the intervention.[35, 54, 57, 63]

With varying researcher or evaluator involvement, community partners monitored implementation, discussed data, and identified successes and challenges. Engagement with data ranged from ongoing data surveillance to one-time discussions of the collected data and their implications. In some instances, community members were offered formal training to build their capacity to review and interpret the data.

Implementation Examples from the Literature

- Communities That Care, a substance use prevention and behavioral health promotion program for youth, **trained coalition** members on how to **use data to prioritize risk and protective factors** and **select appropriate programs and policies** to reduce youth substance use. The coalition also learned to **monitor youth outcomes and implementation fidelity** (the degree to which the intervention components were adhered to and delivered as intended) and use these **data to inform adjustments** to the prevention plan when needed.[57]
- The Utah Opioid Community Collaborative held **monthly meetings** with community stakeholders to **review data in real-time**, discuss lessons learned and areas for improvement, and consider future priorities. Data captured information on treatment and recovery support services delivered in the community.[35]

Community-Led Dissemination of Intervention Outcomes

Community input into how and where to disseminate outcomes can broaden reach, improve understanding of results, and help attract more community members to participate in subsequent rounds of the intervention. One study detailed how community members directed the dissemination of intervention outcomes to other members of the community.[33]

Implementation Example from the Literature

- *Sister to Sister,* a tobacco cessation program that engaged Black women residing in select Georgia public housing neighborhoods, included a multi-stage pilot program that used **focus groups** to tailor the programming to local social structures and customs. After each round of piloting, researchers conducted **community focus groups** and disseminated **results via neighborhood forums and newsletters**. Forums included ethnically preferred food and door prizes, both of which were identified by Community Advisory Board (CAB) members as an incentive to participate. Members wrote newsletters at a reading level recommended by community partners.[33]

Outcomes Summary

The 41 studies reviewed examined diverse outcomes at the implementation, service, and individual levels. Outcomes resulted from implementation efforts that usually included more than one community engagement activity. Therefore, outcomes cannot be attributed to any single community engagement activity. Aside from the community engagement activities, other factors affected outcomes; these factors included community context, the effectiveness of the specific EBP or intervention implemented, intervention intensity, and the quality of community engagement activities implemented.

Implementation-Level Outcomes

- **Coalition functioning.** Nineteen studies assessed coalition functioning, which is the intensity and/or quality of coalition members' interactions, communications, and partnerships; coalition influence and reach in the community; and achievement of coalition goals and objectives.[34, 37-40, 42, 44, 47, 49-52, 56-58, 60, 63, 68] Outcomes were diverse. Examples included improved relationships among stakeholders and increased sense of community involvement in the process.
- **Acceptability of EBPs and/or prevention strategies.** Twelve studies measured community acceptability of EBPs or prevention strategies following implementation.[33-34, 36, 38, 43, 46, 59, 61-64, 66] Acceptability is the degree to which an intervention or intervention component was considered satisfactory by the intended audience.[24] Interventions employing community engagement were generally found to be acceptable by participants, facilitators, and other community members.
- **Appropriateness of EBPs and/or prevention strategies.** In eight studies, evaluators assessed the appropriateness of their intervention or intervention components following implementation.[28, 32-33, 36, 38, 46, 63, 64] Appropriateness refers to the extent to which the intended audience considered EBPs or prevention strategies relevant and usable.[24] Researchers found community engagement, particularly cultural adaptation activities, increased appropriateness of interventions.

- **Adoption of EBPs and/or prevention strategies.** Sixteen studies reported on adoption.[30-32, 39, 42, 44, 49, 50, 52, 53, 57, 59, 62, 63, 66, 68] Adoption reflects how well communities implemented and used the intervention or intervention components.[24]
- **Cost.** One study evaluated the cost associated with the implemented intervention.[65] Benefits from reduced crime, improved earnings, and reduced healthcare costs exceeded the costs of implementing the prevention system intervention.
- **Feasibility.** Three studies assessed feasibility[33, 36, 66]—the level to which the intended audience could use an intervention or intervention component.[24] Community engagement during needs assessment and planning phases yielded information that improved feasibility.
- **Fidelity.** Seven studies evaluated fidelity[32, 35, 39, 54, 57, 59, 63]—a measure of how closely intervention components were adhered to and delivered as intended.[24] Several studies noted that interventions had been conducted with a high degree of fidelity to the original intervention design, even after incorporating adaptations based on community engagement activities.[32, 35, 54, 63]
- **Sustainability.** Four studies assessed the sustainability of the intervention[43, 48, 54, 58]—the duration and degree to which the intervention or intervention components remained in use and/or were further institutionalized.[24] These studies noted elements associated with community engagement, such as improved stakeholder relationships, as facilitators of sustainability.

Service-Level Outcomes

- **Service interaction.** Five studies noted impacts at the service level, including community member engagement with and retention in behavioral health services and/or changes in community provider behavior (e.g., prescribing, screening and assessment).[31, 32, 35, 61, 63] Intervention activities employing community engagement were associated with increased service interaction.

Individual-Level Outcomes

- **Behavioral health functioning.** Eighteen studies reported positive impacts on substance use and/or other measures of behavioral health functioning, such as overdose, hospitalizations, and justice system involvement.[25, 29, 31-33, 35, 41-43, 45, 49, 54, 55, 57, 59, 61, 62, 65] However, it is important to note that no study attributed these outcomes to community engagement activities alone.
- **Protective factors.** Four studies documented improvements in protective factors for substance use among community residents.[29, 30, 38, 59] Again, attribution of these outcomes to community engagement activities alone was not possible in most cases.

Research Opportunities

The activities and outcomes discussed in this chapter represent the results of a comprehensive review of the published literature. Studies of substance use prevention, treatment, harm reduction, and recovery support services commonly noted community engagement activities. However, the literature provides few details on how to implement community engagement activities most effectively or which outcomes can be attributed to community engagement.

Association is evidence demonstrating a *statistical relationship* between an intervention and an outcome measured in the study's sample population.

Causation is evidence demonstrating that an intervention *causes* or is *responsible for* the outcomes measured in the study's sample population.

Association is *not* causation.

Limitations and Gaps in Current Literature

This review did not find studies that evaluated specific community engagement activities for their effectiveness or assessed community engagement outcomes relative to quality of implementation, intensity, or adherence to the community engagement principles presented in Chapter 1. More research is needed on estimating the quality and intensity of various community engagement activities.

Further, it was difficult to assess the impact of community engagement on prevention interventions and their outcomes. The studies reviewed here merely indicated an *association* between outcomes and community engagement activities. In most cases, a *causal* relationship between the two cannot be established because:

1. Studies did not use suitable methods to infer causality, such as a randomized controlled trial, and
2. Community engagement activities were not examined individually, but instead were combined and collectively examined in the same study, often as part of a broader intervention.

Community-defined evidence is "a set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community."[69]

Practice-based evidence is "local aggregate evidence collected from individual client histories to learn what is happening in community practice."[70]

The behavioral health field and community members would benefit from more experimental research and research methodologies focusing on specific community engagement activities and their outcomes.

Finally, common practice details and insights that have emerged from communities engaging in community engagement may not be fully reflected in the research. The reviewed studies did not explicitly include community-defined evidence and practice-based evidence, which measures effectiveness as perceived and experienced by community members. This absence may leave readers currently implementing community engagement with a description of community engagement that feels incomplete or unfamiliar.

Future Research

Communities and prevention systems would greatly benefit from research that treats community engagement as the primary focus of study. Leaders across the prevention system need more specific guidance regarding the nature of community engagement practice and the outcomes they can expect. While some of this guidance may be derived from existing sources, research can play a prominent role through the following:

- **Position community engagement as the primary focus of study**. More research is needed where community engagement is the central focus of study. While the research literature reviewed studied community engagement as part of a larger effort, no articles thoroughly examined impacts made by specific community engagement activities.
- **Include measurement of community engagement efforts in analytic plans**. Even in cases where community engagement is not the central focus of study, researchers should include community engagement-specific measurements, so impacts can be examined. Literature concerning the perceived utility of community engagement is strong enough to warrant formal inclusion in measurement plans.
- **Measure implementation and quality of community engagement efforts.** Studying the quality of community engagement activities and how well communities implement them will address a significant blind spot in current research. Our literature review found minimal assessment of the quality of community engagement activities, hindering determination of the impacts of community engagement. While community engagement activities will necessarily vary from community to community, there is likely a minimum threshold for implementation quality that will achieve the desired impacts. Determining implementation quality thresholds would be a substantial contribution to the field.
- **Share results from community engagement efforts.** Researchers, evaluators, and community leaders are encouraged to publicize or publish the outcomes they obtain from community engagement. Providing more visibility to these efforts will accelerate learning and reinforce the viability of good community engagement practice.

CHAPTER

3

Guidance for Community Engagement

Community engagement can support planning and implementation of effective prevention activities, enhance community buy-in for evidence-based practices (EBPs), and increase the likelihood of their sustainability. Community engagement is context-specific, so can look different from community to community, making it difficult for newcomers to know how to do it and challenging for community stakeholders to know when it is done well. This chapter presents key considerations and strategies for incorporating community engagement in substance use prevention.

Prioritizing Community Engagement

Consideration:

Prevention systems should prioritize community engagement and integrate it into the prevention infrastructure.

Prevention efforts occur at many different levels (e.g., cities, counties, tribes, states, jurisdictions) and involve community stakeholders within different sectors (e.g., health care, housing, law enforcement, and social services), as well as members of the general community. Without a shared value for community engagement among prevention leaders and sufficient capacity to implement community engagement effectively, prevention programs will not benefit from the value added by community engagement.

Community Engagement Activities in Substance Use Prevention

- Gathering the community through coalition development or other community organizing structures
- Community-driven needs assessment
- Community capacity building to deliver the intervention
- Community-led selection of EBPs or other prevention interventions
- Refinement or adaptation of interventions in response to community feedback
- Community-led implementation and data collection
- Community interpretation of data collected
- Community-led dissemination of intervention outcomes

Diverse community stakeholders should participate in all stages of prevention programming: assessment, capacity building, planning, implementation, and evaluation. Stakeholders comprise those adversely affected by substance use disorders, including parents and family members, people with lived experience, and residents in neighborhoods impacted by substance use-related problems. They also include prevention professionals,

and representatives of agencies that can influence risk and protective factors associated with substance use. By ensuring community members have a voice, communities build on local strengths, address local needs, and recognize local preferences while planning, promoting, and implementing EBPs.

Strategies:

- **Make community engagement a requirement.** Prevention systems and organizations should prioritize community engagement through development of policies, processes, or minimum program requirements —for example, by mandating that prevention programs use community engagement. Recipients of state and federal prevention funds may also be required to engage community members and other stakeholders in planning, implementation, and evaluation.
- **Create a new coalition or engage an existing one to formalize community engagement and lead community prevention efforts.** Community coalitions, a common organizing structure for communities, bring together diverse stakeholders to address a common issue of concern. To be effective, coalitions need to represent a community's diversity and unite community members from multiple community sectors, such as health, education, criminal justice, child welfare, business, faith communities, parents, and youth. There are nuances to be attended to when including all audiences, such as youth. Recruiting people with lived experience may be challenging, but finding strategic ways to include them is critical for comprehensive community engagement. Coalitions or community organizations may already exist in a community; they ought to be identified and their potential for leading community prevention efforts assessed.

> An effective coalition has clearly defined and manageable goals, allows adequate time for planning, bases decisions on empirical data, implements EBPs, and evaluates programs and strategies to ensure fidelity and efficacy.[71]

- **Use existing frameworks to guide community engagement.** Frameworks exist that can guide prevention planning and implementation as well as community engagement. For example,
  - SAMHSA's Strategic Prevention Framework (SPF) provides a structured, data-driven approach that supports community-led efforts to address substance use problems in communities.[21]
  - Communities That Care (CTC) provides a structure for engaging community stakeholders, assessing risk and protective factors related to adolescent health and behavior problems, and selecting EBPs and implementing them with fidelity.[72]
  - The Promoting School-Community-University Partnerships to Enhance Resilience (PROSPER) model provides a comprehensive approach for completing a needs assessment, selecting and implementing EBPs, receiving ongoing technical assistance (TA) in program implementation, monitoring implementation quality and partnership functions, and evaluating program outcomes.[73]
  - Gathering of Native Americans (GONA) is a culture-based planning process, where community members gather to address community-identified issues. The GONA approach reflects AI/AN cultural values, traditions, and spiritual practices, serving as a roadmap for the journey to be traveled by all community members. These models can serve as a tactical roadmap or resource for guidance and insight.

Addressing Diversity, Equity, Inclusion, and Accessibility

Consideration:

Community engagement prioritizes addressing inequities within communities, including health inequities. Efforts to reduce and eliminate health inequities are more successful when they:[74]

- Include community members who are representative of community demographics in the selection and implementation of processes for interventions that are intended for them

- Mitigate power dynamics, which might prevent authentic engagement with residents
- Explicitly address structural racism and other forms of oppression as a meaningful and influential part of the context[74]
- Validate the knowledge and experiences of marginalized communities

Community engagement brings together skills, knowledge, and experiences and fosters connections and trust among diverse sectors and individuals experiencing health inequities.

Strategies:

- **Prioritize representation and diversity.** Representation and diversity ensure that needed community perspectives are available to guide selection, adoption/adaptation, and implementation of EBPs. Efforts should seek diversity in terms of race and ethnicity, age, immigration status, education, socioeconomics, sexual orientation, gender identity, disability, and geography.

> External entities, such as prevention professionals and researchers, can prioritize principles of trust and inclusion by listening to and learning from communities, which encourages community engagement efforts to initiate from communities themselves.

- **Select the most robust engagement strategy possible.** Community engagement can vary significantly in intensity—from simple consultation to full community collaboration and ownership—reflecting increased community involvement, trust, participation in decision-making, impact, and bi-directional communication flow.[18] Communities should implement community engagement practices based on the purpose of the engagement (e.g., to inform, obtain input, understand community concerns, collaborate on decisions, or empower) and the resources available. It is important to avoid engagement efforts that are one-directional or transactional in nature. They can be perceived as marginalizing, placating, or simple tokenism.[75]
- **Encourage decisions to emerge from local contexts and practices.** Community members are well-positioned to identify what will be most feasible to implement and most responsive to their needs, resources, culture, and norms.[76] They can also suggest potential adaptations to programs and practices, to increase the "fit" of the intervention to the local community and its diverse cultures.[77, 78] Doing so is an effective strategy to ensure the resulting research or intervention is not experienced as something imposed or introduced from the outside.

- **Promote more inclusive decision-making.** Community members feel valued and engaged when they are full and equal partners in decision-making. A decentralized, shared leadership structure fosters a sense of buy-in and can contribute to the overall capacity of the community coalition or partnership itself.
- **Promote inclusion and control power dynamics.** Communities should formally identify and address barriers that groups have faced due to oppression, because of race and ethnicity, age, immigration status, socioeconomics, education, homelessness, sexual orientation, disability, gender identity, or other characteristics. Everyone should be ensured access to all conversations and decisions, and the processes and information that support them. Additionally, communities should make cultural adaptations to community engagement processes, as necessary, to ensure that opportunities for participation are responsive to and comfortable for all included groups. Finally, all participants need to continually reflect on their participation and how they might unintentionally influence power dynamics. Implicit bias and internalized racism have the potential to reinforce oppressive power dynamics within a community engagement effort if not consciously examined and addressed.

Establishing Trust

Consideration:

Authentic community engagement efforts must recognize that there may be distrust in the community. The process of establishing trust starts with dispelling myths and honestly acknowledging community members' shared traumatic history, structural racism that perpetuates inequities, and other trauma experienced by communities, including the lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQI+) community. Such admissions need to be made with the intention to promote needed healing and reconciliation, so that meaningful, trusting relationships can develop.

Strategies:

- **Commit to the process of individual growth.** Community members should actively seek information, earnestly visualize what needs to change, and engage in shared learning. They should have conversations and embrace a spirit of humility, and not make assumptions regarding the experiences of marginalized communities. When people share their experiences, others should affirm and validate them.
- **Focus on relationships and identify trusted messengers.** Building trust and relationships is critical to effective community engagement but it takes time. Identifying trusted messengers, establishing strong relationships, and respecting local cultural and community norms will help support the process of adoption or necessary adaptation, enhancing buy-in and support for the resulting program or strategy. It is important to understand that trusted messengers are not found, rather they emerge from community suggestions. They are not always a community leader, and they may be an individual or a whole organization.
- **Consider measuring community readiness to identify potential mistrust and safety concerns.** Community members can provide insight regarding current levels of trust within the community and underlying drivers of trust issues, as well as information regarding any historical trauma and perceived safety concerns. This information will allow conveners to respond to underlying concerns, enabling trust to develop. Community readiness assessments can also identify differences in perceptions among various community stakeholder groups.

Learning From the Experiences of Other Communities

Consideration:

With limited practice detail available from formally published research and the inability to draw causal relationships between community engagement and reported outcomes, communities may need to turn elsewhere for guidance when operationalizing principles of community engagement to their local context.

Evidence-based decision making combines the best available research evidence with the experiential evidence of field-based expertise and context.

Community-defined evidence and practice-based evidence document the experience of community members and stakeholders, providers, and researchers. Such resources provide detail on community engagement practices, including implementation successes and challenges.

Strategies:

- **Apply lessons from other organizations serving communities like yours.** Practitioners, researchers, and organizations with a track record of working closely with community stakeholders can guide community engagement. Communities should identify other communities within their state, neighboring states, or from Indian Nations that are similar in size, demographics, and substance use issues, and reach out to their health department or prevention programs to learn about their community engagement practices, implementation tips, and lessons learned. Doing so will also expand those communities' capacities to help their communities. Seeking out the knowledge and experiences of other communities can prevent the privileging of academic knowledge and create a space for hybrid knowledge and indigenous theory.[79]
- **Seek out formal guidance to support community engagement.** To help navigate the complexities of planning, developing, implementing, and executing community engagement, communities should request TA and/or coaching on community engagement practices (e.g., TA from someone in another community, the Prevention Technology Transfer Centers, or another TA provider).

Ensuring Capacity to Carry Out Community Engagement

Consideration:

Community engagement requires leadership, technical expertise, and adequate staff support and financial resources. While meaningful infrastructure may exist to encourage and support community engagement, the capacity to do so may be missing or inadequate. Evaluations of CTC and PROSPER, which are coalition-led approaches to selecting, implementing, and sustaining EBPs, found that community coalitions require sufficient funding, leadership, support, and capacity to select, monitor, scale-up, and sustain programs and practices.[43, 57, 65] Also, organizations must have sufficient capacity, commitment, leadership, and vision to build an effective coalition or partnership.[80]

Strategies:

- **Select an individual to coordinate the community engagement effort.** Implementation of community engagement requires leadership, planning, and resource management. Communities should select an individual to coordinate community engagement efforts. The coordinator will ensure that stakeholders and community members receive consistent and timely messaging and direction, community engagement core principles are maintained, prevention systems are accountable to all community stakeholders, and problems are addressed as they arise.
- **Share strengths and capacities through formal partnerships.** Community engagement should build on existing strengths and capacities within the community. Community engagement coordinators should establish partnerships (often formalized through a memorandum of understanding (MOU) or memorandum of agreement (MOA)) between key partners (e.g., service providers, schools, law enforcement, healthcare organizations, universities, businesses, media). Coalitions and similar partnership structures provide a mechanism for communities to access and share resources and build capacity. Sharing information and resources makes community coalitions better equipped to support the adoption of EBPs, enhance community buy-in for these interventions, and increase the likelihood of their utility and sustainability.
- **Budget for the cost of community engagement.** Prevention systems and specific programs should budget for meaningful community engagement. Strategies can be costly, requiring not only fiscal, but also human, informational, organizational, and physical, resources.[81] Execution of community engagement takes time, management, and logistics. It may also require new skillsets.[82] A comprehensive community engagement plan and budget should be developed. When possible, make planning and budgeting participatory and incorporate community voices in funding decisions.

- **Use training to increase capacity and engagement.** Prevention systems and organizations should provide training and other capacity-building activities to enable community members and stakeholders to participate in community engagement. The training might discuss assessing needs; reviewing and selecting programs and practices; collecting and interpreting data; facilitating meetings; incorporating participatory approaches; enhancing diversity, equity, inclusion, and accessibility; and communicating and conducting media relations.

Sustaining Community Engagement Efforts

Consideration:

Developing and implementing a community prevention strategy is an ongoing effort, with the effects of prevention programs taking time to become apparent. Sustaining community engagement can be difficult but is important for providing continued support for initiated programs as well as for increased responsiveness to changing and emerging needs. While community engagement structures may be formed in response to a single community issue or need, they can be leveraged to address future needs if the structures are sustained. Stakeholders should proactively focus on sustainability by making it an early priority.

Strategies:

- **Establish clear goals and priorities with a plan of action.** Defining goals and setting clear priorities gives the community an opportunity to define a plan of action and estimate the time and resources needed to achieve desired outcomes. Action plans serve as short- and long-term roadmaps that allocate resources and help maintain focus and momentum.
- **Monitor community engagement processes and adjust, as needed.** Community needs may evolve over time. The suitability and effectiveness of some community engagement activities may also change. It is important to monitor community engagement processes to ensure continued community satisfaction with the community engagement approach and effective implementation of community engagement strategies.
- **Give coalition members a reason to stay involved.** Providing community members with opportunities for direct responsibilities, actively sharing useful information, and fostering collaborations among members are strategies to keep members engaged.
- **Develop a marketing strategy**. A marketing approach can increase understanding of the vision, mission, and goals of the community engagement. Marketing approaches should document ways the community can get involved. Engaging the media in recognizing the coalition's work is also an effective way to sustain and increase commitment.
- **Share results and celebrate successes.** Community engagement takes time and can reflect a significant amount of hard work and patience. In this context, even the smallest wins can serve as inspiration and motivate members to keep pushing and moving forward. Celebrating progress and recognizing the contributions of community members can inspire continued and increased participation.

Implementing Community Engagement Remotely

Consideration:

Community engagement is most often carried out in person. However, communities may need to communicate with people unable to meet face-to-face, such as people living in remote locations or those with limited mobility, chronic health conditions, work constraints, or transportation issues. Recently, the COVID-19 public health emergency presented challenges for community engagement, precluding in-person gatherings for months. The increased reliance on remote gatherings throughout the pandemic, and the insights and lessons learned as a result, should be leveraged to support and sustain increased access and engagement.

Strategies:

- **Identify digital and non-digital tools for community engagement.** Digital tools include simple connection tools for meetings (e.g., Google Meet), platforms for webinars and trainings (e.g., Zoom; WebEx; GoToMeeting), social media platforms (e.g., Facebook; LinkedIn; Instagram),[83] and true collaboration tools (e.g., Google Docs; Mural). Non-digital tools and techniques (e.g., phone trees; mailings) may also assist in community engagement. Tools will vary in terms of ease of use and cost, so it is important to determine stakeholders' abilities to use them and to get a full accounting of what is available before committing.
- **Assess the capacities and benefits of different platforms and tools for remote connection.** Community engagement coordinators and others should understand what a tool can and cannot do. It may be easy to see the promoted benefits of various platforms and tools but taking the time to identify the potential limitations or disadvantages of using particular tools is critical to finding the right product.
  - Common benefits may include ease of use, affordability, reliability, compatibility, and the ability to create multiple modes of engagement/participation.
  - Common limitations may include security challenges and susceptibility to cyberattacks, affordability, reliability, quality, access limitations, accessibility for people with disabilities, and ease of use.
- **Identify access issues to ensure inclusive engagement.** Individuals responsible for community engagement should make sure that all community members have access to reliable Internet or cellphone service. They should also be sure that the selected platforms and tools are affordable.
- **Ensure safety of participants.** When discussing sensitive topics, it is vital that the technology provides a sense of safety for all participants. Precautions may include password protection, securing active consent if recording content, providing culturally sensitive and knowledgeable moderators if using an open chat platform, and sending anonymous exit surveys to ask if community members felt safe and heard.
- **Train coalition members and others on use of remote connection tools.** For selected tool(s) to work as intended, it will be important to provide adequate training on their use. Training ensures all coalition members have access to the tool and that the community takes full advantage of it.

Resources

In addition to the guidance provided above, the following resources support communities to develop and implement effective community engagement strategies.

Community Engagement Strategies and Practices

- SAMHSA's Technology Transfer Centers created a community engagement handout with useful links.
- The Centers for Disease Control and Prevention (CDC) produced a summary of community engagement principles.
- The World Health Organization developed a health promotion guide centered on community engagement.
- The Pennsylvania State University created a Community Engagement Toolbox.

Supporting Frameworks for Implementing Community Engagement

- SAMHSA published a guide to its Strategic Prevention Framework (SPF).

- CTC developed a comprehensive implementation guide.
- PROSPER documented an overview of the process.
- Community Coalition Action Theory (CCAT)'s authors developed materials, which can be requested directly from authors.
- Active Community Engagement (ACE) Continuum is documented online.

Adopting/Adapting EBPs

- SAMHSA developed an evidence-based resource guide on culturally adapting EBPs.
- SAMHSA's Prevention Technology Transfer Center (PTTC) created a quick guide for adapting EBPs.
- SAMHSA created a resource for selecting prevention programs that best fit the community.

Community-Defined Evidence/Practice-Based Evidence

- CDC developed a resource that discusses various types of evidence.

Equity-Focused Community Engagement

- Annie E. Casey Foundation documented the opportunity of community involvement in addressing health inequities in its Bringing Equity to Implementation Guide.
- Movement Strategy created the Spectrum of Community Engagement to Ownership, which offer training materials for creating more inclusive engagement efforts.
- The Racial Equity Tools website compiled over 600 resources for groups and individuals working to achieve racial equity.
- The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care detailed action steps to advance equity and quality and eliminate disparities in service delivery. Think Cultural Health from the U.S. Department of Health & Human Services (HHS) compiled more CLAS resources.
- HHS created a behavioral health implementation guide for the national standards for culturally and linguistically appropriate services in health and health care.

Assessing Community Readiness

- The Tri-Ethnic Center for Prevention Research created Community Readiness: A Handbook for Successful Change.

Implementing Community Engagement Remotely

- The University of California, Davis assembled a collection of Tools and Resources for Remote Community Engagement.
- Urban Institute created a guide for Community Engagement During the COVID-19 Pandemic and Beyond.

Training and TA Organizations

- PTTC Network developed training and technical assistance services to the substance use prevention field, including professionals/pre-professionals, organizations, and others in the prevention community.
- Community Anti-Drug Coalitions of America created resources and customized trainings to support member coalitions.
- NNED – National Network to Eliminate Disparities in Behavioral Health documented information sharing, networking, and engagement among organizations and communities dedicated to the behavioral health and well-being of diverse communities.

CHAPTER

4

Examples of Community Engagement for Substance Use Prevention

This chapter highlights three organizations using community engagement in their substance use prevention interventions. The examples do not reflect all racial or ethnic groups; however, they vary in culture and setting, approach to gathering the community, and the community engagement practices they use.

- The first example, **South Portland (SoPo) Drug-Free Communities Coalition: SoPo Unite – All Ages All In**, describes how an existing community coalition was leveraged to address an emerging problem in South Portland, Maine. Students and families were unhappy with the handling of substance use violations in school and on athletic teams. SoPo Unite engaged representatives across 12 sectors (including youth and parents, law enforcement, health care, and local officials), educated teachers and school staff on restorative practice, and deployed student coalition members to increase buy-in and tailor communication. As a result, the school board and school athletic department adopted a restorative policy. Since enacting the policy, the school found that students caught using substances had better outcomes, and the school climate improved.
- The second example, the **Cherokee Nation HEAL Initiative**, describes a partnership between Cherokee Nation Behavioral Health and Emory University's public health scientists to

develop, implement, and evaluate a community intervention to prevent youth substance use in Oklahoma. The intervention combines a school-based approach (computer-based screening and brief intervention) with a community-based approach, Communities Mobilizing for Change and Action. Together, these approaches aim to reduce the demand for and supply of alcohol and other drugs among teens and young adults.

- The third example, **Papa Ola Lokahi** in Honolulu, Hawai'i, illustrates a government-designated organization with a community engagement focus, describes how they have used community engagement to conduct a substance use needs assessment across populations with different needs and practices, and documents how Papa Ola Lokahi's community engagement activities were able to continue during the COVID-19 public health emergency.

As these examples demonstrate, community engagement involves a set of activities and can look different across communities, aligned to the goals of the particular community and prevention intervention. The examples affirm the benefits of community engagement in addressing substance use. Several common themes emerged:

- Gathering the community occurred, either through a coalition or a community-organizing model.
- Community engagement provided stakeholders with an understanding of the complexity of substance use issues in the community and the role of the community in addressing local needs.
- Community members participated in discussions of local needs and offered critical insights in interpreting results.
- Respecting cultural practices helped establish trust and successful engagement of community members.

South Portland (SoPo) Drug-Free Communities Coalition: SoPo Unite – All Ages All In—*Restorative School Substance Use Policy*

South Portland, Maine

Program

SoPo Drug-Free Communities Coalition: SoPo Unite – All Ages All In aims to prevent youth substance use through policy change and community capacity building. SoPo Unite's activities focus on middle and high school students in South Portland, Maine, including students whose families immigrated from 40 countries.

Challenge

In 2014, there were several substance use violations in the high school and on athletic teams that were handled in a punitive manner, without equity or transparency. At the same time, South Portland legalized adult marijuana use.

Intervention

Building on an existing coalition, SoPo Unite engaged representatives across 12 sectors: youth, parents, schools, law enforcement, media, local officials, civic agencies, youth-serving organizations, health care, faith-based groups, substance use prevention agencies, and businesses. Their goal was to change the school policy for responding to student substance use, from suspension to a restorative practice. Restorative practices build connection, accountability, and healing in response to a harmful situation.

Educating teachers, school staff, and police on restorative practice expanded **community capacity to deliver the intervention**. A training consultant taught two 37.5-hour courses to 40 district staff. The Program Director led a subcommittee on restorative practice and policy with approximately 10 coalition members, including school staff, licensed alcohol and drug counselors, Restorative Justice Institute of Maine staff, and students.

Students played a critical role in implementing and adapting the new policy. Student coalition members were instrumental in getting buy-in for the new athletic code, shaping the approach to parental involvement, and tailoring communication for families from different cultures (e.g., those from countries where alcohol is restricted versus those for whom it is part of the culture), including translation and interpreter needs.

Several school staff supported this work: a social worker, a licensed alcohol and drug counselor, two assistant principals, and a school resource officer. A full-time in-school restorative coordinator was added when the policy was enacted. School staff are funded through the school budget. The Drug-Free Communities Grant provided funding for the training consultant and additional training for the in-school restorative coordinator and the SoPo Unite Youth Consultant (a four-day International Institute of Restorative Practices course).

Outcomes and Other Benefits

- When this work began, only three students were involved in SoPo Unite—all athletes. As of this writing (2022), the group is composed of 80 students, including those whose families immigrated from Rwanda, Somalia, and Mexico.
- In 2018, the School Board passed the new restorative policy, and the school athletic department adopted a restorative athletic code. Community engagement was critical to the implementation and adoption of the new policy.
- Benefits associated with the new policy include an improved school climate (students feel respected and support peers, and teachers and coaches are more engaged), more involved parents, powerful panel discussions with athletes and coaches, increased access to behavioral health resources (full-time school clinician and full-time restorative coordinator), and provision of technical assistance to other local schools and coalitions to enable them to replicate the policy. Local youth-serving agencies (such as the Teen Center at the Redbank Community Center) have also adopted the school's restorative policy and process.

South Portland (SoPo) Drug-Free Communities Coalition: SoPo Unite – All Ages All In—*Restorative School Substance Use Policy*

South Portland, Maine

- SoPo Unite collects quantitative and qualitative data to measure outcomes of the restorative policy. For example, the Maine Integrated Youth Health Survey assesses substance use trends, perception of risk, and peer and parental disapproval of substance use. The school administration keeps records of violations and responses. Under the new policy, students caught using substances are more likely to stay and be successful in school. All students are less likely to use substances.
- Research suggests that city-level restrictions on the sale of high-alcohol content beverages result in reductions in crime, like assaults and vandalism, and can reduce alcohol retailers' risky alcohol-related operating practices.[87-88] In Miami Gardens, additional laws and better enforcement of existing laws can significantly reduce access to these products.

"There has been a shift in culture toward repairing harm. Students have increased their empathy for other students and lowered their defensiveness. Students, on their own, have taken responsibility and reached out in person (or via email) to take accountability for their actions with both peers and teachers. The policy has had a ripple effect and the restorative approach is now used for other behaviors (conflicts, etc.)—not just for substance use."

—*School social worker*

Lessons Learned

- Be prepared to educate key leaders continually; new people will always be joining the community (e.g., new parents, students, coaches, superintendents).
- Familiarize everyone with what good prevention looks like. Provide community education on the benefits of using evidence-based and best practices.
- Recognize that policy-level change takes time. When engaging community members in this process, develop a realistic timeline and plan for activities.

Related Resources

- SoPo Unite home page
- Maine Department of Education Newsroom article

Cherokee Nation and Emory University—HEAL Preventing Opioid Use Disorder in Older Adolescents and Young Adults Initiative

Cherokee Nation of Oklahoma

Program

The Cherokee Nation Helping to End Addiction Long-term (HEAL) Preventing Opioid Use Disorder in Older Adolescents and Young Adults Initiative is a multi-level community intervention to prevent drug use among adolescents and young adults by reducing the demand for and supply of alcohol and other drugs. The intervention combines two distinct approaches, one school-based and one community-based. This work is part of the broader National Institutes of Health (NIH) HEAL Initiative to identify solutions to the opioid crisis.

Cherokee Nation Behavioral Health's and Emory University's public health scientists partnered in the development, implementation, and evaluation of an intervention to prevent youth substance use. The two organizations have been working together since 2010, and this is their second NIH-funded prevention trial.

Challenge

Nationally, American Indian/Alaska Native populations are at higher risk for substance use,[84] and in 2014–2016, the counties in the Cherokee Nation had a higher overdose death rate than the Oklahoma state average.[85, 86]

Intervention

Emory University public health scientists and Cherokee Nation Behavioral Health leaders collaborated to select and refine the intervention, design the study, and implement the intervention.

Community-led selection of interventions, accomplished by working closely with Cherokee Nation Behavioral Health scientists and health practitioners, ensured the intervention would be appropriate for communities in small, rural towns in the 14 Oklahoma counties that partially or fully fall within the Cherokee Nation reservation. Community engagement is fundamental to the two approaches of the intervention, both of which employ **community capacity building** and **community-led implementation and data collection**.

- The school-based intervention—Connect—focuses on reducing demand, using computer-based screening and brief intervention. All students are screened and as needed, connected with substance use or mental health treatment and other resources. Through Connect, school staff, parents, and community members are trained to identify risk and connect with youth.
- In the community-based intervention—Communities Mobilizing for Change and Action (CMCA; community organizing as implemented in Communities Mobilizing for Change on Alcohol)—the focus is on creating safe environments and reducing the supply of alcohol and drugs to teens and young adults. CMCA includes trainings and tools, including Family Action Kits, to support local families, community organizations, and citizens. Community organizers recruit and assist adult volunteers in assessing community needs, engaging community members, planning and implementing action steps for prevention, evaluating results, and refining next steps. Team members (from Cherokee Nation and Emory University)—experienced with community organizing and substance use prevention—supervised, trained, and supported community organizers.

Connect coaches and community organizers **engage community members to increase awareness of the issue and train them** to identify and respond to signs of substance use disorders. Strategic media campaigns support Connect and CMCA. Campaigns are designed to reinforce prevention messages in different community audiences (e.g., youth, families), and include news coverage, paid media, and social media.

The National Institutes of Health (NIH) HEAL Initiative provides funding for the program.

Cherokee Nation and Emory University—HEAL Preventing Opioid Use Disorder in Older Adolescents and Young Adults Initiative

Cherokee Nation of Oklahoma

Outcomes and Other Benefits

- Community engagement is critical to effective implementation and evaluation of the intervention.
  - **This work builds upon an existing relationship** between Cherokee Nation Behavioral Health and Emory University.
  - **Ongoing engagement** with Cherokee Nation Behavioral Health increases community capacity to collaborate on research and ensures the interventions are responsive to current community needs (e.g., previous interventions targeted underage drinking, while the present work focuses on opioid and other drug use).
  - **Community-led implementation and data collection** should help maximize participation rates.
  - **Community members participate in measuring improvement in their own community's health**. The research partners at Cherokee Nation Behavioral Health assisted in designing the study and selecting outcome measures. A team at Cherokee Nation Behavioral Health implements the survey data collection.
  - By hiring the school-based Connect coaches through Cherokee Nation Behavioral Health, the goal is for this work to continue after the study ends.
- A study of Connect and CMCA in the Cherokee Nation found that students receiving these interventions reported significantly lower prevalence of drinking and heavy drinking and significantly lower drug use compared with students who did not receive the interventions.

Lessons Learned

- Engage a variety of local stakeholders and find a passionate champion who can make things happen. You need broad support for prevention efforts.
- Be creative in looking at what has worked in different places and in communities like yours. Consider how different approaches are tailored for the local community, while keeping key components that make the approach effective.
- Remember that youth substance use is a complex problem, and prevention requires multi-level or multi-component strategies. You cannot only provide skills or knowledge to young people; you must also provide support at all levels of influence.

Related Resources

- Study protocol for the Cherokee Nation HEAL Initiative
- Summary of current intervention
- Summary of previous intervention

Papa Ola Lokahi—Substance Use Needs Assessment

Hawai‘i

Organization

Papa Ola Lokahi, the Native Hawaiian community-based health board, oversees the Native Hawaiian Health Care Act across the state, supporting health systems on six islands: Kaua‘i, Ni‘ihua, O‘ahu, Moloka‘i, Maui, and Hawai‘i. Papa Ola Lokahi partners with federally qualified health centers and community-based organizations.

Challenge

A 1985 report (*E Ola Mau – The Native Hawaiian Health Needs Assessment*) found that Native Hawaiians experienced health disparities and provided guidance on how to serve the Native Hawaiian community. In response, Papa Ola Lokahi was created in 1988 to help reduce disparities and improve the health and well-being of Native Hawaiians through consultation with communities.

Papa Ola Lokahi oversees the Native Hawaiian Health Care Improvement Act, administers the Native Hawaiian Health Scholarship Program, conducts legislative advocacy, supports Native Hawaiian traditional healing practices, and provides funding and technical assistance to Native Hawaiian community-based organizations. Traditionally, outside knowledge holders have been brought in to conduct focus groups and assess community needs, but they do not understand the community and end up collecting surface-level information.

Intervention

Papa Ola Lokahi created a substance use advisory group composed of community advocates, including treatment providers, those in recovery, health professionals, and community members. The advisory group examines practices and engagement strategies for Native Hawaiian residents of Kaua‘i, Ni‘ihua, O‘ahu, Moloka‘i, Maui, and Hawai‘i.

In the fall of 2021, the advisory group **assessed community needs** through stakeholder meetings on substance use to discuss gaps in services, what's working and what's not, and strategies for peer support. Participants were community members from the different islands, and participation was open to all individuals, including those in recovery. Separate conversations were held with Native Hawaiian groups on each island, as each island has different needs and its own norms and practices. In early 2022, the advisory group held follow-up **conversations with participants to report back and discuss the findings**.

Each community stakeholder meeting was two hours, and each follow-up conversation lasted one hour. The advisory group conducted community stakeholder meetings and follow-up conversations using web-based videoconference technology. The increased use of web-based virtual meetings because of the COVID-19 public health emergency made it easier and more cost effective to have conversations with groups on different islands.

This work is supported by the Hawai‘i State Department of Health.

Outcomes and Other Benefits

- The Papa Ola Lokahi substance use advisory group brings subject matter expertise and a cultural perspective to assessing the needs of Native Hawaiian populations across the state. In this way, they can collect rich information about Native Hawaiian needs on each island and work with local populations to address these needs.

Lessons Learned

- Overlaying a cultural mindset in a Western system is challenging. An hour-long training introduces people to the importance of addressing cultural needs in planning. Attending to cultural or community uniqueness requires thoughtful and intentional engagement of community members.
- Engaging community members in prevention requires careful planning and a shift in thinking. Prevention must begin early, and it is hard to see an impact. Carefully consider the target population and set realistic goals for outcomes.

Papa Ola Lokahi—Substance Use Needs Assessment

Hawai‘i

Related Resources

- Papa Ola Lokahi homepage
- Native Hawaiian and Pacific Islander Hawai‘i COVID-19 Response, Recovery, & Resilience Team

CHAPTER

5

Resources for Evaluation

Traditionally, communities think of evaluation as a tool for measuring the implementation, outcomes, and impact of specific prevention interventions. While evaluation can help identify the contribution of community engagement to such efforts, it is also valuable in assessing the quality and effectiveness of community engagement activities implemented and the specific impacts brought about through community engagement efforts themselves. This chapter begins with the importance of practice standards and an overview of the types of evaluations that state, tribal, and community leaders can conduct to improve community engagement practice and address accountability concerns. It then discusses how evaluation can help communities reinforce community engagement principles through application of culturally responsive and equitable evaluation practices, and provides illustrative indicators for evaluating community engagement. The chapter concludes with specific evaluation resources focused on improving community engagement.

Importance of Minimum Practice Standards and Measurement of Community Engagement

Evaluation can play a critical role in assessing whether principles and minimum practice standards of community engagement are being followed and sustained.

Application of practice standards and measurement of community engagement implementation and quality are emerging concepts, with significant contributions being made by UNICEF and the National Academy of Medicine.[87, 88] Centered on community engagement principles, practice standards attempt to move the work of community members forward by directly attending to concerns related to quality, accountability, and efficiency. The proposed benefits are to:

1. Determine if community members feel engaged and if the community engagement strategy reflects the principles of community engagement presented in Chapter 1
2. Inform ongoing adjustments and adaptations necessary to maintain responsive community engagement
3. Strengthen the ability to determine the relationship between community engagement activities and outcomes

Through the process of defining key actions and indicators, standards can be established to ensure meaningful and impactful community engagement. Development of practice standards is a fundamental step in centering evaluative feedback on what matters most—the degree to which community members feel engaged in prevention and will remain engaged over the long term.

Creating And Measuring Community Engagement Practice Standards: An Illustrative Example			
Standard and Description	**Quality Criteria**	**Actions**	**Indicators**
Participation: Communities assess their own needs and participate in the analysis, planning, design, implementation, monitoring, and evaluation of interventions. Community views and needs are given due weight in all aspects of policy, planning, research, and practice.	Meaningful participation is recognized as a right and is essential for informed decision-making and collective self-determination.	1. Have clear objectives for levels of participation based on necessary minimums for achieving outcomes and impacts. 2. Create transparency around the proposed levels of participation.	1. A mechanism for ensuring participation has been developed. 2. Operational policies and procedures for participation of community members are in place.

Note: Adapted from UNICEF's Minimum Quality Standards and Indicators for Community Engagement

Types of Evaluations

Evaluation is an integral part of any planning and implementation process and should be considered from the start. Several types of evaluation[89] can be conducted; three of which are especially relevant for community engagement:

- **Process (implementation) evaluation**: Documents the quality of the community engagement strategy and particular community engagement activities, adherence to community engagement principles, barriers to implementation, and factors that support successful implementation. This enables prevention leaders or project managers to assess whether they have implemented community engagement as planned and documents factors that supported or challenged implementation. Process evaluation may continue while conducting an outcome or impact evaluation.
- **Outcome evaluation**: Assesses short- and long-term outcomes of community engagement or the contribution of community engagement to the larger intervention it is supporting. Such outcome assessments may involve collection of baseline data and data at defined intervals (e.g., annually) during and after implementation of community engagement. These outcome data provide leaders or project managers with information regarding the efficacy of community engagement and can inform changes or improvements associated with it, including unintended consequences (adverse or beneficial).
- **Impact evaluation**: Documents short- and long-term impacts of community engagement or the contribution of community engagement to the larger intervention it is supporting. Impact evaluations attempt to identify the direct, causal impact of community engagement on specific goals or whether outcomes from the intervention can be attributed to the implemented community engagement. These evaluations can be challenging to implement.

Regardless of the type of community engagement evaluation, it must adhere to two important considerations:

1. The evaluation must maintain community involvement at all stages—planning, data collection, data analysis and interpretation, development of recommendations based on evaluation findings, and dissemination.
2. At the time of reporting, the evaluation must allow for feedback from community members, to ensure that outcomes are consistent with community priorities and expectations. Doing so can serve as a powerful opportunity for community members to hold funders and providers accountable for interventions that are culturally and linguistically relevant to the community.

Using Process Evaluation to Measure the Quality of Community Engagement

A process evaluation should document community engagement activities and participants, assessing the extent to which community members feel engaged in prevention planning, implementation, and evaluation.

As with each type of evaluation, community members should decide on the questions and indicators for what meaningful community engagement looks like. A process evaluation should assess the quality of community engagement activities implemented; the extent to which community engagement is equitable; fidelity to the overall community engagement implementation strategy; general functioning of the community engagement process; and efficacy of each community engagement activity. Minimum practice standards can verify the degree to which implementors have adhered to key community engagement principles. The community should identify improvements to the implemented community engagement, based on evaluation findings.

Sample Questions	Sample Indicators	Possible Measures/ Data Sources
• Have attitudinal, environmental, and institutional barriers to participation for disadvantaged and marginalized groups been adequately addressed? • Have systemic two-way communication mechanisms between conveners and community members been developed? • Have community priorities, resources, and needs been integrated into project plans effectively?	• Engagement level of participants • Perceived equity of processes • Fidelity to strategy and underlying principles	• Surveys • Focus groups • Key informant interviews • Participation rates

Using Outcome and Impact Evaluations to Measure the Effects and Contribution of Community Engagement

Outcome and impact evaluations should document the short- and long-term outcomes and impacts associated with community engagement. As laid out in the National Academy of Medicine conceptual model, outcomes and impacts can be effectively assessed across four primary domains: 1) Strengthened partnerships and alliances; 2) Expanded knowledge; 3) Improved health and healthcare programs and policies; and 4) Thriving communities. These domains address specific changes associated with the community engagement efforts themselves, as well as changes generated by the interventions/initiatives that community engagement efforts are supporting.

When community engagement is used to support an intervention or initiative (e.g., selection and implementation of an EBP), evaluation efforts should attempt to measure the unique contribution community engagement made (among other factors). By implementing specific measures, the evaluation team can account for community engagement's role in observed outcomes and impacts.

While this approach has attribution challenges, efforts to measure community engagement's discrete contribution are critical in allaying the belief that community engagement is a passive actor in a larger system of change.

Culturally Responsive and Equitable Evaluation (CREE)

Equitable evaluation is a culturally responsive evaluation method that does not consider culture as a subjective factor needing to be controlled. Instead, it explicitly acknowledges culture and context when assessing program effectiveness.[90] Equitable evaluation relies heavily on engaging community members, including those who are involved in community engagement, participate in prevention programs, and provide evaluation data. According to the Equitable Evaluation Initiative,[91] evaluation efforts should be in service of equity, and evaluators should consider the following aspects while developing their evaluation approach:

- Diversity of their evaluation teams, including cultural backgrounds, disciplines, beliefs, and lived experiences

Assessment Domain	Indicators	Possible Measures/ Data Sources
Strengthened partnerships and alliances	• Diversity and inclusivity: multicultural, multiethnic, and multigenerational, including those not traditionally involved in healthcare policies • Partnerships and opportunities: ensure participants are fully benefiting • Acknowledgment, visibility, recognition: recognition of community participants as equals and public acknowledgments of their contributions • Sustained relationships: to maintain continuous communications • Mutual value: ensures communities are equitably benefiting from the partnership • Trust: to build a long-lasting and robust relationship; • Shared power: community participants are actively engaged in leadership roles • Structural supports: infrastructure needed for continued community engagement	• Surveys • Focus groups • Key informant interviews • Document reviews
Expanded knowledge	• New curricula, strategies, and tools: formal community engagement products that permit dissemination of new knowledge • Bi-directional learning: community and partners collaboratively generate new knowledge • Community-ready information: creates actionable findings and recommendations for community use	• Document reviews • Surveys • Focus groups
Improved health and healthcare programs and policies	• Community aligned solutions: ensures that models and solutions fit the community needs • Actionable, implemented, and recognized indicators of success, with solutions endorsed by community members • Sustainable solutions: new interventions and resources that remain in the community after application, to support future programs, if needed	• Surveys • Focus groups • Key informant interviews • Document reviews • Incidence rates of targeted behaviors
Thriving communities	• Physical and mental health: "whole-person" health, including shared healthcare decision-making • Community capacity and connectivity: growth in community skills and capacity • Community power: ensures the community initiates, guides, and owns new efforts • Community resiliency: reflects the community's strength and capacity to self-manage • Life quality and well-being: improvements in the drivers of health, including health equity	• Surveys • Focus groups • Community-level secondary data (e.g., crime data; ER visits related to substance use; education data related to absences, suspensions, and graduation rates)

Note: Adapted from National Academy of Medicine Conceptual Model for Achieving Health Equity & System Transformation Through Community Engagement[88]

- Cultural appropriateness and validity of evaluation methods
- Involvement of community members in the evaluation design, implementation, and dissemination, including selection of evaluation questions and indicators
- Ability of the evaluation design to reveal structural and systems-level drivers of inequity (present-day and historical)
- Degree to which communities have the power to shape and own how evaluation happens

Expanding the Bench Initiative defines Culturally Responsive and Equitable Evaluation (CREE) as "evaluation that incorporates cultural, structural, and contextual factors (e.g., historical, social, economic, racial, ethnic, gender) using a participatory process that shifts power to individuals most impacted. CREE is not just one method of evaluation; it is an approach that should be infused into all evaluation methodologies."

Strategies to Practice Equitable Evaluation

State, tribal, and community leaders can use the following questions to apply CREE practices at each stage of the evaluation process.

Evaluation Process Step	Guiding Questions
Putting together an evaluation team	• Are proposed team members culturally and racially diverse? • Do they represent different backgrounds and beliefs and have lived experience with the issue at hand? • What types of training or capacity building are necessary to enable all members of the evaluation team to participate in the evaluation?
Evaluation purpose(s) and audience(s)	• Does the overall evaluation purpose explicitly reference progress toward equity at multiple levels (e.g., individual, structural, or systemic)? • Do evaluation audiences include the under-resourced and other populations served?
Evaluation questions	• Has the organization involved community members in the identification and prioritization of evaluation questions? • Do the evaluation questions consider the extent to which different groups experience community engagement and prevention services differently?
Outcomes and indicators	• Have community members participated in the identification of outcomes and indicators? • Are outcomes and indicators meaningful and relevant to community members? • Do selected outcomes and indicators reflect community engagement principles and community-identified community engagement priorities and practice standards? • Do selected outcomes and indicators provide the community with evidence of progress?
Data collection, analysis, and dissemination	• Is the organization or community transparent about how and why it collects and uses data? • Are community members involved in data collection, and how? • Are data collection tools culturally relevant to and appropriate for the community? • Is disaggregated data prioritized to account for contextual and cultural differences? • Is the organization actively engaging the community in interpreting the data and formulating recommendations? • Is the community involved in presenting evaluation results to different audiences?

Note: Adapted from National Academy of Medicine Conceptual Model for Achieving Health Equity & System Transformation Through Community Engagement[88]

Evaluation Resources

UNICEF's Minimum Quality Standards and Indicators for Community Engagement presents a framework and considerations for evaluating community engagement strategies using indicators developed for each community.

The CDC summarizes essential elements of program evaluation Framework for Program Evaluation in public health.

The Rural Health Information Hub's module on Evaluating Rural Programs offers information on evaluating rural community health programs.

University of California, San Francisco's Family Health Outcomes Project includes resources for program evaluation and performance monitoring.

The Center for Community Health and Development at the University of Kansas' Community Toolbox includes a step-by-step guide to develop an evaluation of a community program or initiative, and offers specific tools and examples.

SAMHSA' Substance Abuse and Mental Health Data Archive provides access to useful datasets and analysis tools.

SAMHSA's annual Behavioral Health Equity Report is a helpful data resource to support evaluation.

CREE Resources

The Equitable Evaluation Initiative's Equitable Evaluation Framework™ seeks to provide foundations and nonprofit organizations with an understanding of equity and how to use an equity lens while performing evaluations.

Mathematica's Using a Culturally Responsive and Equitable Evaluation Approach to Guide Research and Evaluation introduces the CREE approach and tools to maximize its utilization.

Child Trends' How To Embed a Racial and Ethnic Equity Perspective in Research provides researchers with guiding principles in accomplishing research and evaluation in an equitable manner.

WestEd Justice & Prevention Research Center's Reflections on Applying Principles of Equitable Evaluation deals with how equitable evaluation principles can be applied and the implications of equity-focused research and evaluation.

The Handbook of Practical Program Evaluation, Fourth Edition's Culturally Responsive Evaluation Theory, Practice, and Future Implications provides a foundation for culturally responsive evaluation—from preparation for the evaluation to disseminating and using the results.

Cultural Competence Resources

The American Evaluation Association's Public Statement on Cultural Competence in Evaluation affirms the importance of cultural competence in evaluation and provides a guide to the essential practices for cultural competence.

The Foundation Review's Raising the Bar – Integrating Cultural Competence and Equity: Equitable Evaluation presents a framework for building equitable evaluation capacity.

The CDC provides practical strategies for Culturally Competent Evaluation.

The Great Plains Tribal Epidemiology Center created an Indigenous Evaluation Toolkit.

A Language Justice Framework for Culturally Responsive and Equitable Evaluation proposes an evaluation framework grounded in language justice, defined as the right to communicate in the language in which one feels most comfortable.

SAMHSA developed a Treatment Improvement Protocol, Improving Cultural Competence, which includes guidance for conducting culturally responsive evaluation.

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Glossary

Association: Evidence demonstrating a statistical relationship, either positive or negative, between an intervention and an outcome measured in the study's sample population. Association is not causation.

Causation: Evidence demonstrating that an intervention causes or is responsible for the positive or negative outcome measured in the study's sample population.

Community engagement: A process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes.

Community stakeholders: Individual community members or organizations in a community that have a direct interest in the process and outcomes of a project, research, or policy endeavor.

Community-based participatory research (CBPR): An approach that involves the engagement and equal participation of individuals affected by an issue or problem at hand and recognizes and appreciates the unique strengths and resources that each person contributes. It is a cooperative, empowering, co-learning process that involves systems development and local community capacity building.

Culture: A broad, multi-dimensional construct that refers to integrated patterns of human behavior, including language, spirituality, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Cultural adaptation: The systematic modification of an evidence-based practice's protocol and/or content to incorporate language, culture, and context that is compatible with a client's cultural patterns, meanings, and values.

Cultural competence: A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable the system, agency, or those professions to work effectively in cross-cultural situations.

Culturally Responsive and Equitable Evaluation (CREE): Evaluation that incorporates cultural, structural, and contextual factors (e.g., historical, social, economic, racial, ethnic, gender) using a participatory process that shifts power to individuals most impacted.

Evidence-based practices (EBPs): Interventions that are guided by the best research evidence with practice-based expertise, cultural competence, and the values of the persons receiving the services, that promote individual-level or population-level outcomes.

Equity in behavioral health: The right to access high-quality and affordable health care services and supports for all populations, including Black, Latino, and Indigenous and Native persons, Asian Americans and Pacific Islanders, and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, queer/questioning and intersex (LGBTQI+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality

Fidelity: The extent to which an intervention was delivered as conceived and planned.

Health inequities: Differences in health status or in the distribution of health care and other resources between different population groups or geographic areas, arising from the social conditions in which people are born, grow, live, work, and age.

Historical trauma: A complex and collective trauma experienced over time and across generations by a group of people who share an identity, affiliation, or circumstance, and which is frequently linked to health disparities.

Implementation-level outcomes: Indicators of success for implementation of prevention strategies and EBPs and related community engagement efforts. They include quality of the community engagement strategy and particular community engagement activities, adherence to community engagement principles, acceptability of an EBP within the community, EBP sustainability, and appropriateness, or relevance, of the EBP at addressing the identified problem.

Implementation science: The scientific study of methods to promote the systematic uptake of clinical research findings and other evidence-based practices into routine practice and hence improve the quality and effectiveness of health care.

Indicators: Quantitative or qualitative metrics that enable monitoring of performance, achievement, and accountability.

Individual-level outcomes: Individual-level changes in substance use behavior, health conditions, and satisfaction.

Infrastructure: Funding, training and technical assistance, personnel, and policy supporting prevention activities, including community engagement.

Protective factors: Factors that directly decrease the likelihood of substance use and behavioral health problems or reduce the impact of risk factors on behavioral health problems.

Recovery support services: A range of non-clinical support services designed to help people with mental health and substance use disorders manage their conditions.

Risk factors: Factors that increase the likelihood of beginning substance use, of regular and harmful use, and of other behavioral health problems.

Service-level outcomes: Outcomes that are related to service quality, including efficiency and efficacy.

Social capital: Social relationships, shared norms, values, and trust that help to achieve desired outcomes.

Social determinants of health: Conditions in the environment where people are born, live, learn, work, play, worship, and age that affect health.

Structural racism: A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity.

Substance misuse: Use of any substance in a manner, situation, amount, or frequency that can cause harm to users or those around them. For some substances or individuals, any use would constitute misuse (e.g., underage drinking, injection drug use).

Substance use: Use—even one time—of alcohol or other drugs.

Sustainability: The process of building an adaptive and effective prevention system that achieves and maintains desired long-term results.

Under-resourced communities: Population groups or geographic areas that experience greater obstacles to health, based on characteristics such as, but not limited to, race/ethnicity, socioeconomic status, age, gender, disability status, historical traumas, sexual orientation/gender identity, and/or location.

APPENDIX 1: Acknowledgments

This guide is based on the thoughtful input of SAMHSA staff and the *Technical Expert Panel on Community Engagement: An Essential Component of an Effective and Equitable Substance Use Prevention System* from October 2021 through August 2022. Two expert panel meetings were convened during this time. A series of guide development meetings was held virtually over a period of several months.

SAMHSA Staff

Brian Altman, JD, National Mental Health and Substance Use Policy Laboratory

Anthony Bethea, MPA, Center for Substance Abuse Prevention *

Thomas Clarke, PhD Center for Behavioral Health Statistics and Quality

Tanya Geiger, PhD, MPH, Center for Behavioral Health Statistics and Quality *

Morris Flood, DHSc, Center for Substance Abuse Prevention *

CAPT Donelle Johnson, PhD, MHSA, National Mental Health and Substance Use Policy Laboratory *

Nelia Nadal, MPH, Center for Substance Abuse Prevention *

Krishnan Radhakrishnan, MD, PhD, MPH, National Mental Health and Substance Use Policy Laboratory

Mary Roary, PhD, MBA, Office of Behavioral Health Equity

Carter Roeber, PhD, National Mental Health and Substance Use Policy Laboratory *

Technical Expert Panel

Scott Gagnon, MPP, PS-C, AdCare Maine and New England Prevention Technology Transfer Center

Ralph Hingson, PhD, National Institute on Alcohol Abuse and Alcoholism

Jo Ann Kauffman, MPH, Kauffman & Associates, Inc.

Priscilla Lisicich, PhD, Safe Streets, Tacoma, WA

Roslyn Holliday Moore, Office of Minority Health

Rita Noonan, PhD, National Center for Injury Prevention and Control, Centers for Disease Control (CDC)

Barbara Oudekerk, PhD, Prevention Research Branch, National Institute on Drug Abuse (NIDA)

Dallas Pettigrew, MSW, University of Oklahoma

Gail Maddox Taylor, Virginia Department of Behavioral Health and Developmental Services

Princess Mae Visconde, MPH, Asian & Pacific Islander American Health Forum

Contract Staff

Jeffrey Knudsen, MA, Guide Lead, Abt Associates *

*Members of Guide Planning Team

APPENDIX 2. Literature Review Process

STEP 1. The systematic literature review for this guide began with a **search strategy** to identify relevant literature in research databases. We selected the following databases, which are standard for searches of medical, health, and psychology studies: PubMed (medicine), ScienceDirect (health), CINAHL (nursing), PsycINFO (psychology), and SSCI (social sciences). Key search terms were determined in consultation with prevention experts, and are listed below:

((“community engagement”) OR (“strategic prevention framework”) OR (“communities that care”) OR (“Community Readiness Assessment”) OR (“Native Connections”) OR (“PROSPER”) OR (“HEALing Communities”))

AND

((substance) OR (drug) OR (alcohol))

AND

((abuse) OR (use) OR (addiction) OR (dependence))

AND

(prevention)

AND

((impact) OR (acceptability) OR (adoption) OR (appropriateness) OR (feasibility) OR (fidelity) OR (cost) OR (penetration) OR (sustainability) OR (equity) OR (“health disparity”))

STEP 2. We then conducted a **title review** with every citation captured from the database search, a total of 7,749 citations. We reviewed the titles for the inclusion criteria below:

- The publication was a journal article, or research or technical report (relevant dissertations/theses, systematic reviews, meta-analyses, and scoping reviews were also retained, and their references reviewed using the same criteria).
- The work focused on community engagement, or included community engagement, for behavioral health or public health prevention, treatment, or recovery support services.
- The article was published after 2002 and was written in English.
- The study was conducted in the United States.

1,467 studies met the inclusion criteria and moved to STEP 3.

STEP 3. The team conducted an **abstract review** with every citation included from the title review, a total of 1,467 abstracts. We reviewed the abstracts for the inclusion criteria below:

- The work was an implementation study or process or outcome evaluation.
- The study used experimental design, quasi-experimental group design, correlational design, or observational design.
- The work focused on substance use prevention, treatment, or recovery support services.
- The study reported on at least one relevant outcome (implementation, service, or client level).
- If the study reported on the same intervention as other studies included in STEP 3, only the most well-cited study or the most recent publication from a longitudinal study was included.[1]

Sixty-nine articles met inclusion criteria and moved to STEP 4.

[1] Citation frequency was weighted by year using PlumX Metrics and Altmetric citation metrics, which compared citations of an article with articles of a similar age in all journals and with articles of a similar age in the same journal. If these metrics were not available for a given article, we used citation metrics from PMC, SpringerLinks, Semantic Scholar, and/or ResearchGate in that order. This order was determined based on availability of metrics from each source for the included articles. We compared metrics from the same source whenever possible for closest comparability.

STEP 4: We reviewed the full text of each article and extracted information into a systematic literature review table. The review table captured information about the study design, population, setting, intervention or prevention strategy, community engagement strategy, and outcomes. During this process, 28 articles were excluded based on the above criteria, resulting in 41 articles, which were all included.

STEP 5: The team synthesized findings across community engagement strategies and outcomes.

Study	Gathering		Community Engagement Activity							Outcome									
	Coalition engagement	Ongoing engagement with community during implementation	Community-driven needs assessment	Community capacity building to deliver the intervention	Community selection of EBPs or other prevention interventions	Refinement or adaptation of intervention in response to community feedback	Community-led implementation and data collection	Community interpretation of data collected	Community-led dissemination of program/intervention results	Acceptability	Adoption	Appropriateness	Coalition functioning	Cost	Feasibility	Fidelity	Sustainability	Service interaction	Symptomatology	Protective factors
Alexandridis, et al. (2018)	✓			✓	✓	✓	✓				✓	✓				✓		✓	✓	
Allen, et al. (2009)			✓		✓	✓					✓									✓
Andrews, et al. (2007)	✓	✓	✓		✓	✓	✓		✓	✓		✓			✓				✓	
Apata et, al. (2019)		✓			✓	✓	✓			✓								✓	✓	
Arria & Jernigan (2018)	✓	✓	✓	✓	✓		✓			✓			✓							
Brunisholz et al. (2020)	✓	✓		✓	✓	✓	✓	✓								✓		✓	✓	
Calvert, et al. (2014)	✓	✓		✓	✓	✓	✓			✓		✓			✓					
Chambers, et al. (2021)		✓	✓		✓	✓	✓			✓	✓								✓	
Chilenski, et al. (2015)											✓		✓							
Davoust, et al. (2021)	✓												✓							
Derzon, et al. (2012)	✓				✓						✓		✓						✓	
Edberg, et al. (2021)					✓	✓													✓	✓
Fujimoto, Valente, and Pentz (2009)	✓										✓		✓							

Study	Gathering		Community Engagement Activity							Outcome										
	Coalition engagement	Ongoing engagement with community during implementation	Community-driven needs assessment	Community capacity building to deliver the intervention	Community selection of EBPs or other prevention interventions	Refinement or adaptation of intervention in response to community feedback	Community-led implementation and data collection	Community interpretation of data collected	Community-led dissemination of program/intervention results	Acceptability	Adoption	Appropriateness	Coalition functioning	Cost	Feasibility	Fidelity	Sustainability	Service interaction	Symptomatology	Protective factors
Goldstein, Sapere, and Daviau (2017)	✓												✓							
Keene Woods, et al. (2014)	✓	✓		✓			✓				✓		✓							
Kuklinski, et al. (2021)				✓	✓		✓							✓					✓	
Lanter, et al. (2015)	✓		✓				✓				✓									
Linowski and DiFulvio (2012)	✓	✓	✓		✓	✓	✓	✓								✓	✓		✓	
Lohrmann et al. (2005)	✓				✓	✓	✓												✓	
McGinty, et al. (2019)	✓												✓							
Oesterle, et al. (2018)	✓	✓		✓	✓		✓	✓			✓		✓			✓			✓	
Ogilvie, et al. (2008)			✓	✓								✓								
Palombi, LaRue, and Fierke (2019)	✓												✓				✓			
Paschall, et al. (2018)	✓						✓			✓	✓					✓			✓	✓
Powell and Peterson (2014)	✓												✓							
Raghupathy and Forth (2012)			✓		✓	✓				✓		✓								
Rasmus (2014)	✓				✓	✓				✓		✓	✓							✓
Roman, Butts, and Roman (2011)	✓										✓		✓			✓				
Rugs, et al. (2011)	✓		✓										✓							

Study	Gathering		Community Engagement Activity							Outcome									
	Coalition engagement	Ongoing engagement with community during implementation	Community-driven needs assessment	Community capacity building to deliver the intervention	Community selection of EBPs or other prevention interventions	Refinement or adaptation of intervention in response to community feedback	Community-led implementation and data collection	Community interpretation of data collected	Community-led dissemination of program/intervention results	Acceptability	Adoption	Appropriateness	Coalition functioning	Cost	Feasibility	Fidelity	Sustainability	Service interaction	Symptomatology	Protective factors
Santos and Lindrooth (2021)	✓																		✓	
Santos, et al. (2008)		✓	✓		✓	✓	✓	✓		✓	✓	✓	✓			✓		✓		
Scaglione (2021)	✓				✓						✓		✓						✓	
Shelley, et al. (2008)		✓	✓								✓							✓	✓	
Spoth, et al. (2017)	✓			✓	✓		✓			✓							✓		✓	
Tsatoke, et al. (2021)					✓	✓	✓			✓	✓				✓					
Valente, et al. (2007)	✓		✓	✓							✓		✓							
Wagenaar et al. (2006)	✓	✓		✓	✓								✓						✓	
Weisman, Lamberti, and Price (2004)	✓																		✓	
Whitesell, et al. (2019)	✓				✓	✓	✓			✓		✓								
Wolfson, et al. (2017)	✓			✓	✓	✓	✓	✓					✓							
Yaugher, et al. (2020)	✓			✓			✓										✓			

Photos are for illustrative purposes only.
Any person depicted in a photo is a model.

Publication No. PEP22-06-01-005

SAMHSA
Substance Abuse and Mental Health Services Administration

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EVIDENCE-BASED RESOURCE GUIDE SERIES

Implementing Community-Level Policies to Prevent Alcohol Misuse

SAMHSA
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Implementing Community-Level Policies to Prevent Alcohol Misuse

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Released 2022

Abstract

Approximately 70 percent of adults in the United States report drinking alcohol in the past year, as do 30 percent of youth under the age of 21. Alcohol misuse is associated with a variety of harms that include multiple health conditions, like high blood pressure, cancer, and other diseases; mental health disparities; violence and crime; fatal and non-fatal motor vehicle crashes; and others, even death. As rates of alcohol use and related harms continue to remain high, it is important for communities to know the most effective options to prevent and reduce alcohol misuse.

This guide provides an overview of effective prevention policies that can be implemented at the local, state, tribal, and/or territorial levels. It lays out key considerations and strategies for these policies, including the most equitable ways to implement and enforce them. The guide illustrates how three United States communities have implemented these policies and concludes with guidance on conducting policy evaluations.

MESSAGE FROM THE ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

As the Assistant Secretary for Mental Health and Substance Use in the United States Department of Health and Human Services and the leader of the Substance Abuse and Mental Health Services Administration (SAMHSA), I am pleased to present this new resource: *Implementing Community-Level Policies to Prevent Alcohol Misuse*.

SAMHSA is committed to improving prevention, treatment, and recovery support services for individuals with mental illnesses and substance use disorders. SAMHSA's National Mental Health and Substance Use Policy Lab developed the Evidence-Based Resource Guide Series to provide communities, clinicians, policymakers, and others with the information and tools to incorporate evidence-based practices into their communities or clinical settings. As part of the series, this guide aims to highlight community-level policies to prevent and reduce alcohol misuse.

This guide and others in the series address SAMHSA's commitment to behavioral health equity, including providing equal access for all people to evidence-based prevention, treatment, and recovery services regardless of race, ethnicity, religion, income, geography, gender identity, sexual orientation, and disability. Each guide recognizes that substance use disorders and mental illness are often rooted in structural inequities and influenced by the social determinants of health. Behavioral health practitioners and community stakeholders must give attention to health equity to improve individual and population health.

Adapting evidence-based practices, while retaining core practice components, can help mitigate the disparities too often seen in behavioral health services for under-resourced populations and improve outcomes. This guide discusses the different policies that have been effectively implemented in communities across the United States to prevent and reduce alcohol misuse and related harms. I encourage you to use this guide to ensure that the interventions your community is implementing have the strongest potential to improve the health and safety of our neighbors, peers, colleagues, and families.

Miriam E. Delphin-Rittmon, PhD
Assistant Secretary for Mental Health and Substance Use
U.S. Department of Health and Human Services

FOREWORD

Evidence-Based Resource Guide Series Overview

The Substance Abuse and Mental Health Services Administration (SAMHSA), specifically its National Mental Health and Substance Use Policy Laboratory (Policy Lab), is pleased to disseminate information on evidence-based practices and service delivery models.

The Evidence-Based Resource Guide Series is a comprehensive set of modules with resources to improve health outcomes for people at risk for, experiencing, or recovering from mental and/or substance use disorders. It is designed for prevention practitioners, coalitions, community leaders, health professions educators, and others considering an intervention for their organization or community.

Expert panels of federal, state, and non-governmental participants provided input for each guide in this series. The panels include accomplished researchers, educators, service providers, community members, community administrators, and federal and state policymakers. Members provide input based on their lived experience, knowledge of healthcare systems, implementation strategies, evidence-based practices, provision of services, and policies that foster change.

Implementing new policies requires a comprehensive, multi-pronged approach. This guide is one piece of an overall approach to implement and sustain change. Readers are encouraged to review the SAMHSA website for additional tools and technical assistance opportunities.

Behavioral health equity is the right to access high-quality and affordable healthcare services and supports for all populations, including Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, queer/questioning, and intersex (LGBTQI+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. As population demographics continue to evolve, behavioral healthcare systems will need to expand their ability to fluidly meet the growing needs of a diverse population. By improving access to behavioral health care, promoting quality behavioral health programs and practice, and reducing persistent disparities in mental health and substance use services for under-resourced populations and communities, recipients can ensure that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with promoting access to high-quality services, behavioral health disparities can be further mitigated by addressing social determinants of health, such as social exclusion, unemployment, adverse childhood experiences, and food and housing insecurity. In all areas, including preventing alcohol misuse, SAMHSA is committed to behavioral health equity.

Content of the Guide

This guide contains a foreword (FW) and five chapters (1-5). Each chapter is designed to be brief and accessible to anyone working to prevent and reduce alcohol misuse.

This guide reviews the literature on prevention of alcohol misuse among youth and adults, distills the research evidence into recommendations for practice, and provides illustrative examples of how stakeholders have implemented these recommendations.

FOCUS OF THE GUIDE

Alcohol misuse is a major public health concern in the United States, responsible for more than 140,000 deaths each year, and is a leading preventable risk factor for chronic diseases and injuries. This guide provides an overview of alcohol misuse in the United States, including rates and related harms across different populations. It views these data with a health equity lens, looking at the disparate conditions affecting these populations.

The purpose of this Evidence-Based Resource Guide is to provide communities, the prevention workforce, and other stakeholders with policies that governmental agencies and organizations can implement at the local, state, tribal, and territorial levels for preventing alcohol misuse. Each policy includes a description of the intervention, implementation examples, and considerations for health equity.

In addition, this guide summarizes other policies and strategies grounded in public health theory that communities are implementing to reduce alcohol misuse and related harms. It provides considerations and strategies for implementing policies, with a focus on equitable implementation. This guide illustrates how communities and legislators have developed and implemented these policies.

CHAPTER

1

Issue Brief

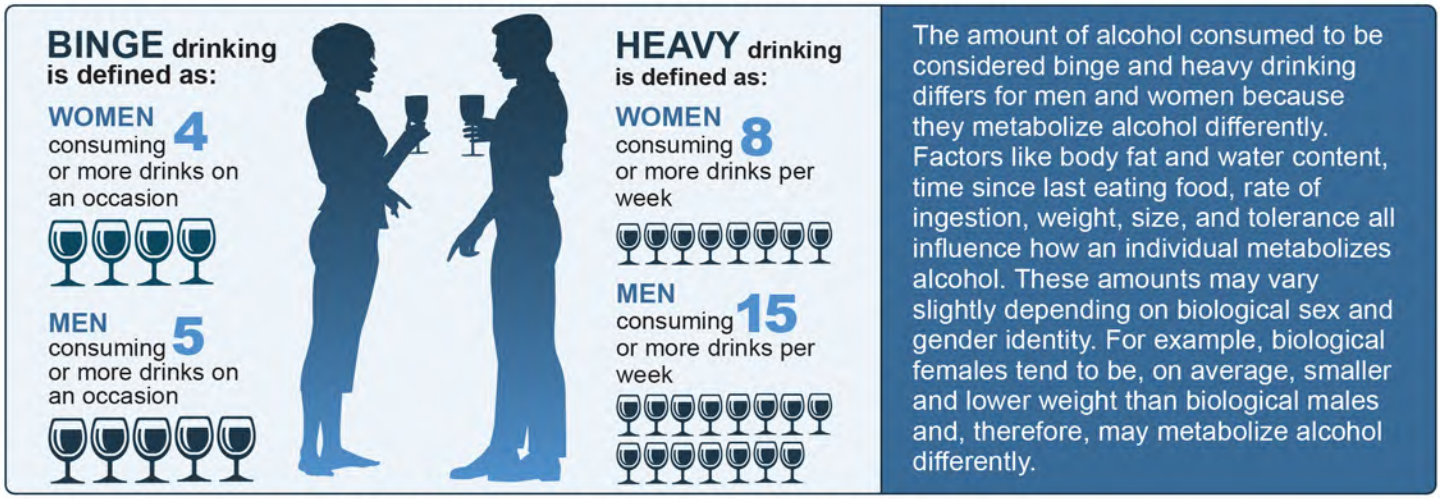
In the United States, alcohol misuse is responsible for approximately 140,000 deaths per year; nearly two-thirds (89,697) are among adults aged 20 to 64,[1-2] and 4,000 are among those under 21.[2] Prevention of alcohol misuse is critical for reducing potential harms to individuals who consume alcohol and those around them, as well as to communities that experience alcohol-related violence and crime. Prevention efforts that focus on reducing alcohol misuse and related adverse outcomes are broader than prevention efforts or the provision of treatment for alcohol use disorder (AUD). Preventing alcohol misuse can reduce the risk of individuals developing AUD.

This guide focuses on alcohol misuse, given that it affects many people.[3] Most alcohol-related harms occur among people who drink relatively low or moderate levels, simply because they are more numerous in the population,[4-5] even though people who drink higher levels of alcohol have a higher individual risk of experiencing alcohol-related harms. This concept is often referred to as the "prevention paradox," and it supports implementing interventions affecting all people who drink—not just those who consume high amounts of alcohol.

Terminology

- **Alcohol misuse**, also referred to as excessive alcohol use, is defined as binge drinking, heavy drinking, driving under the influence of alcohol, any underage drinking, or any alcohol consumption by pregnant people. Other commonly used terms are "risky drinking," "problem drinking," or "excessive drinking." This guide will use the term "alcohol misuse."
- **Community** can be understood in multiple ways, including place-based communities (e.g., neighborhoods, cities, rural areas) or groups of identity (e.g., racial/ethnic groups, sexual and gender minorities, those in recovery from alcohol or substance use).
- **Sex/Gender:** Where possible, this guide uses the specific language used in the original data sources it references; for example, sex assigned at birth (male/female) or gender identity (man/woman/non-binary). Non-binary responses are included when available in the data sources, though such responses are often missing. Individuals whose gender identity corresponds to their sex assigned at birth are referred to as cisgender, and individuals whose gender identity differs from their sex assigned at birth are referred to as transgender.

Definitions of Binge and Heavy Drinking



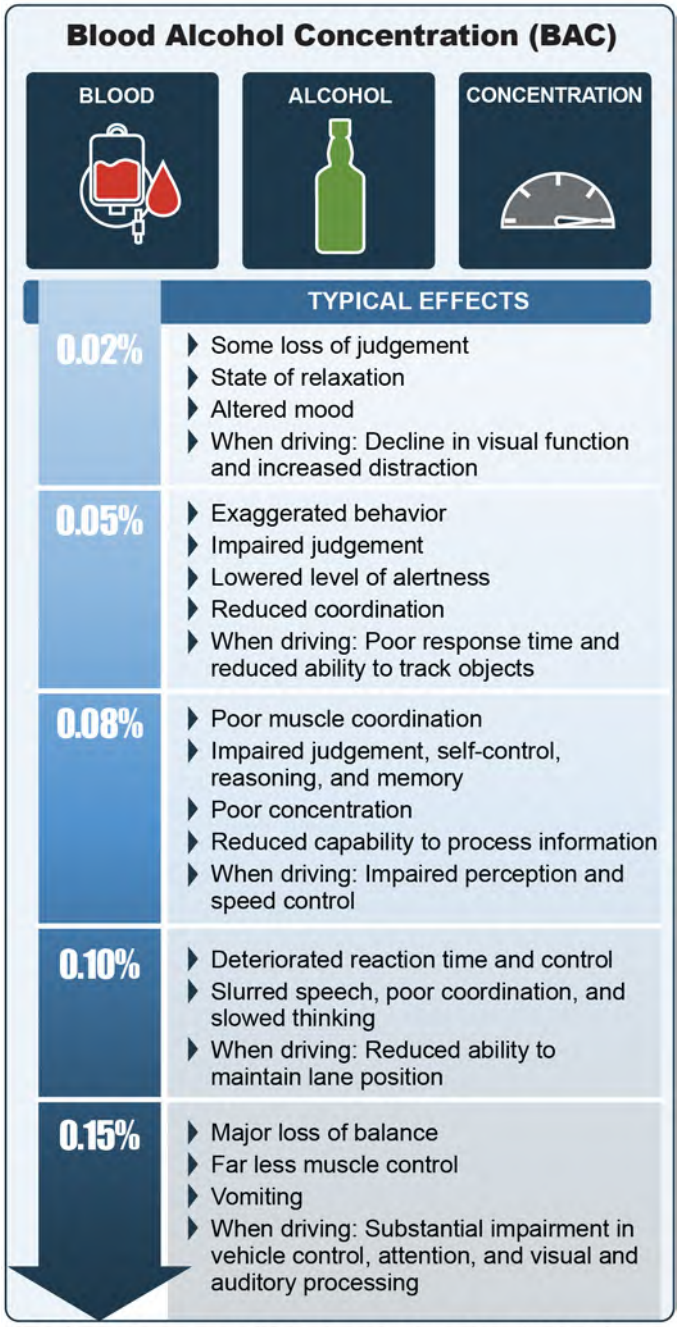
Source: Substance Abuse and Mental Health Services Administration (SAMHSA). (2018). *Alcohol use facts and resources.* https://www.samhsa.gov/sites/default/files/alcohol_use_facts_and_resources_fact_sheet_2018_data.pdf

What Is Alcohol Misuse and Alcohol Use Disorder?

Alcohol misuse is a pattern of drinking resulting in harm to one's own or others' health and safety, one's interpersonal relationships, or one's ability to function at work, school, or home. It includes binge and heavy drinking, as well as underage drinking, driving under the influence (DUI, also called drunk driving or driving while intoxicated, DWI), and drinking by pregnant people.

There is no universally agreed-upon safe level of alcohol use. The United States Dietary Guidelines for Americans recommend that men limit intake to two drinks in a day and women to one drink or less.[6] These amounts were established based on how men and women metabolize alcohol. There are currently no established guidelines that include number of drinks for individuals whose gender identities do not match their sex assigned at birth.[7] The rate at which alcohol is metabolized impacts an individual's blood-alcohol concentration (BAC), which measures the percent of alcohol in a person's bloodstream. Physical and mental impairment from alcohol use is assessed by BAC (see graphic).

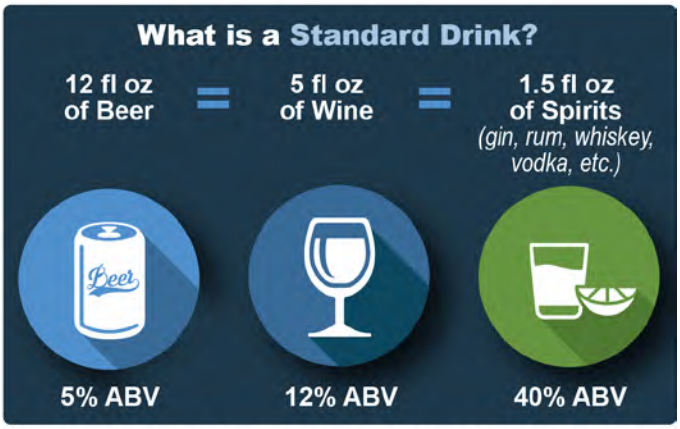
Alcohol use disorder (AUD) is a chronic medical condition that meets criteria in the Diagnostic and Statistical Manual of Mental Disorders[8] and is characterized by the impaired ability to stop or control alcohol use, to relieve or avoid withdrawal symptoms, despite adverse social, occupational, or health consequences.



Note: These effects are generalized and may vary depending on individual factors. The federal limit to legally drive in the United States is a BAC of 0.08%, except Utah where it is 0.05%. Many states have set lower BAC limits to legally drive for individuals under the age of 21, known as zero tolerance laws.
Source: Centers for Disease Control and Prevention (CDC). (n.d.). *Blood alcohol concentration*. https://www.cdc.gov/motorvehiclesafety/pdf/bac-a.pdf

Alcohol Products

All alcohol products contain ethyl alcohol, or ethanol, that is produced through fermentation of different materials like grains (beer) and grapes (wine). The most common alcohol products are beer, wine, and liquor/spirits. The percentage of pure alcohol in these products is measured using alcohol by volume (ABV). Beer and wine are



Variation in ABV is reflected in standard drinks for the same size. For example, a 12 oz beer that is 8% ABV is 1.6 standard drinks and a 5 oz glass of wine that is 15% ABV is 1.25 standard drinks.

typically thought of as the safest alcoholic beverages because of their relatively low ABV, while liquor/spirits are thought of as more potent due to their higher ABV. However, no one alcoholic beverage is safer to drink than any other; the amount of alcohol *consumed* is what affects people the most, across all beverage types.[9]

Over the years, alcohol products have evolved beyond these standard types. The alcohol industry has introduced several new alcohol products since the 1990s that have raised public health concerns about higher levels of alcohol consumption, more alcohol consumed by youth, and greater physical and social harms. The most recent products, potentially associated with a high risk of alcohol-related harm, include:

- *Alcohol mixed with energy drinks*, in ready-to-drink cans or mixed at bars or restaurants (note: these are banned in some states).[10]
- *Flavored alcoholic beverages*, also called "alcopops," which are sweetened beverages designed to appeal to youth or consumers who are less familiar with the taste of more traditional alcoholic beverages.[11]
- *Ready-to-drink cocktails*, which are pre-mixed cocktails available wherever alcohol is sold to-go.
- *"Hard" drinks*, such as hard kombucha or hard seltzers and sodas that add flavor and alcohol to previously alcohol-free beverages; these drinks have approximately the same alcoholic beverage content as beer.
- *High alcohol content beer*, such as those above 7 percent ABV and some even above 67 percent ABV.

- *Powdered alcohol*, available in capsule or packet form and containing alcohol that has been absorbed by a sugar derivative; individuals can consume alcohol capsules orally as a pill or dissolve them in water to make an alcoholic beverage.
- *Grain alcohol*, which is high-strength alcohol (e.g., above 100 proof, or 50 percent ABV) that has been restricted or banned in ten states as of 2019.[12]

Demographic Characteristics of People Who Are Impacted by Alcohol Misuse

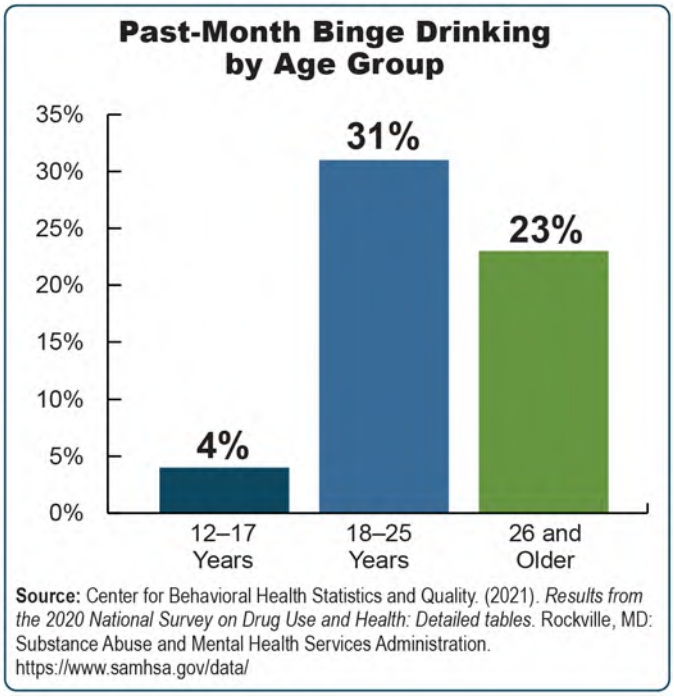
As communities recognize alcohol's role in individual and community harms, it is important to assess who is affected by alcohol misuse and the rates of alcohol misuse among different population groups. Paired with data on the broader context of where and how retailers market and sell alcohol, consumption data can assist communities in determining the best prevention approach to address their specific issues (see Chapter 2 for a list of evidence-based policies and Chapter 3 for implementation recommendations).

Age

In 2020, almost 70 (69.6) percent of people living in the United States age 21 and older (166.6 million people) reported drinking alcohol in the past year, as did 29.7 percent of underage individuals aged 12 to 20.[13] Nearly one in four individuals (24.3 percent) age 21 and over reported binge drinking in the past month.[13] Individuals aged 18 to 25 exhibited the highest rates of past-month binge drinking (31.4 percent), followed by individuals aged 26 and older (22.9 percent) and 12 to 17 (4.1 percent).[13] Younger people are more likely than older people to drive under the influence of alcohol; of drivers involved in fatal car crashes, 27 percent were aged 25 to 34, with the next largest groups being 21 to 24 (26 percent) and 35 to 44 (22 percent).[14]

Underage drinking remains a major concern in the United States, even though purchasing or possessing alcohol is illegal for those under the age of 21 in most circumstances.[a]

In fact, in 2016, underage drinking accounted for $17.5 billion in alcohol sales, and people aged 12 to 20 drank 9 percent of all alcohol consumed that year.[15] Alcohol products, such as flavored alcoholic beverages, are particularly popular among youth, and evidence suggests that these products are specifically marketed to attract youth.[16] The link between youth exposure to marketing and underage drinking is clear: reducing youth exposure to marketing reduces youth alcohol consumption.[16-17] Early initiation of alcohol use sets young people up for greater likelihood of harm later in life.[18-20] Reducing youth exposure to alcohol advertising is just one example of a policy intervention that can help delay initiation, and thus reduce alcohol misuse and related harms.



Source: Center for Behavioral Health Statistics and Quality. (2021). *Results from the 2020 National Survey on Drug Use and Health: Detailed tables*. Rockville, MD: Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/

In recent years, alcohol misuse has also been increasing in older adults. One study found that 20 percent of older adults surveyed drank alcohol 4 or more times per week, 27 percent reported having 6 or more drinks on at least 1 occasion in the past year, and 7 percent reported alcohol-

[a] Thirty-seven states allow the consumption of alcohol for those under the age of 21 when with a parent, guardian, or spouse, or in private locations, such as a private residence or parent/guardian's home.

related blackouts.[21] Alcohol misuse in older adults can place these individuals at additional risk because they metabolize alcohol more slowly, are more susceptible to injury, and are more likely to be taking multiple prescription medications that may not be mixed with alcohol.[22]

Sex/Gender

Sex assigned at birth and gender identity impact alcohol misuse and associated risks in many ways. The former has a greater effect on impaired functioning, inhibition, and other behavioral impacts, while the latter has a greater effect on responses to marketing and susceptibility to sexual assault.[23] In the past, researchers did not collect data specific to sex assigned at birth and gender identity;[7, 24] however, these data are becoming more readily available and are improving our understanding of how these factors influence alcohol misuse and differences between majority and minority groups.[25-27] Given the current understanding of the interactions between sex assigned at birth, gender identity, and alcohol misuse, prevention programming should encompass and address all components of sex and gender.

Sex assigned at birth. In the United States, males have historically reported much higher rates of drinking and alcohol misuse than females. Males in the United States drink three times more alcohol than their female counterparts.[28] In 2020, among individuals aged 12 and

Alcohol Misuse by Gender Identity

Definitions and measures of alcohol misuse have not always considered the complexity of biological characteristics, sex assigned at birth, gender identity, or the interactions among these factors. However, data on gender and sexual identities are becoming more readily available. Research in the areas of understanding and measuring alcohol misuse in transgender populations and how they differ from cisgender populations is ongoing. Data on alcohol misuse for gender minorities (e g , transgender, non-binary) have been inconsistent, but differences have been noted in alcohol misuse among these individuals and cisgender people across several behaviors, indicating that different groups have distinct health risks.

Compared to cisgender individuals, individuals who identify as transgender are more likely to use substances, including alcohol.

Gender non-conforming individuals have higher odds of binge and heavy drinking than do gender-conforming individuals.

Transgender females have higher odds of binge and heavy drinking compared to cisgender females.

Women and gender minority college students drink less than cisgender, heterosexual college men but experience more alcohol-related consequences per drink.

Individuals who identify as transgender may be more influenced by norms associated with gender identity than those associated with their birth-assigned sex.

Stress related to gender identity is associated with risky drinking behavior.

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older, the prevalence of binge drinking in the past month was higher among males than females (24.9 percent versus 19.7 percent, respectively).[13] An estimated half of all violent crimes involve alcohol use, including sexual assaults; nearly all perpetrators are male, while nearly all victims are female.[29-30] Males are four times as likely to drive under the influence compared to females.[31]

Female misuse of alcohol is, however, increasing.[32] In 2020, the prevalence of binge drinking in the past month among males and females aged 18 to 25 was nearly equal (31.3 percent and 31.4 percent, respectively).[13] Moreover, 2019 data on high school students, analyzed separately for male and females showed that females report current binge drinking at a higher rate than males in the same grade.[33] This pattern suggests that young females may be at particularly high risk of engaging in alcohol misuse, compared to male peers and older females. These findings are concerning, given that, compared to males, females are at higher risk for medical problems associated with alcohol misuse, including liver, brain, and heart damage;[34-35] and alcohol use is also a major risk factor for breast cancer.[36]

Gender identity. The impact of gender on alcohol misuse is influenced by gender roles and norms, relations, identity, and other components of gender in addition to sex assigned at birth and the intersection of these different factors.[23] Although gender-specific risks associated with drinking have been historically researched based on sex assigned at birth, gender identity may influence these risks. For example, alcohol products and marketing are often geared towards stereotypical preferences of women. This includes the commercialization of lower calorie beer, sparkling alcoholic beverage products, and wines named and branded for a moms' or girls' night out. Alcohol marketing also capitalizes on gendered messaging and stereotypes, such as using significant pink branding, focusing on all-women friendships, talking about the gender pay gap, and attaching to International Women's Day.[37]

These marketing tactics may influence alcohol consumption among women, compounding risks because, in addition to being subjected to gender-specific marketing practices, people in gender minority groups are more likely than majority groups to consume alcohol.[23]

Sexual Orientation

Sexual minorities tend to have a higher rate of alcohol misuse.[27, 38] According to the 2020 National Survey on Drug Use and Health, 32.6 percent of people identifying as lesbian, gay, or bisexual (LGB) aged 18 and older reported binge drinking in the past month.[13] This rate was higher than the national binge drinking prevalence rate of 24.2 percent:[13]

- Women aged 18 and over who identify as sexual minorities reported a higher percentage of past month binge drinking (34.3 percent) than did women overall (31.3 percent).
- Men aged 18 and over who identify as sexual minorities also reported a higher percentage of past month binge drinking (29.8 percent), compared to men overall (27.3 percent).

Similarly, the 2019 Youth Risk Behavior Survey found that LGB youth also had a significantly higher rate (33.9 percent) of current alcohol use than their heterosexual peers (28.8 percent).[39]

Federal surveys that have begun to ask sexual orientation questions in recent years find that substance misuse and substance use disorders, in general, are more prevalent among individuals who identify as lesbian, gay, bisexual, transgender, queer/questioning, and/or intersex (LGBTQI+) as compared to those who identify as heterosexual and/or cisgender.[40-41] Other research has produced similar findings, and indicates a nuanced intersection between sexual orientation and gender identity that influences social and biological risk factors for substance misuse. For example, one study found that sexual minorities assigned female sex at birth were more likely to report substance misuse, compared to the general population, in which more people assigned male sex at birth tend to report substance misuse.[42] Another study found that the intersection of gender and sexual orientation and how it influences alcohol misuse, specifically, may vary by identity, as youth who were questioning both their gender and sexual orientation had greater odds of initiating alcohol use before age 15.[27]

While biological traits that influence alcohol misuse appear more frequently in some populations than others, genetics account for half of AUDs,[43] and social/environmental influences account for the rest.

There are a range of social issues, such as stigma, discrimination, and other challenges not experienced by people who identify as heterosexual, that may put LGBTQI+ individuals at greater risk for behavioral health issues, including alcohol misuse.[40-41] Sponsored events in bars, product labeling that relies on rainbows and pride themes, advertisements in gay press publications, strategic advertising campaigns, and support of pride events increases the exposure of alcohol to LGBTQI+ populations.[44-45] These marketing practices entrench alcohol further in LGBTQI+ communities, potentially increasing the risk of alcohol misuse and alcohol-related harms in already disenfranchised and susceptible groups.

Race/Ethnicity

Rates of alcohol misuse differ among racial and/or ethnic groups in the United States.[46,b] Many of the observed differences in alcohol misuse by different races or ethnicities are rooted in social-structural inequities; for example, although men who identified as White were most likely to report driving under the influence of alcohol (followed by men who identified as American Indian/Alaska Native (AI/AN) and mixed race),[48] men who identified as Black/African American and Latino were more likely to be stopped, searched, and convicted for doing so.[49]

Among individuals aged 12 and older, past 30-day binge drinking rates are reported highest among those who identify as White (23.1 percent) and Hispanic (23.7 percent), closely followed by those who identify as Black/African American (20.8 percent) and as two or more races (20.6 percent). Lowest past 30-day binge drinking rates are reported among people who identify as Asian Americans (12.1 percent). Reliable estimates for alcohol misuse among people who identify as AI/AN and Native Hawaiians/Pacific Islanders are not currently available.[13]

When compared to White populations, AI/AN communities have lower rates of alcohol use overall, but higher rates of binge and heavy drinking among people who currently drink alcohol.[52] AI/AN populations also experience greater harms from alcohol misuse, as well as numerous health disparities that are associated with current and historical legacies of systemic racism and stigmatization.[53-54] American Indian youth are more likely to report drinking, heavy drinking, and initiation of alcohol use at a younger age than White youth and are more likely to access alcohol from social sources like parties, siblings, non-parent adults, bars, and retail stores.[50] Other research suggests that American Indian youth access alcohol at higher rates than all other demographic groups except White youth.[50] Additionally, researchers have documented disproportionate marketing of alcohol to American Indians for decades.[55] According to a recent analysis of trends in alcohol-induced deaths in the United States during 2000–2016, both the death rate and its average annual rate of increase were highest amongst AI/AN individuals.[56] Furthermore, a commentary on the analysis cited that these extremely high rates are likely still undercounted due to racial misclassification on death certificates, making these rates even more concerning.[57]

Many Black, Indigenous, and People of Color (BIPOC) communities experience disproportionately greater exposure to alcohol than do Whites, largely through high densities of alcohol outlets (i.e., the number of bars, restaurants, and stores selling alcohol in a certain geographic area).[50] For example, low-income, predominantly Black neighborhoods in Baltimore had up to eight times as many liquor stores compared to communities with different socioeconomic and racial demographics.[50-51]

BIPOC communities also face high levels of exposure to alcohol marketing. One study found that there are five times more alcohol advertisements in Latino neighborhoods than in White neighborhoods;[58] similar patterns exist for billboard advertising in predominantly non-White communities.[59] Additionally, low-cost, high-alcoholic beverages, such as malt liquor, are more readily available and heavily marketed in communities of color than in predominantly White communities.[60-61]

[b] The United States Census Bureau defines race and ethnicity as a person's self-identification with one or more social groups based on ancestral region of origin.[47] Information on race is collected to make funding decisions and understanding disparities in housing, education, employment, health care, and other sectors.[47] While there are no biologically distinct "races," there are biological traits that are more common in certain races than others.

Despite these environmental risk factors, non-White populations typically have lower drinking rates than Whites. However, they still experience disproportionate harm from alcohol consumption, particularly those with the lowest income levels.[62] The discrepancy between lower rates of drinking and higher rates of harm may be due to the combination of additional stress, stigma, and discrimination that non-White populations face, unresolved individual and community-level trauma, and exposure to drinking environments and settings associated with a high risk of harm.[63-64]

Socioeconomic Status

In general, people with higher socioeconomic status report drinking more frequently and more heavily than those with lower SES; however, people with lower socioeconomic status are, on average, more negatively affected by alcohol-related harms.[65] One study found that people who belonged to a household with a low income (below $20,000) were more likely to either abstain from alcohol or drink heavily; they were less likely to report light or moderate drinking.[66]

Another study showed binge-drinking prevalence was highest among those with the highest income (>$75,000); the relationship between high income and high binge drinking rates have been duplicated in numerous studies.[67-68] When looking at education level, data show that higher education is associated with higher odds of a person drinking at some point in their life.[69] More recently, researchers found that, within the same urban area, people living in higher income neighborhoods drank more alcohol and reported more alcohol-related problems, compared to people in lower income neighborhoods.[70]

Harms Associated with Alcohol Misuse

There are more than 200 conditions associated with alcohol misuse, many leading to chronic disease and death;[71-72] it is a leading preventable cause of death in the United States.[73] Harms related to alcohol misuse also have negative impacts on non-drinking individuals, family members, communities, and society.[74] Negative consequences of alcohol misuse can uniquely affect different sectors of society.[75] For example, alcohol misuse is associated with a host of long-term physical harms, which influence productivity in the workplace. Alcohol misuse may also jeopardize public safety.

Impacts of Alcohol Misuse on Individuals, Family/Relationships, and Communities/ Society[9, 71, 76-78]

Individual Morbidity and Mortality	Family/Relationships	Communities/ Society
• Unintentional injuries such as motor vehicle crashes, falls, drownings, and burns • Alcohol poisoning • Risky sexual behaviors • Effects on pregnant people and their babies, including miscarriage and stillbirth • Cardiac issues, such as high blood pressure, heart disease, and stroke • Liver disease, gastritis, pancreatitis, and digestive issues • Several different types of cancer, including mouth, throat, larynx, esophagus, liver, breast, colon, pancreatic, and rectum • Neurological issues, including learning and memory problems, poor school performance, difficulty walking (ataxia), blindness, encephalopathy, and dementia • A weakened immune system • Weight and blood sugar level changes • Behavioral health conditions, such as depression, anxiety, concurrent substance misuse, AUD, and suicide • Fertility issues affecting both males and females	***Partners*** • Intentional injuries and violence, like sexual assault, homicide, domestic/intimate partner violence • Decreased quality of life • Physical and mental health problems • Divorce and/or separation ***Children*** • Poor school performance • Negative effects on infants, children, and adults whose mothers drank during pregnancy, like pre-term birth, low birth weight, and fetal alcohol spectrum disorders • Abuse and neglect • Riding with driver under the influence • Adverse childhood experiences	***Workplace*** • Unemployment • Decreased productivity and career advancement and/ or opportunities • Workplace problems (e.g., harassment) ***Public Safety*** • Motor vehicle crashes • Violent crime (e.g., assault, homicide) • Disruptive behavior (e.g., threats, disorderly conduct) • Incarceration and penal costs

People experiencing harm due to others' drinking increases the broader community impact of alcohol misuse. One study found that one in five adults reported experiencing at least one harm due to others' drinking in the past year.[79] These secondhand effects of alcohol use include harassment or threats, financial harms, physical aggression, driving-related harms, and more.

The negative consequences of alcohol misuse create not only a social burden, but also a financial burden to society. In 2010, the most recent data available, the economic costs related to excessive alcohol use in the United States were estimated at $249 billion. This resulted from lost workplace productivity, healthcare costs, criminal justice expenses, and costs associated with alcohol-related motor vehicle crashes and other property damage.[80] Costs to communities include those for law enforcement and social, healthcare, ambulatory, and emergency services to respond to and treat alcohol-related problems, including crashes, violent crimes, public intoxication, and other public nuisances. These costs can be substantial burdens for communities.

Community-Level Risk and Protective Factors

Many community-level factors may influence an individual's drinking behavior and contribute to alcohol misuse.[81-82] Risk factors for alcohol misuse are characteristics associated with a *greater* likelihood of negative outcomes related to drinking, while protective factors are those associated with a *lower* likelihood of negative outcomes or reduced impact of risk factors.[83]

Many risk factors for alcohol misuse are tied to an individual's or family's behavior or circumstances. However, one's community—and the corresponding structural, societal, and cultural factors within it—can also create both risk and protective factors.

Key risks at the community level relate to alcohol availability and cost. When alcohol is low cost, widely available, and unrestricted, and when its use is normalized, individuals who are at risk for alcohol misuse have greater opportunities to drink at high or harmful levels.[84-88] More specifically, these community-level risk factors include:

- Beliefs and practices that normalize underage drinking.
- Alcohol use at younger ages (e.g., under 21), abundant alcohol advertising, and laws that do not prohibit alcohol misuse, such as permitting driving while under the influence if BAC is legally low enough.[89]
- Alcohol that is easily and cheaply available, as is the case with low alcohol taxes and prices, weak restrictions and regulations on alcohol use in public places and at community events, weak retail restrictions and regulations (e.g., density, hours, and days of sale), and minimal point of sale restrictions (e.g., displaying alcohol at or near the checkout).
- Socioeconomic factors, like low neighborhood income.

The opposite of each of these risk factors can be considered protective factors and are important considerations for building and supporting healthy, resilient communities. For example, raising the price of alcohol through taxes or banning price promotions is a protective factor, as is limiting the number of alcohol outlets in a community.[86, 90]

Individual- and Family-Level Risk and Protective Factors

While community-level risk factors are critical to understanding the most appropriate policy interventions to reduce alcohol misuse, it is helpful to understand that many individual- and family-level factors may also influence an individual's drinking behavior. These

individual-level factors should not be considered in isolation, but in the broader context of community-level factors.[82-83, 91]

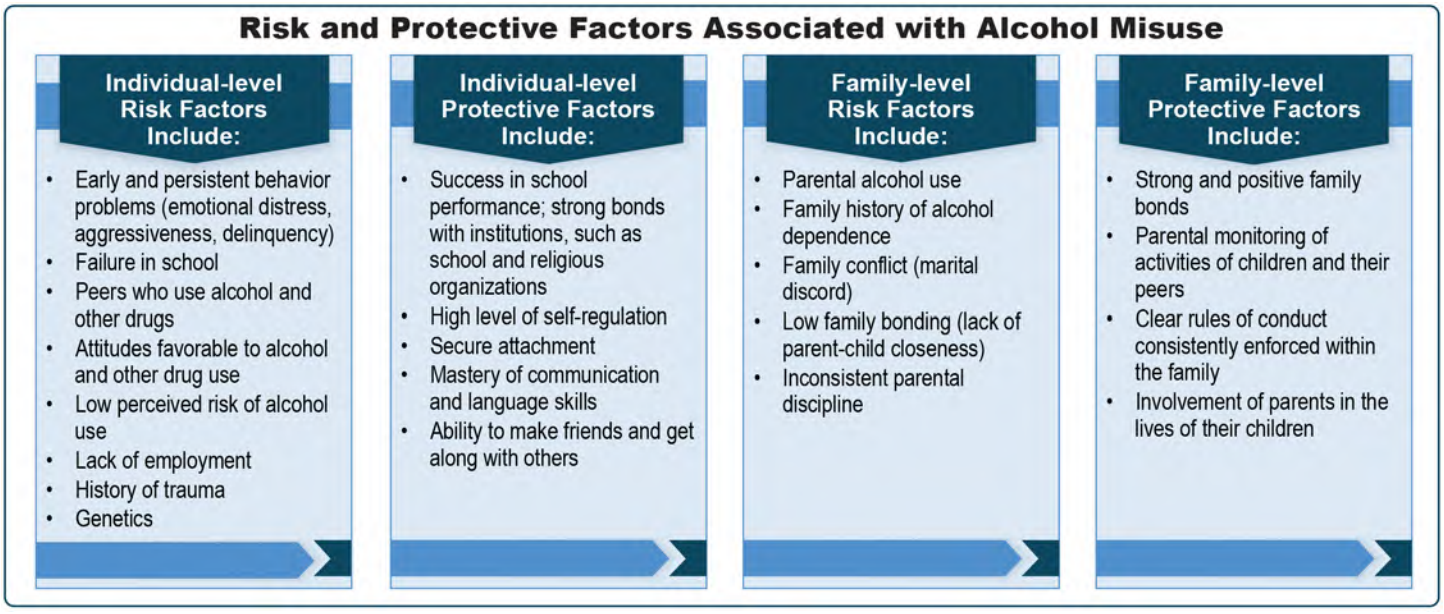
Broader social determinants of health should be considered when assessing risk and protective factors across individuals, families, and the communities in which they live. Racial/ethnic, sexual, and gender minorities in the United States face a range of hardships that may directly affect their health, including income disparities, unemployment, residential segregation, substandard housing, discrimination, and less access to health care as compared to White, cisgender, or heterosexual populations.[92] The cumulative effects of these factors over a period of time may lead to high chronic stress, strain on the body, and negative coping skills, which are associated with poor health and alcohol misuse.[93]

All aspects of an individual's identity, including their age, race/ethnicity, genetic makeup, sexual orientation, gender, and SES, contribute to a person's relative advantage and disadvantage across life experiences.[94] These aspects cannot be considered in isolation when seeking to prevent or reduce alcohol misuse or related harms. For this reason, and as described in Chapter 2, focusing prevention efforts at the community level has the greatest opportunity to affect the broader social factors that influence drinking habits and associated harms.[86]

Importance of Universal Prevention Efforts

Prevention efforts that focus on all people in a population (known as "universal interventions" or "universal prevention") have shown greater impact on substance misuse and related harms, compared to interventions that focus solely on individual-level changes in alcohol misuse.[95-96] Universal prevention has also been shown to be cost-effective while reducing the costs associated with alcohol misuse and related harms within communities. Universal interventions work to improve the lives of all individuals within a community, including those experiencing greater health inequities.

Finally, policies focused on alcohol misuse prevention (e.g., raising alcohol taxes, reducing the density of alcohol outlets, reducing hours of sale), through their secondary effects—such as reducing associated crime and violence—can help promote and maintain healthier, more resilient communities. Chapter 2 contains more details on this prevention approach.



CHAPTER

2

What Research Tells Us

This guide identifies policies implemented to prevent alcohol misuse by changing or influencing community conditions, systems, and behaviors. These policies should not be considered in isolation as they are most effective when coordinated to complement and reinforce one another to reduce the influence of alcohol in the overall environment.[97]

The policies included in this guide were selected after a comprehensive literature review and in collaboration with subject matter experts. Policies eligible for inclusion met the following criteria:

- Are clearly defined and replicable
- Have been evaluated through independent study
- Address the target outcome of reduction or prevention of alcohol misuse
- Are currently in use
- Have accessible implementation supports, such as implementation guides

A substantial body of evidence supports the policies included in this chapter; many have been researched for decades—in different settings and within different communities. However, it is important to note that the alcohol policy and regulatory landscape is continually changing, and interventions must adapt. Policies must keep pace with a dynamic industry that includes, but is not limited to, the following:

- Release of high-alcohol content products (such as high-alcohol supersized alcopops, hard seltzers, and high-alcohol craft beers)
- Increase in the number of establishments that sell alcohol, such as movie theaters and coffee shops, thus increasing availability
- Innovative marketing of alcoholic beverages (e.g., increased use of social media; paid social media influencers who discuss and market the product to a large network of followers; new digital marketing techniques, such as engaging with social media comments and connecting events and user locations directly to products and purchase opportunities)
- Different ways of selling and providing alcohol (e.g., curbside pick-up and carry out, providing free alcohol, online alcohol sales, home delivery)

As prevention practitioners[a] look for options to address emerging changes in their alcohol environments, they should consider policies that fit under the broader theory of creating safer communities through reducing **alcohol availability** via regulation and policy. Policies grounded in this approach have shown the greatest effectiveness in reducing alcohol consumption and related harms across the general population.[96] Strategies to affect availability can be conceptualized using the following framework:[98]

[a] For simplicity, the term "practitioner" is used throughout this guide to refer to individuals providing health care, including behavioral health services. The authors recognize that some settings may use other terms, such as clinician or provider.

Alcohol Policy: Key Resources

- The Community Guide
- Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health
- Surgeon General's Call to Action to Prevent and Reduce Underage Drinking
- National Academies of Science and Engineering: Reducing Underage Drinking: A Collective Responsibility
- CollegeAIM
- STOP Act Report to Congress
- Getting to Zero Alcohol-Impaired Driving Fatalities

- **Physical availability**, including restricting how, when, where, and to whom retailers can sell alcohol or where alcohol is consumed (such as parks, home parties, or beaches). Reducing the ease of accessing alcohol requires consumers to then devote more effort and intention to obtaining and consuming the product, which in turn reduces consumption and harm.
- **Financial availability**, including mechanisms to raise the price of drinking, such as taxes, minimum unit price policies (setting a minimum price per standard drink, defined as approximately 14 grams of pure alcohol, found in 12 ounces of regular beer—usually about 5 percent alcohol, 5 ounces of wine-typically about 12 percent alcohol, and 1.5 ounces of distilled spirits—about 40 percent alcohol[99]), and bans on price discounting such as "happy hours." By increasing the price of alcohol, demand decreases, reducing alcohol consumption and harm.
- **Social availability**, including assessing how marketing can be used to create a powerful normative climate that is positive towards drinking, impeding prevention efforts. By changing the perceived norms and social acceptability of alcohol through reducing alcohol marketing and discouraging access in peer and family networks, individuals (particularly youth) are less likely to begin drinking and more likely to decrease alcohol consumption.[100]
- **Psychological availability**, including understanding individuals' perceptions of how accessible alcohol is to them and their lifestyle—often influenced by how they respond to alcohol marketing. By limiting or reducing exposure to alcohol marketing, people (and especially youth) are less likely to consume alcohol.[16-17]

The policies discussed here are grounded in the concept of availability, which has a substantial evidence base.[81, 101] Where possible, this chapter also highlights if and how these policies have been implemented and studied in diverse communities (such as predominantly Black or Brown communities, rural communities, or with LGBTQI+ populations). It is important to note that not all of these policies have been tested or implemented in various communities, and all policies should be viewed through the lens of health equity.

This chapter organizes the policies into three categories.

Policies with the *Strongest Evidence*: Policies that are a high priority for implementation, based on level of evidence and population impact
Regulating alcohol outlet density
Minimum legal purchase age
Limiting days or hours of sales
Increasing alcohol taxes
Minimum pricing
Limiting alcohol advertising and marketing (specific to underage drinking)
Dram shop (commercial host) liability laws
Policies with *Moderate Evidence*: Policies that have mixed research evidence and should be pursued only together with the high priority policies
Restricting social availability of alcohol (e.g., social host ordinances)
Alcohol-impaired driving countermeasures
Limiting price promotions
Policies with *Limited to No Evidence*: Policies that are only effective when done in conjunction with high priority policies
Responsible beverage service
Retail environment limitations (e.g., limiting floor space for alcohol in retail establishments; banning products with a high risk of alcohol-related harm)
Restrictions on public places where alcohol is sold/ consumed

Policies With the Strongest Evidence

The policies included in this section have a strong evidence base and have shown reductions in alcohol misuse and related harms. Importantly, research shows they affect populations broadly, rather than focus on small groups with a high risk of alcohol-related harm. These policies are endorsed or recommended by the World Health Organization; the Community Preventive Services Task Force; the Surgeon General's Report on Alcohol, Drugs, and Health; the National Academy of Science and Engineering's Getting to Zero report; and others. When considering policies for implementation, communities should prioritize this set of policies, as they will have the greatest impact on alcohol misuse.

Physical Availability

Alcohol consumption and related harms decrease when communities reduce where, when, and how alcohol can be sold and consumed.[87-88, 102-103] Leading interventions to decrease alcohol availability include regulating alcohol outlet density, maintaining the legal purchase age of 21, and limiting the hours and days that establishments can sell alcohol.

Types of Alcohol Outlets

On-premises: Alcohol served in food and entertainment establishments, such as bars, restaurants, and other locations, for consumption on-site.

Off-premises: Alcohol purchased from liquor stores, grocery stores, convenience stores, or other retail establishments for consumption off-site.

Some establishments may allow on-premises consumption and off-premises purchases, like breweries and wineries.

Regulating Alcohol Outlet Density

Jurisdictions can regulate the alcohol retail environment, including outlets that sell alcohol for consumption on-premises and off-premises, by restricting the number and/or locations of alcohol outlets in a neighborhood or community. These policies limit the sale of alcohol through:

- Licensing restrictions that generally regulate the type or number of outlets per population (e.g., per 1,000 residents) or geographic area
- Zoning laws that apply land use provisions to determine the permissible locations for alcohol outlets[86, 104]

Licensing authority depends on the regulatory structure of the state and the degree to which it permits or preempts local policy on how, when, and where retailers can sell alcohol. States generally regulate licensing, although some localities may share licensing powers with the state or have local licensing power over certain kinds of alcohol outlets (e.g., on- or off-premises) or

outlets selling certain alcoholic beverages.[105-106] Zoning authority gives local jurisdictions the ability to use planning and land use procedures to determine the placement and practices of businesses operating within their borders. Nuisance ordinances are often enacted in conjunction with zoning laws and licensing restrictions and allow local jurisdictions to regulate alcohol retailers who are consistently cited for poor business practices, such as lack of exterior lighting, sales to minors, graffiti, extensive advertising, or loitering or crime at their establishment.

Governments may want to consider the above three regulatory policies as a complementary trio. Regardless of jurisdiction over licensing, town, city, and county governments most often employ zoning and nuisance powers to regulate access to alcohol. For example, pairing a zoning ordinance with a licensing policy that limits the number of retailers can help avoid clustering numerous outlets within one small area, which has been associated with youth alcohol consumption and increased crime.[107-109] It also helps ensure that alcohol establishments are not disproportionately located in low-income areas.[110]

Policy: Regulating Alcohol Outlet Density	
Description	**Examples of Outcomes**
Limiting/restricting where alcohol retailers may be located through licensing or zoning	**Reduction in alcohol consumption**[86, 111] • Limiting alcohol outlets to 70 per square mile in New York City decreased binge drinking prevalence by 0.7 percent.[112] • Across six urban cities, increases in the density of alcohol outlets per square mile was associated with a 7- to 11-percent increase in total weekly alcohol use.[113] **Reduction in alcohol-related harms**, including motor-vehicle crashes, injuries, violence, and medical conditions[86, 114] • Removing alcohol outlets in Baltimore's residential areas was associated with 22 fewer homicides each year.[115] • Intentional and unintentional injuries are significantly greater in areas with a higher density of off-premises alcohol outlets.[114]

Health Equity Considerations of the Policy

High alcohol outlet density in the United States is associated with communities that have higher levels of poverty and greater proportions of Black and Hispanic/Latino populations,[116-118] particularly for off-premises outlets.[119] Studies have shown that communities of color tend to have the highest alcohol outlet density and associated problems, yet the lowest consumption levels, suggesting that systemic racism could partially explain these patterns.[120] Multiple studies have found that a history of discriminatory lending practices ("redlining"), which resulted in more alcohol retailers located in neighborhoods with higher population density, helps explain the overconcentration of alcohol outlets in these areas.[110, 120-121] A reduction of alcohol outlet density in communities of color could help reduce alcohol-related inequities, such as violence and other crimes.

Real World Implementation Examples

- The local city council of Atlanta, Georgia enacted a series of policies to reduce alcohol availability in 2003. These policies led to a decrease in alcohol density in the Buckhead neighborhood, which is 75 percent White and relatively young, with half the population aged 15 to 34 and the other half older than 35. A 3-percent reduction in outlet density was associated with a 28-percent reduction in violent crime—twice the decrease that occurred in comparable neighborhoods where outlet density had not changed.[108]
- In 1997, New Orleans, Louisiana implemented a series of policies, including increased licensing fees, enforcement, and expanding licensing board powers, that led to alcohol outlet density reductions, resulting in a significant decrease in violent assaults.[122] In addition, literature suggests that reducing the number of alcohol retailers reduces injury and crime.[86]

Minimum Legal Purchase Age

The minimum legal purchase age law (often referred to as the minimum legal drinking age or MLDA) specifies the age when a person can legally purchase an alcoholic beverage. The federal National Minimum Drinking Age Act of 1984 created incentives so that, by 1988, every state had adopted a minimum purchase age of 21.

Despite subsequent efforts by some advocates to reduce the drinking age to 18, the Community Preventive Services Task Force, Mothers Against Drunk Driving, the National Highway Traffic Safety Administration, and other organizations all recommend maintaining the age of 21. The Community Guide, a collection of evidence-based recommendations and findings from the Community Preventive Services Task Force, found that well-enforced minimum legal purchase age policies reduced youth access to alcohol.[123]

Policy: Maintaining the Minimum Legal Purchase Age of 21	
Description	**Examples of Outcomes**
Sets the MLDA at 21 years old	**Reduction in alcohol consumption** among high school students, college students, and other young adults[124-128] • After adoption of age 21 MLDA, the prevalence rates of past month drinking and of binge drinking among those aged 18 to 20 decreased from 59.1 and 31.4 percent in 1985 to 46.5 and 24.1 percent in 1999; some increases in these behaviors were noted between 1997 and 1999. In 2020, 32 percent of individuals aged 18 to 20 reported past-month drinking.[13] **Reduction in alcohol use disorder (AUD) among adults[130]** **Reduction in motor vehicle crashes** • The National Highway Traffic Safety Administration estimates that the law prevented 31,959 deaths from 1975 through 2017 due to alcohol-related traffic crashes.[131] **Reductions in crime** • Research has shown that early initiation of alcohol use is associated with greater alcohol-related violence, dating violence, and unintentional injury, among other negative consequences.[125]

Health Equity Considerations of the Policy

Given that the minimum legal purchase age affects all individuals in the United States under the age of 21, it does not have disproportionate impacts on particular communities or populations. However, as with many policies, it requires enforcement to be effective, and communities should ensure equitable enforcement of policies. The Community Preventive Services Task Force recommends ensuring community buy-in for enforcement of underage drinking laws,[132] which may assist in equitable implementation.

Real World Implementation Example

- By 1988, all states set a minimum legal purchasing age of 21, in accordance with the 1984 federal law. However, states continue to find loopholes in this law that allow for youth consumption, such as drinking on private premises with parental consent. As of January 2021, 15 states had no exceptions to this law, which is in alignment with the best evidence on this policy.

Limiting Days or Hours of Sales

Localities, states, tribes (federally recognized AI/AN tribal governments), and territories can limit access to and availability of alcohol by reducing the number of days or hours that businesses can sell it for consumption on- or off-premises. In the United States, research on these policies has largely focused on the impact of legalizing Sunday sales at off-premises outlets or restricting hours that on- or off-premises stores can sell alcohol.

In the context of this guide, "limiting" can mean maintaining existing limits in response to any efforts to expand current days or hours of sale or enacting more stringent limits than currently exist. Limiting the hours of sale decreases alcohol availability and reduces consumption and related harms. Several scientific bodies have recommended limiting hours and days of sale, including the World Health Organization[133] and The Community Preventive Services Task Force.[87]

Policy: Limiting Days/Hours of Sale	
Description	**Examples of Outcomes**
Limits the days and hours that retailers can sell alcohol, both on- and off-premises	***Limiting Days of Sale*** **Reduction in alcohol consumption**[134-135] • One additional day of alcohol sales significantly increased per capita consumption of all alcohol by 3 percent, of beer by 5 percent, and of wine and liquor by 3 percent.[102] **Reduction in alcohol-related harms**[136-137] • In seven states that repealed Sunday sales bans for off-premises outlets, violent and property crimes increased significantly, by between 16 and 23 percent on Sundays.[138] • In Virginia, an additional day of sale for stores that sell alcohol was associated with increased alcohol-related crimes committed on Sundays in areas near outlets that allowed Sunday sales.[139] Similar results were found in Pennsylvania, which showed a significant increase in crime occurring around Sunday-open state liquor stores in low-socioeconomic-status neighborhoods.[137] ***Limiting Hours of Sale*** **Reduction in alcohol consumption**[87] **Reduction in alcohol-related harms** • Allowing alcohol sales for an extra two hours or more was associated with increases in injuries from vehicle crashes, alcohol-related assaults and injuries, and admissions to the emergency department.[87]

Real World Implementation Examples

- *Sunday sales*: There are no United States examples of reducing the numbers of days in which retailers can sell alcohol; instead, the trend has been to increase the number of days by allowing sales on Sundays.
- *Hours of sale*: In 2020, one legislative district in Baltimore reduced the allowed hours of alcohol sales in on- and off-premises establishments from 6:00 a.m.–2:00 a.m. to 10:00 a.m.–10:00 p.m.

Health Equity Considerations of the Policy

Following a partial repeal of Sunday sales bans in Philadelphia, one study found increases in property and overall crimes on Sundays in the immediate vicinity of alcohol outlets, but only around outlets in neighborhoods with low socioeconomic status.[137] The authors noted that many of these neighborhoods had above average rates of crime prior to the intervention, and that the findings were consistent with previous analyses showing that alcohol availability is associated with crime in areas with high poverty.[137] These findings suggest that increasing the hours and days of sale may disproportionately lead to increased harm in under-resourced communities. See the earlier section on "Regulating Alcohol Outlet Density" for more on this issue.

Financial Availability

Increasing the price of alcohol has shown reduced consumption among both youth and adults.[141] Price increases can be accomplished by raising alcohol taxes, implementing minimum pricing policies, and banning price promotions, such as "happy hours."

Increasing Alcohol Taxes

The evidence on the association between raising alcohol prices, usually by increasing taxes on alcohol, and decreased consumption and associated problems has been growing for more than 50 years. Policymakers at the federal, state, and some local, tribal, and territorial levels can pass alcohol tax policies.

Excise taxes are based on the volume of alcohol sold, are different for different alcoholic beverages (beer, wine, liquor), and their real dollar value will decline if not adjusted for inflation.[142] It is critical that excise taxes be adjusted regularly for inflation so they do not lose effectiveness as a prevention measure over time.[143]

Sales taxes are a percentage of the price of alcohol, may or may not differ by type of alcohol, and increase as the price of the alcoholic beverage increases, which will help account for some inflation.[142]

Raising the price on only one type of alcoholic beverage (e.g., beer, wine, or spirits) may lead to a switching of preference to the now cheaper option. A study of substantial tax increases on distilled spirits and wine, but not beer, enacted in Illinois in 2009 found that sales of spirits and wine decreased significantly but beer sales increased sufficiently to largely offset the decline in overall alcohol sales volume.[144] Nevertheless, there was still a reduction in alcohol-related harms.[145-146] For this reason, stakeholders may want to consider raising taxes across all product types. Alcohol taxes are recommended by The Community Preventive Services Task Force and are listed as one of the World Health Organization's "best buys" (effective and cost-effective ways to reduce non-communicable disease, including AUD).

The State Alcohol Control System

Alcohol is sold in two different types of states: 1) Control states/jurisdictions, where the government controls alcohol sales, and 2) License states/jurisdictions, where governments license private businesses to conduct alcohol sales. In the United States, state or local control of alcohol sales is primarily limited to off-premises establishments. States/jurisdictions that move from control to privatized systems have experienced increases in the number of off-premises outlets, as well as longer hours and days of sale. Additionally, privatized systems have more alcohol advertising, greater numbers and types of alcohol products sold, and poorer enforcement of sales laws, including enforcing MLDA. Ultimately, privatization is associated with increases in alcohol misuse.[88] As a result of these findings, the Community Guide recommends against privatization.[140]

Policy: Increasing Alcohol Taxes	
Description	**Examples of Outcomes**
Increases in the price of alcohol, either by volume (excise tax) or retail sale price (sales tax)	**Alcohol consumption** across the general population,[85] as well as among underage populations[85] and Hispanic people[147] • A 10-percent increase in price is estimated to decrease:[85] – Beer consumption by 5 percent – Wine consumption by 6 percent – Liquor consumption by 8 percent – Total alcohol consumption by 8 percent **Alcohol-related harms** • Based on data from 50 studies, a doubling of the alcohol tax was estimated to result in average reductions in alcohol-related mortality (35 percent), motor vehicle fatalities (11 percent), sexually transmitted infections (6 percent), violence (2 percent), and crime (1 percent).[148] • Lower risk of alcohol-related consequences among Black women.[119]

Health Equity Considerations of the Policy

Despite concerns that these taxes are regressive in nature, meaning they disproportionately impact those with lower incomes, research has shown that it is people who drink excessively who most experience the increased cost for alcohol taxes, regardless of income level.[143, 149] A study specifically looking at whether alcohol taxes disproportionately affect low-income communities found that if there are regressive effects, they are small and primarily concentrated among the heaviest drinking populations, not the broader population of people who drink alcohol.[150] Research has shown that alcohol taxes primarily affect the heaviest consumers of alcohol, who tend to be White, college-educated males between the ages of 21 and 50 earning $50,000 or more per year.[149]

Finally, the benefits of higher alcohol taxes are generally progressive—meaning particularly beneficial to populations with fewer resources—as tax revenues are typically used to fund government services, which people with lower incomes are more likely to use than those with more personal wealth. Tax revenues can benefit prevention directly, by designating a portion of the derived revenues specifically for prevention and treatment services at the local, state, tribal, or territorial level.

Real World Implementation Examples

- After Maryland increased its sales tax on alcohol from 6 to 9 percent in 2011, the amount of total alcohol sold declined 4 percent in the 18 months following the increase.[151] Between 2011 and 2016, there was a 17-percent reduction in binge drinking by Maryland adults compared to an average national reduction of 6 percent.[152] There was also a 28-percent reduction in the number of Maryland high school students who reported binge drinking in the past 30 days between 2011 and 2015.[152] The implementation of this policy was also associated with a significant 6-percent annual reduction in the rate of alcohol-impaired drivers on Maryland highways.[153]
- After a 2009 increase in alcohol excise taxes in Illinois there was a 26-percent reduction in fatal alcohol-related motor vehicle crashes in the following 28-month period (from September 2009 to December 2011)—a decrease of nearly 10 deaths per month.[145]
- Following a 1983 alcohol tax increase in Alaska there was a 29-percent decrease in alcohol-related deaths; an additional alcohol tax in 2002 was associated with an additional 11-percent decrease in such deaths.[154]

Minimum Pricing

Alcohol minimum pricing policies are another way of maintaining or raising the price of alcohol and reducing practices that create risk of alcohol-related harms. There are two different ways to establish minimum prices: through a minimum unit price (MUP), which establishes a floor price per "unit" of pure alcohol, or a minimum price based on the container size of a specific alcoholic beverage type, regardless of the alcohol content within that beverage (such as a minimum price for a liter of beer, a liter of wine, or a liter of liquor).[155]

These policies can be made specific to on- or off-premises alcohol outlets, and retailers cannot sell alcohol for less than that price. MUP policies can be particularly effective for reducing alcohol use and related harms among people who drink excessively because they purchase larger quantities of alcohol; therefore, they purchase less, even though they tend to spend the same amount on alcohol after MUP policies are implemented.[156-157] As a result, MUP policies can reduce consumption and related harms, raise tax revenue, and reduce health inequalities.[156] Like excise taxes, MUPs will lose their effectiveness over time if they are not regularly adjusted for inflation. Minimum pricing has not been consistently implemented in the United States but is being explored based on the evidence from other countries, including Scotland and Canada.[157-159]

Policy: Increasing the Minimum Unit Price of Alcohol	
Description	**Examples of Outcomes**
Sets a minimum price per unit of alcohol or amount of alcoholic beverage, either on- or off-premises, or both	**Decrease in alcohol sales** • In May 2018, Scotland set an MUP per unit of alcohol (at the time equal to approximately $1.34 for a standard drink) that was associated with an 8-percent reduction in alcohol sales. Wales implemented the same policy in March 2020, which was associated with a 9-percent reduction in alcohol sales.[157] **Decrease in alcohol-related harms** • In British Columbia, a 10-percent increase in the minimum price of alcoholic beverages was associated a year later with a 9-percent decrease in alcohol-related hospital admissions,[158] a 32-percent decrease in alcohol-attributable deaths,[159] and a 10-percent reduction in all crimes.[160]

Health Equity Considerations of the Policy

The research on health inequalities related to MUP has been done primarily in the United Kingdom[161] and Canada.[160] Overall, minimum pricing policies mainly affect people who drink the most alcohol, regardless of income level.[155] Modeling results showed that the price increase was mostly assumed by people who drink heavily, but this group also had the greatest decrease in consumption. Additionally, the health benefits of the MUP policy particularly benefited individuals with the lowest socioeconomic status through greater reductions in harms. Individuals with the lowest socioeconomic status were 42 percent of the total study sample, but accounted for 82 percent of the reduction in premature deaths and 88 percent of the improvement in quality-adjusted life years.[162]

Real World Implementation Examples

- MUP policies have been introduced in Australia, Ireland, and Scotland.[155]
- In 2021, the Oregon Liquor and Cannabis Commission implemented a new minimum pricing policy for distilled spirits.[163]

Social and Psychological Availability

Restricting alcohol marketing is the primary way to decrease the social and psychological availability of alcohol, known to be a risk factor for alcohol consumption. This research has primarily been done with youth, and increasingly shows that greater exposure and receptivity to marketing leads to:

- More developed norms and expectations (social availability)
- More identity building around drinking (psychological availability)[164]

Overall, the evidence is clear that youth exposure to alcohol marketing is associated with increases in youth drinking.[17]

Local, state, and territorial efforts to reduce alcohol advertising have largely focused on limiting outdoor advertising, such as on billboards, and limiting advertising at the point of sale, such as on alcohol outlet windows (including grocery/liquor stores and bars/restaurants) and within the establishments themselves. Similar to alcohol outlet density, zoning policies can determine where alcohol can be seen, to reduce youth exposure (e.g., near schools and playgrounds) and disproportionate marketing to racial/ethnic populations (e.g., in predominantly Black, Indigenous, and People of Color (BIPOC) communities).[165] Full advertising bans have been determined to be the most effective option,[166] but can be difficult to achieve; more limited restrictions are possible, as described below.

Research has shown increased evidence of the harmfulness of digital marketing on youth alcohol consumption, suggesting the need for additional policy options to reduce youth exposure to online alcohol marketing.[167] Reducing or banning alcohol advertising is one of the World Health Organization's top recommendations to reduce non-communicable diseases, including AUD.

Health Equity Considerations of the Policy

Equity considerations around alcohol advertising and marketing are particularly relevant for youth populations and individuals living in under-resourced communities. For example, a study of alcohol advertising in Boston subway and streetcar stations found that Boston public school students reported seeing 1.34 alcohol advertisements per day at those locations, while the population as a whole saw just 1.09. Additionally, there were more advertisements in neighborhoods with high poverty rates (1.27 ads per station) than in neighborhoods with low poverty rates (1.16 ads per station).[171] A study of youth in Los Angeles found that African American and Hispanic youth were exposed to nearly twice as many alcohol advertisements across all media than their non-Hispanic, White peers, and that girls were exposed to 30 percent more advertising than boys.[172]

Given that women, BIPOC populations, and those living in lower socioeconomic status neighborhoods face greater exposure to alcohol advertising, reducing alcohol advertisements is considered an effective policy to help address this inequity. Additional research on the effects of policies that restrict alcohol advertising would further inform how these policies can reduce racial or ethnic disparities regarding exposure to alcohol marketing. Reducing disproportionate exposure to alcohol advertising may also reduce harms in neighborhoods of predominantly LGBTQI+ individuals, though there is little research exploring this specific population.

Policy: Limiting Alcohol Advertising and Marketing	
Description	**Examples of Outcomes**
Limit or ban alcohol advertisements and marketing; bans may limit advertising on or in alcohol establishments, on billboards, or on city-owned property (such as bus or subway stations)	**Reduction in alcohol consumption**[17] • Each additional alcohol advertisement that youth are exposed to is associated with a 1-percent increase in the number of drinks consumed.[168] **Decrease in positive drinking expectancies and norms among youth**[169-170]

Real World Implementation Examples

- In 2017, New York City banned alcohol advertisements on city buses, subway cars, and in subway stations, and in 2019 implemented a ban on alcohol advertising on city-owned property. Los Angeles, Philadelphia, and San Francisco have enacted similar policies.
- All European countries, except the United Kingdom, have banned one or more types of alcohol advertising,[173] including a total ban in Norway passed in 1975 that has since shown a sustained 8-percent reduction in consumption.[174]

Dram Shop (Commercial Host) Liability Laws

Dram shop, or commercial host, liability laws make an on-premises alcohol outlet (e.g., a bar, tavern, or similar commercial establishment) liable for the harmful actions of intoxicated patrons when the establishment serves alcohol to clearly intoxicated people or minors. Dram shop liability laws are an effective strategy to reduce alcohol consumption and alcohol-related harms,[175-176] with the potential benefit of business environments that support responsible beverage service without penalizing those who follow liquor control laws.[176] However, such laws may be limited by caps on the financial liability of servers and managers, statutes of limitations, and the standards for required evidence.[176]

Health Equity Considerations of the Policy

This policy must be implemented equitably across all retailers to ensure that establishments owned by BIPOC individuals are not disproportionally targeted for liability.

Real World Implementation Examples

- Most states have enacted dram shop (commercial host) liability laws for service to intoxicated adult customers and to underage customers.[175, 177]

Policies With Moderate Evidence

There are several other effective policies that communities should consider while they work towards the high priority policies listed above. These policies are grounded in either evidence or in the theories of availability described above.

- **Restricting social availability of alcohol** (i.e., social host policies). Social host ordinances hold individuals responsible for hosting or providing a location for underage drinking and impose citations or fines. Research on the effects of these policies is limited to those that levy criminal penalties, which raises equity issues because of disparities in enforcement. The best practice is a civil social host liability law, which levies a civil fine rather than criminal prosecution; there have been few scientific evaluations of this law to date.[178-179]
- **Alcohol-impaired driving countermeasures**. Countermeasures for alcohol-impaired driving include reducing the blood alcohol content legal limit from 0.08 to 0.05, collecting information on the establishment that served alcohol to those cited for impaired driving (known as place of last drink), use of ignition interlocks,

Policy: Dram Shop (Social Host) Liability Laws	
Description	**Examples of Outcomes**
On-premises alcohol outlets are liable for the harmful actions of the intoxicated patrons they continue to serve alcohol	**Decreases in alcohol-related automobile crash fatalities and injuries** • Alcohol-related motor vehicle crash fatalities decreased by a median of 6 percent across six studies throughout the United States[175] • Dram shop liability lawsuits in 1983 and 1984 in Texas led to decreases in single vehicle nighttime crashes of 7 percent and 5 percent after two separate, high-profile cases.[175] **Reduced alcohol consumption**[175, 176]

and sobriety checkpoints. These approaches are effective, particularly for reducing automobile crashes, but less so for reducing alcohol misuse and other alcohol-related harms; they often only target people who drink heavily. Decreasing the impaired driving blood alcohol content has shown reductions in injury, single vehicle nighttime crashes, fatalities, and more.[89]

- **Limiting price promotions**. Another policy that affects the price of alcohol is to restrict price discounting, such as "happy hour," all-you-can-drink specials, and two-for-one purchases. These policies can be passed at the local, state, tribal, or territorial levels. Limited research assesses the impact of these policies in a United States context, but associations have previously been noted between lower alcohol prices and increased consumption and other alcohol-related harms including violence, crime, and traffic fatalities,[85] leading to the recommendation that such restrictions be pursued or maintained if already in place.

Policies With Limited to No Evidence

There are several policies with limited evidence of effectiveness when done in isolation that communities may nonetheless adapt. They are best implemented in conjunction with policies that have demonstrated strong to moderate evidence of effectiveness. Examples include:

- **Voluntary responsible beverage service (RBS)**. It has been suggested that server demographic characteristics (e.g., age) are related to alcohol sales made to minors and intoxicated customers.[180] RBS is a training for servers and sellers to address such sales, but there is limited evidence demonstrating the effectiveness of this strategy in reducing alcohol misuse.[181]
- **Retail environment limitations**. These limitations may include reducing the floor space dedicated to alcohol products and banning products with a high risk of alcohol-related harm. Communities have also implemented numerous other strategies and policies that address the broader retail environment, like prohibiting end-of-aisle placement; however, the evidence on these approaches is still emerging.
- **Restrictions on public places where alcohol is sold/consumed**. Communities may also restrict locations where alcohol is consumed, such as parks, festivals, and sporting events—additional research is needed to understand how effective these policies are; they may also raise equity issues, if they are selectively enforced.

Future Research

Across the nation, some communities might find it challenging to address the increased availability of alcohol due to the general deregulation of alcohol policies over the years. Additional policy changes during the COVID-19 public health emergency increased the availability of alcohol, with an expansion in the number of states that allowed home delivery of alcohol. Some states have also made permanent the emergency allowances for curbside pickup of alcohol, and expanded restaurants and bars that allow alcohol consumption on adjacent sidewalks, parking lots, or other designated outdoor areas. Effects of these policies continue to be studied. Prevention practitioners and communities should rely on the basic principles of availability theory, as described above, to institute policies and strategies that address the deregulation of previously implemented policies.

To further support the implementation of effective alcohol policies in communities, researchers can continue evaluating the effects of implemented policies, including assessing whether there are disproportionate effects on different communities (e.g., rural/urban/suburban) and populations, to ensure equitable implementation, enforcement, and outcomes. One option would be to build health equity impact assessments into law and rulemaking efforts at the local, state, tribal, and territorial levels; other countries, such as Canada, have implemented similar approaches to prioritize establishing equitable policies.

CHAPTER

3

Identifying and Implementing Evidence-Based Policies to Prevent Alcohol Misuse

This chapter provides key considerations for implementing prevention interventions, recommendations for addressing implementation challenges for the policies described in Chapter 2, and implementation resources.

Key Considerations for Implementing Policies to Prevent Alcohol Misuse

One of the first steps in any policy effort is conducting capacity and needs assessments: a capacity assessment can help identify and define the existing strengths in the community while a needs assessment will identify gaps in the current policies. These assessments can help communities define the problem (such as high rates of crime, traffic crashes, or sexual assault), identify how alcohol may contribute to that problem, and determine the specific factors leading to alcohol misuse.

During this time, communities may also want to consider developing and reviewing community histories of policies and organizing—these stories provide useful insight into why the current situation exists and how structural and systemic systems have shaped the current risk and protective factors related to alcohol misuse.[182] Periodic capacity and needs assessments will ensure that communities are implementing the best possible interventions for their circumstances at that specific time and are not overly relying on previously implemented policies.[183]

Potential Questions for a Capacity or Needs Assessment

Capacity Assessment

- ✓ What resources are currently available in the community?
- ✓ Who are the policy allies and champions?
- ✓ What policies currently exist?
- ✓ Are there model policies available?
- ✓ Are there existing funding sources?

Needs Assessment

- ✓ Are there high rates of underage drinking?
- ✓ Are there high rates of adult alcohol misuse?
- ✓ Are pregnant people using alcohol?
- ✓ Are there certain settings that are consistently associated with alcohol consumption and are likely to have a high risk of harm, such as a park or a bar?
- ✓ Did a precipitating event happen that prompted interest in the community to intervene on alcohol misuse, such as a drunk driving fatality or an upcoming change in availability (such as new alcohol outlets opening in certain neighborhoods)?
- ✓ Does the community have the data to support the selected policy?

When developing policy, community members should serve as leaders and help to drive policy change. It is critical to engage a host of partners, such as people with lived experience, community members who experience alcohol-related harm, public health and policy/legislative experts, parents, educators, law enforcement, funders, and youth. A community prevention organization, often a community coalition, focused on preventing or reducing alcohol misuse can play this role. These individuals can help develop the policy language and decide the best communication and media strategies to advance political will and raise public awareness. Community members often mobilize their peers and the broader population to educate policymakers and support the policy. Community mobilization is a key component of any policy passage and is critical throughout the policy development process: planning, advocacy, education, policy passage, and implementation.

There is an identified substance use prevention policy implementation process that coalitions and stakeholders can use when beginning any policy activity, detailed by SAMHSA's Prevention Technology Transfer Center (PTTC) Network.

Implementing policy changes takes political will, community power, persistence, and knowledge of the policy process. Those responsible for driving and adopting policy change include the local, state, tribal, territorial, or federal agencies that will be responsible for regulating and reporting requirements; the elected officials who will vote on the policy; any other public or elected officials who pass and implement policies; and engaged stakeholders who can provide important insight into designing and implementing new policies that will ultimately affect them as well as provide timely feedback on policy implementation. Alcohol retailers who make changes to their outlets, either voluntarily or through new policy action, may also influence the shaping and implementation of a new policy.

There are at least four key elements in successful implementation of a new alcohol policy, whether at the city, county, state, tribal, territorial, or federal level:

1. **Public Awareness**: Any rule change will require educating the public and/or the affected organizations. For example, if a city prohibits "happy hours" or two-for-one price promotions, officials must notify bars, restaurants, and the broader public of this change after policy passage, preferably including data to explain why they made this change.
2. **Regulations**: If a new policy affects structures or systems, jurisdictions will need to establish new or update existing procedures. In the example of implementing licensing and zoning laws, policymakers will need to decide how jurisdictions will track licenses and permits and how and when they will provide new licenses or permits.
3. **Enforcement**: Nearly all policies require some level of monitoring and enforcement. For example, cities that pass ordinances limiting what alcohol products retailers can sell and where and when they can sell them will need to ensure that retailers have the correct license or permit and maintain consistent enforcement of the new policy. For instance, they could implement regular retail assessments to ensure retailers do not sell disallowed products.
4. **Economic Impacts**: The economic impact of any new policy should be considered at the outset of the policy process, including the cost of enforcing and monitoring the policy and the potential savings expected from reducing alcohol misuse (such as reduced costs for health care and emergency services utilization, disability adjusted years of life (DALYs), and loss of productive labor). Alcohol licensing and permitting fees should be earmarked for compliance and enforcement activities to ensure that the policy is implemented and operating as intended.

Considerations for Equitable Implementation of Policies

Equity implications of policy implementation are also key considerations. Some prevention practitioners may want to focus their policy efforts specifically on communities and populations that governments and policies have historically disenfranchised, thus limiting their opportunity to experience optimal health, safety, and wellbeing. Such communities include tribal nations; LGBTQI+ populations; and communities of color. Advancing health equity and social justice requires partnerships and collaborative action. For those focused on the prevention of alcohol and other drug use, it may mean developing new relationships with organizations and

individuals outside the usual participants. The Prevention Institute has identified five strategic opportunities to advance social justice and health equity:

1. **Synergistic data creation and analysis**: Work with partners to identify the data and measures that help policymakers and other stakeholders understand health- and alcohol-related inequities, assess opportunities for change, and determine which measures to track over time.
2. **Aligned framing and strategic communications**: Identify, frame, and communicate shared visions, values, and strategic directions for alcohol policy work.
3. **United multisector partnerships**: Identify opportunities to develop shared visions and solutions that bring together organizations to encourage and sustain change.
4. **Blended approaches to power building, policy, and systems change**: Work with social justice advocates on community organizing and transformation of power relations, to change the policies and conditions that lead to the disproportionately harmful effects of alcohol on under-resourced communities.
5. **Transformative resources for health equity and social justice**: Prioritize the capacity-building of organizations focused on health equity and environmental- and community-level changes to prevent alcohol misuse and related harms and establish partnerships with organizations from under-resourced communities.

Considerations and Strategies for Policy Implementation

In addition to these important initiatives, prevention practitioners and coalitions must further consider the actions described below when implementing policies to prevent alcohol misuse among youth and adults.

Building Coalitions with Capacity

Consideration:

- Coalitions bring together members of different sectors across a community (e.g., prevention practitioners, people with lived experience, parents, those who experience harms from alcohol use, medical professionals, law enforcement) to work on a common issue, such as substance use prevention. Coalitions can conduct a needs assessment to begin to understand the local conditions related to alcohol misuse and associated harms. This critical process requires resources—both in funding and human capacity—and the more resources available, the more comprehensive the needs assessment and resulting actions can be.
- Once communities form and fund coalitions, they often need training to build the coalition's capacity to do the assessment, implementation, and evaluation activities. Topics for training may include community mobilization strategies, conducting a needs assessment, analyzing and interpreting data, selecting evidence-based interventions, advocating to and educating policymakers, and ensuring policy enforcement and monitoring.

Strategies:

- Coalition builders should conduct intentional outreach to individuals and groups to ensure coalitions are diverse (see text box, "Coalition Membership"). Given that alcohol affects nearly every segment of society, broadening the stakeholder base is an important role of coalitions. This varied representation can help focus the coalition on building policies and implementation plans that improve equity within a community. Coalitions should be particularly thoughtful about reaching out to tribes who may be affected by local alcohol environments, as these are communities highly affected by alcohol misuse and related harms and are often left out of these important efforts. Additionally, coalition rules should ensure that all coalition members have an equal voice in discussions, regardless of title or position.

Coalition Membership

- Diversity in sexual orientation, gender identity, socioeconomic status, and race/ethnicity
- People in recovery from alcohol use disorder or who experience alcohol-related harms
- People from different community sectors (e.g., education, law enforcement, health care, faith community, parent-teacher organizations, treatment professionals, recovery organizations, chronic disease organizations)
- Community leaders
- Grassroot organizers

- There are many state and federal grant programs focused on substance use prevention that provide funding to communities to build coalitions or further their prevention work. Programs include, but are not limited to, the Drug-Free Communities grant program, Partnerships for Success grant program, Sober Truth on Preventing (STOP) Underage Drinking Act grant program, and the Substance Abuse Prevention and Treatment Block Grant.
- Many organizations provide training and technical assistance to engage in this work for free or at a reduced cost. Organizations can seek out training or technical assistance from programs such as SAMHSA's PTTC Network, the Community Anti-Drug Coalitions of America, and the Center for Advancing Alcohol Science to Practice funded by the Centers for Disease Control and Prevention (CDC).

Evolving Community Needs

Consideration:

- Patterns of alcohol consumption and related harms are continually changing, and the most appropriate program or policy for the state or community may change over time.

Strategy:

- Regularly collecting and analyzing data on alcohol misuse by both youth and adults will help determine what products people are using, if certain subgroups are misusing alcohol at higher rates than others, where they are obtaining alcohol, and in what settings they are using the products. Stakeholders engaged in prevention efforts, including parents and youth, can provide first-hand information about alcohol misuse patterns and behaviors within the state/community. This strategy will ensure that the state/community implements the best interventions for their particular needs. These data may support existing policy efforts or suggest the need for changes. More information on this subject is provided in Chapter 5.

State Preemption

Consideration:

- State governments heavily regulate alcohol, and this regulation can be preemptive, limiting the ability of localities to pass policies entirely or that are more restrictive than state policies.

Strategy:

- The first step in addressing this preemption is to understand what the state's alcohol laws are, and then explore the available options for local policies. Additionally, there may be non-alcohol-specific local powers available for jurisdictions to use for local alcohol policy, such as exploring land use laws to regulate alcohol outlet density. Legal experts on alcohol policy can help a jurisdiction better understand potential preemption issues and nuances or gray areas in the law, as well as encourage lawmakers to enact policies that protect against future preemption. There are often avenues that legal experts can find through careful analysis of state preemption laws, to allow local policy passage. The ability for jurisdictions to pass more restrictive policies or policies not specifically named in state alcohol laws that address local needs is critical. Numerous entities, including CDC, Healthy People 2030, and the National Association of County and City Health Officials have noted that state preemption laws around tobacco and/or alcohol use do not advance public health priorities. Further, resources exist that explain preemption for specific alcohol policies, such as this list of state laws preempting local regulation of alcohol outlet density.

Necessity of Long-Term Commitment

Consideration:

- It can take considerable time to assess a community's local conditions, determine an appropriate policy intervention, develop and enact that policy, educate the community and local leaders about the policy, implement and enforce the policy, and evaluate its effects. It is important for a coalition to maintain consistent efforts across this period, even if policy adoption and enforcement may seem far away.
- It can take months or even years to see the results and impact of the policy. Policies to prevent alcohol misuse and reduce harm require time to develop and implement and see the effects.

Strategies:

- Coalitions should establish sustainable funding and policy campaign financing at the beginning of the policy development process. Funding may come from federal sources, such as programs that support efforts to prevent underage drinking or address community substance use, or from private sources, such as local hospitals, foundations, or insurance companies. Stakeholders should identify sources and the level of funding needed to implement the effort.
- It is important for coalitions to celebrate small victories along the way, such as getting the media to cover the issue of alcohol misuse or gaining key new coalition partners or staff. Acknowledging these victories will help keep coalition members engaged and motivated throughout the process. It is also valuable for coalitions to bring in and recognize other partners and policy champions along the way, to reinforce appreciation of their partners' work.
- Coalitions should prepare their members, partners, and lawmakers for the time required for policies to effect changes in alcohol misuse rates. Setting expectations early in the process will help reduce the chances of disappointment and frustration that may arise if it takes a year or more to see the positive outcomes of these policies.

Concerns Around Lobbying

Consideration:

- Many coalitions and organizations that receive federal funding do not think they can engage in policy work due to federal lobbying restrictions. This concern may dissuade organizations from working to implement evidence-based policies that may have substantial benefits for their communities.

Strategies:

- Many of the steps needed to pass a policy do not involve lobbying. Allowable activities include:
  - Conducting analysis or research on proposed or potential legislation
  - Talking to and educating elected officials broadly about alcohol misuse, without encouraging action on a specific legislative proposal
  - Responding to requests from policymakers and government officials on alcohol misuse questions
  - Talking to the media about legislative proposals without indicating specific support or opposition

- Coalitions and organizations funded by the federal government must consider lobbying limitations before undertaking policy work. There are several situations in which members of an organization or coalition can legally lobby for policy change using non-federal funds. For example, citizens can lobby on their own time and staff can lobby if using unrestricted funds. Building a diverse coalition that includes those who can legally lobby is a valuable consideration.

Policy Enforcement

Consideration:

- To be effective, jurisdictions must enforce policies regularly, actively, and equitably. Such enforcement requires resources and a commitment to the activity from a variety of enforcement bodies, including law enforcement, licensing and regulatory bodies, health departments, and others.

Strategies:

- Including explicit enforcement instructions and funding for enforcement bodies in the actual legislation or policy language ensures there is a political mandate to conduct enforcement activities according to the best possible evidence. Such activities include ensuring that enforcement does not disproportionately target individuals or retailers of color or the LGBTQI+ community; conducting efforts on a regular cadence; and transparently reporting the results of these efforts. Legislating a funding mechanism for enforcement will ensure its sustainability. Funding mechanisms may include licensing and permitting fees, block grants, or budget appropriations. Legislative language can specifically allocate funds for compliance checks and enforcement agents/activities at the local, state, tribal, or territorial level.
- The consequences associated with the implemented policy should be decided in conjunction with a diverse array of community leaders, as well as law enforcement, the health department, social services, judicial system, code enforcement, planning department, and local and state alcohol regulatory bodies (such as alcohol beverage control entities). Consequence options may include drug courts, tribal wellness courts, local drug courts, and victim restitution or other restorative justice programs. This language should be built into the policy itself when drafted.
- The Alcohol Policy Information System provides useful background on enforcement activities and measures, and SAMHSA's Report to Congress on the Prevention and Reduction of Underage Drinking tracks each state's alcohol policy enforcement efforts—this information can be helpful when drafting the enforcement component of any policy.

Industry Influence

Consideration:

- The alcohol industry may try to influence policy based on economic interests.[184] For example, in 2020, the alcohol industry spent around $30 million on lobbying at the federal level, with two companies accounting for almost one-third of the total expenditures.[185] The industry has also funded research and provided funding for interventions with minimal, if any, public health impact.[186]
- At the community level, the alcohol industry is often a vocal minority of bar and restaurant owners, breweries and wineries, and alcohol retailers and distributors. These businesses are often represented by broader trade organizations with funding from larger alcohol corporations,[186] and maintain a presence in local, state, tribal, and territorial government offices and at regulatory meetings about potential policies.
- Jurisdictions with less regulatory authority and controls may be more susceptible to industry influence because of economic factors, which are often a higher legislative priority than public health and safety.[184] Many policies implemented to prevent alcohol misuse are done so by state and local jurisdictions, which can limit the impact of industry-sponsored lobbying efforts and help promote public health.

Strategies:

- Local jurisdictions have the greatest opportunities to limit the impacts of industry influence, and efforts should be made to strengthen their authority as it pertains to regulatory authority. As state and community leaders, parents, and other stakeholders collaborate to pass and implement policies to prevent alcohol misuse, they must become aware of industry efforts to block such efforts and prepare counter-messaging to gain support for public health policies.

- A comprehensive policy should also include media campaigns that promote messages to counter industry influence and reach youth who are most susceptible to such influence. Various anti-tobacco media campaigns, at both state and national levels, provide models for this kind of messaging.[187-188]
- Establishing conflict of interest policies that prohibit the formation of partnerships and funding mechanisms among alcohol regulatory bodies, prevention coalitions, and other organizations working in the policy space can reduce industry influence on policy and rulemaking around these issues. Additionally, bodies that create, implement, or enforce alcohol policies could be required to include public health representatives, to ensure they consider research and science in policy discussions.

Implementation Guides and Manuals

Policy implementation is complex, and detailed guidance for implementing alcohol policies is limited. Below are several tools and resources to help stakeholders implement the policies described in Chapter 2, with implementation guides specific to those policies included where possible. The list also incorporates resources that provide general public health guidance, as many of the recommendations and suggestions tailored to other health topics are also relevant to alcohol policy.

Regulating Alcohol Prices

- The Community Anti-Drug Coalitions of America (CADCA), in partnership with the Center for Science in the Public Interest, created a Strategizer on Increasing Alcohol Taxes to Fund Programs to Prevent and Treat Youth-Related Alcohol Problems, to help coalitions and communities implement alcohol taxes.
- The Center on Alcohol Marketing and Youth (CAMY) created a tool for states to analyze the effects on consumer costs and job impacts from a tax increase, with numerous options for customization.
- ChangeLab Solutions created frequently asked questions specific to alcohol taxes.
- The Alcohol Policy Research Center has a resource explaining alcohol compliance checks that includes tips and suggestions for successfully engaging in this practice.

Regulating Retailers

- CDC published a Guide for Measuring Alcohol Outlet Density and an Alcohol Outlet Density Surveillance Toolkit.
- CADCA, in collaboration with CAMY, created a Strategizer on Regulating Alcohol Outlet Density and another on Dram Shop Liability for local communities.
- Ventura County Behavioral Health Department (Alcohol and Drug Programs) published Best Practices in Municipal Regulation to Reduce Alcohol-Related Harms From Licensed Alcohol Outlets.
- ChangeLab Solutions produced frequently asked questions documents on local authority to regulate alcohol outlet density and on dram shop liability.

Tools to Conduct Strengths/Needs Assessment

- The National Highway Traffic Safety Administration published a Community How-To Guide on Needs Assessments and Strategic Planning specific to reducing underage drinking.
- The Public Health Institute created a detailed guide on how to conduct needs assessments across a variety of health topics, titled Best Practices for Community Health Needs Assessment and Implementation Strategy Development.

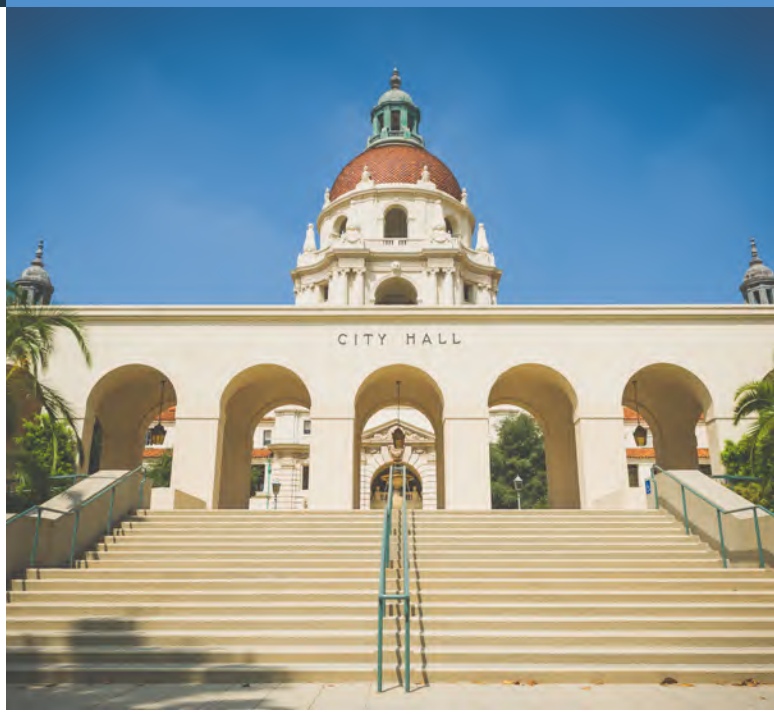
- The Rural Health Information Hub provides information on how to conduct a needs assessment in rural settings.
- CADCA's Primer on Community Assessments includes information on collecting data, analyzing issues, and creating a plan for change.
- This journal article describes strategies that activists have used to reduce alcohol-related harm and advance social justice.

Resources to Support Policy Interventions

- The Southeast Prevention Technology Transfer Center created a guidebook on Implementing Policy to Prevent Alcohol, Tobacco, and Other Drug Misuse that includes a 10-step policy process.
- CAMY created a preemption tool to help communities determine their state's preemption level.
- ChangeLab Solutions conducted legal research on the status of state preemption laws.
- CADCA created a webpage on policy communication and the legislative process, including a briefing on the legislative process and tips for talking to stakeholders.
- The World Health Organization created a tool for measuring alcohol policy implementation that may be translatable to states and localities.
- The Campaign for Tobacco-Free Kids developed toolkits for media and policy campaigns; state and local governments can use these toolkits.
- The Network for Public Health Law identifies policy approaches that will advance the goals of an organization or community and has a series of resources on preventing substance use and making healthier communities.
- The PTTC Network has an abundance of substance use prevention resources and tools, including webinars and trainings.
- The CDC Alcohol Program has factsheets on many topics, including binge drinking, cancer, drinking and driving, and pregnancy.
- The Center for Advancing Alcohol Science to Practice provides technical assistance and resources for advancing evidence-based, population-level alcohol policies.
- The Alcohol Policy Information System maintains an updated list of whether localities have authority to regulate alcohol sales within each state, as well as a detailed inventory of most of the alcohol policies currently in place at the state level.
- The Partnership to End Addiction created an Advocacy Toolkit, which provides tips on building relationships and communicating with policymakers at the federal, state, territorial, tribal, and local levels.
- The Alcohol-Related Disease Impact (ARDI) Application provides national and state estimates of alcohol-related health impacts, including deaths and years of potential life lost.
- The Northwest PTTC created an Alcohol Awareness Toolkit to raise awareness about alcohol-related harms and the importance of strong alcohol policies.

CHAPTER

4



Examples of Policies to Prevent Alcohol Misuse

This chapter highlights three examples of different policies and regulations enacted at both the state and local levels to prevent alcohol misuse in different communities. These examples illustrate the importance of advocacy and community involvement in developing policies and regulations and how the development and capacity building of community organizations facilitate actionable change.

- The first case example, Miami Gardens, Florida, describes a coalition-driven initiative implemented to reduce alcohol consumption associated with crime and a high risk of harm and to address inequitable alcohol marketing practices.
- The second example, the state of Oregon, explains how the state's regulatory agency instituted a minimum pricing policy on distilled spirits to reduce alcohol misuse, particularly among those who drink the most, to make a positive impact on public health and reduce alcohol-related harm.
- The third example, Baltimore, Maryland, illustrates how community collaboration and advocacy led to legislation that limits alcohol sale hours in a defined geographic area by using a data-driven approach that addressed public safety issues in and near off-premises alcohol establishments.

Policies Described in Chapter 2

- Regulating alcohol outlet density
- Minimum legal purchase age
- Limiting days and/or hours of sale
- Increasing alcohol taxes
- Minimum pricing
- Limiting price promotions

Each case example differs from the others in terms of context, policy or regulation, and adaptions made to meet the needs of the community. The examples only highlight key components of the policy or regulatory action process—they are not meant to be exhaustive narratives of a community's policy planning and implementation processes. Additional information can be found in the "Related Resources" section of each case example.

Specific information about the policies and regulations presented in this chapter was gathered from experts and through an environmental scan of policies, regulations, resources, and publications from state and federal government agencies and nonprofit organizations.

Reducing Alcohol Consumption Associated with Alcohol-Related Harm and Crime

Miami Gardens, Florida

Setting

The Live Healthy Miami Gardens (LHMG) Initiative and its Alcohol, Tobacco, and Other Drugs (ATOD) Sub-Council is a partnership of 100 organizations and residents working together to develop and implement effective community-level health strategies that improve health outcomes in the City of Miami Gardens, Florida. Miami Gardens is the third largest city in Miami-Dade County, with more than 105,000 residents.[189] It is a diverse, working- and middle-class community, where approximately 71 percent of residents identify as African American and 26 percent as Hispanic.[190]

Issue

The rates of alcohol sales to minors, illegal after-hours sales, and police calls for service to alcohol retailers and surrounding areas, coupled with the negative impacts of alcohol use on youth and neighborhoods, caused concern among residents and law enforcement officials. During 2018 and 2019, more than 30 percent of off-premises alcohol retailers sampled sold alcohol to underage decoy shoppers and more than 90 percent sold alcohol products after hours, both in violation of state and local laws. Research conducted by the ATOD Sub-Council identified concerns with predatory marketing practices that specifically targeted communities of color in Miami Gardens. In addition, LHMG documented that the marketing and sale of alcohol products with high risk of alcohol-related harms in their community was disproportionately high compared to surrounding towns. An assessment found that 71 percent of retailers carried a large volume of high-content alcohol products, compared to 12 percent in a predominantly White neighboring town, and that the types of products also varied at stores operated by the same retailer in different neighborhoods. For example, the same pharmacy chain sold and promoted alcohol products with a high risk of alcohol-related harm in Miami Gardens, but not in the neighboring White community. Even within Miami Gardens, the LHMG Initiative found higher risk alcohol practices and products in lower income sections of the city compared to higher income sections.

Solution

LHMG organized community support to change the alcohol environment in the city. After years of building a coalition to assess the alcohol risk environment and explore the inequities present in their community, the LHMG Initiative worked with the Miami Gardens City Council to develop new policies and enforcement procedures based on local research and observations. The Miami Gardens City Council decided to enforce various ordinances more diligently and revise existing protocols. These ordinances included:

- Sign ordinance limiting window space dedicated to promotional materials: the total area of all signs affixed or displayed in windows shall not exceed 20 percent of the window area, up to a maximum of 40 square feet.
- Local ordinance requiring all outlets selling beer and wine to ensure the sale of these products will make up no more than 15 percent of a store's gross receipts and that merchants must comply with the existing sign ordinance.
- Local ordinance that alcohol may not be sold between midnight and 6:00 a.m.

The Miami Gardens City Council also adopted three new ordinances:

1. Set of nuisance standards on existing and new alcohol outlets to reduce the negative impacts of nuisance and criminal activity in areas surrounding retailers.
2. Ordinance that requires establishments to lock coolers containing alcohol after midnight if the floor area of the outlet is less than 500 square feet.
3. Ordinance that requires establishments to move coolers and ice bins containing alcohol at least 20 feet from the register.

Intervention

Policy development occurred in three phases: readiness, research, and development.

Reducing Alcohol Consumption Associated with Alcohol-Related Harm and Crime

Miami Gardens, Florida

- **Phase 1: Readiness** focused on developing community readiness, obtaining stakeholder buy-in, establishing interest and capacity, securing resources, and cultivating relationships with state officials and senior city staff and department heads in Miami Gardens, such as those in code and law enforcement. The effort began in 2004 and took more than a decade to achieve its goal of community readiness.
- **Phase 2: Research**, from 2017 to 2019, conducted information gathering and data collection to identify the nature of the alcohol problems in the city, which resulted in potential policies and strategies to address them.
- **Phase 3: Development**, from 2019 to 2021, prioritized revising existing ordinances and enforcement protocols, developing new policies, and leveraging connections and relationships to enforce existing policies and strategies.

Phases 1 and 2 (activities conducted in 2004–2019) cost approximately $500,000. Phase 3 (2019–2021) cost approximately $100,000. The three phases included building a coalition, training staff on environmental strategies, collecting data to understand the scope of the problem, educating and organizing staff and community members, and adopting policies addressing the retail environment, to reduce nuisance behavior and violence. Policy development was supported by grants from the Health Foundation of South Florida, a philanthropic nonprofit agency focused on policy and system changes that improve the health of South Florida communities. Federal, state, and local government agencies provided funding to support early phases of implementation.

At the time of this guide's publication, all phases of policy development and passage were complete, and work was underway to implement the policies.

Outcomes and Other Benefits

- The policy process in the City of Miami Gardens included the revision and enforcement of existing policies, as well as the development of new policies, which arose out of work conducted over a decade in the community. Through their work, LHMG successfully reframed alcohol consumption as a public health issue in the City of Miami Gardens.
- Research suggests that city-level restrictions on the sale of high-alcohol content beverages result in reductions in crime, like assaults and vandalism, and can reduce alcohol retailers' risky alcohol-related operating practices.[87-88] In Miami Gardens, additional laws and better enforcement of existing laws can significantly reduce access to these products.

Lessons Learned

- **Coalition Development:** Policy development can take considerable time. Forming a coalition solidifies community commitment and maintains engagement throughout this process. A coalition will also serve as a community resource, as members become experts on alcohol policy through the work they are doing, ultimately providing a forum for solving other community-level problems.
- **Relationship Building and Stakeholder Buy-in:** LHMG established relationships with state and local officials, which helped to ensure that new policies were sensitive to the roles and interests of code enforcement, law enforcement, and the state (including alcoholic beverage control and the health department). Because of these relationships, key stakeholders viewed the coalition as a valued member of the community, which fostered collaboration based on mutual trust.
- **Data-Driven Approach:** LHMG modeled local data collection on national research on alcoholic beverages with a high risk of alcohol-related harm, alcohol outlet density, and marketing practices. When these national data were compared to conditions in the local community, they provided additional context that helped explain local observations. This context facilitated buy-in by and collaboration of some stakeholders, including law enforcement.

Related Resources

- Live Healthy Miami Gardens
- LHMG ATOD Sub-Council

Implementing a Minimum Pricing Policy Through Regulatory Action

State of Oregon

Setting

Established in 1933 as a state agency, the Oregon Liquor and Cannabis Commission (OLCC, formerly called the Oregon Liquor Control Commission) regulates the sale and service of distilled spirits and the production, processing, and sale of both medical and non-medical cannabis products.[191] The purpose of the OLCC is to support businesses, public safety, and community livability through education about and enforcement of liquor and cannabis laws.

Issue

Alcohol misuse is a substantial issue in Oregon. In 2020, the state ranked sixteenth in the nation for per capita alcohol consumption, according to a report published by the National Institute on Alcohol Abuse and Alcoholism;[192] and in 2020, data from SAMHSA's National Survey on Drug Use and Health found that 12 percent—nearly one in eight—of Oregonians aged 12 and older had an alcohol use disorder, the sixth highest rate in the country.[193] In addition to high rates of alcohol misuse, in 2020, Oregon had the greatest proportion of individuals in need of substance use disorder treatment but who did not receive it, compared to all other states.[194] Excessive alcohol use has had a negative effect in Oregon, costing the state $4.8 billion in 2019— approximately $1,100 per person.[195] Most of this cost was due to lost earnings for businesses and employees, and nearly 15 percent resulted from hospitalizations and other care related to excessive alcohol use.

Solution

Recognizing rising rates of alcohol misuse and related harms in the state, the OLCC proposed a minimum pricing policy that balances public health and business interests.[196] OLCC developed the policy with input from stakeholders, including public health agencies (such as the Oregon Health Authority), alcohol manufacturers and retailers, alcohol licensees (e.g., restaurants, bars), advocacy organizations, and the public. The policy provides a "floor" price for distilled spirits, but beer and wine are excluded. This policy increased the cost of high-proof, formerly low-priced spirits. All products that contain a high percentage of alcohol are subject to the floor pricing policy, resulting in higher prices for products with a greater alcohol content. For example, the minimum price for a 750 ml bottle of 80-proof spirits was set at $8.95, with higher minimum prices for larger bottles or higher-proof liquors. Once developed, OLCC implemented the policy through regulatory action, not legislation. It is important to note that this rule could be implemented because of OLCC's control over distilled spirits. States, counties, tribal nations, or territories with different alcohol control systems may need to seek alternative mechanisms to implement a minimum pricing policy. After monitoring the policy for a year, the OLCC will review it to determine whether to adjust minimum prices, based on factors like the current market and inflation.

Intervention

OLCC's goal of reducing liquor consumption by heavy and binge drinkers drove development of the minimum pricing policy structure. With that goal in mind, the OLCC began to research regulatory actions that would align with public health and prevention objectives, as well as create revenue for the state. OLCC identified and discussed additional options, such as ceiling pricing and quantity limits, and conducted a SWOT (strengths, weaknesses, opportunities, and threats) analysis for each option identified. Throughout the development of the policy, OLCC collaborated closely with stakeholders to ensure the final regulatory action represented the interests of all parties and that the formula for pricing was fair and consistent with the original goal.

The identification-to-implementation process took 18 to 20 months to complete. Work began in early 2020, and consisted of strategy development, stakeholder identification, and compilation of resources. The first public notice was published in January 2021, and the policy went to the commission for verbal testimony in April 2021. Once these processes were complete, OLCC passed the regulatory action in July 2021, and it took effect in October 2021. OLCC staff developed the policy as part of their normal work, so there was no additional cost associated with this policy beyond staff time, which is funded by the state budget.

Implementing a Minimum Pricing Policy Through Regulatory Action

State of Oregon

Outcomes and Other Benefits

- The regulatory action affected the price of approximately 112 alcohol products sold in Oregon, and the OLCC expects a 0.5-percent reduction in overall demand for alcohol.[197]
- Implementation of this regulatory action will raise revenue while reducing alcohol-related harms. Research suggests that an increase in the price of alcohol is associated with reductions in alcohol misuse, underage consumption, and alcohol-related harms.[96] There is also evidence to suggest that increasing the price of alcohol will reduce health inequities among different income groups.[197]
- As the state of Oregon receives revenue from the sale of distilled spirits, OLCC estimated that the General Fund would increase by $7.5 million between 2021 and 2023 as a result of the higher prices required by the policy.[197]

Lessons Learned

- **Collaboration**: Working with various stakeholders was vital to ensure that the final regulatory action aligned with their interests. Stakeholders included representatives from the alcohol industry, industry groups, alcohol licensees (e.g., restaurants, bars), alcohol manufacturers and suppliers, retail liquor agents, public health stakeholders (such as the Oregon Health Authority), and the public. OLCC also received support from the State of Oregon Public Health Division, the Oregon Health Authority, and the Oregon Alcohol and Drug Policy Commission, all of whom sent letters of support for this regulatory action.
- **Options**: OLCC researched different policy options with the potential to produce the desired outcomes. They then approached their partners with the options—a key step that was instrumental in maintaining momentum and interest.
- **Advocacy:** The Alcohol and Drug Policy Commission and community advocacy groups were eager for additional action that addresses the high alcohol and other drug use rates in Oregon. In fact, the Commission's 2020–2025 strategic plan included language to increase the price of alcohol, and a 2021 bill introduced in the Oregon House would have raised alcohol taxes. These efforts, along with many others, helped create an environment that supported the OLCC effort to pass the above regulatory action.

Related Resources

- Oregon Liquor Control Commission
- OLCC Price Floor Summary
- Oregon Recovers

Baltimore City Council – Limiting Hours of Alcohol Sales

Baltimore, Maryland

Settings

As the legislative branch of the state's government, the General Assembly of Maryland is responsible for representing constituents, passing laws, managing revenue and funding, and overseeing executive agencies. The Assembly includes a 47-member Senate and a 141-member House of Delegates, with 1 senator and 3 delegates representing each of the state's 47 legislative districts. The 45th legislative district is in the city of Baltimore and is home to approximately 115,000 people. As of 2018, the population of the 45th legislative district is approximately 73 percent Black, 20 percent White, and 7 percent other races; roughly 3 percent identify as Hispanic. The median household income in the district is $39,600, with more than 20 percent of the population living at or below the poverty level.[198-199]

Issue

In one neighborhood of the 45th legislative district in Baltimore, political representatives and community members grew increasingly concerned with the number of fatal and non-fatal shootings. In October 2019, there were two shootings in a single week in one retail alcohol establishment, prompting concern among residents and local officials. State legislators met with local officials and law enforcement and learned that in the previous three years 29 shootings had occurred in front of that establishment or within 500 feet.

Upon learning this fact, legislators and other officials collaborated with the Baltimore City Police Department and examined data related to gun-related violence in this neighborhood to assess the extent of violence. Police data showed that one neighborhood in the 45th legislative district was experiencing high rates of gun violence directly outside of off-premises alcohol outlets in the area. Data revealed that there were more than 20 alcohol establishments within a one-mile radius, and that at least 3 shootings had occurred in or around each establishment during the past three years—for a total of 130 shootings and 68 homicides. Most of these crimes occurred between the hours of 10:00 p.m. and 2:00 a.m.

Solution

In Maryland, the state legislature regulates much of local alcohol availability, but legislators traditionally defer to local representatives regarding these decisions. Senator Cory McCray, who represents the 45th legislative district, introduced legislation to reduce crime and violence occurring at and around off-premises alcohol outlets in the neighborhood. The legislation limited the hours of alcohol sales in a defined geographic area of Baltimore City, drawing on evidence that such limits reduce alcohol-related harms, including homicides and other crimes. Specifically, the state passed legislation restricting "taverns" in this area to limit alcohol sales from 9:00 a.m. to 10:00 p.m. A tavern, the most common license category in Baltimore, is an establishment that is permitted to sell for both on- and off-premises consumption. Outside this defined geographic area, Baltimore City allows taverns to sell alcohol from 6:00 a.m. to 2:00 a.m., unless otherwise stated.

Intervention

The Senate introduced the legislation on January 31, 2020, and the language was ultimately included in House Bill 954, which went into effect on July 1, 2020. Once in effect, alcohol retailers needed to be notified about the change in law. Additionally, enforcement was needed to ensure retailers were following the new law. The Liquor License Board is the agency primarily responsible for enforcement, with additional support from the Baltimore City Police Department, as needed. A financial review of the new policy found that there was no extra cost to the state or Baltimore City, which had the necessary resources for enforcement of this new policy.

Since the legislation passed, legislators meet with the Baltimore City Police Department once a month to monitor the data related to violent crime and make sure that the city is meeting its goal of reducing gun violence in the neighborhood.

Baltimore City Council – Limiting Hours of Alcohol Sales
Baltimore, Maryland

Outcomes and Other Benefits

- The legislation took effect on July 1, 2020, and in the first 30 days after the legislation took effect, only 3 of the more than 20 affected establishments failed to comply with the new regulations. Two months after the legislation went into effect, officials observed a 50-percent reduction in homicides and violent crime near these establishments during the hours they were closed, compared to the same month in the previous year (i.e., comparing September 2019 to September 2020).[200] During the same time period, there were 34 fewer homicides within 500 feet of an alcohol establishment.
- Subsequently, the General Assembly passed similar laws to limit the hours of alcohol sales in Baltimore neighborhoods within the 40th and 41st legislative districts.

Lessons Learned

- **Data-Driven:** The data provided by the Baltimore City Police Department clearly showed an association between the rates of violent crime and number of alcohol establishments in the neighborhood and their hours of sales. Collecting and analyzing data to support legislative interventions and continuing to assess the influence of the legislation on outcomes were critical.
- **Buy-in from Legislators:** Though there had been coalitions advocating for a focus on alcohol and violence throughout Baltimore for years, it was difficult to create new policies until support was received from legislators and local officials. Through the work of legislative champions, the bill received support from the Baltimore City Police Department and local officials and legislators, who prioritized the issue and directed public resources towards its implementation.
- **Collaboration:** State legislators, local officials, and community members worked together to find approaches that would address violent crime, leading to a solution that improved both public health and safety. This example showed that community members have a responsibility to work together to create positive change that improves the health and safety of their neighbors.

Related Resources

- Maryland Senate Bill 571
- Maryland House Bill 954
- 40th Legislative District – Data on Liquor Establishments and Crime

CHAPTER

5

Guidance and Resources for Policy Evaluation

The primary purposes of evaluating public health interventions are to:[201]

- **Assess implementation**: Was the intervention implemented as intended and what factors are influencing the intervention's success?
- **Determine effectiveness**: Did the intervention achieve its goals and objectives and expected outcomes? Were there any unintended consequences of the policy?
- **Assess attribution***:* Did the intervention cause or contribute to progress on goals and objectives, or are other interventions and environmental or organizational factors also affecting outcomes?

A policy evaluation answers critical questions about whether an intervention is producing the intended outcomes, and why or why not. Evaluation can show how a policy benefits individuals and communities and provide evidence of its effectiveness.[202] Evaluation results may be helpful in ensuring sustainability of the implemented policy as well as in implementing future alcohol-related policies. In addition, practitioners can use these results for dissemination and to encourage adoption of successful interventions in other communities. Conducting an effective evaluation requires considerable technical expertise, and communities should consider working with an experienced evaluator to help collect and analyze data, potentially from local universities or consultants with the necessary technical skills to conduct policy evaluations. In planning interventions, communities should also consider the results of interventions designed to address similar problems in other communities.

This chapter presents an overview of approaches to evaluate the implementation and outcomes of interventions to prevent alcohol misuse, starting with a framework to ensure that individuals and organizations conduct evaluations with equity in mind. It concludes with specific evaluation resources, including potential outcomes to track and how to use evaluation findings.

Culturally Responsive and Equitable Evaluation (CREE)

As described in Chapters 1 and 2, alcohol misuse and related harms affect populations differently. When evaluating the effects of policies to prevent or reduce alcohol misuse, it is important to ensure that they are not benefiting or harming one community or population more than another. Equitable evaluation is a culturally responsive evaluation method that does not consider culture as a subjective factor that needs to be controlled;[203] instead, it explicitly acknowledges culture and context when assessing policy effectiveness. Equitable evaluation relies heavily on engaging the very participants who are affected by and responsible for implementing the policy and from whom evaluation

Expanding the Bench Initiative defines Culturally Responsive and Equitable Evaluation (CREE) as "evaluation that incorporates cultural, structural, and contextual factors (e.g., historical, social, economic, racial, ethnic, gender) using a participatory process that shifts power to individuals most impacted. CREE is not just one method of evaluation; it is an approach that should be infused into all evaluation methodologies."

data will be collected. According to the Equitable Evaluation Initiative (EEI),[204] evaluation efforts should be in service of equity, and evaluators should consider the following while developing their approach:

- Diversity of their evaluation teams, including cultural backgrounds, disciplines, beliefs, and lived experiences
- Degree to which communities have the power to shape and own the evaluation
- Cultural appropriateness and validity of evaluation methods, such as including language that represents diverse populations, developing evaluation materials that are clear and have accessible readability levels, and using data collection methods that are responsive to cultural differences
- Ability of the evaluation design to reveal structural and systems-level drivers of inequity (present-day and historical), such as ensuring that qualitative data are a key component of the evaluation design to give members of all populations an opportunity to identify how the policy affects different racial/ethnic communities, geographic neighborhoods, and socioeconomic classes

Types of Evaluations and Study Designs

Individuals and organizations should start their evaluation activities during the policy planning process. There are four basic types of evaluation, as follows:

1. Formative evaluation assesses the readiness of an organization or community to implement the intervention, articulates a theory of change (often illustrated in a logic model), and determines the extent to which evaluators can assess an intervention's implementation and outcomes.[205] Communities and organizations can also use formative evaluation findings to adjust the intervention to achieve desired results.
2. Process (implementation) evaluation collects data about an intervention's implementation. This type of evaluation enables program managers and policymakers to assess whether they have implemented the intervention as planned (fidelity), and whether and to what extent it reached the intended audience. Process evaluation may continue while conducting an outcome or impact evaluation.
3. Outcome evaluation collects baseline data and data at defined intervals (e.g., monthly, annually) during and after implementation of the intervention to assess both short- and long-term outcomes related to the targeted behaviors. These outcome data provide program managers and policymakers with information to assess changes or improvements in attitudes and behaviors that can be associated with the intervention, as well as any unintended outcomes.
4. Impact evaluation assesses an intervention's effectiveness in achieving its ultimate goals. Impact evaluations determine whether, and sometimes to what extent, the newly implemented intervention led to changes in indicators. Conducting impact evaluations of policy implementation can be challenging; it often takes many years to see changes in behavior that may be associated with policy change, during which time other factors can also influence the behaviors and outcomes the intervention targets. Impact evaluations typically require either comprehensive data collected before policy passage to do a pre/post comparison, or data from a similar jurisdiction that has not implemented the policy. Stakeholders and funders should be aware that an impact evaluation of the policy may not be feasible without substantial funding and technical expertise.

Each of these evaluation types is useful in judging an intervention's effectiveness in preventing alcohol misuse. However, when considering policy evaluation, it is important to remember there is rarely a concrete end date—the outcomes from a policy may not be observed for years, and the timeline for short-term outcomes (e.g., reductions in the number of alcohol outlets) may differ from that of longer-term outcomes (e.g., reductions in problem drinking). Both qualitative and quantitative methods, including community-based participatory approaches, are important when evaluating policies. Collection of baseline data, or data from before the policy was implemented, is critical across evaluation types. Communities and organizations should ensure they identify and collect data at the beginning of any policy process and then continue collecting those data as described below.

Evaluation Plans

CDC identified six key steps to policy evaluation that practitioners should consider at the beginning of any evaluation and include in an evaluation plan:[202]

1. **Engage stakeholders**: Multiple stakeholders with diverse backgrounds should be involved in the evaluation. Stakeholders may include policy experts, evaluation experts, subject matter experts, people with lived experience, those implementing the policy, and those affected by the policy, such as community members.
2. **Describe the policy**: Regardless of the type of evaluation conducted, it can be helpful for practitioners and stakeholders to develop a logic model that articulates the components of the policy they are evaluating, what the intended outcomes are, and how they hypothesize it will achieve the intended impact. Communities and organizations should consider the unintended consequences of the proposed policy and how it may affect different groups because of their social identities (e.g., race/ethnicity, age, sexual orientation, ability). A Community Anti-Drug Coalitions of America (CADCA) primer on developing logic models may be found here.[206]
3. **Focus the evaluation design**: As described above, communities and organizations can conduct several types of evaluation. It may be necessary for organizations to conduct multiple evaluations to understand fully how jurisdictions implemented a policy and what the outcomes were. Once the organization or coalition has selected the types of evaluation to conduct, it is necessary to identify evaluation questions and determine meaningful indicators (more information on this subject is provided below).
4. **Gather credible evidence:** There are five questions that can help guide a data collection plan: 1) What do you need to know to answer your evaluation questions? 2) In what timeframe will you collect data, and how often? 3) What is your budget, and what is your staff capacity to collect data? 4) Are there ethical considerations, such as anonymity or privacy, that affect your data collection? and 5) Are the data reliable and valid?
5. **Justify conclusions**: Once results are available, the team should present them in a way that is meaningful and understandable to the audience(s)— policymakers, health departments, and/or the community at large. Stakeholders identified earlier in the evaluation process should have an opportunity to provide guidance and input on data interpretation. Coalitions and organizations should consider using this opportunity to look at and present the data through an equity lens, analyzing outcomes by different subpopulations the policy may affect (e.g., different racial/ethnic groups, populations with different socioeconomic characteristics, different age groups). During this phase, it is also valuable to compare the results with other evaluation findings and consider alternative explanations for the findings that those critical of the policy may find fault with.
6. **Ensure use and share lessons learned**: Coalitions and organizations can use evaluation results both internally (for continuous feedback on policy implementation) and externally (to provide information on the effectiveness of the policy, increase the evidence base, increase awareness about the policy, or justify the policy's continued existence and/or expansion to other jurisdictions). For each audience, coalitions and organizations should consider detailing what the communication objectives are, how to communicate the results, and what is the key focus. Other considerations specific to the target audience include what their priorities are, whether background information is needed, and how much time the audience will be given to review results.

Outcomes

An important, but often challenging, step in implementing policies is determining whether they have produced desired outcomes. An **outcome** is the actual change resulting from an intervention's implementation. Implementers may see **short-term outcomes** of a policy immediately, such as changes in knowledge, beliefs, or perceptions, or reductions in the number of alcohol licenses given or reduced monthly alcohol sales. **Long-term outcomes** include change in behavior at both individual and population levels, including reductions in initiation and prevalence of alcohol misuse, and changes at the system level, such as reduction in alcohol-related healthcare costs. Collecting data on the patterns of alcohol misuse, including who is misusing alcohol, what products they are using, and how they are using them, will help communities conduct their regular needs assessments, as described in Chapter 3.

Given changing patterns of alcohol misuse, there are several key data elements that communities need to collect to understand alcohol misuse prevention and reduction efforts. Stakeholders working to prevent alcohol misuse among youth and adults should:

- Collect data on existing policies at the national, state, local, tribal, and/or territorial levels (depending on the scope of the policy)
- Examine how retailers are marketing alcohol products in their community to understand the potential impact of future policy
- Track patterns of alcohol misuse in populations at high risk, such as by race/ethnicity, gender identity, and sexual orientation

Below is a list of potential outcomes, illustrative outcome indicators, and data sources that communities and organizations may use to evaluate policies to prevent alcohol misuse among youth and adults.

Outcome	Illustrative Indicators	Illustrative Data Sources
Short-Term Outcomes		
Change in knowledge of the harms of alcohol use, strengthened social norms	Level of perceived harm of alcohol products among youth, young adults, and adults	Monitoring the Future Survey
Change in perceived social norms about alcohol behaviors	Proportion of youth (12-17) who overestimate the alcohol use rate among their peers	National Survey on Drug Use and Health
Changes in policy and enforcement efforts	Proportion of jurisdictions with public policies that establish a fee on each alcohol product sold	State or local policy tracking systems
	Proportion of jurisdictions with comprehensive policies that require retail licenses to sell	
	Enforcement intensity measured by citations/warnings given to retail establishments	Local or state law enforcement or licensing entities maintaining citation data
Change in price of alcohol products	Amount of alcohol product taxes and fees	NIAAA Alcohol Policy Information System, local or state agencies responsible for collecting alcohol taxes (e.g., alcohol beverage control organizations, departments of revenue)
Change in availability of alcohol products	Density of stores selling alcohol products, hours/days of sale	Government bodies/organizations licensing alcohol retailers
Change in exposure to alcohol marketing	Number and content of alcohol advertisements	Media scans and tracking, surveys

Outcome	Illustrative Indicators	Illustrative Data Sources
Long-Term Individual-, Systems-, and Population-Level Outcomes and Impacts		
Change in initiation of alcohol use	Proportion of youth and young adults who report never having tried an alcohol product	National Survey on Drug Use and Health
Change in alcohol use prevalence	Prevalence of alcohol use among youth, young adults, and adults	National Survey on Drug Use and Health, Youth Risk Behavior Surveillance System
Change in sales of alcoholic products	Fewer sales reported in a community	Tax data, retail establishments
Change in alcohol availability	Reduction in number of alcohol outlets, limiting hours/days of sale	Local or state alcohol license data
Change in alcohol-related consequences	Reduction in violence and crime, rates of sexually transmitted infections, motor vehicle crashes and fatalities, sexual assault, emergency department visits	Law enforcement calls for service, health department surveillance, emergency departments, local surveys

Potential Sources of Outcome Data

Quantitative Data. Several publicly available datasets include quantitative measures on alcohol use. Communities wanting more localized data should look at the surveillance measures their county and state public health departments collect at the county or census tract level. Organizations or coalitions can also consider local surveys of schools or community members (either existing surveys or new ones created as part of the policy), as well as conducting mapping of alcohol establishments, collecting calls for service data from law enforcement, tracking alcohol establishment license data, and analyzing data on alcohol sales.

Additional sources of data include hospitals and law enforcement, alcohol marketing (social media, retail signage, billboards, radio, and television spots), and observational assessments, such as environmental scans, which are particularly helpful in measuring changes in the retail environment. For example, an observational assessment could be conducted to determine whether alcohol advertisements are located in primarily lower-income neighborhoods, or near places with high youth traffic, such as schools or parks. Scans can also measure the number and type of products, advertisements, and other risk and protective factors in and around alcohol retailers. Communities should consider whether they can compare their data with data from a similar community, such as a city or county with similar characteristics, or with state averages.

Sources of National Data on Alcohol Use Among Youth and Adults					
Survey Characteristic	**National Survey on Drug Use and Health (NSDUH)**[13]	**Monitoring the Future (MTF)**[207]	**Youth Risk Behavior Surveillance System (YRBSS)**[208]	**Behavioral Risk Factor Surveillance System (BRFSS)**[209]	**National Health and Nutrition Examination Survey (NHANES)**[210]
Sponsoring agency or organization	Substance Abuse and Mental Health Services Administration	National Institute on Drug Abuse	Centers for Disease Control and Prevention	Centers for Disease Control and Prevention	Centers for Disease Control and Prevention
Level of data available	National, state, sub-state regions	National, regional	National, state, district	State, counties, and metropolitan/ micropolitan areas	National
Type of survey	Cross-sectional	Cross-sectional and longitudinal	Cross-sectional	Cross-sectional	Cross-sectional
Mode of survey administration	Combination of web-based interviews with questionnaires accessed over the internet and in-person, face-to-face audio- and computer-assisted interviews	School-based, self-administered questionnaire	School-based, self-administered questionnaire	Telephone survey administered by states	Interviews and physical examinations
Ages/grades	≥12 years	8th and 10th grades (since 1991) and 12th grade (since 1975); ≥18 years to 60 years	9th–12th grades	≥18 years	All ages; however, data on alcohol use is available only for those ≥18 years
Disaggregated data that could be included in a CREE	Race/ethnicity; gender identity; geographic breakdown	Gender identity	Race/ethnicity; gender identity; sexual orientation	Race/ethnicity; gender identity; urban/rural status	Race/ethnicity; gender identity

Qualitative Data. Throughout an evaluation, it is important to engage both those implementing the policy and those affected by it. Encouraging and collecting the voices of key stakeholders, through qualitative data collection via interviews or focus groups, provides necessary context and allows evaluators to gain a deeper understanding of the story behind the quantitative data collected. It is important to note that qualitative data can be used across all the evaluation types discussed above (formative, process, outcome, and impact).

Evaluators can collect qualitative data from those who misuse alcohol, both initially to understand attitudes and perceptions of alcohol use, such as why and how they use the product, and during and after policy implementation to understand what is and is not working from the perspectives of those who misuse alcohol. Evaluators can also interview the policy implementors to understand what is going well, as well as community members to ensure that the policy is being appropriately enforced and determine if changes need to be made. For example, if survey data show that an increase in tax policy is affecting one demographic group differently than others, focus groups may help stakeholders understand why these differences may be occurring. Additionally, these data can identify inequitable distribution of unintended consequences of a policy, so policymakers can create community solutions.

Discussions around policy implementation—in social media and in more traditional forms—can also facilitate evaluation of policy implementation and enforcement. Other methods include observational assessments, listening sessions, and open online forums for broader community feedback on policy consequences. Coalitions can also conduct media tracking to assess news coverage of the policy or review the types of alcohol advertisements present in their community (whether on social media, on television, in alcohol establishments, or elsewhere).

Qualitative data collection efforts both at the beginning of any evaluation and at the end can help provide context for quantitative study findings.[211]

Using Evaluation Findings Internally

Coalitions can use data from a policy evaluation internally for process improvement, partner coordination, and celebration.[212]

- **Improvement**: Organizations can use data as soon as they are collected for immediate monitoring and rapid assessment of policy implementation and outcomes. Qualitative and quantitative data allow coalitions and prevention practitioners to judge whether a policy is reducing alcohol misuse and other related outcomes, such as car crashes, and to assess if there are any unintended and inequitable consequences. Policymakers and implementers can then adjust the policy and/or how it is implemented.[201]
- **Coordination**: Coalitions and prevention practitioners can also use data to coordinate with other community sectors. Findings from policy evaluations allow coalition members and stakeholders to understand what other communities are doing to address alcohol misuse, how this work may align with their own goals, and opportunities for collaboration.[212]
- **Celebration:** Data collection and analysis allow coalitions, prevention practitioners, and communities to identify and celebrate successes during the policy process, which may occur even before a policy is implemented. Regular acknowledgement and celebration of accomplishments, whether big or small, are an important part of sustaining community and practitioner motivation.[212]

Policy process successes could include:

- Securing a meeting with a policymaker
- Publishing an article in a news media outlet about alcohol misuse
- Gaining new members and partners
- Passing policy

Using Evaluation Findings Externally

The findings from a policy evaluation can be used outside of a coalition to ensure accountability and sustainability, in the following ways:[212]

- **Protection of Existing and Future Policies**: Opponents may try to reverse the recently passed policy or find other ways to weaken it. Being able to provide data on the new policy's positive effects is critical to ensuring the long-term viability of the effort. Additionally, these data can support the need for additional policies to prevent or reduce alcohol misuse.
- **Celebration**: In addition to organizations and coalitions celebrating successes internally, sharing the successes of the policy process and changes in outcomes with the broader community is important so everyone is aware of the significance of the work and what these policies can or have accomplished. These celebrations can support the protection of existing and future policies, as discussed above.
- **Diffusion of Information**: Other communities and states are often looking for examples of effective policies and policy processes as they address their own alcohol misuse issues. Creating infographics, data briefs, and publications about the policy and evaluation findings that can be shared with other coalitions, advocates, policymakers, and stakeholders can help support other communities in their prevention efforts.
- **Accountability:** Coalitions rely on parties outside their organizations for support, such as volunteers, funders, community stakeholders, and lawmakers; sharing evaluation findings allows coalitions to remain accountable to these stakeholders. Those who contribute their time, money, creativity, and/

or political support to the coalition will want to make sure the coalition's work is helping to reduce alcohol misuse and related outcomes. Findings from policy evaluations allow coalitions and prevention practitioners to describe what contribution they are making to reduce alcohol misuse. Stakeholders will then know that they are supporting a coalition whose work is grounded in outcomes.

- **Sustainability:** Addressing alcohol misuse requires consistent and long-term effort and collaboration from various stakeholders, such as volunteers, funders, and lawmakers. Information from policy evaluations can help to foster long-term support from stakeholders. Positive outcome data can also help coalitions assure stakeholders of the continued importance, effectiveness, and relevance of the implemented policies.

These internal and external data-sharing activities are critical to ensuring the current and long-term success of not only the recently implemented policy, but also all future policies aimed at preventing alcohol and other drug misuse in the community.

Ways to share findings could include:

- Press releases
- Guest opinion pieces ("op-eds")
- Town hall meetings
- Social media postings
- Presentations to the community
- Recognition events

Evaluation Resources

- SAMHSA's Strategic Prevention Framework and Selecting the Best Fit guidance includes assistance on how coalitions and prevention planners can evaluate programs and environmental strategies.
- CDC's Introduction to Process Evaluation focuses on Tobacco Use Prevention and Control, defines process evaluation and describes its rationale, benefits, key data collection components, and evaluation management procedures. Additional evaluation resources from CDC are also available, including a brief on Using Evaluation to Inform CDC's Policy Process.
- CADCA created an Evaluation Primer on Setting the Context for a Community Anti-Drug Coalition Evaluation, which specifically addresses coalition evaluation.
- The National Institutes of Health has a presentation with tools and guidance for evaluation.
- CDC's Evaluating Violence and Injury Prevention Policies provides concrete recommendations on conducting policy evaluations.
- The Rainbow Framework provides tools for the many methods and processes that individuals and organizations can use in monitoring and evaluation.

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Glossary

Alcohol misuse: A pattern of drinking resulting in harm to one's health, interpersonal relationships, or ability to work. Alcohol misuse includes binge and heavy drinking, as well as underage drinking and drinking by pregnant people.

Alcohol use disorder: A chronic medical condition characterized by an impaired ability to stop or control alcohol use, despite adverse social, occupational, or health consequences.

Binge drinking: Consuming four or more standard drinks on an occasion for a woman, or five or more standard drinks on an occasion for a man. A standard drink is 12 fluid ounces of beer (5 percent alcohol), 8 to 9 fluid ounces of malt liquor (7 percent alcohol), 5 fluid ounces of wine (12 percent alcohol), or 1.5 fluid ounces of 80-proof distilled spirits (40 percent alcohol).

Cisgender: Individuals whose current gender identity is the same as the sex they were assigned at birth.

Community-based participatory approach: An approach that involves the engagement and equal participation of individuals affected by an issue or problem at hand and recognizes and appreciates the unique strengths and resources each person contributes. It is a cooperative, empowering, co-learning process that involves systems development and local community capacity-building.

Community Stakeholders: Members or organizations in a community that have a direct interest in the process and outcomes of a project, research study, or policy initiative.

Culturally Responsive and Equitable Evaluation (CREE): Evaluation that incorporates cultural, structural, and contextual factors (e.g., historical, social, economic, racial, ethnic, gender) using a participatory process that shifts power to individuals most impacted.

Disability Adjusted Years of Life: The disability-adjusted life year (DALY) is a measure of overall disease burden. One DALY represents the loss of the equivalent of one year of full health. DALYs for a disease or health condition are the sum of years of life lost due to premature mortality and years of healthy life lost due to disability from cases of the disease or health condition in a population.

Evidence-based practices: Interventions that are guided by the best research evidence with practice-based expertise, cultural competence, and the values of the persons receiving the services, that promote individual-level or population-level outcomes.

Fidelity: The extent to which an intervention is delivered as conceived and planned.

Formative evaluation: An evaluation that assesses the readiness of an organization or community to implement the intervention, articulates a theory of change, and determines the extent to which evaluators can assess an intervention in a reliable and credible fashion.

Health inequities: Differences in health status or in the distribution of healthcare and other resources between different population groups or geographic areas, arising from the social conditions in which people are born, grow, live, work, and age.

Heavy drinking: Consuming eight or more standard drinks per week for a woman, or 15 or more standard drinks per week for a man.

Impact evaluation: An evaluation that assesses an intervention's effectiveness in achieving its ultimate goals. Impact evaluations determine whether, and sometimes the extent to which, the newly implemented intervention led to changes in desired and unexpected outcomes.

Indicators: Quantitative or qualitative metrics that provide information to monitor performance, achievement, and accountability.

Intervention: A program, initiative, service, or policy designed to reduce excessive alcohol use and related harms.

Lived experience: Personal knowledge gained through direct, first-hand involvement. In the context of this report, lived experience refers to individuals who have experienced mental illness, substance use or substance use disorder, or homelessness.

Male/female: Terms used for an individual's sex assigned at birth based on physiological characteristics, including genitalia and chromosome composition.

Man/woman: Two genders with which a person may self-identify. Gender is a spectrum, in that there are many identities, and may include transgender, non-binary, or gender neutral.

Minimum pricing: A policy that sets a minimum price based on the amount of a specific alcoholic beverage type, regardless of alcohol content within that beverage (such as a liter of beer, wine, or liquor). For example, a 25-ounce bottle of wine that is 10 percent ABV will have the same minimum price as a 25-ounce bottle of wine that is 12 percent ABV.

Minimum unit price: A policy that sets a minimum price based on the amount of alcohol. Setting a minimum unit price makes stronger alcohol products more expensive. Retailers cannot sell alcohol for less than that price no matter where they are selling (e.g., bar, restaurant, liquor store).

Nuisance ordinances: Local ordinances that allow jurisdictions to regulate alcohol retailers who are consistently cited for their business practices, such as extensive advertising, loitering, or crime at their establishment.

Off-premises: Alcohol purchased through liquor, grocery, convenience, and other stores for consumption off-site.

On-premises: Alcohol served in bars and restaurants for consumption in these locations.

Outcome evaluation: An evaluation that collects baseline data and data at defined intervals (e.g., annually) during and after implementation of the intervention, to assess short- and long-term outcomes related to the targeted behaviors.

Process (implementation) evaluation: An evaluation that assesses the quality of an intervention's implementation and conditions that facilitate or create barriers to successful implementation. Process evaluation enables program managers and policymakers to assess whether they have implemented the intervention as planned, and whether and to what extent it reached the intended audience.

Social determinants of health: Conditions in the environments where people are born, live, learn, work, play, worship, and age that affect health.

Social media influencer: Individuals or groups who have a reputation as having expertise on certain topics, such as food, fashion, music, or pop culture. Influencers, who may be paid by commercial interests such as alcohol marketers, make regular posts on social media to generate interactions, and promote product purchasing by their large base of followers.

Stakeholders: Individuals, organizations, or communities that have a direct interest in the process and outcomes of a project, research, or policy endeavor/initiative.

Standard drink: One "standard" drink (or one alcoholic drink equivalent) contains roughly 14 grams of pure alcohol, which is found in 12 ounces of regular beer (usually about 5 percent alcohol); 5 ounces of wine (typically about 12 percent alcohol); 1.5 ounces of distilled spirits (about 40 percent alcohol).

Substance misuse: Use of any substance in a manner, situation, amount, or frequency that can cause harm to users or those around them. For some substances or individuals, any use would constitute misuse (e.g., underage drinking, injection drug use).

Substance use: Use—even one time—of alcohol or other drugs.

Sustainability: The process of building an adaptive and effective prevention system that achieves and maintains desired long-term results.

Transgender: Individuals whose gender identity differs from the sex they were assigned at birth.

Under-resourced communities: Population groups or geographic areas that experience greater obstacles to health, based on characteristics such as, but not limited to, race/ethnicity, socioeconomic status, age, gender, disability status, historical traumas, sexual orientation/gender identity, and/or location.

Universal interventions: Prevention efforts that focus on all people in a population.

APPENDIX 1: Acknowledgments

This guide is based on the thoughtful input of SAMHSA staff and the Technical Expert Panel on Implementing Community-Level Policies to Reduce Alcohol Misuse from October 2021 through June 2022; two expert panel meetings were convened during this time.

SAMHSA Staff

Brian Altman, JD, National Mental Health and Substance Use Policy Laboratory

Robert Baillieu, MD, MPH, Center for Substance Abuse Treatment *

Jerry Campbell, Center for Substance Abuse Prevention *

Tanya Geiger, PhD, MPH, Center for Behavioral Health Statistics and Quality *

Kirk James, MD, Center for Substance Abuse Treatment *

CAPT Donelle Johnson, PhD, MHSA, National Mental Health and Substance Use Policy Laboratory *

Krishnan Radhakrishnan, MD, PhD, MPH, National Mental Health and Substance Use Policy Laboratory *

Robert Vincent, MSEd, Center for Substance Abuse Prevention *

Technical Expert Panel

Tom Babor, PhD, MPH, University of Connecticut School of Medicine

Ruben Baler, PhD, National Institute on Drug Abuse

Gregory Bloss, MA, MPP, Division of Epidemiology and Prevention Research, National Institute on Alcohol Abuse and Alcoholism

Marissa Esser, PhD, MPH, Alcohol Program, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Tiffany Hall, MPA, Recover Alaska

Beth Han, MD, PhD, MPH, National Institute on Drug Abuse

David Jernigan, PhD, Boston University School of Public Health

Elisabeth Kato, MD, MRP, Agency for Healthcare Research and Quality

Bill Kerr, PhD, Alcohol Research Group

Juliet Lee, PhD, Prevention Research Center, Pacific Institute for Research and Evaluation

Rod Robinson, MA, MAC, LAT, Bureau of Indian Affairs

Michael Sparks, MA, SparksInitiatives

Contract Staff

Alicia Sparks, PhD, MPH, Guide Lead, Abt Associates *

*Members of Guide Planning Team

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Abstract

Tailoring care, programs, and services to the cultural, social, gender, and other socio-demographic contexts of individuals served yields positive outcomes.[1] Communities and individuals benefit when they receive behavioral health services that are clinically proven effective, equitable, and culturally appropriate.

This guide focuses on the process of adapting evidence-based practices (EBPs) for under-resourced populations who experience obstacles in obtaining healthcare services because of their socio-demographic characteristics, and the research supporting such adaptations. The guide provides examples of research on adapted EBPs for mental health and substance use disorders for clients with a wide range of demographic characteristics.

The guide provides considerations and strategies for community leaders and advocates, behavioral health practitioners, administrators, and organizational decision-makers.

[1] Lee, S. J., Altschul, I., & Mowbray, C. T. (2008). Using planned adaptation to implement evidence-based programs with new populations. *American Journal of Community Psychology, 4*1, 290-303. https://doi.org/10.1007/s10464-008-9160-5

MESSAGE FROM THE ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

As the Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the head of the Substance Abuse and Mental Health Services Administration (SAMHSA), I am pleased to present this new resource: *Adapting Evidence-Based Practices for Under-Resourced Populations.*

SAMHSA is committed to improving prevention, treatment, and recovery support services for individuals with mental illnesses and substance use disorders. SAMHSA's National Mental Health and Substance Use Policy Lab developed the Evidence-Based Resource Guide Series to provide communities, clinicians, policy makers and others with the information and tools to incorporate evidence-based practices (EBPs) into their communities or clinical settings. As part of the series, this guide aims to inform behavioral health practitioners and other interested parties and stakeholders about the process of culturally adapting evidence-based practices for under-resourced populations. On the care continuum, although this guide focuses predominantly on adapting treatment EBPs, the adaptation process outlined in the guide is applicable to any EBP in behavioral health, including prevention, treatment, and recovery practices for substance use and mental health.

This guide and others in the series address SAMHSA's commitment to behavioral health equity, including providing equal access for all people to evidence-based prevention, treatment, and recovery services regardless of race, ethnicity, religion, income, geography, gender identity, sexual orientation, and disability. Each guide recognizes that substance use disorders and mental illness are often rooted in structural inequities and influenced by the social determinants of health. Behavioral health practitioners and community stakeholders must address health equity as a strategy for improving individual and population health.

Increasing robust inclusion of under-resourced populations in clinical trials and health research is a key goal to mitigating disparities. Simultaneously adapting evidence-based practices, while retaining core practice components, can help mitigate the disparities too often seen in behavioral health outcomes for these populations. This guide discusses the different types of adaptations and key steps in the adaptation process. I encourage you to use this guide to ensure that all populations benefit from culturally appropriate and clinically effective care.

Miriam E. Delphin-Rittmon, PhD
Assistant Secretary for Mental Health and Substance Use
U.S. Department of Health and Human Services

FOREWORD

Evidence-Based Resource Guide Series Overview

The Substance Abuse and Mental Health Services Administration (SAMHSA), specifically its National Mental Health and Substance Use Policy Laboratory (Policy Lab), is pleased to disseminate information on evidence-based practices (EBPs) and service delivery models.

The Evidence-Based Resource Guide Series is a comprehensive set of modules with resources to improve health outcomes for people at risk for, experiencing, or recovering from mental health and/or substance use disorders. It is designed for practitioners, administrators, community leaders, health profession educators, and others considering an intervention for their organization or community.

Expert panels of federal, state, and non-governmental participants provide input for each guide in this series. The panels include accomplished researchers, educators, service providers, community members with lived experience, community administrators, and federal and state policy makers. Members provide input based on their lived expertise, knowledge of healthcare systems, implementation strategies, EBPs, provision of services, and policies that foster change.

A priority topic for SAMHSA is ensuring that behavioral health services reach under-resourced populations for prevention, engagement, early intervention, treatment, and recovery. Additionally, President Biden's Executive Order 13985: *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government* directs federal agencies to evaluate whether their policies produce racially inequitable results when implemented and to make the necessary changes to ensure underserved communities are properly supported. Implementation of evidence-based policies, programs, and practices can reduce the impacts of mental health and substance use disorders for individuals and communities. However, implementation and uptake of EBPs can be challenging for states, tribes, communities, and organizations.[2] Nationally, EBPs are reported to be only a small fraction of the prevention, treatment, and recovery programs that behavioral health programs implement.[3,4] In addition, an EBP must be adapted to the cultural norms and values of the group to whom practitioners deliver it. As a result, individuals in need of certain behavioral health services do not always receive the benefit of EBPs. This guide reviews the diverse types of cultural adaptations, the process for adapting EBPs

[2] Walker, S.C., Whitener, R., Trupin, E. W., & Migliarini, N. (2013). American Indian perspectives on evidence-based practice implementation: Results from a state-wide Tribal mental health gathering. *Administration and Policy in Mental Health and Mental Health Services Research, 42,* http://doi.org/10.1007/s10488-013-0530-4

[3] National Research Council and Institute of Medicine. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities.* Washington, D.C.: National Academies Press.

[4] Glasgow, R. E., Vinson, C., Chambers, D., Khoury, M. J., Kaplan, R. M., & Hunter, C. (2012). National Institutes of Health approaches to dissemination and implementation science: Current and future directions. *American Journal of Public Health, 102*(7), 1274–1281. https://doi.org/10.2105/AJPH.2012.300755

to serve under-resourced populations, and the research supporting such adaptations.

Implementing new programs and practices requires a comprehensive, multi-pronged approach. This guide is one piece of an overall approach to implement and sustain change. Readers are encouraged to review the SAMHSA website for additional tools and technical assistance opportunities.

Behavioral health equity is the right to access high-quality and affordable healthcare services and supports for all populations, including Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. As population demographics continue to evolve, behavioral healthcare systems will need to expand their ability to fluidly meet the growing needs of a diverse population. By improving access to behavioral health care, promoting quality behavioral health programs and practice, and reducing persistent disparities in mental health and substance use services for under-resourced populations and communities, recipients can ensure that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with promoting access to high-quality services, behavioral health disparities can be further mitigated by addressing social determinants of health, such as social exclusion, unemployment, adverse childhood experiences, and food and housing insecurity.

Content of the Guide

This guide contains a foreword (FW) and five chapters (1–5). Each chapter is designed to be brief and accessible to community leaders and advocates, behavioral health practitioners, administrators, researchers, organizational decision-makers, and others working to meet the needs of individuals at risk for, experiencing, or recovering from a mental health or substance use disorder.

FW	**Evidence-Based Resource Guide Series Overview** Introduction to the series.
1	**Issue Brief** This chapter provides definitions of evidence-based practice adaptation, reasons for adapting EBPs, comparing fidelity versus fit, and different levels and types of cultural adaptations.
2	**What Research Tells Us** This chapter highlights research on adaptations of EBPs and describes the steps in the process of adapting an EBP.
3	**Guidance for Adapting EBPs** This chapter provides best practices for adapting EBPs and then implementing the adapted practice.
4	**Examples of Cultural Adaptations of EBPs** This chapter highlights three examples of organizations developing and implementing adapted EBPs for under-resourced populations in their communities.
5	**Resources for Evaluation and Quality Improvement** Guidance and resources for documenting and evaluating the process of adapting an EBP and the implementation of the adapted practice.

FOCUS OF THE GUIDE

Tailoring care, programs, and services to the cultural, social, gender, and other demographic contexts of individuals served yields positive outcomes. Communities and individuals benefit when they receive behavioral health services that are clinically proven effective, equitable, and culturally appropriate.

This guide describes various types of cultural adaptations of EBPs for under-resourced populations and the multiple steps in the adaptation process. The guide also focuses on research supporting such adaptations.

The guide does not focus on a sole behavioral health outcome or a specific under-resourced population. Instead, it details the adaptation process practitioners can tailor and implement for their individual programs. This guide is intended to be broad and provide information for practitioners across both the mental health and substance use disorder fields.

On the care continuum, this guide focuses predominantly on adapting treatment EBPs, although the adaptation process that this guide describes is applicable to any EBP in behavioral health, including prevention, treatment, and recovery practices for substance use and mental health.

CHAPTER

1

Issue Brief

Health inequities adversely affect under-resourced communities and are reflected across a number of physical and behavioral health outcomes.[1] Under-resourced communities are defined population groups that experience greater obstacles to health, based on characteristics such as, but not limited to, race, ethnicity, religion, income, geography, gender identity, sexual orientation, and disability. While recent data suggest that prevalence of mental health and substance use disorders are generally *not* higher for under-resourced racial groups, people in these groups are less likely to seek or receive treatment services.[3-4] In another example, a 2015 survey of transgender adults found that 7 percent of transgender adults had attempted suicide in the past year and 40 percent in their lifetime, compared to 0.6 and 4.6 percent of the general U.S. population.[6]

Health inequities are differences in health status or in the distribution of health resources among different population groups, arising from the social conditions in which people are born, grow, live, work, and age.[2]

Structural racism is defined as a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity.[5] It remains a root cause of persistent health disparities in the United States.

Clinical research shows that evidence-based practices (EBPs) improve behavioral health outcomes for children, adolescents, and adults.[7-8] However, for an EBP to be effective for a population with whom it was not tested, it must be adapted to the cultural norms and values of the group to whom it is to be delivered.[9] Additionally, there is often a "know-do" gap, with an estimated time frame of 17 years between the development of an EBP to its optimal implementation in communities of need.[4]

Evidence-based practices are interventions for which there is consistent scientific evidence showing that they improve client outcomes.[10]

Often, the demographic characteristics of participants in research on an EBP are different from those of the population that hopes to benefit from its implementation[17]; demographic characteristics include social and cultural factors. Under-resourced communities are commonly underrepresented in the research that tests the efficacy of substance use and mental health prevention and treatment EBPs.[8, 18] Further, as few EBPs have been adapted to under-resourced populations, there is limited implementation of EBPs with these populations.[19]

Historically, under-resourced populations are excluded from clinical trials and large studies in health research.[11] Research cites multiple reasons for this exclusion[12]: mistrust and fear or exploitation experienced by some under-resourced populations; shortage of researchers who themselves identify with and represent the under-resourced populations and who could help address some of the trust issues; and logistical barriers potential participants face, such as inflexible schedules and lack of transportation. As a result of this exclusion, clinicians find it hard to apply lessons from health research to the under-resourced populations in their care.

The optimal solution to this problem would be to tackle the above barriers and increase diversity in health services research.[13] This change needs to be deliberate, systemic, and pervasive throughout the research enterprise. Until such a shift happens, cultural adaptation and/or tailoring of EBPs are valuable and empirically sound approaches to treating behavioral health concerns of under-resourced populations.[14] The cultural adaptation of EBPs allows a practitioner to integrate cultural competence into therapy.[15] Cultural adaption serves as a "unifying bridge" between practitioners who uphold the need for new treatment approaches for the behavioral health issues of under-resourced populations and those who recommend that existing treatment methods should be tested, unchanged, with these populations.[16]

This chapter:

- Defines adaptation
- Discusses why practitioners[5] should adapt EBPs for under-resourced populations
- Examines the distinction between fidelity and fit
- Describes the different levels and types of cultural adaptations

Culture is a broad, multi-dimensional construct, influenced by the context of social norms and experiences. Culture refers to integrated patterns of human behavior that include the language, spirituality, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.[22]

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals, enabling them to work effectively in cross-cultural situations.[23]

Five essential elements contribute to the ability of a system, institution, or agency to become more culturally competent:

1. Valuing diversity
2. Having the capacity for cultural self-assessment
3. Being conscious of the dynamics inherent when cultures interact
4. Having knowledge of institutionalized culture
5. Having the knowledge and capacity to adapt service delivery that reflect an understanding of cultural diversity

Cultural adaptation is the systematic modification of an EBP's protocol and/or content to consider language, culture, and context such that it is compatible with the client's cultural patterns, meanings, and values.[24]

Cultural integrity is the practice of respecting and honoring the ownership of materials, traditions, and knowledge of a particular culture or community.[25]

[5] The terms *provider* and *practitioner* are used throughout this guide to refer to individuals providing services. The specific term depends on context. Similarly, for simplicity, *client* is used throughout this guide to refer to individuals receiving behavioral health services. The authors recognize that while some professional roles or settings may use this term exclusively, other organizations, professional roles, or settings may use the term patient or other term.

What Does Adaptation Mean?

Adaptation of an EBP involves making changes to better fit the needs of the population being served without negatively affecting, removing, or changing key or core implementation elements.[20] Core elements are defined as "the essential program components that are believed to make an EBP effective and that should be kept intact to maintain intervention effectiveness."[21] Examples of adaptations include, but are not limited to, additions, deletions, or modifications of non-core program components; changes in content; and changes in who delivers the EBP and how the practitioner engages with clients.[4] Outcomes measured with consistently applied adaptations can help ensure the ongoing effectiveness of specific EBPs within the populations being served. Adaptation of an EBP can occur within the context of implementation science and/or cultural adaptation.

Only the **non-core elements** of the EBP can be adapted. Further, adapting an EBP does not automatically make the adaptation an EBP. Rigorous evaluation discussed in Chapter 5 is required to establish the evidence for the adaptation.

Implementation Science View of Adaptation

Implementation science is defined as "the scientific study of the methods to promote the systematic uptake of clinical research findings and other EBPs into routine practice and hence improve the quality and effectiveness of health care."[26] Implementation science defines adaptation as "a process of thoughtful and deliberate alteration to the design or delivery of an intervention, with the goal of improving its fit or effectiveness in a given context."[27] Improving fit includes ensuring cultural relevance. Cultural integrity in the adaptation of an EBP increases the likelihood of equitable implementation and desired outcomes.

Behavioral health practitioners may also adapt an EBP organically to suit the individual needs of a particular client. While this is a form of adaptation, it is not the focus of this guide.

In 2013, the U.S. Department of Health and Human Services Office of Minority Health (OMH) released the enhanced *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*, originally developed in 2000, to provide a blueprint for individuals and healthcare organizations to implement CLAS.[29]

The National CLAS Standards are intended to advance health equity, improve quality, and eliminate healthcare disparities. The standards are based on principles of respect and responsiveness and include a principal standard: *Providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.* They also include standards in three additional categories: governance, leadership, and workforce; communication and language assistance; and engagement, continuous improvement, and accountability.

Further, in 2021, the Substance Abuse and Mental Health Services Administration (SAMHSA) and OMH published a *Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care*, which describes strategies for the behavioral health community to provide CLAS.[30]

Cultural Adaptation of EBPs

Cultural adaptation of EBPs refers to modifying existing programs to best suit the worldviews (i.e., attitudes, values, stories, and expectations about the world) of specific populations, cultures, and/or communities.[24] It can help to address social, cultural, demographic, and other contextual differences between the community in which the EBP was tested and the community in which the EBP will be implemented.[8]

Cultural adaptation often is aimed at increasing the cultural sensitivity of the EBP. Cultural sensitivity is the extent to which the ethnic and cultural characteristics, experiences, norms, values, behavioral patterns, and beliefs of a population, as well as relevant historical, environmental, and social forces, are incorporated into the design, delivery, and evaluation of targeted health promotion materials and programs.[28]

Why Adapt EBPs for Under-Resourced Populations?

Adapting an EBP can improve the overall effectiveness of that EBP for the specific population with which it will be implemented. Culturally tailored EBPs can be more effective than those developed for a general population,[30] and studies comparing adapted and non-adapted versions of substance use and mental health EBPs have likewise found that cultural adaptation can increase efficacy and effectiveness.[31]

For adaptation of an EBP to be successful, it should happen within the broader context of addressing **systemic inequities**. The adaptation content and process should recognize and be informed by knowledge of the effects of racism, historical discrimination, minority stress, and other **structural forms of oppression** experienced by the under-resourced populations.[33-34]

Without cultural adaptation, implementing EBPs that have been supported solely by research with advantaged populations may result in ineffective or even harmful results,[8] including increasing health disparities.[32]

A final consideration is that, practically speaking, developing a new EBP is a massive undertaking, often requiring years of human and financial resources. In comparison, adapting an EBP for a new population allows practitioners to draw on existing evidence and work from an established EBP, including any training, fidelity support, or documentation already available.

Fidelity vs. Fit

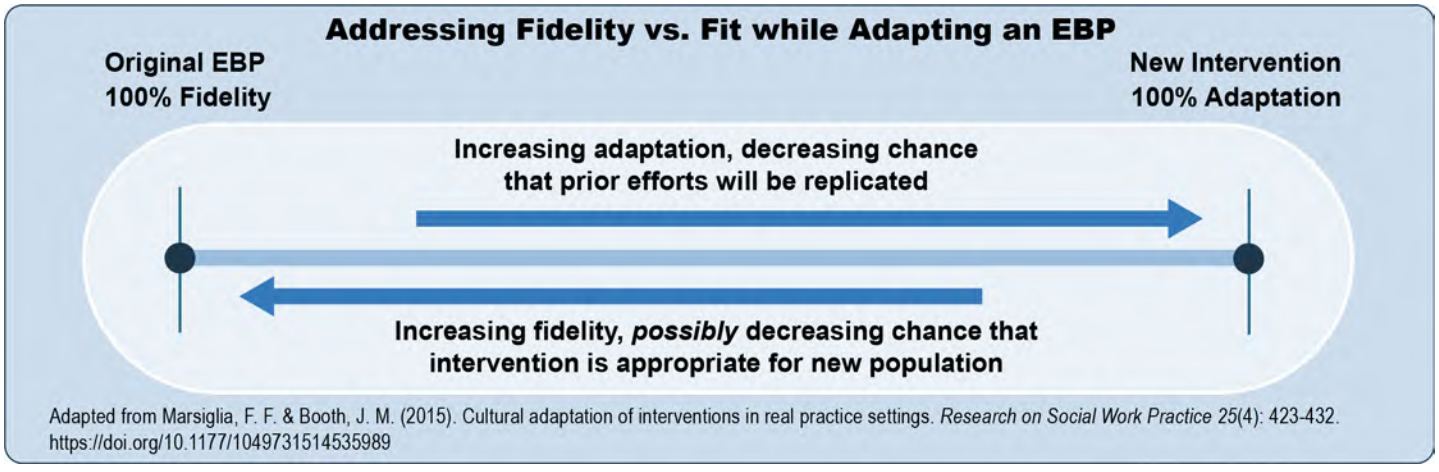
Historically, researchers and program developers have been hesitant to encourage deviations from the researched, manualized forms of EBPs. They tend to emphasize implementing EBPs with high fidelity and minimal change. Those who advocate strict adherence to an EBP's original design and delivery assume that deviations will reduce efficacy and result in suboptimal outcomes, compared to the research evidence.[35]

Fidelity has been defined as the extent to which an intervention was delivered as conceived and planned, to arrive at valid conclusions concerning its effectiveness in achieving the target outcomes.[35]

Fit refers to how well a program matches, or is appropriate for, the community, organization, stakeholders, and potential participants.[36]

However, this "one size fits all" approach does little to address the concerns that some EBPs are not culturally appropriate or a good "fit" for under-resourced communities. Imposing EBPs when they do not consider the perspectives of a new population may result in clients' lack of interest or engagement in the treatment program.[4] In addition, encouraging strict fidelity to the EBP during implementation limits both a practitioner's ability to be culturally appropriate and the opportunity for practitioners and researchers to learn from cultural adaptations that may actually improve outcomes.[37-38]

Also, it is essential to distinguish between ***cultural adaptation***—purposeful modification of the program — and ***lack of fidelity***—unplanned modifications in program content and delivery because of barriers, such as time constraints, inappropriate training, or poor preparation.[37]



Adapted from Marsiglia, F. F. & Booth, J. M. (2015). Cultural adaptation of interventions in real practice settings. *Research on Social Work Practice 25*(4): 423-432. https://doi.org/10.1177/1049731514535989

For these reasons, fidelity and cultural adaptation should not be considered as either-or choices.[37] Both maintaining fidelity and adapting the EBP can and should occur. Recent theories of cultural adaptation suggest that if program implementers modify an EBP in a systematic way without compromising its "core components," they can maximize benefits for a given population.[31, 35, 39] Implementation with fidelity to the original EBP and complete adaptation are two ends of a continuum; an effective, adapted EBP lies somewhere between the two.

Maintaining an appropriate balance between fidelity and cultural adaptation is a complex but key aspect in tailoring EBPs for new populations. The process of cultural adaptation should be systematic and well-documented and done in dialogue with the EBP developers, who can help ensure the maintenance of core components. When the adapted EBP maintains the key components of the original EBP, it can reasonably be expected to deliver similar positive outcomes. Continued evaluation and research of the adapted EBP can lend further support for its use with the new population and potentially other under-resourced communities, as well.[24]

What Are the Different Levels of Cultural Adaptation?

Cultural adaptation can be made at various levels—practitioner, program, and organizational.

- At the *practitioner* level, an organization needs to consider the cultural understanding of the participant-facilitator relationship required for successful implementation of the practice.[40]
- At the *program* level, an organization may tailor the modes in which the EBP is delivered—for example, delivering an EBP online to increase access for clients, providing additional training to the practitioners to bring a person-centered approach to their work,[19] or changing the examples/stories practitioners use during therapy sessions to ensure cultural relevance.
- At the *organizational* level, cultural adaptation might involve taking a closer look at the organizational culture (e.g., policies, leadership support) and its alignment with the norms and culture of the population of focus.

What Are the Different Types of Cultural Adaptation?

The following elements are typically considered when culturally adapting an EBP and play a role in determining the balance between fidelity and fit[24, 41]:

- **Content**: What is being delivered? How does the EBP align with the cultural norms of the population of focus?
- **Implementation**: Who delivers the EBP and what additional training do they need? How is the EBP being delivered? How long is the program? What is the dosage of the EBP? Where is the EBP delivered?

Organizations should adapt an EBP with input from various stakeholders and members within the community where the organizations will implement it. Organizations should engage stakeholders at every step in the adaptation process. Chapter 2 elaborates on the process involved in cultural adaptation of EBPs and presents a model for adaptation based on the following steps:

1. Engage the community and define the issue
2. Assess organizational capacity and readiness
3. Review EBPs, choose one, and re-assess the organizational capacity
4. Select non-core components that can be modified and adapt the EBP
5. Train staff and test adapted materials
6. Implement the adapted EBP and evaluate implementation and outcomes
7. Assess and make further adaptation

CHAPTER

2

What Research Tells Us

Evidence-based practices (EBPs) improve behavioral health outcomes for specific populations when the content and implementation of the EBP is made culturally relevant.[30, 42-44] This process of cultural adaptation includes modifying the EBP to meet the cultural norms and values of the group to whom practitioners deliver it.[5] Adaptation of an EBP does not automatically make it evidence-based; rigorous evaluation and testing of the adapted model (described throughout the guide) is required.

Cultural adaptation is the systematic modification of an EBP's protocol and/or content to consider language, culture, and context such that it is compatible with a client's cultural patterns, meanings, and values.[15]

This chapter discusses research on adaptations of treatment EBPs, although the outlined adaptation process is applicable to any EBP in behavioral health, including prevention, treatment, and recovery practices for substance use and mental health. The first section describes the process of adapting an EBP. The second section illustrates the process using examples of adaptations for three EBPs: cognitive behavioral therapy (CBT), motivational interviewing (MI), and dialectical behavior therapy (DBT). These EBPs were specifically selected, based on a thorough literature review and input from a technical expert panel (TEP) brought together for this guide. While research on EBP adaptations is limited, researchers have studied adaptations of these three practices more than for other EBPs (Appendix 2 provides background information on these EBPs, with accompanying information on the process of adaptation).

The adaptation examples include a wide range of mental health and substance use outcomes in various populations. This guide is not limited to certain outcomes or populations; it provides practitioners with best practices they can use to adapt and implement non-core components of an EBP for their client population.

For the discussed adapted EBPs, studies only indicate an *association* between the outcomes reached and the modification made to the EBP. In most cases, a *causal* relationship between the two cannot be established because:

1. The studies do not use suitable methods to infer causality, such as randomized controlled trials (RCTs) or quasi-experimental designs (QEDs).[45]
2. Adaptations or types of adaptations are not examined individually, but rather combined and collectively examined in the same study. For example, studies often compare an adapted EBP to a control (no intervention) or minimal treatment control group, which only informs research on whether the adapted intervention as a whole works; it does not identify whether specific parts of the adapted intervention had meaningful effects.

Association is evidence demonstrating a *statistical relationship* between an intervention and outcomes measured in the study's sample population. An association may or may not have clinically relevant meaning. Association is *not* causation.

Causal impact is evidence demonstrating that an intervention *causes* or is *responsible for* the outcomes measured in the study's sample population.

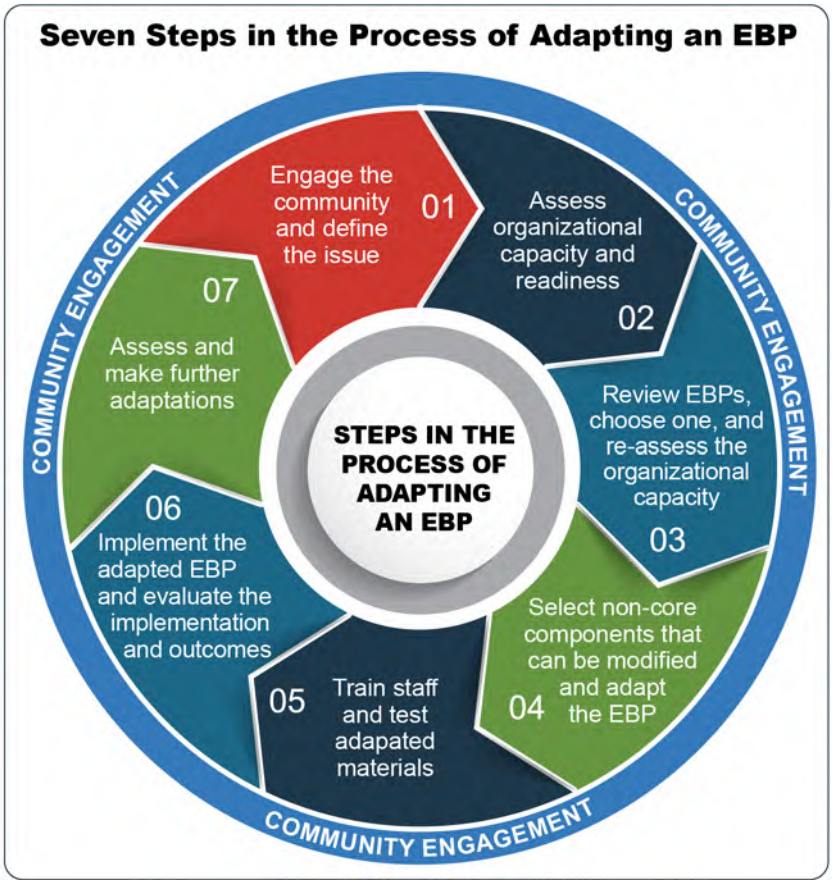
Additionally, most studies of adapted EBPs have not looked at whether cultural adaptations that explicitly address historical racism and oppression are more effective than cultural adaptations that do not. In one study that asked this question, researchers found that health outcomes were differentially improved when adaptations addressed systemic oppression directly.[46] The behavioral health field would benefit from experimental research on specific adaptations of behavioral health programs and practices and their use with particular populations.

Cultural Adaptation Process

Multiple frameworks describe the necessary steps to adapt an EBP. Most common among these frameworks are:

- Cultural Adaptation Process Model[47]
- ADAPT model[48]
- ADAPT ITT Framework[49]
- M-PACE (Method for Program Adaptation through Community Engagement[50])
- Planned Adaptation[51]
- Integrated Strategy for Cultural Adaptation of Interventions[24]

Although the steps in each model's adaptation process differ, common themes emerge. Below is a description of the comprehensive process based on these common themes, also depicted schematically.



Step 1. Engage the community and define the issue

a. Engage all stakeholders within the community.

b. Understand the community's cultural beliefs, values, needs, and expectations. Keep an open mind and listen carefully, acknowledging that unless you are part of a given community, you will never know it like the stakeholders know it. Within appropriate boundaries, stakeholders should include children and adolescents when adapting EBPs for those populations.

c. Understand the historical discrimination, injustices, and contextual adversity issues affecting the population of focus.

d. Work with stakeholders to identify and define the problem at hand.

Step 2. Assess organizational capacity and readiness

a. Assess the capacity of one's organization to implement an EBP, including available resources (e.g., funding, physical space, staff time, and staff experience).

b. Assess the organizational readiness for adapting and implementing the intervention.

Step 3. Review EBPs, choose one, and re-assess the organizational capacity

a. Identify potential EBPs through a literature search.

b. Review EBPs with all stakeholders to understand how an EBP's objectives align with the needs of the population for which you are adapting.

c. Understand the goals of and implementation strategy for each EBP being considered.

d. Assess the fit between community norms and those underlying each EBP to gauge its acceptability to the community.

e. Identify the core components of the EBPs that are critical to maintaining program fidelity.

f. Re-assess the organizational capacity and choose the most applicable EBP based on information collected thus far.

Step 4. Select non-core components that can be modified and adapt the EBP

a. Once an EBP has been selected, use information gathered from community assessment and stakeholder consultation to identify content and implementation modifications.

b. Document what was adapted and the rationale for the adaptations, to create a record available for review by administrators, funders, evaluators, and other organizations.

Step 5. Train staff and test adapted materials

a. Increase organizational capacity for the adapted intervention (i.e., hiring staff and providing ongoing training on key components of adapted intervention).

b. Pilot the adapted intervention with representatives from the intended service population to better understand potential challenges and/or mismatch of assumptions between the adapted EBP and the target community.

c. Test intervention materials considering reading level (Grade 5 reading level is preferred [90]), comprehension, language, and usability.

d. Revise as needed.

Step 6. Implement the adapted EBP and evaluate implementation and outcomes

a. Implement the intervention while ensuring adherence to the core components of the original intervention.

b. Consider the contextual/environmental issues that could affect the implementation (e.g., advocating for the under-resourced population and active case management).

c. Evaluate the implementation: document EBP delivery, assess adherence to fidelity, track participant outcomes, and gather participant feedback.

d. Continually assess implementation of the EBP's core components to ensure fidelity.

Step 7. Assess and make further adaptations

a. Based on the evaluation data, make any necessary additional adaptations that continue to be culturally tailored or relevant to the population of focus.

b. Repeat steps 3 through 5, above, as appropriate.

It is essential to highlight certain guardrails about the above adaptation process:

- ***The process of cultural adaptation described above is not always linear***. Organizations should always begin with community engagement and continue this engagement throughout the process. Individual organizations can change the sequence of next steps based on data gathered from the community during the previous steps.
- ***The process of cultural adaptation is iterative***. Cultural adaptations occur in many ways. For example, sometimes adaptations are made to the content or implementation of a specific EBP. In other cases, adaptations focus on changing the organizational culture and are holistic, resulting in all EBPs that organization delivers reflecting this cultural approach.
- ***It is critical to engage stakeholders and experts throughout the process***. Organizations should engage stakeholders and community members early and throughout the seven steps of the adaptation process.
- ***Fidelity and fit are both important considerations during the adaptation process***. There is often a tension between maintaining ***fidelity***—the idea that EBPs should be delivered with adherence to original models—and ***fit***—the idea that EBPs should be adapted to reflect the cultural values and norms of the client and address issues of systemic racism and discrimination. However, well-executed cultural adaptations of EBPs can be respectful of both perspectives and still achieve desired outcomes.[52]
- ***Adaptations are planned and systematic***. Cultural adaptations cannot be spontaneous and need to be planned and systematic to be effective.
- ***Evaluation of the adaptation is extremely important***. Organizations need to evaluate the adaptation and consider collaboration with researchers to expand awareness of the new model. Evaluation will assess effectiveness, safety, and adherence to the adaptation's original intention. Testing and evaluating will also confirm that the EBP adaptation does not lead to unintentional harm to the population with whom organizations implement it.

In the comprehensive process of cultural EBP adaptation described above, step 4 involves decisions about which non-core components can and should be adapted. The following section elaborates on this step's execution.

Selecting Non-Core Components to Adapt

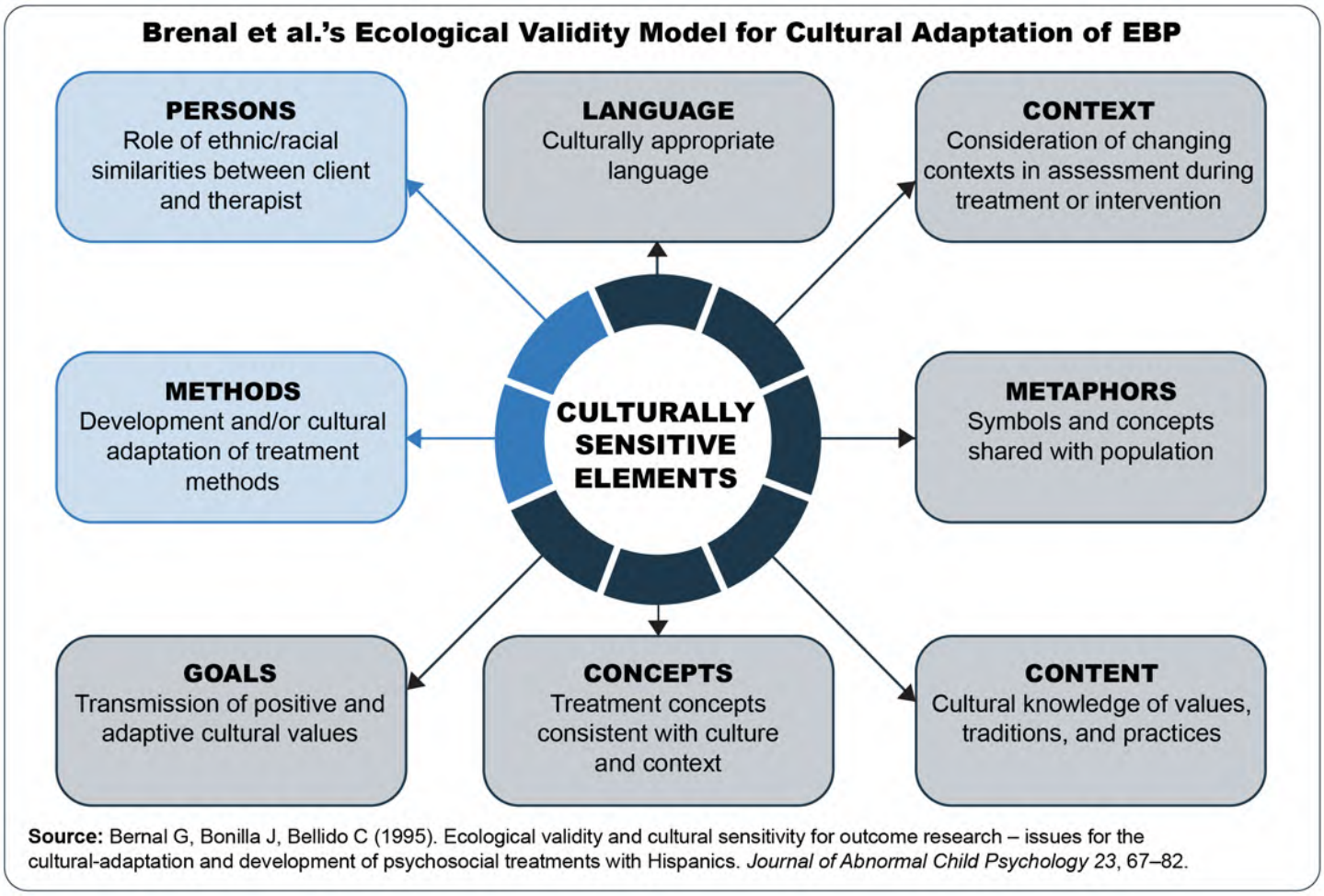
Bernal et al. (1995) presented one of the earliest theoretical frameworks on adapting an existing EBP to a specific community or population.[53] They argued that bringing a culturally sensitive perspective increases the ecological validity of the treatment. The framework includes eight dimensions of adapting an EBP to bring in the lens of cultural sensitivity (see graphic). These eight dimensions overlap with and influence the expression of other dimensions.

Ecological validity is the generalizability of study findings or therapy situations to the participant's real-life settings.[54]

The eight elements can be categorized into two areas of adaptation:

1. **Content** (adaptation of *what* information is delivered)
2. **Implementation** (adaptation of *how* information is delivered)

Content-related adaptations are shown in grey; implementation-related adaptations are in blue. Each adapted EBP can include adaptations in one or both areas. The studies examined for this guide adapted EBPs for different populations and sought to change behavior related to several outcomes.



Source: Bernal G, Bonilla J, Bellido C (1995). Ecological validity and cultural sensitivity for outcome research – issues for the cultural-adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology 23*, 67–82.

Study	EBP	Population	Outcome	Content Adaptation	Implementation Adaptation
Lee et al. (2013)[55]	MI	Latino adults	Alcohol consumption	✓	✓
Venner et al. (2016)[56]	MI	Native American Tribal adults	Substance use	✓	✓
Hanson et al. (2017)[57]	MI	American Indian women	Alcohol consumption in pregnancy	✓	
Golin et al. (2007)[58]	MI	People living with HIV/ AIDS	Safe sex	✓	
Cheng & Merrick (2016)[59]	DBT	Chinese American adult case study	Eating disorder and depression	✓	
Mercado & Hinojosa (2017)[60]	DBT	Latina woman case study	Anxiety and depression		✓
Ross et al. (2007)[61]	CBT	Lesbian, gay, bisexual, and transgender (LGBT) adults	Depression	✓	
Paris et al. (2018)[62]	CBT	Latino adults	Substance use	✓	
Hwang et al. (2015)[63]	CBT	Chinese American adults	Depression	✓	
Kohn et al. (2002)[64]	CBT	African American women	Depression	✓	
Kuhajda et al. (2011)[65]	CBT	Low literacy rural populations	Chronic pain	✓	✓
Kananian et al. (2020)[66]	CBT	Afghan refugees	Posttraumatic stress disorder (PTSD)		✓
Bahu (2019)[67]	CBT	Tamil refugees	Trauma and well-being		✓

Content Adaptation

Content adaptation involves increasing the EBP's cultural relevance by tailoring the content to the audience, which is by adding cultural elements, substituting non-core elements, or reordering program elements.[68] Content adaptation also may involve including metaphors or references appropriate to that population.

Examples of content adaptation include:

- Lee et al. (2013) used **culturally adapted MI** for reducing **alcohol consumption** and related problems among **Latino adults**.[55] The adaptation included expanding the focus of MI from the individuals and their drinking contexts to the individuals' broader cultural and social contexts, and how they might affect drinking behavior. The adaptation included discussion of additional stressors stemming from experiences of discrimination and acculturation. Acknowledging these important aspects of the social context enhanced the client's feeling of being understood and helped improve the therapist-client relationship.
- While implementing **MI** as a treatment for **substance use disorder outcomes** within a **Southwest tribe**, Venner et al. (2016) used culturally consistent greetings and introductions that involved the spiritual aspect of social interactions.[56] The adaptation also included a discussion of how the counselor and client may be related by clan. The use of spirituality and relationships with the extended family and the community helped enhance motivation for behavioral change.
- Hanson et al. (2017) implemented a version of CHOICES (Changing High-risk Alcohol Use and Increasing Contraception Effectiveness Study), which is an **MI-based EBP,** focused on pre-conception prevention of **alcohol-exposed pregnancy**, adapted for **American Indian women**.[57] The adapted curriculum included local images and pictures. Providers shared alcohol consumption data relevant to the community and information on birth control measures available at local clinics. Finally, they modified the readability level by editing specific words on some surveys in the curriculum.
- During their development of Start Talking About Risks (STAR), an **MI-based safer sex counseling program** for **people living with HIV/AIDS**, Golin et al. (2007) refined their resources and materials using feedback from interviews and meetings conducted with a community advisory board.[58] As an example, providers used appropriate photographs to reflect clients' diversity.
- While using a cultural adaptation of **DBT** for an **international student** from China with an **eating disorder, depression, and cultural adjustment issues**, Cheng & Merrick (2016) included topics from the client's social-cultural framework, such as understanding of attachment, obligation to family, child–parent relationship, separation–individuation, and interdependence.[59]
- With the goal of improving treatment for **LGBT** people with **depression**, Ross et al. (2007) adapted the existing **CBT** protocol for Mind Over Mood[69] to address homophobia, biphobia, and transphobia and associated structural oppression.[61] Wherever deemed appropriate, providers contextualized group discussion within an anti-oppression framework; for example, practitioners discussed how stereotypes of LGBT relationships may affect the way clients view their own relationships. The providers added sessions specifically related to the coming-out process and to internalized homophobia, biphobia, and transphobia to discuss how these experiences and feelings may impact an individual's depression.
- Paris et al. (2018) delivered a culturally adapted **computer-based CBT** program focused on reducing **substance use** for **Latino adults**.[62] The providers retained CBT skills and strategies from the base intervention—CBT4CBT[70] —and adapted its modularized approach to use a Latin American television soap opera (telenovela) format highlighting culturally relevant experiences, such as immigration-related family separation. In addition, the adapted program emphasized Latino cultural values, such as respect (*respeto*), family orientation (*familismo*), and the value of interpersonal relationships (*personalismo*).

- Using a community-based participatory (CBP) approach, Hwang et al. (2015) adapted and implemented a **CBT** program for **Chinese American adults** with **depression**.[63] The adapted program integrated cultural metaphors and symbols, as well as philosophical teachings that were identified during pre-implementation focus groups. Therapy placed a greater emphasis on goal-setting and problem-solving than the original CBT intervention, and addressed traditional Chinese conceptions of mental illness and stigma.

  Community-based participatory (CBP) approach upholds the engagement and participation of those who are affected by the issue or problem at hand and recognizes and appreciates the unique strengths and resources each stakeholder contributes to the process. It is a cooperative, co-learning process that involves systems development and local community capacity-building.[71]

- Kohn et al. (2002) included culturally specific content in their **CBT** adaptation for **African American women** experiencing **depression**.[64] Adapted content focused on creating healthy relationships, discussing African American family issues, identifying faith-based coping strategies and the roles of spirituality, and combatting negative images and perceptions of Black women.
- In their work implementing **CBT** with **low-literacy, rural populations**, Kuhajda et al. (2011) worked to lower the associated reading level for the patient workbook.[65]

Implementation Adaptation

Implementation adaptation typically includes modifying the role of the personnel delivering the intervention and/or modifying the format or channel of delivery (e.g., using a web-based delivery platform instead of in-person group sessions).[68] Less common methods of adapting EBP implementation include modifying procedures for training practitioners delivering the EBP and adjusting the evaluation methods.

Examples of implementation adaptation include:

- In their implementation of **MI** with **Latino adults** seeking to reduce their **alcohol consumption**, Lee et al. (2013) modified staff training to ensure MI therapists had the skills to elicit and then discuss stressful events that provoked thoughts about drinking.[55] Training enhanced therapists' abilities to facilitate discussions about experiences with being discriminated against, difficult relationships with close family members, or obstacles faced due to language barriers.
- While implementing **MI** as a treatment for **substance use disorders** for a **Southwest tribe**, Venner et al. (2016) recruited counselors who were fluent in their clients' language.[56]
- For their case study of **DBT**, Mercado and Hinojosa (2017) ensured that the practitioner assigned to work with a Latina woman to treat her **anxiety and depression** was culturally competent and understood the culturally influenced parts of the client's behaviors.[60]
- In their work implementing **CBT** with **low-literacy, rural populations** for **chronic pain**, Kuhajda et al. (2011) included pre-service trainings for therapists focused on improving cultural sensitivity, particularly in relation to income and minority populations.[65] During the intervention, therapists also adopted semi-flexible make-up sessions.
- In their implementation of **CBT** with **Afghan refugees** experiencing **PTSD**, Kananian et al. (2020) recruited Farsi-speaking therapists to deliver the program in the clients' native language.[66] The providers also decreased the treatment length, to minimize attendance issues or dropout caused by changes in the participants' life situations. Finally, providers held gender-homogenous therapy groups based on client preferences shared during preliminary focus groups.
- Bahu (2019) delivered their adapted **CBT** program on **trauma and well-being** for **Tamil refugees** and asylum seekers at a local Hindu temple and hired Tamil-speaking therapists to facilitate the program and create a supportive environment for the clients.[67] Therapists also offered tea and biscuits to clients after they shared wartime experiences in group sessions.

Gaps in Research on Cultural Adaptations of EBPs

Research on cultural adaptations of EBPs using experimental methods, such as RCTs and QEDs, is lacking. This is due to reasons such as inherent bias among researchers that favors the majority white/male demographic, disinterest from communities who have been over-surveyed without any benefit to them, and fear or insecurity some vulnerable populations face (e.g., sexual and/or gender minorities and undocumented immigrants). The lack of experimental studies prevents researchers from establishing causal relationships between the implementation of cultural adaptations and mental health and substance use outcomes.

The adaptation process and associated outcomes have often not been well-documented in studies, leading to a shortage of evaluations of adapted EBPs.[26] Researchers should be encouraged to describe what they adapted, why they adapted it, how they adapted it, and the effectiveness of the adapted intervention with different populations.

Available studies do not address questions about the extent of adaptations needed to achieve cultural relevance and desired outcomes. One way to answer this question would be to implement an intervention that has been adapted in different ways (e.g., comparing adaptations that address contextual factors such as racism to adaptations that do not address such factors) to test their efficacy, feasibility, and cultural acceptability.[72]

Finally, researchers and funding sources should consider alternative ways to conduct research on the effectiveness of cultural adaptations such as **practice-based evidence studies** and **pragmatic clinical trials**. Practice-based evidence involves "the use of clinical expertise, the synthesis of evidence obtained from programs with similar (but not necessarily the same) aims and outcomes, and the gathering of evidence during practice."[73] Pragmatic trials "inform a clinical or policy decision by providing evidence for adoption of the intervention into real-world clinical practice."[74]

CHAPTER

3

Guidance for Adapting Evidence-Based Practices

This chapter provides best practices for adapting and then implementing the adapted evidence-based practices (EBPs). Specifically, individual sections summarize key considerations and strategies for organizations in carrying out each step of the adaptation process, as outlined in Chapter 2:

1. Engage the community and define the issue
2. Assess organizational capacity and readiness
3. Review EBPs, choose one, and re-assess the organizational capacity
4. Select non-core components that can be modified and adapt the EBP
5. Train staff and test adapted materials
6. Implement the adapted EBP and evaluate implementation and outcomes
7. Assess and make further adaptations

The final section of this chapter includes a list of selected resources that provide further information on the adaptation process and best practices for working with under-resourced populations. Evaluation is the last step in the implementation process, as it is important to document what adaptations organizations made and why, as well as their effectiveness. Chapter 5 discusses equitable evaluation.

Step 1: Engage the community and define the issue

Consideration:

With input from the community and its stakeholders, an organization should assess community needs. Based on the results of these assessments, organizations should define the problem in the population that they seek to address.[75]

> **Stakeholders** are defined as "individuals, organizations, or communities that have a direct interest in the process and outcomes of a project, research, or policy endeavor."[76]

Making decisions based on community input will ensure that the adapted EBP is appropriate for that population and will generate "buy-in" and trust from the community, which, in turn, facilitates a more successful implementation.[77]

Strategies:

- **Identify all stakeholder groups** within the community, such as community members, clients, practitioners, and funders. Ensure that stakeholders have familiarity and experience with the community in question. Organizations should work with these stakeholders to systematically gather and analyze information about the community's service needs and the issue at hand.[78]
- **Solicit direct input from community stakeholders** on the differences between the population of focus and the population for which the EBP was developed. Recognizing that under-resourced populations historically have not had significant input into the services they receive, organizations should gather information from community members regarding their past experiences with EBPs, their satisfaction with services, and their cultural beliefs. Organizations can gather this information through a community-based participatory (CBP) approach. Practitioners can get training on, and then use, strategies like focus groups, one-on-one interviews, and phone or online surveys, to learn more about the needs and experiences of the community. Activities such as surveillance studies and needs assessments are useful in determining what problems community members face, their perceived causes, and suggestions for helpful services.[79] If possible, organizations should compensate the community stakeholders for their time, experience, expertise, and contribution. In addition to monetary compensation, organizations should consider childcare arrangements, travel reimbursement, and provision of food during community engagement activities.
- **Identify funding to support community engagement activities.** Community engagement activities are resource- and time-intensive. Resources, such as the Rural Community Toolbox, provide information on available grants and other tools to support these activities.

An Example of the CBP Approach to Engage Stakeholders

Parra-Cardona et al. (2012) describe community engagement in the cultural adaptation of an established parenting intervention for low-income Latino/a immigrants.[80] The adaptation team held several meetings with leaders from local mental health agencies, community organizations, and churches to learn about their perspectives on parenting, thus ensuring all stakeholders were included. The team also conducted a study with Latino/a immigrant parents to learn in-depth about their aspirations and challenges as parents.

Based on the findings from this study, the team learned about:

- Adverse contexts and life circumstances of those Latino/a immigrant parents in their countries of origin.
- Parents' own experiences of neglectful parenting as children.
- Parents' experiences as immigrants in the United States, such as long working hours, language barriers, and racial/ethnic discrimination.
- Parents' own child-rearing needs, such as their desire to instill cultural values in their children, while utilizing safe and non-punitive parenting practices.

The team then used this information to adapt the parenting curriculum, thereby increasing buy-in to the program from the immigrant parents.

Step 2: Assess organizational capacity and readiness

Consideration:

Early on, an organization needs to assess its own and the community's readiness for adapting and implementing an EBP. In response to the readiness assessment, an organization may need to undertake capacity-building efforts before adapting and implementing the adapted EBP.

Strategies:

- **Assess community readiness**, which is the degree to which a community is willing and prepared to act on an issue. Organizations can use measures, such as the Community Readiness Model, to evaluate its readiness.
- **Assess current resources and barriers** and the capacity to provide culturally competent services.[77]
  - Organizations can use tools, such as the Evidence-Based Decision-Making Measure, for this purpose.
  - The Cultural Competency Assessment Scale provides actions that an organization can take to become more culturally competent.
  - The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care or the Behavioral Health Implementation Guide for CLAS can also guide organizations in adopting policies and practices that promote health equity and cultural competency.
- **Form steering committees or other teams** to inform development of the adapted EBP. Ideally, these teams should include practitioners, researchers, community advocates, parents, youth, and those who will benefit from the EBP.[49, 80]

Consideration:

An organization needs to identify resources that are available to support adaptation, implementation, evaluation, and sustainability of the adapted EBP. This continuous process requires money and other resources, including those associated with staffing, conducting research, holding new training, developing materials, and conducting community outreach. Other resource considerations include the ability of community members to pay for the EBP services, as it will be a key determinant of whether the new population of focus can access services.

Strategies:

- **Identify resources that could affect which and how services can be delivered** (e.g., staffing, physical space, and technology capabilities). This strategy will have implications for which EBPs organizations consider for adaptation.[75]
- **Identify and obtain additional funding** from government agencies, foundations, or other sources to improve the organization's ability to adapt the EBP and to implement services and/or the community's ability to access them. Organizations can use federal resources, such as the Rural Health Information Hub and Department of Health and Human Services or private organizations like the Robert Wood Johnson, W. K. Kellogg, and Bill and Melinda Gates foundations to identify additional funding. Organizations can also consider non-traditional sources of funding, such as insurance companies and nonprofit hospitals.

Step 3: Review EBPs, choose one, and re-assess the organizational capacity

Consideration:

Based on the community input gathered in step 1, organizations should define the goal of the intervention (e.g., the desired behavior change). This strategy will be key as the organization and its adaptation team identify which (if any) existing EBPs are suitable and feasible given the organization's readiness and resources.

Strategies:

- **Assess how well the EBP might fit into the new cultural context or population of focus** by examining previous research and details about the EBP's components. Core elements of the EBP cannot be eliminated, so the team should verify that they are applicable to the new population.[51] Organizations should consider the various costs associated with EBPs, such as training and materials, while choosing the EBP to be adopted. Online resources document EBP details, including assessments of program effectiveness. These resources are provided at the end of this chapter under the Identifying Evidence-Based Practices heading.
- **Review studies demonstrating general program effectiveness or effectiveness for particular populations**. These studies can inform decisions on which EBPs to consider. In particular, the adaptation team may wish to focus on identifying key differences or similarities between the research contexts and their own organizational setting to determine whether the EBP is likely to be similarly effective in the new setting, and under what conditions.
- **Continue to engage community stakeholders**. Continued conversations with stakeholders will help ensure that adaptations are appropriate.

Consideration:

When adapting EBPs, organizations should give careful attention to the potential role of the EBP developer. Intervention developers typically have expertise on the core components of their EBP. For that reason, they can provide valuable input to the adaptation process, particularly when it comes to ensuring fidelity to key principles. However, some developers may have narrow definitions of what an EBP implementation should look like and may also require payment; these implications could restrict adaptation possibilities and the likelihood of achieving fit within the community.[75]

Strategy:

- **Collaborate and, when possible, establish working relationships with the EBP developers**. In addition, branded interventions may involve intellectual property issues that necessitate inclusion of the developer (or which impose other constraints on adaptation). Developers may also have a vested interest—financial or otherwise—in EBP delivery and evaluation. Adaptation teams should consider legal implications and conflicts of interest when selecting EBPs to adapt. Establishing clear guidelines upfront can mitigate the effect of such issues on the adaptation process.[75]

A Note on Intersectionality

Organizations and practitioners may serve many different populations. Each service participant will have a unique background and set of identities. For example, they may belong to more than one historically disenfranchised group, such as those defined by sex, race, religion, gender identity, socioeconomic status, or sexual orientation, and may experience mutually reinforcing effects of disparity and/or systemic inequality.[82] Individuals with multiple, marginalized identities may face challenges that cause or exacerbate health issues and make seeking and receiving treatment more difficult.

Previous studies provide evidence that individuals experiencing discrimination are more likely to use alcohol and other substances as a coping strategy, and that those with multiple, marginalized identities are more likely to experience PTSD symptoms.[83-86] Alternately, individuals' perceived mental illness or substance use status increases the chances of having been discriminated against.[87] While adapted EBPs are likely to address treatment with a particular community in mind, organizations should take issues of individual identity into consideration throughout the engagement and treatment process.

Step 4: Select non-core components to adapt and adapt the EBP

Consideration:

Organizations should carefully consider which elements of the selected EBP are suitable for and/or require adaptation. Core elements should not be adapted, while other non-core components can be. Changes to the EBP should always be motivated by the goal of increasing effectiveness or feasibility when delivered to the community of interest. Finally, organizations should deliver and advertise services in the language, dialect, and method most appropriate for the community served.

Strategies:

- **Consider the specific risk factors** for the community in relation to the outcomes of focus to help organizations identify where changes are needed.[32] For example, research has shown that individuals from ethnic minority backgrounds who experience structural racism are more likely to experience mental health problems.[88] Consequently, organizations may need to adapt interventions conducted with such populations to address experiences of racism and discrimination explicitly and implicitly in relation to mental health.[89] Organizations should be cautious to avoid overemphasis on cultural issues and assumptions about cultural groups that are not grounded in treatment needs and response; adaptations based on such assumptions are unlikely to increase intervention effectiveness.[32, 53]
- **Modify the language in resources and materials**. These modifications could include translating materials into a community's preferred language or reducing the reading level of the language used to 5th grade or below.[90] The Flesch-Kincaid test in Microsoft Word is a free resource that assesses the reading level of a document. If program materials need to be translated, the best practice is to use an experienced translator from the community of focus, as well as to "back-translate" the

An Example of Adapting Language and Other Components of an EBP

Kuhajda et al. (2011) describe adaptation of cognitive behavioral therapy for rural adults with low literacy.[65] As an initial step in the adaptation, the adaptation team worked to "translate" the existing manual for a lower-literacy population, following the Plain Language Action and Information Network's (PLAIN's) federal plain language guidelines. The team simplified manual language, metaphors, and layout to improve readability. Following the translation, the adaptation team conducted key informant interviews and focus groups with community members to refine the manual further.

Interviews and focus groups helped the adaptation team make other changes to the manual, including:

- Incorporating cognitive load theory guidelines—for example, completing homework examples during sessions before homework was assigned to clients, to familiarize them with the content and tasks. Likewise, the team used worksheets with completed example responses, to help patients generate their own responses.
- Using the "teach back" method when introducing new concepts—a strategy healthcare providers use to confirm whether a client understands what is explained to them. These methods were specifically incorporated into pre- and post-session understanding checks to see whether the content needed further review.
- Enlarging key illustrations from the manual and distributing them as poster-sized laminated figures to reinforce core concepts.
- Removing language and phrases from the initially translated manual that might have been considered condescending, due to oversimplification.
- Breaking the manual into session notebooks and providing those to clients sequentially, so as not to overwhelm them with the entire treatment manual.

This information also helped advise the organization's recruitment strategies. For example, one informant recommended emphasizing that the treatment was not a medication trial, given that the region's African American population may be distrustful of treatments involving medication for historical reasons.

materials into the original language to ensure that the content was translated clearly and accurately.[91] Translation of materials is also an opportunity to ensure that they are at the appropriate literacy level.[78] When it comes to oral translation, it may be tempting to solicit help from family members (e.g., bilingual children) to assist in communications between provider and service user, but it is an inappropriate practice. Instead, organizations should consider hiring bilingual staff and/or interpreters to assist in program delivery and provide sufficient training, so that they deliver translated content with fidelity.[77, 92]

An Example of Pilot-Testing an Adapted EBP

Chu, Huynh, & Areán (2011) describe adaptation of problem-solving therapy (PST) for older Chinese adults.[94] After initial modifications to the PST manual and using the preferred language of the population, the adaptation team piloted the new intervention in a single case study. The provider delivered the entire 12-week intervention to a single patient, who was assessed with the Patient Health Questionnaire-9 (PHQ-9) before and after treatment. Following the intervention, both the practitioner and the patient were interviewed to gather opinions on the feasibility and acceptability of the treatment, including whether any further changes were needed.

This pilot test provided feedback that helped the adaptation team refine the manual. For example, the team incorporated feedback that older Chinese clients may have difficulty brainstorming solutions to their particular problems on their own, and consequently added therapist-assisted questions and prompts. The pilot test results also suggested that practitioners provide a binder of visual aids and materials for clients to create more of a feeling of legitimacy (in comparison to separate worksheets and handouts) and improve engagement with at-home assignments. Post-pilot interviews also confirmed that the materials and content were acceptable and comprehensible to the patient.

Step 5: Train staff and test adapted materials

Consideration: Once an organization adapts an EBP, it will need to ensure that staff are trained to deliver the adapted content and/or adhere to the adapted methods of delivery with fidelity.

Strategies:

- **Provide formal training or certification** from the developer. Organizations should inquire about these trainings and offer them to practitioners, along with any additional trainings specific to the adaptation.
- **Consider the characteristics** of an organization's practitioners and determine whether it may be preferable or necessary to hire additional staff whose backgrounds align more closely with the community being served. Research indicates that service users often prefer to work with a provider from the same cultural background.[93] When possible, aligning the provider's and the service user's culture can help reduce language barriers or miscommunication of content or sentiments and can improve retention in treatment and achievement of desired outcomes.[95]

Step 6: Implement the adapted EBP and evaluate implementation and outcomes and Step 7: Assess and make further adaptations

Consideration:

Organizations should pilot the adapted program before initial delivery to assess whether they have addressed issues adequately and whether the adapted intervention is acceptable to the community and feasible to deliver.[79] The community members receiving the EBP services should be heavily involved in these assessments, and organizations should make any necessary modifications for improving quality based on the results. Organizations should seek Institutional Review Board (IRB) approval whenever deemed necessary. Finally, organizations should ensure a community's access to the implemented EBP. Additional considerations and strategies on evaluation are described in Chapter 5.

An IRB is an appropriately constituted group that has been formally designated to review and monitor biomedical research involving human subjects. In accordance with FDA regulations, an IRB has the authority to approve, require modifications in (to secure approval), or disapprove research. This review serves an important role in the protection of the rights and welfare of human research subjects.

The purpose of IRB review is to assure, both in advance and by periodic review, that appropriate steps are taken to protect the rights and welfare of humans participating as subjects in the research. To accomplish this purpose, IRBs use a group process to review research protocols and related materials (e.g., informed consent documents and investigator brochures) to ensure protection of the rights and welfare of human subjects of research.

Strategies:

- **Use measures from the original EBP to assess fidelity**—the extent to which the adapted intervention reflects the core components and is delivered with careful attention to the original intended process. The scale of this assessment can be based on the resources available within the organization.
- **Eliminate barriers to care**, either as part of the adapted EBP or as a preliminary step before implementation to increase service receipt and improve outcomes. For example, organizations should locate services in appropriate community spaces or along public transportation routes and offer services at convenient hours, when possible.[77, 95] Additionally, organizations should consider offering incentives to the under-resourced populations they serve. These incentives may pose financial challenges for organizations but will increase the likelihood of equitable access.
- **Gather information on the implementation** from providers, peer recovery coaches and specialists, and families and extended families, using the wraparound method.
- **Avoid additional or spontaneous changes to the intervention** (e.g., in response to unforeseen user circumstances) during full-scale implementation as they may impact core components and are not carefully planned.[96-97] Any changes, if needed, should be made only after repeating all steps in the process of adaptation.

Resources

Online, free resources are available to help practitioners and administrators adapt EBPs and implement the adapted versions.

Resources on Adapting Interventions

- The Research Foundation for Mental Health's Toolkit for Modifying Evidence-Based Practice to Increase Cultural Competence provides mental health services organizations with a structured method and considerations for adapting interventions and meeting the needs of their clients.
- The National Research Center on Hispanic Children & Families' Developing Culturally Responsive Approaches to Serving Diverse Populations: A Resource Guide for Community-Based Organizations aims to help organizations recognize and meet the cultural and linguistic needs of diverse populations.
- The Prevention Technology Transfer Center Network's Quick Guide For Adapting Evidence-Based Interventions (EBIs) gives practitioners an overview of the process of adapting evidence-based interventions.
- The University of Texas at Austin Child & Family Research Institutes' Developing Strategies for Child Maltreatment Prevention: A Guide for Adapting Evidence-Based Programs provides practitioners with tools to make decisions on whether they need to make adaptations to an intervention and how to make them.
- The TA Network's (National Technical Assistance Network for Children's Behavioral Health's) Cultural Adaptation Planning Tool can be used to assess the cultural fit of a program, in partnership with the communities being served, prior to selecting the program and also during the cultural adaptation process.

Resources on Identifying Evidence-Based Practices

- SAMHSA's Evidence-Based Practices Resource Center provides clinicians, communities, and policy makers with information on implementation of various EBPs.
- The California Evidence-Based Clearinghouse for Child Welfare is a registry tool that can help organizations identify, select, and implement interventions for children and families affected by the child welfare system.
- The Title IV-E Prevention Services Clearinghouse reviews and rates programs and services aimed at providing support to families and preventing foster care placement. The Clearinghouse provides information about interventions and their evidence base.
- Blueprints for Healthy Youth Development is a registry of scientifically rigorous and accessible prevention and intervention programs aimed at addressing youth health and behavior issues, such as preventing antisocial behavior and reducing obesity rates.
- The Home Visiting Evidence of Effectiveness website presents evidence for early childhood home visiting models that assist families with pregnant women and children.
- The Social Programs That Work website identifies programs through a systematic review process, to create a registry of proven EBPs in a variety of policy areas.
- The What Works Clearinghouse reviews studies of education interventions, including those for student behavior and development.

Resources on Treating Particular Populations

- SAMHSA's Treatment Improvement Protocols on:
  - Substance Use Treatment for Persons With Co-Occurring Disorders helps practitioners understand the impact of substance use treatment on persons with co-occurring mental health and substance use disorders.
  - Substance Abuse Treatment: Addressing the Specific Needs of Women helps practitioners understand the specific needs of women when addressing substance use disorders.
  - Behavioral Health Services for People Who Are Homeless helps practitioners understand how to provide health services for people living with housing instability.

  - Addressing the Specific Behavioral Health Needs of Men helps practitioners understand how to address the specific behavioral health needs of men.
  - Trauma-Informed Care in Behavioral Health Services helps practitioners understand the impacts of trauma and develop models of trauma-informed care to support recovery.
  - Improving Cultural Competence helps practitioners understand the role of culture in service delivery and discusses racial, ethnic, and cultural considerations.
- SAMHSA's Psychosocial Interventions for Older Adults With Serious Mental Illness explains approaches to providing care to older adults with substance use or mental health considerations.
- The Council of National Psychological Associations for the Advancement of Ethnic Minority Interests published a brochure on Psychological Treatment of Ethnic Minority Populations containing guidance for practitioners working with minority patients.
- Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling's (ALGBTIC's) Competencies for Counseling LGBQIQA and Competencies for Counseling Transgender Clients present steps that practitioners can take to improve their counseling approach and produce a safe, supportive, and caring environment for sexual and gender minority individuals.
- SAMHSA's A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals informs administrators and clinicians about appropriate diagnosis and treatment approaches that will help ensure the development or enhancement of effective LGBT-relevant programs.
- Multi-Racial/Ethnic Counseling Concerns' Competencies for Counseling the Multiracial Population contains a list of competencies developed to help practitioners utilize sound professional counseling practices to address the needs of diverse populations.
- Uniformed Services University's Military Culture Course Modules contains a list of competencies for healthcare professionals.

Additional Tools

- Human Services Research Institute's Toolkit on Translating and Adapting Instruments equips evaluators with a list of descriptions of methodologies and instruments for use in assessing specific topics.
- The World Bank's A Guide to Assessing Needs: Essential Tools for Collecting Information, Making Decisions, and Achieving Development Results is designed to aid practitioners in learning practical strategies, tools, and guides that address the assessment needs of communities.
- The Community Tool Box's Assessing Community Needs and Resources provides instructions for administering assessments of community needs and resources.
- The Multi-Lingual Orientation Service Association for Immigrant Communities' The Partnership Toolkit includes tools to help organizations build and sustain partnerships with communities and meet the challenges, and achieve the benefits associated with partnering.

CHAPTER

4

Examples of Cultural Adaptations of Evidence-Based Practices

This chapter highlights three examples of organizations developing and implementing adapted evidence-based practices (EBPs) for under-resourced populations in their communities. The three examples differ from one another in terms of the context, EBP, and adaptations to the EBP.

- The first example, **Youth AFFIRM**, describes the adaptation and implementation of cognitive behavioral therapy (CBT) for Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ+) young people. The creators found a shortage of evidence-based treatment interventions created for and tested among LGBTQ+ young people with mental health conditions and identified components of standard CBT that could be adapted to resonate more deeply with individuals they hoped to serve.
- The second example describes how the **Choctaw Nation Department of Behavioral Health** has adapted motivational interviewing (MI) as a culturally resonant and effective form of treatment for members of the Choctaw Nation. Providers integrated behavioral health into primary care; incorporated cultural values like collectivism, stickball, and storytelling into MI; and trained non-Native therapists to understand the history and culture of the Choctaw Nation.
- The third example does not focus on a specific EBP; it describes the **Ma'at Program**, which is a holistic, therapeutic approach to delivering behavioral health services to Black individuals and families in San Francisco. Designed to uplift the Black/African American community's mental health and wellness, the Ma'at program uses an Afri-centric approach for the delivery of all behavioral health services.

Chapter 2 describes a process of cultural adaptation, which is not always linear. Programs typically begin with community engagement, and the sequence of next steps is often driven by information gathered previously. The process is also iterative. Cultural adaptations occur in many ways, as is evident from the examples presented in this chapter. Sometimes adaptations are made to a specific practice through modification of a program's content or implementation (as discussed in Chapter 2). In other situations, cultural adaptations may begin holistically and become part of the organizational culture; all programs and practices delivered by the organization then reflect this cultural approach.

Despite differences in cultural adaptations and the populations for which they are intended, the three programs presented in this chapter have several common features.

1. The goal for each adaptation is to enable the program to better meet the needs of specific populations and communities the program serves.
2. Each example demonstrates how programs put into practice steps of the adaptation process and implement both types of adaptations (content and implementation), as described in Chapter 2.

3. Each program begins the adaptation process with community engagement and continues to value community engagement at every step in the process. Each program's goal is to engage all stakeholders in a meaningful and authentic way.
4. Each program uses client and stakeholder feedback to assess program fit and make continual modifications.
5. For each program, building trust was an important initial step in the process. While this is critical for most behavioral health services, it is particularly relevant when working with under-resourced populations. Building trust takes time and is an essential element for successful outcomes.
6. Engagement from community members and other stakeholders with lived experience helped strengthen the effectiveness of each program and its chance for success.

Youth AFFIRM

Shelley Craig and Ashley Austin designed, implemented, and evaluated an adapted version of CBT. The adapted program, called AFFIRM, reflects the needs and lived experiences of LGBTQ+ populations. Various settings and communities across the United States have implemented the program since it was first developed in 2012.

Program

AFFIRM is an eight-module, manualized, group CBT curriculum adapted specifically for LGBTQ+ youth and young adults. Schools, child welfare and health centers, behavioral health clinics, and community organizations are implementing the curriculum, both in person and online.

Challenge (steps 1, 2, and 3 in adaptation process)

While leading standard therapy groups for youth, the creators of the AFFIRM program recognized that standard CBT does not focus on LGBTQ+ young people's unique needs and contexts, which can include discrimination, rejection, bullying, and minority stress.[98] For example, it is difficult for a young person who self-identifies as LGBTQ+ to challenge the automatic thought, "I am worthless," when the society, community, media, and family may be saying that LGBTQ+ individuals are less worthy than their straight and/or cisgender counterparts. Additionally, studies typically do not track depression or anxiety outcomes for LGBTQ+ youth in standard CBT programs.

Other therapeutic adaptions to CBT have been relevant for specific identities within the LGBTQ+ community (e.g., gay men), but AFFIRM creators wanted a program that would be effective for all individuals in the LGBTQ+ community. Adapting CBT to focus on the common underlying stressors for LGBTQ+ individuals and build social support was a primary objective.

Having identified these challenges, AFFIRM practitioners embarked on an "adapt and evaluate" process.[99] They conducted an extensive community needs assessment and enhanced the standard CBT tenets with additional context, strategies, examples, and modules that speak to the LGBTQ+ experience.[100]

Solution (steps 4 and 5 in adaptation process)

Developers embedded a trauma-informed, affirmative practice, and minority stress framework throughout all aspects of the intervention—manual content, therapist training, and implementation. The program uses a CBT approach to explore the impact of structural oppression and discrimination.

Developers adapted the CBT components to reflect the unique and varied elements of the LGBTQ+ experience. Certain CBT tenets are less relevant to the LGBTQ+ population than to other populations. For example, applying the concept of "universalizing," which is the idea that "everyone goes through this," to LGBTQ+ specific stressors such as parental rejection, is counterproductive. Using the concept with this population undermines and invalidates the unique experiences of minority stress faced by LGBTQ+ people. Hence, during AFFIRM therapy sessions, therapists help their clients explore automatic thoughts and their triggers through a lens of oppression, stigma, and minority stress.

Developers added modules focused on hope and social supports. A module on *hope for the future* was added to specifically address hopelessness and suicidality, two common presentations in LGBTQ+ youth. The hope module involves goal-setting for the future and creating a Hope Box, which is an evidence-based tool where clients put tangible items that represent hope for the future (e.g., notes from family, comfort objects, pictures that bring up positive memories) into a container. A module identifying social supports is already part of CBT, and AFFIRM developers adapted this module to include a discussion on building *affirming* social support networks and how to assess and modify social supports that invalidate LGBTQ+ experiences, identities, and communities.

Developers piloted the adapted components.[101] Before the adapted curriculum was rolled out, developers conducted a feasibility study, resulting in minor modifications to the session pace, processing of key activities, facilitator coaching processes, relevant content examples, and workbook visuals. During the pilot, many participating LGBTQ+ youth stated that it was their first time participating in a program that was designed specifically for them. The experience was validating while increasing trust and buy-in from youth.

Youth AFFIRM

Developers gathered regular feedback from youth, the community, and AFFIRM facilitators. Program developers seek continual feedback from community and youth advisory boards (including AFFIRM graduates), as well as from facilitators in community organizations. The developer uses this feedback to inform updates that they regularly make to the participant workbook, facilitator manual, and the training. Updates include implementation processes of telehealth groups[102] and the inclusion of relevant identity and regional examples.

There are costs associated with AFFIRM implementation. To facilitate AFFIRM, providers participate in an AFFIRM training, whose cost includes training and the facilitator manual. Providers are encouraged to integrate AFFIRM into their existing services to avoid extra costs for clients. Payment options vary considerably. In many instances, AFFIRM is free for clients (e.g., implemented in schools, provided through grant-funded programs) and in other instances, health insurance may cover the cost.

Outcomes and Other Benefits (steps 6 and 7 in adaptation process)

Longitudinal research on AFFIRM, including randomized controlled trials with LGBTQ+ youth ages 14 to 24, have demonstrated the following mental health outcomes in both in-person and telehealth groups[101-105]:

- Reduced depression symptoms, as measured by the Beck Depression Inventory (BDI-II)
- Increased coping skills, as measured by the Brief Coping Orientation to Problems Experienced Inventory (COPE)
- Improved stress appraisal, as measured by the Stress Appraisal Measure-Adolescents (SAMA)
- Increased hope, as measured by a modified Adult Hope Scale (AHS)

Lessons Learned

- Organizations should be ready and have the capacity to implement the adapted curriculum, demonstrated through commitment from leadership and staff to serve the unique needs of LGBTQ+ young people.
- Organizations should seek ongoing input from the community and youth served to ensure effective and relevant facilitation and implementation.
- Staff delivering AFFIRM should be willing to engage in training and continued coaching. Staff need to complete the evidence-based AFFIRM training to facilitate the AFFIRM intervention.
- Organizations should avoid assuming that because a facilitator has lived experience in the LGBTQ+ community, it alone qualifies them to deliver the curriculum; competence in CBT as well as LGBTQ+ affirmative practice skills are imperative.

Related Resources

- Affirmative Research Collaborative
- AFFIRM at the Center of Excellence on LGBTQ+ Behavioral Health Equity
- AFFIRM Infographic

The Choctaw Nation Department of Behavioral Health (Oklahoma)

The Choctaw Nation Department of Behavioral Health provides integrated health services for adults, adolescents, and children. Therapists implement Native American MI, which is an adaptation of evidence-based MI tailored to the American Indian population.

Program

The Choctaw Nation Department of Behavioral Health serves the Choctaw Nation, a vast, rural territory covering approximately 11,000 square miles in southeastern Oklahoma. Services include outpatient and inpatient counseling, integrated behavioral health within primary care, residential treatment with a particular focus on opioid use disorder, and a residential therapeutic school for children. The department serves other tribes as well, but its primary population is the 85,000 Oklahoma members of the Choctaw Nation.

Challenge (step 1 in adaptation process)

The Choctaw Nation has cultural touchpoints that are relevant to how members approach and engage with behavioral health services, specifically MI. Members tend to focus on the collective well-being of the tribe and are usually highly motivated to maintain culture and engage in cultural activities. These values are not incorporated in the standard MI practice. Additionally, members of the Choctaw Nation are often reluctant to access behavioral health services.

Solution (steps 4 and 5 of adaptation process)

The department integrated behavioral health into primary care, mainly to serve those in the precontemplation stage. The first step in adapting MI for the Choctaw Nation was to integrate behavioral health services into primary care settings by offering brief relationship building, care, and referrals to outpatient services. Since many tribal members were in the precontemplation stage, this integration increased member engagement and buy-in.

Services incorporate Choctaw values. MI helps individuals clarify their values, motivations, and reasons for changing identified unhelpful behaviors. To adapt MI for members of the Choctaw Nation, practitioners incorporated the Choctaw's focus on identity, collectivism, cultural understanding of time, and traditions like storytelling and stickball.

- **Identity:** Choctaw identity is central to the delivery of Native American MI. Practitioners understand that there can be healing in finding and relating to the Choctaw identity, particularly because many individuals in the Choctaw Nation have been prevented from expressing cultural identity. When conducting Native American MI with Choctaw individuals, practitioners explore how the Choctaw identity has shaped the person and what factors motivate the individual to remain connected to the Choctaw identity, which is central to understanding an individual's motivations and values.
- **Collectivism:** Choctaw Nation places strong emphasis on collectivism versus individualism. Unlike in standard MI, the family often participates in therapy with the identified client and, frequently, the individual's reason for living and/or motivation for change involves the well-being of the family.
- **Storytelling:** Practitioners use storytelling to both elicit values and motivation from the client and allow the client to identify values. For example, one clinician at the Chi Hullo Li Women's Residential Treatment Center tells the story of a time when she was instructing the group in basket weaving. A large wasp flew down to the center water bucket, and the atmosphere of the group went from calmness and relaxation to one of fear and anxiety. In this teachable moment, the group discussed their relationship to nature, their responses to stimuli and fear, how to quiet anxiety with breathing, and the respect and value their Choctaw ancestors held for all living beings.

The Choctaw Nation Department of Behavioral Health (Oklahoma)

- **Stickball:** Stickball is a full-contact tribal sport played by many southeastern tribes. Providers within the Choctaw Nation use stickball to help teach emotional regulation and identify values and motivations. In playing the sport, it is easy to act impulsively and react to stimuli in the heat of the moment. Practitioners use stickball to practice reactions, identify where in the body individuals are experiencing emotions, and choose how to respond, based on values and desired outcomes. They can also link the activity with storytelling to discuss triggers (i.e., how an individual reacts in a game may be connected to how they react outside of a game). Stickball can provide a safe place for clients to test different responses and then process those outcomes.
- **Time:** Practitioners understand that time is culturally relevant to clients in the Choctaw community, which could translate into variable therapy durations.

Building trust is essential. Practitioners understand that it may take longer to build rapport and develop a therapeutic relationship, given the mistrust sometimes held against therapists, particularly those who are non-Native.

Training non-Native staff in the Choctaw culture is important. Many therapists in the Choctaw Nation Department of Behavioral Health are Choctaw themselves, which can increase the therapeutic alliance because of lived experience and shared community. For therapists who are non-Native, the department provides cultural training to learn the history of the Choctaw tribe and understand the community's cultural components. The program teaches non-Native therapists about the treaty at Dancing Rabbit Creek and the forced removal of the Choctaw people from their land, as well as Choctaw traditions and cultural values.

Cost associated with services are covered. Practitioners participate in specific trainings and obtain certifications in MI, both of which are paid for by the Choctaw Nation. There is no cost to Choctaw Nation members to receive MI services.

Outcomes and Other Benefits (steps 6 and 7 of adaptation process)

Qualitative and anecdotal data indicate that the number of behavioral health services offered to tribal members has increased, which has reduced the number of individuals with untreated severe mental illnesses.

Clients' self-referrals, referrals of their families, and community buy-in to behavioral health services have increased. Clients have shared that they are benefiting from involvement in cultural and traditional activities like social dancing, stickball, and basketry as part of participating in behavioral health services.

Lessons Learned

- It is important to be patient and start small. MI is one component of therapy offered by the Choctaw Nation. Adapting MI to be culturally relevant (one that is respectful of Choctaw values, motivations, and traditions) can produce benefits for therapy in general, leading to better clinical outcomes for clients.
- It is essential to pay attention to the people. While activities and traditions like Choctaw social dancing and stickball are crucial to Choctaw culture, practitioners should keep in mind that Choctaw culture is more than just activities. It is a way of thinking, teaching, and living and carries specific cultural values and motivations for being.

Related Resources

- Choctaw Nation Cultural Center
- Choctaw Nation Language Department
- Native American Motivational Interviewing

Homeless Children's Network's Ma'at Program

The Ma'at Program, a supportive, holistic, therapeutic community program of the San Francisco Homeless Children's Network, provides culturally responsive behavioral health care to Black/African American families and individuals. Ma'at refers to the ancient Egyptian concepts of truth, balance, order, harmony, and justice. This model affirms and uplifts the Black/African American community's mental health and wellness through collaboratively focused, Afri-centric, heartfelt behavioral health services. Ma'at services include individual and family therapy, mobile community outreach, group support, case management, youth leadership and development, culturally based referrals, violence prevention and intervention, and community organizing and advocacy.

Program

The Ma'at Program aims to improve behavioral health outcomes for Black/African American children, youth, families, adults, and seniors in San Francisco and address the historical legacy of intergenerational racism, inequity, and trauma. Ma'at is a unique Afri-centric initiative that addresses barriers to care for Black people, including stigma associated with mental illness, distrust of the healthcare system, absence of culturally competent providers from diverse backgrounds, and lack of insurance or underinsurance. It employs an Afri-centric approach to behavioral health services by radically and unapologetically affirming Blackness. The community is as much the focal point of these efforts as the direct work with children, families, and adults.

An average of 123 children and youth per month participate in Ma'at Program services. For every young person therapists have a relationship with, they interact with an average of nine other community members who support that young person.

Challenge (step 1 in adaptation process)

While five percent of San Francisco's population is Black/African American, almost half of homeless adults with children are Black, and Black communities continue to be disproportionally affected by poverty and trauma. Experiences of poverty and racism during early years increases risks of mental health problems throughout the lifespan.

Black San Franciscans are in urgent need of mental health support, yet many Black families are reluctant to engage with medicalized, conventional models of mental health service provision. Limited mental health models are centered in Black/African American principles and worldviews, and few community resources for families exist within this community.

Solution (steps 4 and 5 in adaptation process)

Ma'at employs a community mental health model, in which neighborhoods, histories, and families are key factors in service design and delivery. Community partners, peers, experts, and elders provide oversight to ensure implementation of principles that uphold Black/African American community members.

Ma'at's "Hub and Spoke" model empowers collaborations for reciprocal learning. The Homeless Children's Network is the hub for all activities, with community partners, such as schools, churches, shelters, family resource centers, substance use treatment programs, and housing sites serving as spokes and referring clients to the hub activities.

Homeless Children's Network's Ma'at Program

Acting as a trustworthy partner for families and individuals with a historical and reasonable distrust of conventional mental health treatment, Ma'at centers on healing and wholeness. Ma'at therapy is "love-informed", and hesitation to engage in therapy is viewed as informative rather than a barrier. Therapy is based on the seven cardinal values of *balance, order, righteousness, harmony, justice, truth,* and *reciprocity*.

Black therapists deliver the Ma'at Program, and Black administrators, supervisors, and directors support them. Therapists and clientele share lived experience and community while also recognizing the range of culture, language, religious, and spiritual practices within Black communities.

Whole person, trauma-informed care focuses on self-acceptance and resilience, while identifying areas of client strength and normalizing client experience. Ma'at offers space to process collective grief and fear without judgment as well as to celebrate joy and healing, often integrating a client's family and community members in services.

The program regularly conducts culturally relevant activities, such as drumming circles, meditation and prayer revivals, healing circles, quiet corners, and focus and listening groups.

The Ma'at Program thrives on partnerships, offering mental health, outreach, and cultural services to Black/African American LGBTQ+ communities and others. Ma'at services are available free of cost to the community.

Outcomes and Other Benefits (steps 6 and 7 in adaptation process)

Qualitative and survey data collected from children, youth, and their parents/guardians who received services through the Ma'at Program have demonstrated the following outcomes:

- Increased understanding and acceptance of their own Blackness
- Improved communication within the family
- Increased access to a caring, nonjudgmental, culturally affirming therapist with shared lived experience
- Decreased stigma associated with receiving mental health services

Lessons Learned

- An Afri-centric model for behavioral health services starts from within the Black community.
- Programs should gather community feedback and buy-in, in part by approaching individuals in the neighborhood and community and inviting them to engage in services. The programs should embrace community engagement as organic and expansive. Community engagement strategies, as well as intervention modalities, must be Afri-centric in vision, delivery, and implementation.
- Programs need to extend established relationships with providers in the community.
- It is essential to acknowledge vicarious and secondary trauma experienced by Black therapists, supervisors, and directors.
- Therapy should balance the needs of the family with an Afri-centric, culturally responsive approach while incorporating ongoing feedback loops and self-assessment.
- Programs should advocate for less restricted funding, which allows flexibility to leverage multiple approaches and multiple streams to meet the needs of the community.

Related Resources

- Ma'at Program Evaluation Report

CHAPTER

5

Resources for Evaluation

This chapter focuses on the last two of the seven steps of the adaptation process described in Chapter 2:

- Implement the adapted evidence-based practice (EBP) and evaluate implementation and outcomes (step 6)
- Assess and make further adaptations (step 7)

Evaluating an adapted EBP can:

- Document the adaptation process
- Answer critical questions about how well teams implemented the adaptations
- Determine whether the adaptations improve the cultural relevance of an EBP
- Assess the extent to which the adapted EBP produces desired outcomes for specific populations

This information can be helpful in making further adaptations, if necessary, and demonstrating the value of the adapted EBP to justify its continuation. In addition, stakeholders can use information gathered through evaluation to encourage implementation of the adapted EBP in other settings or communities or with other populations. As mentioned in Chapter 2, the adaptation effort should include evaluation costs.

This chapter first highlights equitable evaluation, which organizations can use to guide their evaluation activities. The chapter then provides an overview of the types of evaluations that organizations can conduct to document and assess the adaptation process, as well as the implementation of and outcomes from the adapted EBPs. Additionally, the chapter describes different data sources an organization could use and highlights the importance of community participation in the evaluation process. The chapter concludes with a list of resources specifically focused on evaluating EBP implementations and outcomes.

Culturally Responsive and Equitable Evaluation (CREE)

Equitable evaluation is a type of culturally responsive evaluation. It does not consider culture as a subjective factor that needs to be controlled; instead, it explicitly acknowledges culture and context when assessing program effectiveness.[106] Equitable evaluation relies heavily on engaging the very participants with whom the EBP is implemented and from whom evaluation data are collected.

Expanding the Bench Initiative defines Culturally Responsive and Equitable Evaluation (CREE) as "evaluation that incorporates cultural, structural, and contextual factors (e.g., historical, social, economic, racial, ethnic, gender) using a participatory process that shifts power to individuals most impacted. CREE is not just one method of evaluation; it is an approach that should be infused into all evaluation methodologies."

According to the Equitable Evaluation Initiative (EEI), evaluation efforts should be in service of equity, and evaluators should consider the following aspects while developing their evaluation approach:

- Diversity of their evaluation teams, including cultural backgrounds, disciplines, beliefs, and lived experiences of team members
- Cultural appropriateness and validity of evaluation methods
- Ability of the evaluation design to reveal structural and systems-level drivers of inequity (present-day and historical)
- Degree to which communities have the power to shape and own how evaluation happens

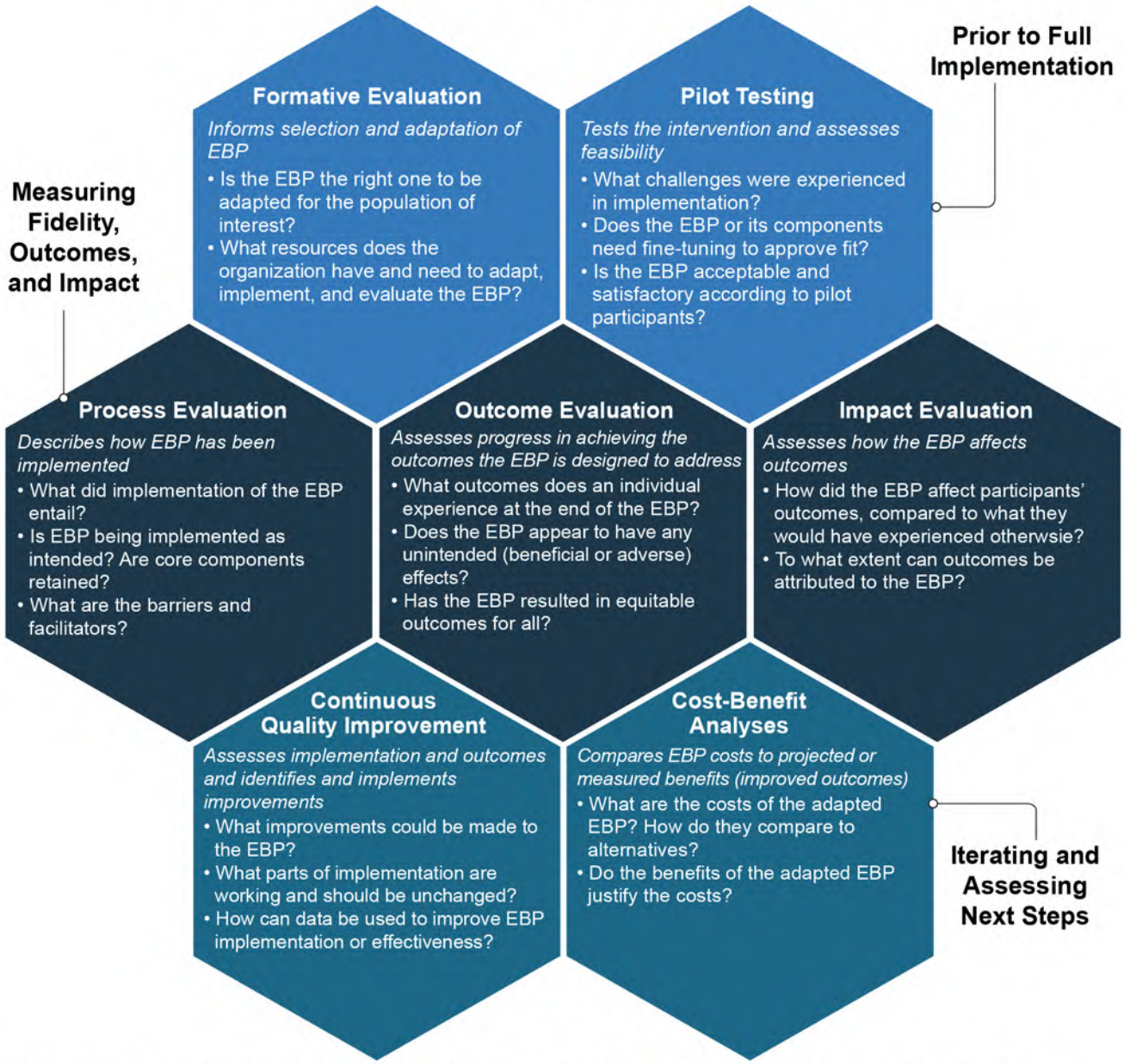
Strategies to Put Equitable Evaluation into Practice

Organizations can use the following questions to apply CREE practices at each stage of the evaluation process.[107]

Evaluation Process Step	Guiding Questions
Putting Together an Evaluation Team	• Are proposed team members culturally and racially diverse? • Do they represent different backgrounds, beliefs, and have lived expertise with the issue at hand? • What types of training or capacity building is needed to enable all members of the evaluation team to participate in the evaluation?
Evaluation Purpose(s) and Audience(s)	• Does the overall evaluation purpose explicitly reference progress toward equity at the level of individual results and at a structural or systemic level? • Do evaluation audiences include the under-resourced populations served? For example, if the EBP adaptation is intended to serve the mental health needs of individuals of a specific race or ethnicity, are these individuals named as stakeholders in the evaluation process?
Evaluation Questions	• Has the organization involved all evaluation stakeholders – in particular, those whom the organization serves – in the identification and prioritization of evaluation questions? • Do the evaluation questions consider whether different groups experience services differently?
Outcomes and Indicators	• Are the outcomes framed in a way that emphasizes the strengths of the people the organization serves? • Are the outcomes meaningful and culturally relevant to the people the organization serves? • Will the indicators provide the organization with information on inequitable results or effects (i.e., are indicators disaggregated in a way that identifies disparities or inequities)? • Will indicators provide the organization with evidence of structural or systemic progress?
Data Collection, Analysis, and Reporting	• Is the organization transparent with all stakeholders about how and why it collects and uses data? • Are all stakeholders involved in data collection, and in what ways? • Are data collection tools culturally relevant and appropriate to the populations served? • Is the organization actively engaging stakeholders in the process of interpreting the data and formulating recommendations? • Does the organization follow equitable communication strategies to share evaluation results with different audiences?

Adapted from: Youth Development Executives of King County. (n.d.) *Equitable evaluation guiding questions.* https://ydekc.org/wp-content/uploads/2021/05/Equitable-Evaluation-Guiding-Questions.pdf

Engagement and Partnership with the Community Throughout all Phases of Evaluation Planning, Data Collection, Analysis, and Dissemination



Adapted from: National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. (n.d.) *Types of Evaluation*. Centers for Disease Control and Prevention. http://www.cdc.gov/std/program/pupestd/types%20of%20evaluation.pdf.

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Types of Evaluations

Different types of evaluation activities can be conducted throughout the adaptation and implementation processes (see graphic for descriptions of each evaluation type). Before an adapted intervention is implemented, *formative evaluations* and *pilot testing* can help determine intervention feasibility and acceptability. When implementation begins in full, *implementation* and *process evaluations* can record how the intervention is being delivered and assess whether fidelity is being maintained. Programs can assess fidelity using checklists provided by EBP developers. When data are collected from participants, *outcome* and *impact evaluations* can measure the extent to which intended outcomes were achieved, to what degree they are attributable to the adapted intervention, and whether positive outcomes are experienced equitably across populations within the community.

Continuous quality improvement activities can be conducted throughout and following implementation to refine intervention components. *Cost-benefit and cost-effectiveness analyses* can help organizations assess how the intervention's benefits compare to its costs and the extent to which the intervention is sustainable.

Evaluation Data

Evaluation data provide information on what did and did not work. Data collected as a part of any type of evaluation are either quantitative or qualitative, which are mutually complementary, with each providing critical insight into whether and how the intervention is operating and achieving the intended objectives.

- **Qualitative data** include any text-based information, such as verbal, visual, or written data. Qualitative data collection methods include interviews, focus groups, clinical observations, gathering data from documents and images, and open-ended survey questions and polling responses.
- **Quantitative data** are any data that can be processed by mathematical or statistical analysis. Quantitative data collection includes close-ended survey questions and polling responses, service and utilization data, and claims and encounter data. Quantitative data may also be collected during interviews and focus groups.

Community-based participatory methods should be used for collecting and analyzing data and disseminating findings throughout the evaluation process.

The community-based participatory (CBP) approach is based on the following foundational principles[108]:

- Promote collaborative and equitable partnerships and involve an empowering and power-sharing process.
- Recognize community as a unit of identity.
- Emphasize building upon the local knowledge of the community, relying on and strengthening community resources, and improving community health.
- Facilitate co-learning and capacity building among all partners.
- Focus on problems of relevance to the local community using an ecological approach that attends to multiple determinants of health and disease.
- Disseminate findings and knowledge gained to the broader community and involve all partners in the dissemination process.
- Promote a long-term process and commitment to sustainability.

The types of evaluations discussed in this chapter are valuable for documenting why and how an EBP was adapted and the extent to which outcomes were achieved and possibly improved because of an organization's adaptations. Evaluations can also provide important lessons for adaptation of other EBPs and help justify costs associated with the adaptation process. However, the resources needed to conduct an evaluation may be limited, and organizations need to consider what is feasible with the available resources. In the three case examples provided in Chapter 4, the types of data collection and evaluations conducted are described in the section "Outcomes and Other Benefits."

Evaluation Resources

Resources on Evaluation

- The Centers for Disease Control and Prevention's (CDC's) Framework for Program Evaluation summarizes essential elements of program evaluation in public health.
- Rural Health Information Hub's (RHIhub's) module on Evaluating Rural Programs offers information on designing and implementing an evaluation of health programs in rural settings.
- University of California, San Francisco's Family Health Outcomes Project includes resources for program evaluation and performance monitoring.
- The Center for Community Health and Development at the University of Kansas's Community Tool Box includes a step-by-step guide to develop an evaluation of a community program or initiative and offers specific tools and examples.

Resources on Culturally Responsive and Equitable Evaluation

- The Equitable Evaluation Initiative's Equitable Evaluation Framework™ seeks to provide foundations, and nonprofit organizations with an understanding of equity and how to use an equity lens while performing evaluations.
- Mathematica Policy Research's Using a Culturally Responsive and Equitable Evaluation Approach to Guide Research and Evaluation introduces the CREE approach and tools to maximize its utilization.
- Child Trend's How To Embed a Racial and Ethnic Equity Perspective in Research provides researchers with guiding principles in accomplishing research and evaluation in an equitable manner.
- WestEd Justice & Prevention Research Center's Reflections on Applying Principles of Equitable Evaluation offers practical solutions stemming from equitable evaluation processes.
- The Handbook of Practical Program Evaluation, Fourth Edition, chapter 12, Culturally Responsive Evaluation: Theory, Practice, and Future Implications provides a foundation for culturally responsive evaluation—from preparation for evaluation to disseminating and utilizing results.

Resources on Cultural Competence

- The American Evaluation Association's (AEA's) Public Statement on Cultural Competence in Evaluation stresses the importance of cultural competence in evaluation and provides a guide for using cultural competence while performing evaluation.
- The Foundation Review's Raising the Bar – Integrating Cultural Competence and Equity: Equitable Evaluation presents a framework for building equitable evaluation capacity.
- The paper A Language Justice Framework for Culturally Responsive and Equitable Evaluation proposes an evaluation framework grounded in language justice, which is defined as the right to communicate in the language one feels most comfortable with.
- The HHS Office of Minority Health's Evaluation of the National CLAS Standards Tips and Resources describes a toolkit developed to guide efforts to evaluate the National CLAS Standards across four settings: ambulatory care, behavioral health, hospitals, and public health.

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Glossary

Association: Evidence demonstrating a *statistical relationship* between an intervention and outcomes measured in the study's sample population. Association is *not* causation.

Behavioral health: The promotion of mental health, resilience, and wellbeing; the treatment of mental health and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.

Causal impact: Evidence demonstrating that an intervention *causes* or is *responsible for* the outcomes measured in the study's sample population.

Cissexism: The belief or assumption that cis people's gender identities, expressions, and embodiments are more natural and legitimate than those of trans people.

Community-based participatory approach: An approach that involves the engagement and the equal participation of individuals who are affected by the issue or problem at hand and recognizes and appreciates the unique strengths and resources each person contributes. It is a cooperative, co-learning process that involves systems development and local community capacity-building.

Culture: A broad, multi-dimensional construct that refers to integrated patterns of human behavior including language, spirituality, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Cultural adaptation: The systematic modification of an evidence-based practice's protocols and/or content to incorporate language, culture, and context that is compatible with a client's cultural patterns, meanings, and values.

Cultural competence: A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable them to work effectively in cross-cultural situations.

Cultural integrity: The practice of respecting and honoring the ownership of materials, traditions, and knowledge that originate from a particular culture or community.

Culturally relevant system of care: A healthcare system that considers and respects individuals' cultural orientations by understanding and honoring attitudes, values, and behaviors unique to each person.

Culturally Responsive and Equitable Evaluation (CREE): An evaluation that incorporates cultural, structural, and contextual factors (e.g., historical, social, economic, racial, ethnic, gender) using a participatory process that shifts power to individuals most impacted.

Ecological validity: The generalizability of study findings or therapy situations to the participant's real-life settings.

Evidence-based practices: Interventions for which there is consistent scientific evidence showing that they improve individual-level or population-level outcomes.

Fidelity: The extent to which an intervention was delivered as conceived and planned.

Health inequities: Differences in health status or the distribution of healthcare and other resources between population groups arising from the social conditions in which people are born, grow, live, work, and age.

Heterosexism or **homophobia**: The marginalization and/or oppression of people who are lesbian, gay, bisexual, queer, and/or asexual based on the belief that heterosexuality is the norm.

Implementation science: The scientific study of methods to promote the systematic uptake of clinical research findings and other evidence-based practices into routine practice to improve the quality and effectiveness of health care.

Stakeholders: Individuals, organizations, or communities that have a direct interest in the process and outcomes of a project, research study, or policy initiative.

Structural racism: A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing, ways to perpetuate racial group inequity.

Appendix 1: Acknowledgments

The guide is based on the thoughtful input of SAMHSA staff and the Technical Expert Panel (TEP) on Adapting Evidence-Based Practices for Under-Resourced Populations from October 2021 through June 2022. A series of guide development meetings and two TEP convenings were conducted during this time.

SAMHSA Staff

Brian Altman, JD, National Mental Health and Substance Use Policy Laboratory

Leslie Chae, MPH, Center for Substance Abuse Treatment *

Thomas Clarke, PhD, Center for Behavioral Health Statistics and Quality

Trina Dutta, MPH, MPP, Office of the Assistant Secretary for Mental Health and Substance Use *

Tanya Geiger, PhD, MPH, Center for Behavioral Health Statistics and Quality

CAPT Donelle Johnson, PhD, MHSA, National Mental Health and Substance Use Policy Laboratory *

Krishnan Radhakrishnan, MD, PhD, MPH, National Mental Health and Substance Use Policy Laboratory

Mary Roary, PhD, MBA, Office of Behavioral Health Equity *

Carter Roeber, PhD, National Mental Health and Substance Use Policy Laboratory *

Technical Expert Panel

Juliet Bui, MSW, MPA, U.S. Department of Health and Human Services, Office of Minority Health

Valeria Chambers, EdM, CAS, CP, Black Voices 4 Recovery

Kimberlye Dean, PhD, Massachusetts General Hospital

Yovanska Duarte-Velez, PhD, Bradley Hospital and Brown University

Joel Dubenitz, PhD, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation

Rachele Espiritu, PhD, Change Matrix

CAPT Karen Herod, MSW, LCSW, Office of Tribal Affairs and Policy

Tracy Johnson, BA, TTJ Group LLC

Rubén Parra-Cardona, PhD, University of Texas, Austin

Nicole Summers-Gabr, PhD, MS, Southern Illinois University School of Medicine

Pamela Thurman, PhD, Colorado State University

Angela Weeks, DBA, Director of the Center of Excellence on LGBTQ+ Behavioral Health Equity

Contract Staff

Rucha Londhe, PhD, Guide Lead, Abt Associates *

* Members of Guide Planning Team

APPENDIX 2: Background Information on the Evidence-Based Practices Discussed in Chapter 2

Motivational Interviewing

Goal

Motivational interviewing (MI) is a treatment approach that helps individuals overcome ambivalent feelings and insecurities. In the process, individuals become motivated to change their undesired behavior. MI developers define it as "a directive, client-centered counseling style for eliciting behavior change by helping clients explore and resolve ambivalence."

Core Principles

Five underlying principles guide how practitioners should interact with clients while using this practice. Practitioners should:[6]

- Express empathy through reflective listening.
- Identify discrepancies between a client's goals, values, or hopes and their current behavior.
- Roll With Resistance through avoiding arguments and direct confrontations with a client and adjust to a client's resistance rather than opposing it directly.
- Support self-efficacy and optimism.

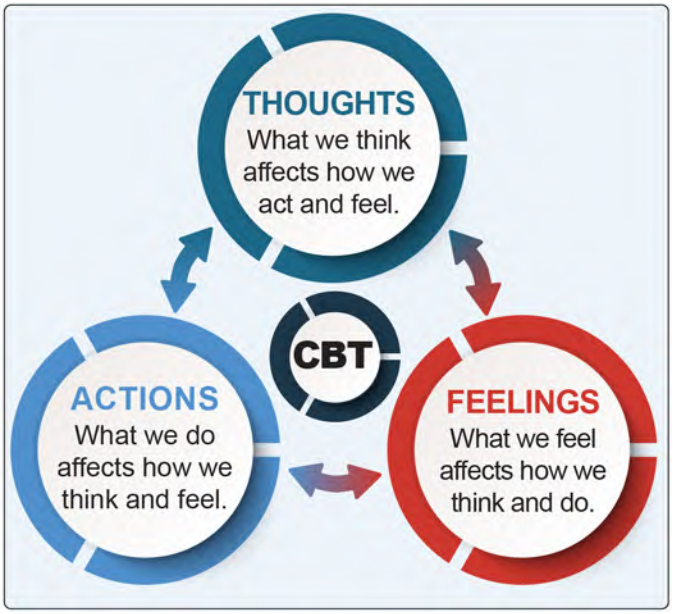
Typical Implementation and Delivery

MI is intended for use by a wide variety of practitioners, including primary care providers, behavioral health professionals, and peer providers. Training on MI is available for clinicians, non-clinicians, peers, and those with minimal or no training in counseling or therapy. Treatment with MI for substance use and mental health outcomes does not have a prescribed time period; it can range from a single session of 15 minutes to multiple, hour-long sessions.

Cognitive Behavioral Therapy

Goal

Cognitive behavioral therapy (CBT) is a short-term, goal-oriented psychotherapy treatment that enables individuals to understand their current problems, challenges, and experiences, in order to change their behaviors and patterns of thinking. CBT helps clients develop accurate assessments of circumstances and their feelings, so that they can develop realistic strategies. CBT also is used to address depressive cognitions and other cognitive distortions associated with depression, generalized anxiety disorders, and substance use disorders.



Core Principles

Through CBT, clients are trained to evaluate faulty patterns of thinking, actions, and negative feelings associated with the desired mental health or substance use outcome. CBT is tailored to the needs of the individual, with the goals of each therapy session uniquely based on the client's experiences and personal circumstances.

[6] Rollnick, S. & Miller, W. R. (1995). What is motivational interviewing? *Behavioral and Cognitive Psychotherapy, 23*, 325-334.

CBT is founded on the following principles[7]:

- Psychological problems are, in part, due to faulty or unhelpful ways of thinking.
- Psychological problems are based, in part, on learned patterns of unhelpful behavior.
- People with psychological problems can learn better ways of coping with them, thereby relieving their symptoms and becoming more effective in their lives.

Typical Implementation and Delivery

Practitioners can use CBT effectively in a wide range of healthcare settings, from inpatient psychiatric rehabilitation to community outpatient programs. A variety of professionals trained in CBT principles can implement the program, including behavioral health professionals, primary care staff, and criminal justice personnel. The National Association of Cognitive-Behavioral Therapists offers CBT training for mental health professionals, as well as non-professionals with a four-year college degree.

CBT is typically customized to the needs of each individual. Most people who seek CBT receive counseling for a period ranging from 5 to 10 months. A standard therapeutic session is approximately 50 minutes long.

A newer approach to CBT uses a digital format for delivery to clients. This format draws on the National Institute on Drug Abuse's CBT manual and offers CBT sessions either online or through an app.

Dialectical Behavior Therapy

Goal

Dialectical behavior therapy (DBT) is a psychotherapy treatment originally developed by Dr. Marsha Linehan to treat individuals at-risk for suicide and/or those with borderline personality disorder (BPD). DBT is commonly used to address depressive symptoms, substance use disorders, posttraumatic stress disorders, and a wide range of other disorders. It focuses on dialectical or opposing strategies of acceptance and change.

Core Principles

DBT is founded on the following principles[8]:

- **Mindfulness:** Accepting and tolerating negative emotions that often arise when clients are confronted with their challenging habits or beliefs or uncomfortable situations.
- **Interpersonal effectiveness:** Addressing the clients' interactions with the people around them and focusing on their interpersonal relationships.
- **Distress tolerance:** Helping clients tolerate, accept, and find meaning in the distress that occurs in their lives.
- **Emotion regulation:** Teaching people in recovery how to identify, regulate, and feel emotion often associated with impulsive behaviors.

[7] American Psychological Association. (2017). *What is Cognitive Behavioral Therapy?* https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral#

[8] Behavioral Tech. (n.d.). *What is Dialectical Behavior Therapy (DBT)?* https://behavioraltech.org/resources/faqs/dialectical-behavior-therapy-dbt/

Source: Behavioral Tech (n.d.) *What is Dialectical Behavior Therapy* (DBT)?. https://behavioraltech.org/resources/faqs/dialectical- behavior-therapy-dbt/

Typical Implementation and Delivery

While DBT was originally designed for use with populations with BPD, it has since been used with a wide variety of populations, to treat an array of mental health concerns.

DBT practitioners typically undergo intensive training to obtain certification. Certification is offered through the DBT-Linehan Board of Certification (DBT-LBC) to licensed mental health professionals. It requires practitioners to complete 40 hours of didactic training and pass a test.

DBT typically has a duration of about 24 weeks, consisting of weekly skills training groups, in addition to hour-long, weekly individual therapy sessions. DBT's phone coaching component permits clients to call their therapist between sessions, to receive real-time coaching and care.

Photos are for illustrative purposes only.
Any person depicted in a photo is a model.

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Substance Abuse and Mental Health Services Administration

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OPIOID-OVERDOSE REDUCTION CONTINUUM OF CARE APPROACH (ORCCA)

PRACTICE GUIDE 2023

NIH National Institute on Drug Abuse

SAMHSA Substance Abuse and Mental Health Services Administration

Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) Practice Guide

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NIH HEAL INITIATIVE
HEALing Communities Study

Released 2023

Contents

Key Terms

TERM	DEFINITION
Addiction	Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases. See American Society of Addiction Medicine Definition of Addiction
Behavioral Health	The term "behavioral health" means the promotion of mental health, resilience, and well-being; the treatment of mental health conditions and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.
Continuum of Care	An integrated system of care that guides and tracks a person over time through a comprehensive array of health services appropriate to the individual's need. A continuum of care may include prevention, early intervention, treatment, continuing care, and recovery support.
Evidence-Based Practice (EBP)	Evidence-based practices are interventions that are guided by the best research evidence with practice-based expertise, cultural competence, and the values of the persons receiving the services that promote individual-level or population-level outcomes.
Harm Reduction	Harm reduction is a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (and their families) with the choice to live healthy, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of people who use drugs, especially those in underserved communities, in these strategies and the practices that flow from them. See SAMHSA–Harm Reduction
Intersectionality	The complex, cumulative intertwining of social identities that result in unique experiences, opportunities, and barriers. People may use "intersectionality" to refer to the many facets of our identities and how those facets intersect. Some use the term to refer to the compound nature of multiple systemic oppressions.
Justice-Involved	This descriptor indicates past or current involvement in the criminal legal system, typically indicating the person has experienced one or more of the following: an arrest, prosecution, incarceration in a jail or prison, and/or community supervision.
Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex + (LGBTQI+)	Lesbian, gay, bisexual, transgender, queer, those who are questioning their sexual orientation or gender identity, and others who are not cisgender or straight/heterosexual. LGBTQI+ is used interchangeably with "sexual and gender minority."

TERM	DEFINITION
Medication for Opioid Use Disorder (MOUD)	This term refers to the class of medications that are FDA-approved for the treatment of opioid use disorder (OUD). They are often used in combination with counseling and other behavioral therapies to provide a whole-patient approach to the treatment of OUD. This class of medications includes buprenorphine, methadone, and naltrexone in different formulations. See SAMHSA Medications, Counseling, and Related Conditions
Peer Distribution	Peers are people with lived experience from the community. In a peer distribution program, peers distribute naloxone to others within the community outside of formal settings (e.g., medical offices, harm reduction agencies).
Peer Support Workers	Peer support workers are people with lived or living experience who help others experiencing similar situations.
Peer Recovery Support Services	Services provided by peer support workers may include emotional (e.g., mentoring), informational (e.g., parenting class), instrumental (e.g., accessing community services), and affiliational (e.g., social events) support. See SAMHSA Peer Support Workers for those in Recovery
People with Lived Experience (PWLE)	People who currently use or formerly used opioids, or their family members.
Recovery	Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. There are four major dimensions that support recovery: • Health: overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being. • Home: having a stable and safe place to live. • Purpose: conducting meaningful daily activities and having the independence, income, and resources to participate in society. • Community: having relationships and social networks that provide support, friendship, love, and hope. See SAMHSA Recovery and Recovery Support
Social Determinants of Health	Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The Social Determinants of Health cover five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. See Healthy People 2030: Social Determinants of Health
Stigma	Stigma arises from the negative feelings that many individuals harbor against people struggling with mental and/or substance use disorders, and their beliefs that poor personal choices, "moral failing," and defects of character are to blame for the disease. Stigma can reduce willingness of policymakers to allocate resources, reduce willingness of providers in non-specialty settings to screen for and address mental health conditions and substance use disorders, impact a person's standing in their community, limit access to employment or housing, and may limit willingness of individuals with these conditions to seek treatment. Some people object to this term as it may perpetuate a negative connotation. Others favor "prejudice and discrimination" as the societal attitudes and actions that reinforce negative stereotypes and policies.

TERM	DEFINITION
Telemedicine	"Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment… [Medicaid] does not recognize telemedicine as a distinct service." See SAMHSA CCBHCs Using Telehealth or Telemedicine
Telehealth	By contrast, telehealth is usually used as a broader term. Telehealth typically includes not only telemedicine but also other forms of telecommunication, including asynchronous or "store and forward" systems, which transfer a patient's data or images for a physician or practitioner at another site to access at a later time. With these systems, the patient and provider do not have to be present at the same time. See SAMHSA CCBHCs Using Telehealth or Telemedicine
Trauma	SAMHSA describes individual trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." See SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach
Trauma-Informed Approach	A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization. Referred to variably as "trauma-informed care" or "trauma-informed approach," this framework is regarded as essential to the context of care. See SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Acronyms

ASAM	American Society of Addiction Medicine
ASTHO	Association of State and Territorial Health Officials
CDC	Centers for Disease Control and Prevention
CME	Continuing medication education
CTH	Communities That HEAL
CTN	Clinical Trials Network
DEA	Drug Enforcement Administration
EBP	Evidence-based practice
FDA	U.S. Food and Drug Administration
HCS	HEALing Communities Study
MAT	Medication-Assisted Treatment
MOUD	Medication for opioid use disorder
OBAT	Office-Based Addiction Treatment
OEND	Opioid overdose prevention education and naloxone distribution
ORCCA	Opioid-Overdose Reduction Continuum of Care Approach
OTP	Opioid treatment program
OUD	Opioid use disorder
PAARI	Police Assisted and Addiction Recovery Initiative
PCSS	Providers Clinical Support System
PDMP	Prescription drug monitoring program
PWLE	People with lived experience
PWUD	People who use drugs
SAMHSA	Substance Abuse and Mental Health Services Administration
SSP	Syringe service program
SUD	Substance use disorder
TTC	Technology Transfer Center
VA	U.S. Department of Veterans Affairs

1. Overview

This guide includes **(1)** a menu of evidence-based practices for reducing opioid overdose deaths and **(2)** real-world tips for implementing the evidence-based practices.

What is the Purpose of this Practice Guide?

This guide was developed to help the workforce, community members, and volunteers that provide opioid use disorder (OUD) treatment, harm reduction and recovery services respond to the opioid crisis in their communities.

Who is This Guide For?

This guide was developed for the Substance Abuse and Mental Health Services Administration (SAMHSA) Technology Transfer Centers (TTC) program and other providers of technical assistance as a resource for individuals working to end the opioid crisis. These individuals include community coalition members, professional treatment providers, recovery support specialists, people with lived experience, policymakers, recovery program administrators, and many others working to prevent, treat, and support recovery from substance use disorders. This guide is particularly designed for individuals at the front lines of the opioid response.

Evidence-based practices are approaches that have been shown, through research and evaluation, to be effective in decreasing opioid overdose deaths.

Care continuum is the span of care across prevention, diagnosis, engagement, and retention in OUD treatment.

Harm reduction is a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (and their families) with the choice to live healthy, self-directed, and purpose-filled lives. (SAMHSA).

Recovery is a "process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential" (SAMHSA).

How Was This Guide Developed?

This guide is based on the Opioid-Overdose Reduction Continuum of Care Approach (ORCCA), which was developed as part of the HEALing Communities Study (HCS). In this study, researchers worked with community coalitions to implement the Communities That HEAL (CTH) intervention, which created data-driven action plans for reducing opioid overdose deaths by implementing evidence-based practices across the care continuum.

See **Appendix B** and the following website for more information about the study: https://hcs.rti.org

To create this practice guide, an eight-person technical expert panel reviewed key ORCCA content and made recommendations for translating ORCCA content into a resource for TTC networks. The panel included people with lived experience, experts from recovery and harm reduction agencies, SAMHSA, National Institute on Drug Abuse, and the HCS. All experts provided input on the guide and reviewed the final product. A companion practice guide, "Engaging Community Coalitions to Decrease Opioid Overdose Deaths," features tools and real-world examples that can be used to build and strengthen community coalitions that work to reduce opioid overdose deaths.

See **Appendices C and D** for more information on technical expert panel members.

What Is in This Guide?

This practice guide includes **guidance**, **resources**, and **insights** from the study sites and subject matter experts on implementing strategies from the ORCCA to reduce opioid overdose deaths.

Throughout this guide, we highlight **"Stories from the Field,"** in-depth examples of the challenges coalitions implementing the CTH intervention faced, their solutions, and their lessons learned.

Section 2 introduces the ORCCA and menu strategies. **Section 3** provides guidance on how to identify higher risk populations and priority settings and assess community needs and assets to inform EBP selection. **Section 4** reviews opioid overdose prevention education and naloxone distribution strategies, including the rationale, supporting research, challenges and solutions related to the strategies, and implementation resources. **Section 5** reviews medication for opioid use disorder strategies, including the rationale, supporting research, challenges and solutions related to the strategies, and implementation resources. **Section 6** reviews safer prescribing and medication disposal strategies, including the rationale, supporting research, challenges and solutions related to the strategies, and implementation resources. **Appendices** present additional information about the HCS study, biographies for the technical expert panel, and additional details on guide development.

2. Introduction

WHAT IS THE ORCCA?

The Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) is designed to help communities reduce opioid overdose deaths. Created by a workgroup of experts from four research sites implementing the Communities That HEAL intervention, the ORCCA menu features a selection of evidence-based practices across **three** overarching "menu" categories:

1

Opioid overdose prevention education and naloxone distribution in higher risk populations

2

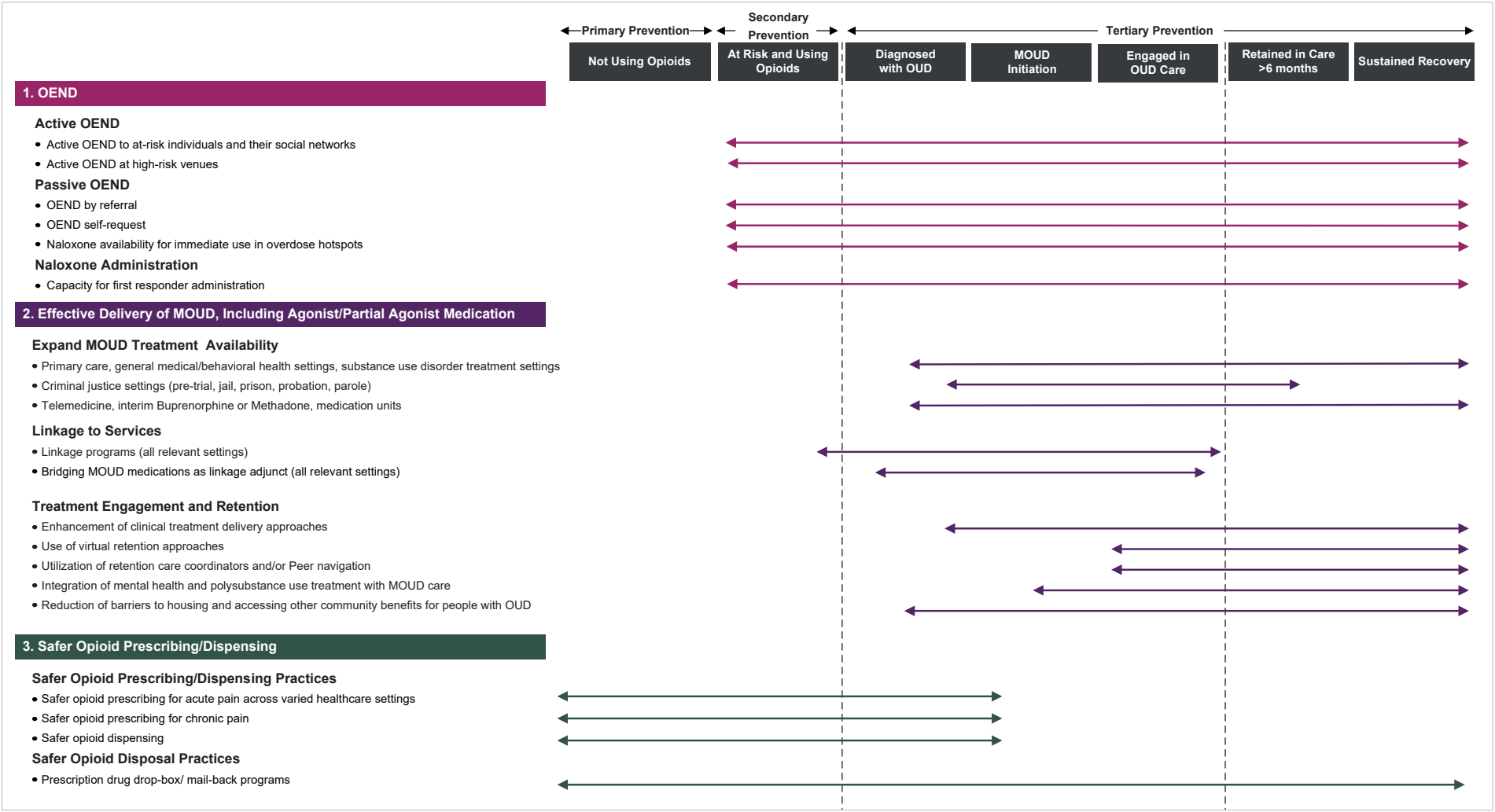
Effective delivery of medication for opioid use disorder treatment with outreach and delivery to higher risk populations

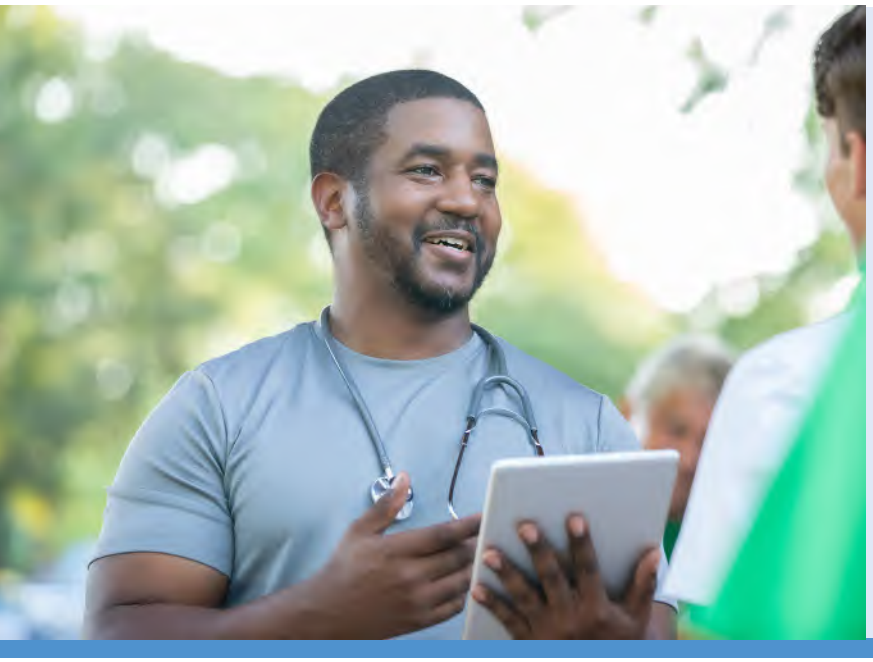
3

Safer opioid prescribing and dispensing

The ORCCA was adapted from the Cascades of Care for OUD developed by Williams and colleagues[1] and is purposefully designed to overlap strategies to reduce opioid overdose fatalities across a continuum of care.

Figure 1. The HEALing Communities Study Opioid-Overdose Reduction Continuum of Care Approach with Sample Strategies





3. Tips for Data-Driven Strategy Selection

Data-driven strategy selection means using community data to guide the selection and implementation of evidence-based practices (EBPs). Communities impacted by the opioid overdose crisis are best positioned to identify what assets or barriers exist that might impact strategy implementation. So, community members should be **front and center** in making the decisions about how to respond to the opioid crisis in their community.

This section of the guide provides tips and resources to help you complete key steps in the data-driven strategy selection process:

1. Engage **community experts**
2. Conduct a **community assessment**
3. Identify **priority populations** (people at higher risk of opioid overdose)
4. Prioritize **settings** (settings used by priority populations)

Engage Community Experts

Ensuring that people most affected by the opioid overdose crisis and those at higher risk of opioid overdose have an **active** role in selecting and implementing strategies will maximize the impact of your opioid overdose interventions.

People with lived experience (PWLE) and people who use drugs (PWUD) include people who currently use or formerly used opioids or their family members. These people can provide key insights on treatment experiences, harm reduction approaches, community-held beliefs that might affect the reach of EBP strategies, and anticipated challenges and facilitators for implementing strategies.

Our expert panel and research sites shared the following best practices for working with PWLE and PWUD:

Prioritizing the Voices of PWLE/PWUD

Harm reduction, considered a social policy and public health model, was born out of grassroots efforts by PWUD and community activists. PWUD play a critical role in identifying emerging issues, particularly in the evolving drug supply and associated health behaviors and outcomes.

PWUD are the only population at risk for overdose and therefore are the very people our work must prioritize and protect. We need their expertise and lived experience to be successful.

KEY INSIGHTS

- Recognize publicly and privately that their knowledge is valuable.
- Allow people to decide how to introduce themselves and their story. Accept that “PWUD” or “PWLE” may not be what experts want to be called.
- Avoid tokenism, or only inviting a person from an underrepresented group to participate to give the appearance that the coalition is diverse and inclusive.
- Foster an environment of listening and open-mindedness.
- Model respectful, person-first language and discuss the impact of stigmatizing terms.
- Advocate that health and wellness is deserved by everyone, including those actively using.
- Don’t assume that one person or a few people can speak for an entire group of people. Seek out multiple perspectives.
- Emphasize that the knowledge and insights of PWLE/PWUD will be incorporated meaningfully into strategy selection, implementation, and evaluation.

Please see the companion practice guide "Engaging Community Coalitions to Decrease Opioid Overdose Deaths" for additional guidance on how to successfully engage PWLE/PWUD in a way that protects their well-being and insights into building and maintaining coalitions to decrease opioid overdose deaths.

Members of local organizations that deliver services to people at higher risk of opioid overdose (e.g., syringe service programs [SSPs], addiction treatment organizations) in your community can share information about how different strategies have worked or might work in their settings. These members can share patient and provider experiences with EBP strategies to date.

Additional resources for engaging people with lived experience

- International Network of People who Use Drugs
- National Harm Reduction Coalition
- National Harm Reduction Technical Assistance Center: offers access to free help in providing or planning to provide harm reduction services

Conduct a Community Assessment

A community assessment seeks to determine what is currently being done to address the opioid crisis in your community, including where services are provided and the extent to which services are reaching people at higher risk for overdose. This information informs the selection and implementation of EBPs. For example, you may decide to expand existing services or select strategies that help fill gaps in services.

Work with community experts to conduct the community assessment **(Tool 1)**. PWLE and service providers can identify service gaps and opportunities for enhancing existing services. You can also use online search tools, such as Google, to gather information about opioid use disorder (OUD) prevention and treatment services in your community.

When seeking community expertise to inform strategy selection, consider your community's:

- Sociodemographic characteristics (race, ethnicity, age distribution, etc.)
- Sociocultural characteristics (political climate, religion, country of origin, languages spoken)
- History of opioid overdose–related work within the community and key leaders

The most successful efforts will establish buy-in and build trust among community members and community leaders.

Tool 1: Guiding Questions for a Community Assessment

Instructions: The following interactive worksheet can be used to answer questions regarding your community. You must download and save the file to your computer before filling it out. Completing the form within your web browser will not save your work.

FOCUS & GUIDING QUESTIONS
Existing Services
» What are existing services for people at higher risk of opioid overdose in our community? – What substance use treatment services are available?
– Recovery support?
– Social services? (refer to the "prioritize settings" subsection for a full list of settings to consider)
Information sources: » Speak with community members about available services, including: – PWLE, including PWUD; Recovery support service providers; Staff at harm reduction agencies; Treatment providers » Search online for community resources » Search for providers using SAMHSA's Buprenorphine Practitioner Locator

continued

Tool 1: Guiding Questions for a Community Assessment (*continued*)

FOCUS & GUIDING QUESTIONS
Service Gaps
» What are the most pressing gaps between existing and needed services?
» What services have people at higher risk of overdose sought out and haven't been able to locate?
» What are the greatest needs expressed by community experts?
» What populations are underserved?
Information sources: » Community members » Recovery support service providers » Staff at harm reduction agencies » Treatment providers

continued

Tool 1: Guiding Questions for a Community Assessment (*continued*)

FOCUS & GUIDING QUESTIONS
Feasibility
» What level of resources (staff, facilities, materials, and funding) are available?
» What time is available to implement the strategy?
» What is community buy-in (i.e., is there support for harm reduction services or new treatment services)?
» How could community factors affect implementation of EBPs?
Information sources: » Available funding opportunities, including grants and opioid settlement funds » Community members and service providers » Local news reports or media coverage on the opioid overdose crisis to assess community buy-in

continued

Tool 1: Guiding Questions for a Community Assessment (*continued*)

FOCUS & GUIDING QUESTIONS	
Potential Impact	
» How can we have the largest potential impact on decreasing opioid overdose deaths in the community?	
» Who is overdosing (e.g., age, race/ethnicity)?	
» Where are overdoses occurring (e.g., which neighborhoods)?	
» In what settings are people overdosing (e.g., shelters, public restrooms, motels, residential settings)?	
Information sources: » Public health department surveillance data on overdose and overdose fatalities: NEMSIS nonfatal overdose dashboard » Mortality data from the coroner/medical examiner's office » 911 call records and 311 data from emergency medical services (EMS)	» Hospital emergency department (ED) data » Police reports of drug arrests » Local drug treatment centers » Harm reduction agencies » State level: NVSS Provisional Drug Overdose Death Counts

continued

Tool 1: Guiding Questions for a Community Assessment (*continued*)

FOCUS & GUIDING QUESTIONS
Sustainability
» What is the plan for sustainability?
» How will success be measured?
» What is the goal timeline for evaluation?
» What populations are underserved?
Information sources: » Available funding opportunities, including grants and opioid settlement funds » Potential evaluation strategies

When implementing the Communities That HEAL (CTH) intervention, research sites engaged communities in EBP strategy selection and implementation through coalitions. Coalitions followed a **phased intervention process** that included conducting community assessments and identifying priority populations and settings for EBP strategies).[2] Additional resources related to community engagement, the phased intervention process, and EBP implementation will be added to the dissemination website as the study winds down.

Identify Priority Populations

To have the biggest impact on opioid overdose deaths, EBP strategies must **reach people who are most at risk of overdose**. This step should not be connected to any criminal legal purpose; this should be emphasized when working with community members and partner organizations, including law enforcement.

Once priority populations are identified, you can select strategies that are most likely to reach priority populations. For example, if community data show that younger people who inject drugs make up most opioid overdose–related deaths in your community, you may consider working with harm reduction agencies to reach this priority population.

When identifying priority populations, consider groups at higher risk of opioid overdose, groups experiencing health inequities, and groups that face racism and discrimination in addition to stigma associated with drug use.

Higher risk populations include people who:

- have had a prior opioid overdose;
- have reduced opioid tolerance (e.g., from completing medically supervised or socially managed withdrawal or upon release from institutional setting such as jail, residential treatment, or hospital);
- use other substances (e.g., alcohol, benzodiazepines, cocaine, or amphetamine-like substances);
- have OUD and major mental illness (e.g., major depression, bipolar disorder, schizophrenia, anxiety disorders);
- have OUD and major medical illness (e.g., cirrhosis, chronic renal insufficiency, chronic obstructive pulmonary disease, asthma, sleep apnea, congestive heart failure; infections related to drug use); or
- inject drugs.

To promote health equity, it is critical to identify and work to reach populations that experience disparities in OUD services and outcomes. Underserved communities have been and remain disproportionately affected by opioid overdose and premature mortality because of substance use, exclusion from access to high-quality care, and criminalization. It is of added importance to tailor strategies with **cultural humility to address racial and ethnic inequities** Some best practice tools for integrating equity into strategy selection and implementation include the following:

- The Opioid Crisis and the Black/African American Population: An Urgent Issue
- Racial Equity and Social Justice Process Guide
- Equitable Hiring Tool
- Fast Track Equity Analysis Tool
- Comprehensive Equity Analysis Tool

Be mindful of intersectionality when identifying groups and tailor strategies to better reach them. Intersectionality impacts people who use substances and have multiple other parts of their identity that are stigmatized. This can lead to compounded challenges in protecting oneself and barriers to accessing and staying in care. Consideration and assessment of the impact on health outcomes for these people is warranted.

Although these special populations may not be specifically prioritized, and technical guidance unique to their identities may be unavailable, **acknowledging membership in these special groups and the discrimination and unique challenges they face** can help to ensure that interventions and programs are inclusive and more equitable. These populations include the following:

- Adolescents
- Pregnant and postpartum women
- People without stable housing, rural populations without transportation, and other populations impacted by factors related to poverty
- Veterans
- Non–English-speaking populations and immigrants
- People with mental health disorders and mental/physical disabilities
- People who use multiple substances
- People involved in transactional sex
- People who have chronic pain
- People who are lesbian, gay, bisexual, transgender, or queer (LGBTQI+)

Approaches to identify higher risk populations

Higher risk populations can be identified through

1. screening in settings where higher risk people seek services,
2. conducting outreach, or
3. using surveillance and other data sources.

Screening in priority settings. Priority settings include SSPs, EDs, hotlines, first responder stations, and other settings (full list in the Prioritize Settings section). People accessing these services can be screened using existing tools (see box to the right). Note that screening within service venues identifies higher risk people who initiate contact with a service venue and self-report their risk. It will *not* identify higher risk people who are not connected to a venue where screening occurs or do not disclose their risk. Outreach is recommended to identify these people.

Potential screening criteria:

Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

Single-item Drug Screening Question

TAPS Tool (Tobacco, Alcohol, Prescription Medication and Other Substance Use)

Rapid Opioid dependency screen (RODS)

Brief Screener for Tobacco, Alcohol, and other Drugs (BSTAD)

Outreach and identification within field settings. Outreach can be used to identify people who do not attend a service venue or who may not disclose their risk, for example, using peer support workers for outreach in neighborhood hotspots to identify people with OUD, post-overdose public health outreach,[4] or mobile vans.[6]

Surveillance systems and other data sources. Another way to identify people who do not initiate contact at priority settings or self-disclose risk is to use surveillance and other data sources. Rapid and proactive use of existing data can also be used to detect overdose "outbreaks." Potential data sources include medical records to identify frequent users of specific health services, substance use treatment records, or records of people with criminal legal system involvement. Please note that using nonfatal overdose records (911 calls/EMS; 311 calls, ED records) and records of people having called hotlines to conduct outreach can have a paradoxical effect (see below), and use of 911 records is *not* a recommended approach.

Approaches and field settings for outreach

- Peers and social networks
- Family members
- Community outreach events
- Mobile vans[5]
- Drug checking
- Media outlets (awareness campaigns)
- Local business leaders
- Barbershops and hair salons
- Elected officials
- Libraries
- Colleges, universities, and trade schools
- Religious organizations and houses of worship

Efforts to identify and reach out to high-risk people should be mindful of the stigma and barriers that many face when seeking care or self-identifying as a person who uses opioids. Guidance on how to conduct post-overdose outreach and follow-up is shared in this SAMHSA guide, which states: "*Visits rest on a foundation of consent and respect for privacy and confidentiality. Outreach teams that include law enforcement should make every attempt to minimize fear of arrest.*" Identification efforts can have the paradoxical effect of making people less likely to seek care if respect for people who use opioids is not considered.

For example, using 911 call records[7] to identify people at higher risk often furthers suspicion of authorities and can lead to people being less willing to call 911 in the future. Therefore, use of 911 record data is not recommended for outreach purposes. Using records of people who have recently discontinued substance use treatment may lead to distrust in the medical system. Working with PWLE in your community can help ensure that the methods of identification and outreach are conducted in a way that engages and empowers those you are seeking to help.

Implementation resources for identifying people at higher risk of opioid overdose

- Screening for Drug Use in General Medical Settings: This NIH toolkit provides guidance on screening for drug use.
- Guide to Developing and Managing Syringe Access Programs: This is a 92-page manual from the Harm Reduction Coalition that describes the process of implementing a Syringe Access Program.
- SAMHSA "Now What? The Role of Prevention Following a Nonfatal Opioid Overdose": This is a 9-page document that describes ED screening and engaging with people following nonfatal overdose.

Prioritize Settings

Based on what you learned from the community assessment, identify priority settings for implementing EBP strategies. Also, consider which settings have the highest potential for reaching priority population groups. In the CTH, communities worked to implement EBP strategies in multiple settings across four sectors: behavioral health, healthcare, the criminal legal system, and the community (**Tool 2**).

Tool 2: Potential Settings for Strategy Implementation

SECTION	SETTING
Behavioral Health	» Syringe service programs » Addiction treatment and recovery facilities » Mental/behavioral health treatment facilities » Homeless shelters » Recovery housing » Department of Community-Based Services » Domestic violence programs
Health Care	» Emergency department » Health department » Pharmacy » Inpatient service » Outpatient clinics » Ambulatory surgery » Dental clinics

continued

SECTION	SETTING
Criminal Legal	» Jails » Community Supervision programs » First responder stations » Pretrial services » Drug courts or other specialty courts
Community	» Media outlets » Chamber of Commerce » Barbershops and hair salons » Libraries » Colleges, universities, and trade schools » Religious organizations and houses of worship » Restaurants/bars » Gas stations

Implementation resources for prioritizing settings

- Position Paper on Community Strategies for Post Opioid Overdose Interventions: This is a 15-page paper written by the New York State Department of Health detailing the development of a Post Opioid Overdose outreach program. It features information about the creation of an outreach team, how to share information, legal issues, and how to conduct a post-overdose outreach visit and program evaluation.
- Kraft Center for Community Health Mobile Addiction Services Toolkit: This toolkit provides a comprehensive overview of how to launch and operate a mobile addiction program following the Community Care in Reach® model. Included are sample protocols, best practices, and lessons learned.
- Police Assisted and Addiction Recovery Initiative (PAARI): This is a website for law enforcement agencies to develop non-arrest pathways to treatment and recovery. This may be useful for developing programs where people are taken to treatment environments rather than being arrested.

Selecting Strategies

Strategy selection and implementation should be tailored to the needs and assets of your community, be informed by local experts (including PWLE), and focus on priority populations and settings. To select EBP strategies, decision-making approaches like a Strengths, Weaknesses, Opportunities, and Threats analysis; developing SMART goals; or other decision-making tools can be helpful. Several example tools developed by sites implementing the CTH intervention are included in **Appendix A**. In general, EBPs that are both high impact and highly feasible should have top priority for selection.

Discussion Guide for Community Leaders: Preventing Opioid Overdose Deaths in Your Community

Prompt: Brainstorm! Think about your community: what you've experienced, what you have learned from your community, and what you envision for the future. Answer the questions below and jot down your thoughts.

Instructions: The following interactive worksheet can be used to answer questions regarding your community. You must save the file to your computer first and then fill it out. Do not complete the form within your web browser or your data will not be saved.

What are we doing well?

What could we do better?

What are our priority populations?

Where can we best engage our priority populations?

Increasing Opioid Overdose Prevention Education and Naloxone Distribution (OEND)

What OEND services already exist?

Who needs OEND in our community?

Where in our community should OEND services be provided?

Community OEND Goals:

1.

2.

3.

4.

continued

Discussion Guide for Community Leaders: Preventing Opioid Overdose Deaths in Your Community (continued)
Enhancing Delivery of Medication for Opioid Use Disorder (MOUD)
What are we doing well regarding MOUD provision?
What MOUD services already exist?
What are the gaps in MOUD care in our community?
Where in our community should MOUD services be expanded?
Where in our community can we reach people with OUD who are not receiving MOUD?
What services does our community need to engage people more effectively in and support people in treatment for OUD?
Community MOUD Goals:
1.
2.
3.
4.

continued

Discussion Guide for Community Leaders: Preventing Opioid Overdose Deaths in Your Community (continued)
Improving Prescription Opioid Safety
What are we doing well in terms of prescription opioid safety?
What prescription opioid safety concerns does our community have?
Who in our community needs to be engaged to improve prescription opioid safety (e.g. organizations, provider specialties, patient groups)?
Community Prescription Opioid Safety Goals:
1.
2.
3.
4.

4. Evidence-based Strategies to Increase Opioid Overdose Prevention Education and Naloxone Distribution

RATIONALE

Naloxone administration reverses an opioid overdose if administered in time. Naloxone is a medication that can be given as a nasal spray (Narcan®) or injected into the muscle, under the skin, or into the veins. Opioid overdose death is unlikely when another person is present and equipped with naloxone. Overdose prevention education is typically coupled with naloxone distribution and includes clear, direct messages about how to prevent opioid overdose in the first place and rescue a person who is overdosing. Opioid overdose prevention education and naloxone distribution (OEND) empowers trainees to respond to overdoses and can be successfully implemented at multiple venues among diverse populations. Community-level implementation of OEND directly to people who use drugs (PWUD) has been associated with reduced community-level opioid overdose mortality.

On March 29, 2023, the U.S. Food and Drug Administration (FDA) approved Narcan (nasal spray) for over-the-counter, nonprescription use.[8] This allows Narcan to be sold directly to consumers in drug stores, convenience stores, groceries, gas stations, and online. However, the retail cost of over-the-counter Narcan will likely be too expensive for many people at higher risk for opioid overdose.[9] Therefore, community distribution of naloxone directly to PWUD at no cost is a central component to an evidence-based response to the opioid crisis.

Goals: The OEND menu is designed to increase the number of:

1. Naloxone doses distributed
2. Overdose events where naloxone is administered
3. Opioid overdose prevention education programs

Active OEND

Active OEND is proactive distribution of overdose prevention and response education and naloxone rescue kits to **higher risk populations and their social networks (Tool 3)**. Examples of an active OEND program include distribution of naloxone through peers (people with lived experience from the community), providing naloxone kits to people upon release from a correctional facility, and first responders leaving behind a naloxone kit when responding to an emergency call related to an opioid overdose. Active OEND programs can be tailored to priority populations or located at venues where higher risk populations are likely to be engaged.

Overdose Education and Naloxone Distribution Outreach Manual

HCS-KY staff at the State Capitol for Overdose Awareness Day in Franklin County, Kentucky

This manual provides a blueprint for sustaining or launching successful OEND outreach programs based on lessons learned from the HEALing Communities Study in Kentucky.

Among its many features are venue outreach and scheduling ideas, a supply checklist, and a breakdown of program costs.

You can download the manual from this website: https://fw.uky.edu/HEALKYResources

Peer-reviewed literature to support OEND strategies

Key messages

- Naloxone administration by bystanders during an overdose significantly increases the odds of survival compared with no naloxone administration (Giglio et al.)
- Communities with enrollment in OEND programs distributing directly to PWUD had lower rates of opioid overdose deaths (Naumann et al., Walley et al.)

Key citations

- Giglio RE, Li G, DiMaggio CJ. Effectiveness of bystander naloxone administration and overdose education programs: a meta-analysis. Injury Epidemiology. 2015 Dec; 2:1-9.
- Naumann RB, Durrance CP, Ranapurwala SI, Austin AE, Proescholdbell S, Childs R, Marshall SW, Kansagra S, Shanahan ME. Impact of a community-based naloxone distribution program on opioid overdose death rates. Drug and Alcohol Dependence. 2019 Nov 1; 204:107536.
- Walley AY, Xuan Z, Hackman HH, Quinn E, Doe-Simkins M, Sorensen-Alawad A, Ruiz S, Ozonoff A. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. BMJ. 2013 Jan 31; 346.

OEND History and Harm Reduction

1961

Created in 1961, naloxone hydrochloride (naloxone) was approved by FDA to reverse opioid overdose.

1990s

Through the 1990s, naloxone was used exclusively by medical personnel in hospital settings.

1996

In 1996, the Chicago Recovery Alliance began distributing naloxone to people who used syringe services, beginning the world's first coordinated naloxone distribution program.

1996–present

Since then naloxone distribution has been a cornerstone of harm reduction, and people have reported using naloxone to revive friends, peers, partners, bystanders, neighbors, and family members.

Source: https://remedyallianceftp.org/pages/history

Multiple sequential doses of naloxone are more likely to be needed because of synthetic opioids: Many overdose reversals now require more than two doses of naloxone to reverse the overdose. During training, provide information on how circumstances surrounding the overdose can impact the way people respond to naloxone and that multiple doses may be necessary. Guidance should be to wait 2–3 minutes between administrations and that people can continue administering every 2–3 minutes until they run out of naloxone, the person becomes responsive, or EMS arrives.

This increased need also has implications on the frequency that naloxone will need to be restocked and the number of kits distributed per person.[10; 11]

Tool 3: Active OEND Strategies

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Active OEND for higher risk people and their social networks	• Are there existing programs in your community that could offer naloxone but don't? • Do the criminal legal venues in your community offer OEND? • What program or person could deliver OEND programming?	• **Identify gaps** in overdose prevention education programs that incorporate naloxone distribution • **Identify organizations to deliver the program** (e.g., community health educators, pharmacists, first responders), provide training on delivery of identified prevention program • **Implement** an overdose prevention education program	• Number of naloxone units distributed in communities through venues or community organizations • Number of jails providing OEND	• Criminal legal venues (jails, prisons, etc.) • Contacts within service venues • Public health department • Community organizations distributing naloxone

Implementation resources for active OEND strategies by priority setting	
Criminal legal settings	» Overdose Prevention in Community Corrections: An Environmental Scan: A 49-page toolkit developed by the National Council for Mental Wellbeing. The toolkit explores information regarding recovery-led practices for people under supervision of community corrections agencies.
Syringe Service Programs	» Harm Reduction Coalition Guide to Developing and Managing Syringe Access Programs: A five-module manual broken down into planning and design, key operational concerns, organizational considerations, external issues, and population-specific considerations. » Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation: A 33-page technical package of strategies to develop and implement SSPs. The document is for use by health departments, community-based organizations, and diverse stakeholders.

continued

Tool 3: Active OEND Strategies (continued)

Implementation resources for active OEND strategies by priority setting	
ED or acute care settings	» Prescribe to Prevent page for Emergency Medicine Providers: Includes sample ED policies and guidance.
"Leave-behind" programs at sites of overdose	» No toolkits currently available; refer to case example at the end of the chapter for details on how one community implemented a leave-behind program. » Research articles: • A scoping review of post opioid-overdose interventions • Post opioid overdose outreach by public health and public safety agencies: Exploration of emerging programs in Massachusetts » Example Leave Behind Protocol for EMS
Primary care, pain management, mental health, and addiction treatment settings	» Prescribe to Prevent page for Primary, Chronic Pain, and Palliative Care: Includes clinician guidance, materials to support naloxone prescribing, and opioid safety materials. » MA Practice Guidance for Integrating Overdose Prevention into Addiction Treatment: Outlines guidance for implementing opioid overdose prevention strategies into addiction treatment. The document should be used in addiction treatment centers and outlines how centers may update policy, change operations, training, and delivery to patients.

Passive OEND

Passive OEND is overdose prevention and response education and naloxone rescue kit distribution to **people referred by other care providers or for those seeking OEND on their own (Tool 4)**. Examples of a referral would be giving a prescription for naloxone to a higher risk person to pick up at a pharmacy or at a community OEND program. Examples of facilitating naloxone distribution include pharmacy standing order programs and community meetings that distribute naloxone rescue kits to people who ask for them.

Passive OEND **also includes programs that make naloxone publicly available for emergency use** in overdose hotspots where overdoses commonly occur, such as public restrooms and addiction treatment programs.

Naloxone administration includes opioid overdose response and rescue by first responders, such as **police, fire, and emergency medical technicians**.

Tool 4: Passive OEND Strategies

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
OEND by referral (e.g., prescription refill at a pharmacy, OEND dispensing program)	• What pharmacies stock naloxone? • What pharmacies don't stock naloxone? • What barriers exist for accessing naloxone at pharmacies? • How to best facilitate the prescription and dispensation of naloxone by providers (e.g. co-prescribing mandates, insurance and copay support and opt-out offers by pharmacists)? • Who can provide education to prescribers on naloxone?	• **Identify pharmacies** with/without naloxone in stock • **Advocate** with state boards of pharmacy to support stocking of naloxone • **Educate prescribers** to prescribe naloxone • **Facilitate** access to prescription naloxone at pharmacies • **Develop and implement** proactive prescribing and dispensing (e.g., co-prescribing mandates, insurance and copay support and opt-out offers by pharmacists) of naloxone among prescribers and pharmacies	• Number of naloxone units distributed in communities through pharmacies	• Pharmacies • Addiction treatment and recovery facilities
OEND by self-request (e.g., at pharmacy, community meetings, or public health department)	• What venues stock naloxone? • What venues don't stock naloxone? • What venues have standing naloxone protocols? • Who can provide naloxone guidance to venues?	• **Identify venues** with and without naloxone available • **Identify venues** with and without standing naloxone protocols • **Provide trainings and increase access** to naloxone at venues	• Number of naloxone units distributed in communities through pharmacies • Number of naloxone units distributed in communities total	• Pharmacies • Addiction treatment and recovery facilities • Community organizations
Naloxone availability for immediate use in overdose hotspots	• Where should naloxone be readily accessible (e.g., locations based on geographic analysis of population density or overdose frequency from local overdose data)? • What protocols need to be in place (e.g., naloxone monitoring and restocking protocols and agreements)?	• **Identify candidate locations** (e.g., based on geographic analysis of population density or overdose frequency) • **Establish** naloxone monitoring and restocking protocols, and agreements • **Secure** naloxone storage boxes • **Implement** naloxone storage container placement, monitoring, and restocking protocol	• Number of locations with naloxone readily available	• Contacts within service venues • Public health department

continued

Tool 4: Passive OEND Strategies (continued)

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Naloxone administration (e.g., increasing first responder administration)	• What are the reported barriers to first responder administration of naloxone in your community? • What protocols are needed to improve first responder administration (e.g., implementation strategy, evaluation measures, procedures)? • Who can provide trainings to first responders?	• **Identify gaps in access** to naloxone and develop protocol including implementation strategy and evaluation measures/procedures • **Provide training** to first responders (as necessary) • **Implement** first responders naloxone program	• Number of emergency medical services (EMS) naloxone administration events • Number of EMS runs for opioid-related incidents/overdoses	• 911 call records and 311 data from EMS • Hospital ED data

Implementation resources for passive OEND strategies by strategy

OEND by referral (e.g., prescription refill at a pharmacy, OEND dispensing program)	» Prescribe to Prevent: Information to prescribe and dispense naloxone (Narcan) rescue kits. Created by prescribers, pharmacists, public health workers, lawyers, and researchers working on overdose prevention and naloxone access. There are links to training materials, overdose prevention and response videos, online training modules, and a research blog that includes updated data summaries of naloxone-related studies. » Prevent & Protect (Agency Outreach): A resource kit that aims to support pharmacists support to expand access to naloxone. Includes a guide to help organizations (e.g., local pharmacy, clinic, substance use disorder (SUD) treatment program, shelter) establish a naloxone standing orders. » Promoting the Importance of Naloxone: Centers for Disease Control and Prevention (CDC) webpage providing links to training, mini modules, interactive patient cases and factsheets for clinicians, health care administrators, family members, caregivers, and pharmacists.
OEND by self-request (e.g., at pharmacy, community meetings, or public health department)	» GetNaloxoneNow: The website includes links and resources regarding drug use, treatment, and ways to obtain naloxone and training for both bystanders and first responders. Community members may complete the Opioid Overdose Prevention, Recognition, and Response Bystander Module. The module is 56 slides and takes approximately 20–30 minutes to complete. The module reviews opioid overdose recognition and opioid overdose response. There is a certificate available for download for a $10 donation. » NEXT Naloxone: An online opioid overdose responder training site that includes mail-based naloxone distribution at no cost to PWUD or people most likely to be first responders in an opioid overdose incident. It has state-specific resource pages with information on how to obtain naloxone locally.

continued

Tool 4: Passive OEND Strategies (continued)

Implementation resources for passive OEND strategies by strategy	
Naloxone availability for immediate use in overdose hotspots	» Prevent & Protect Safety Policy: Page that includes sample policies for staff training and onsite overdose response management.
Naloxone administration (e.g., increasing first responder administration)	» SAMHSA: Opioid Overdose Prevention Toolkit: Five Essential Steps for First Responders: This document outlines the recommended steps first responders can take during an opioid overdose emergency. It can be used for talking points with first responders. » GetNaloxoneNow: See description above.

Cost Considerations and Resources

The cost of implementing OEND strategies is often reported as a barrier by communities interested in expanding access to naloxone. **Tool 5** presents estimated costs for one-time startup costs and ongoing operating costs from a study by Behrends et al. (2022)[12] using 2017–2019 data from programs in New York City. Startup costs included training sessions for staff, developing training materials, and developing an inventory database. Note that these costs exclude naloxone kits (which typically cost $20–$60) and overhead costs (equipment, supplies, consultants, and administrative support).

Research is currently underway to estimate costs associated with specific OEND strategies to enhance MOUD delivery (e.g., EMS leave-behind) implemented in communities implementing the CTH. These studies will be shared (https://hcs.rti.org) over the coming months.

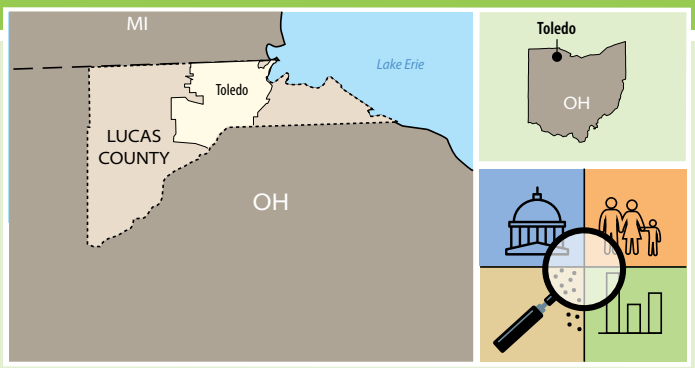
Tool 5: Reported Costs of OEND Programs[25]

Strategy	One-time startup costs (median cost in US$)	Ongoing operating costs (median cost in US$)	Median number of kits distributed per month (range)
Syringe service program (SSP)	$1,024 (range: $522–$5,481)	$1,579 per month	80 (27–187)
Non-SSP with multiple sites (large healthcare systems)	$7,635 ($2,600–$76,858)	$1,959 per month	52 (13–58)
Non-SSP with a single site (including substance use treatment programs, community health centers, other community-based organizations)	$2,403 ($821–$3,800)	$2,737 per month	89 (37–196)

The estimated median cost per unit dispensed was $25 for SSP-based programs and $43 for non-SSP programs, including overhead costs. Costs varied by program and the number of sites. Authors note that startup costs could be reduced by providing virtual or onsite trainings. The following resources may be helpful in informing cost estimates for OEND strategy implementation (**Tool 6**).

Tool 6: Cost Considerations and Resources for OEND Strategy Implementation

Cost consideration	Resource
Free or low-cost source of naloxone for harm reduction programs	» Remedy Alliance/For the People: Buyer's club for harm reduction service programs. Programs can complete an application to receive access to a catalog and have naloxone shipped directly to the program, if eligible.
Free or low-cost OEND training	» Prescribe to Prevent: Includes links to training materials, overdose prevention and response videos, online training modules, and a research blog that includes updated data summaries of naloxone-related studies. » Prevent & Protect (Agency Outreach): A resource kit that aims to support pharmacists to expand access to naloxone. Includes a guide to help organizations (e.g., local pharmacy, clinic, SUD treatment program, shelter) establish a naloxone standing orders.
NaloxBox cost	» $200-$400 per unit, https://naloxbox.org/collections/all » NaloxBoxes are only one option—there may be other, more affordable, options available.
Naloxone vending machine cost	» ~$13,000 » Similar in size and design to snack vending machines, a naloxone vending machine enables people to acquire naloxone anonymously and free of charge.



STORIES FROM THE FIELD

Providing community members with naloxone via EMS Leave-Behind programs

LUCAS COUNTY, OHIO

COMMUNITY PROFILE

Lucas County, Ohio, and the Opioid Crisis

Lucas County, in the northwest corner of the state, experienced 296 deaths from opioid-related overdoses in 2020. This is a 12% increase from the previous year, according to the county coroner's toxicology lab. There were 2,800 opioid overdose Emergency Medical Services (EMS) runs in 2021 alone.[13]

This spike was largely attributed to the COVID-19 crisis. According to the Centers for Disease Control and Prevention, US drug overdose deaths increased from 17,415 in 2000 to 72,151 in 2019 to 100,306 in 2021 (a 39% increase from 2019).[14]

Authors: Jennifer L. Brown, PhD, Department of Psychological Sciences, Purdue University and Jason T. McMullan, MD, Department of Emergency Medicine, University of Cincinnati College of Medicine

EMERGENCY MEDICAL SERVICES AGENCIES

The EMS agencies of Toledo, Ohio, the largest city in Lucas County and fourth largest in the state, frequently respond to 911 calls for opioid overdose or other conditions affecting people with opioid use disorder.

EMS plays an integral role in overdose care. For example, patients who refuse transport to a hospital, which is common, are at much greater risk of a subsequent nonfatal overdose.

Lucas County EMS Leave-Behind Program

Community coalitions in Ohio working to address the opioid crisis identified 22 agencies in six counties, both urban and rural, that had the desire and need for the EMS naloxone leave-behind intervention. Lucas County was identified as one of these counties.

Challenge: Individuals who overdose often are treated at the site of the overdose but are not transported to the hospital

Nontransport to the hospital prevents any emergency-department-based efforts, such as Overdose Education and Naloxone Distribution (OEND), medication for opioid use disorder (MOUD), or linkage to care. Consequently, individuals would benefit from receiving naloxone, even if not transported for hospital-based care, by keeping them alive in case of a subsequent overdose and allowing for the future possibility of MOUD and linkage to care.

Strategy Approach:

Lucas County's EMS Leave-Behind programs were modeled after the successful 2015 launch of the Colerain Township Quick Response Team in Hamilton County, Ohio. This was an EMS leave-behind and linkage-to-care initiative, which resulted in a 42% decrease in EMS overdose calls between 2017 and 2019.

The Colerain Township Assistant Fire Chief/EMS Leave-Behind Coordinator, Chief Will Mueller, who championed those efforts, subsequently provided invaluable expertise to Lucas County to develop and implement their own naloxone leave-behind programs.

The Toledo Fire & Rescue Department (TFRD) partnered with the Lucas County Health Department to develop a protocol and implement procedures for leaving naloxone with individuals who are at risk, particularly when

not transported to an emergency department for further care. Additionally, the initiative worked to streamline data collection to better inform accurate and timely reporting of overdose information and naloxone distribution.

A consistent, free supply of naloxone is provided by the Health Department through Project DAWN (Deaths Avoided With Naloxone), an Ohio Department of Health initiative that ensures naloxone availability across the state.

As a result, in June 2020, TFRD personnel arriving on the scene of an overdose began to "leave behind" intranasal naloxone with individuals who sign an Against Medical Advice order after an overdose reversal. Fire crews that reverse an opioid overdose with naloxone also educate the person or family/friends and provide educational materials about caring for someone who is experiencing an opioid overdose.

According to the State of Ohio Board of Pharmacy Protocol, from August 5, 2022, Ohio EMS agencies are permitted to personally furnish naloxone under Ohio law to any of the following:

1. An individual who there is reason to believe is experiencing or at risk of experiencing an opioid-related overdose.
2. A family member, friend, or other person in a position to assist an individual who there is reason to believe is at risk of experiencing an opioid-related overdose.

To do this, EMS agencies must adhere to the Board of Pharmacy Protocol, which includes the following:

1. Update the organization's protocol to include the authorization for EMS personnel to personally furnish naloxone (sample protocol: Personally Furnishing Naloxone by Emergency Medical Service Personnel).
2. Comply with Board of Pharmacy labeling requirements.
3. Comply with Board of Pharmacy recordkeeping requirements.

> *That is the selling point. Fifty lives have been positively impacted by having one of the naloxone kits TFRD handed out.*
>
> —Lieutenant Zakariya Reed, TFRD, EMS Bureau Supervisor

OUTCOMES AND OTHER BENEFITS

In addition to protocol and procedure development, data collection, dissemination guidance, and connection to a sustainable naloxone supply, other EMS agency efforts include staff training assistance, computer tablet purchases for data collection, and IT assistance with ESO (prehospital electronic patient care reporting system) software or ODMAP (Overdose Detection Mapping Application Program) to provide real-time overdose data and allow for targeted interventions.

Two new programs emerged from the TFRD strategy. First, the Toledo Police Department followed TFRD's lead by partnering with the Lucas County Health Department to develop their own naloxone leave-behind program.

Second, TFRD developed a novel program called Medics on Bikes (MOB). The MOB team is used during large-scale, open-air events to provide emergency care and harm reduction to citizens. The smaller vehicles, which include bicycles and an all-terrain vehicle, can maneuver through large crowds to an emergent situation in ways that the typical EMS vehicle cannot. They are equipped with lifesaving equipment and medications and are capable of stabilizing critical patients following an overdose. The MOB team also provides OEND by distributing leave-behind naloxone kits, educational materials, and information about treatment facilities.

TFRD has documented incidents where patients are (almost) alert and oriented by the time EMS arrive on scene.

AS OF MARCH 2023, TFRD HAS DISTRIBUTED

580 kits, with about **50 kits**

being used in the field after repeat overdoses.

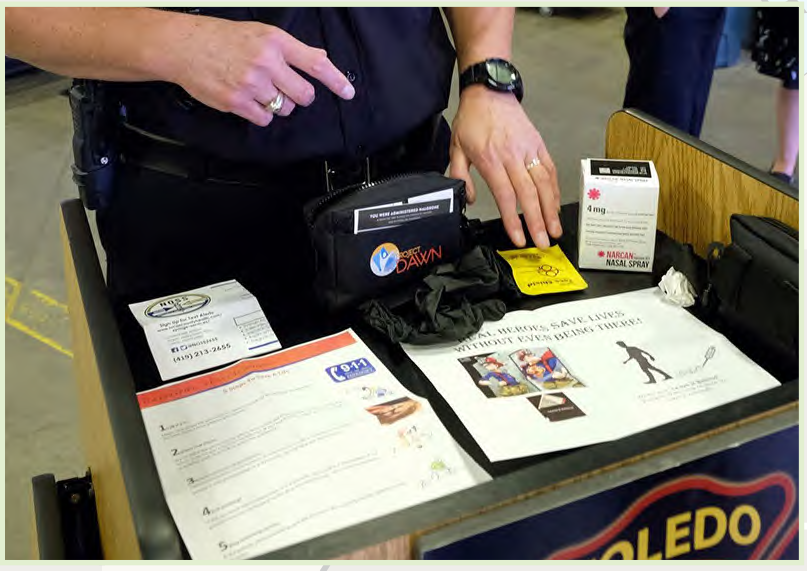
> *One life saved by this simple act [of naloxone leave-behind] is unmeasurable success! A simple idea during the height of COVID has turned into inspiration for fire departments all over the state, and further (Pennsylvania and North Carolina). I am proud of that!*
>
> —Lieutenant Zakariya Reed

Not only do they leave behind naloxone at the site of an overdose, but TFRD has also hosted at least one naloxone giveaway event and participates in other community events when possible, providing naloxone kits, drug deactivation bags to safely dispose of leftover medications, and educational materials to the community.

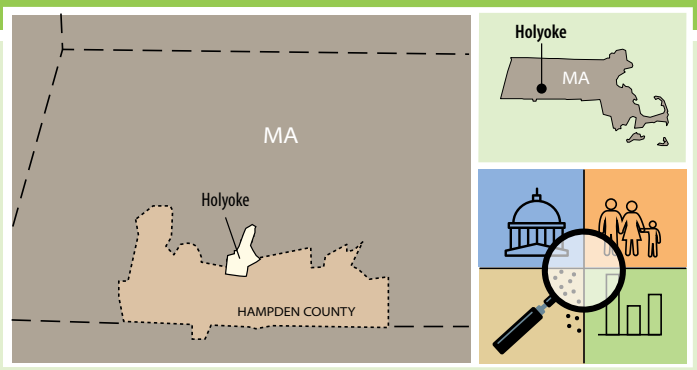
These efforts in Lucas County and other Ohio counties have spread across the state and beyond, into Pennsylvania and North Carolina.

TIPS FOR YOUR COMMUNITY

- Identify a **leave-behind program champion** in a well-respected department/agency.
- Make it simple for the EMS crew, even if it is complicated for administrators. **Use existing processes and technology** as much as possible to limit the barriers to leaving behind naloxone.
- **Initial trainings should be led by the program champion** (can also be co-taught with a physician), but it is useful for agencies to see that it is "their" program.
- **Do not record trainings** because it limits open discussion about stigma that tends to come up.
- Focus the discussion on **stigma during training, toward the end**, after it has naturally come up during training. Helpful resources and guidance can be found in the Anti-Stigma Toolkit: A Guide to Reducing Behavioral Health Disorder Stigma.
- If an agency has staff who are the main point of contact to hand out **naloxone kits**, have the agency leadership/ medical director do **"check ins"** on their well-being because it can be hard for staff to hear the many heartbreaking tales of opioid addiction and its wide-ranging impact on families and communities.



Source: The Blade: Toledo Fire & Rescue announces "Leave It Behind" naloxone program, 9/10/2020



STORIES FROM THE FIELD

Providing cash stipends to peers (people with active drug use) to distribute naloxone and provide harm-reduction services within their social networks

HOLYOKE, MASSACHUSETTS

Holyoke, Massachusetts

Holyoke is a small urban community in Western Massachusetts with an ethnically diverse population of about 38,000. The largest ethnic group in Holyoke is Hispanic (52.25%), including those who identify as White (Hispanic) (38.9%), two or more race categories (Hispanic) (8.24%), and Other (Hispanic) (5.11%). This is followed by White (non-Hispanic) (41.1%) and Black or African American (non-Hispanic) (2.4%). A majority of people who identify as Hispanic are of Puerto Rican descent. In fact, Holyoke has the largest number of Puerto Rican residents per capita in the continental United States. However, only 5.8% of Holyoke's population is foreign born.[15]

As of 2020, 78.4% of Holyoke residents were high school graduates or greater, 54.7% were employed in the civilian workforce, and 96.4% had health insurance coverage. The median income is $45,045, with 26.5% of residents living at or below the poverty level.[15]

Author: Erin Gibson, MPH, Associate Director of Research Operations, MA-HCS

RATE OF FATAL OPIOID OVERDOSES

From 2018 to 2021, the rate of fatal opioid overdose among Holyoke residents aged 18 or older increased 71.5%, from 45.6 to 78.2 per 100,000 residents. However, the change in the overdose death rate in Holyoke varied by race and ethnicity. Among Hispanic/Latino residents 18 years or older, the opioid overdose death rate increased 249.8%, from 27.3 to 95.5 deaths per 100,000 residents. Meanwhile, both the non-Hispanic Black and non-Hispanic White populations' rates remained the same at 225.5 deaths per 100,000 residents and 54.9 deaths per 100,000 residents, respectively.[16]

HOLYOKE COMMUNITY COALITION

Our coalition in Holyoke engaged in a data-driven decision-making process to assess existing resources and gaps in regard to reducing opioid-related overdose, including community naloxone distribution.

Challenge: How to increase naloxone distribution to people who use drugs (PWUD) not reached by current street outreach efforts

As a result of this approach, our priority was to increase naloxone distribution to PWUD—specifically to people who do not tend to access services at Tapestry Health, the community's brick-and-mortar Syringe Service Program (SSP), and were not being reached by the existing street outreach efforts. This included people who do not use opioids and might not see themselves as at risk for overdose. However, with the increasing presence of fentanyl and other illicit substances, the coalition made expanding harm-reduction outreach the priority.

Our coalition proposed a peer-based outreach strategy to reach people who

do not access services, especially those who live and use drugs in homeless encampments and who tend to avoid services because of fear and mistrust. The strategy provided weekly cash stipends to peers who were identified as people who use drugs and have access to these hard-to-reach individuals as part of their social network. In Holyoke, the peers included people experiencing homelessness, who did not speak English, or who identified as engaging in transactional sex. The coalition emphasized the importance of providing stipends in the form of cash to fairly compensate peers without stigmatizing constraints (e.g., lack of a bank account and/or identification to be able to cash a check) and to avoid formal contracting, disclosure of a social security number, or criminal offender record information.

Because of its trusted reputation and long history of providing harm-reduction services to the Holyoke community, we selected Tapestry Health to coordinate the program. Tapestry is a state-funded Overdose Education and Naloxone Distribution (OEND) program that receives funding and naloxone at no cost through the Bureau of Substance Addiction Services (BSAS) at the Massachusetts Department of Public Health.

Strategy Approach:
Coalition-driven, peer-based outreach

Tapestry Health invited interested peers to meet one on one with the Harm Reduction Specialist at the brick-and-mortar service location. During this meeting, the Harm Reduction Specialist provided an overview of the program and assessed peers' commitment to the goal of expanding naloxone distribution to people who are at risk and who otherwise might not have access. Originally, peers signed up to distribute naloxone for a 4-week period. However, peer feedback recommended a shift to a 1-week commitment at a time.

- Each Monday, Tapestry Health assigned peer naloxone distribution spots to the first two approved peers to arrive at Tapestry to pick up their five naloxone kits
- At the end of the week, the peers returned to Tapestry to report on their activities and receive the cash stipend of $5 per kit distributed ($25 maximum)
- Tapestry requested that peers report the number of naloxone kits distributed by week, general descriptions of where distribution occurred, and specific information for BSAS reporting

- Peers submitted this information weekly via a paper form prior to receiving their stipend payment
- Peers also shared their observed insights on the successes and challenges, and ideas to expand distribution

To provide multiple peers the opportunity to participate in this program, each peer was limited to 4 consecutive weeks of naloxone distribution, at which point they would give their spot to another peer. However, peers were welcome to reenroll with Tapestry and wait their turn to participate in the program again.

> *It is easier for the peer distributor to engage with a PWUD.*
>
> —Erika Hensel, Harm Reduction Specialist & Peer Naloxone Distribution Program Coordinator at Tapestry Health

PROGRAM COMPONENT	DETAILS
Hosting Syringe Service Program	Tapestry Health
Duration of program funding	March 2021–June 2022 (15 months)
Program Manager	Harm Reduction Specialist
Identification of peers	Preapproved list based on peer interest
Duration of peer participation	4 consecutive weeks, with option to reenroll
Cash compensation per week	Up to $25 cash per peer per week ($5 per naloxone kit distributed)
Supplies distributed	Naloxone kits
Average program cost per month	$219
Total program cost	$3,510

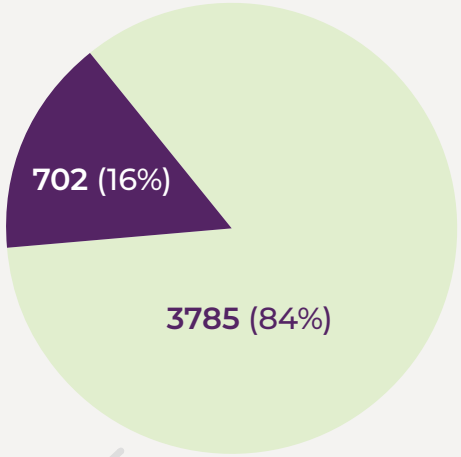
OUTCOMES AND OTHER BENEFITS

Despite staffing and operational challenges posed by COVID-19, Tapestry Health's program to invite peers to distribute naloxone to hard-to-reach individuals who were at high risk engaged an average of five peers per month. The peers' efforts resulted in 702 naloxone kits distributed over 15 months (March 2021–June 2022), equaling 16% of the agency's total naloxone distribution.

Monthly counts of naloxone kit distribution ranged from 10 to 85 kits during this time, with an average of 44 kits per month. Past research in Massachusetts has shown that annual OEND training of >100 potential overdose bystanders per 100,000 residents was associated with a 46% reduction in the opioid overdose death rate compared to communities that did not implement OEND training strategies.

This program achieved a naloxone distribution rate of 109 kits per 100,000 residents, indicating a potential to achieve clinically meaningful reductions in opioid overdose deaths.

Holyoke's Naloxone Distribution, March 2021–June 2022



> *Ninety-five percent of the peer distributors are homeless and I did not want to create further barriers for them. Also, I believe that people should be paid cash for their work, and they did not want a gift card where their earned money was limited.*
>
> —Erika Hensel, Harm Reduction Specialist & Peer Naloxone Distribution Program Coordinator at Tapestry Health

TIPS FOR YOUR COMMUNITY

- **Engaging and providing a stipend for peers** to distribute naloxone and provide other harm reduction services to hard-to-reach populations at high risk in their social network is a feasible, effective, and low-cost approach.
- PWUD have a long history of caring for each other. Given the opportunity, they are willing and uniquely effective at reaching and providing **harm-reduction materials** to their peers at high risk.
- **Cash stipends** provide an accessible, equitably available form of compensation that shows respect for peers' autonomy and unique expertise.
- **Securing long-term funding** for novel naloxone distribution models can be challenging.
- Coalitions seeking funding support for naloxone may **consider collaborating** with local agencies, with OEND programs, and other state funding, such as departments of public health.

Local artwork in Holyoke honoring Tim Purington, public health advocate and a driving force behind harm reduction programs for drug users, such as the first needle exchange program in Western Massachusetts. The mural represents the Holyoke community's strong commitment to harm reduction and care for people who use drugs.

5. Evidence-based Strategies to Enhance Delivery of MOUD Treatment, Including Agonist/Partial Agonist Medication

Rationale

Three medications are approved by the U.S. Food and Drug Administration (FDA) for the treatment of opioid use disorder: methadone (a full *mu* opioid agonist), buprenorphine in several formulations (a partial *mu* opioid agonist), and extended-release naltrexone (a *mu* opioid antagonist). Increasing the number of people with opioid use disorder receiving medication for opioid use disorder (MOUD)-based treatment is at the center of the nation's efforts to address the opioid crisis.

During the COVID-19 pandemic, increased flexibility around MOUD prescribing policies was introduced including telehealth visits to initiate buprenorphine and, for patients in opioid treatment programs, take-home methadone. Despite this increased flexibility, there was no concurrent increase[17] in the proportion of overdose deaths involving buprenorphine or methadone.[18]

Peer-reviewed literature to support MOUD strategies

Key messages

- Methadone and buprenorphine reduced overdose and opioid-related morbidity compared to other OUD treatment modalities (Wakeman et al.)
- Use of methadone and buprenorphine increases retention in treatment and saves lives (LaRochelle et al.; Sordo et al.)
- MOUD decreases opioid use and crime (Bukten at al., Marsh et al., Molero et al.)

Key citations

- Bukten A, Skurtveit S, Gossop M, Waal H, Stangeland P, Havnes I, Clausen T. Engagement with opioid maintenance treatment and reductions in crime: a longitudinal national cohort study. Addiction. 2012 Feb;107(2):393-9.

Considering this evidence and other support for more equitable and low-barrier access MOUD treatment, the federal requirement for prescribers of buprenorphine to have a Drug Addiction Treatment Act waiver (also referred to as the "X-waiver") was removed as of January 2023.[19] Therefore, many more health care providers can now prescribe MOUD. However, significant barriers including lack of awareness, financial constraints, and lack of training have limited the potential impact of this action.[20] In addition, some health care providers and pharmacists hold stigmatizing beliefs around MOUD treatment. People interested in MOUD treatment may have difficulty finding a nonstigmatizing provider or a pharmacy that is willing to fill a prescription for MOUD. Incorporating anti-stigma training and increasing knowledge around the efficacy and purpose of MOUD treatment within provider and pharmacist educational content can help address these barriers.

In summary, strategies to expand MOUD treatment availability, increase linkage to MOUD treatment programs, and improve MOUD treatment engagement and retention can significantly reduce the risk of opioid overdose death.

Goals: The MOUD menu is designed to increase:

1. The number of new settings and opportunities for implementing and expanding MOUD
2. The number of settings expanding MOUD
3. The number of people receiving MOUD
4. MOUD retention rates

- Larochelle MR, Bernson D, Land T, Stopka TJ, Wang N, Xuan Z, Bagley SM, Liebschutz JM, Walley AY. Medication for opioid use disorder after nonfatal opioid overdose and association with mortality: a cohort study. Annals of Internal Medicine. 2018 Aug 7;169(3):137-45.
- Marsch LA. The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behavior and criminality: a meta-analysis. Addiction. 1998 Apr; 93(4):515-32
- Molero Y, Zetterqvist J, Binswanger IA, Hellner C, Larsson H, Fazel S. Medications for alcohol and opioid use disorders and risk of suicidal behavior, accidental overdoses, and crime. American Journal of Psychiatry. 2018 Oct 1;175(10):970-8.
- Sordo L, Barrio G, Bravo MJ, Indave BI, Degenhardt L, Wiessing L, Ferri M, Pastor-Barriuso R. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ. 2017 Apr 26;357.
- Wakeman SE, Larochelle MR, Ameli O, Chaisson CE, McPheeters JT, Crown WH, Azocar F, Sanghavi DM. Comparative effectiveness of different treatment pathways for opioid use disorder. JAMA network open. 2020 Feb 5;3(2):e1920622-.

Expanding MOUD Treatment Availability

Strategies to add or expand MOUD treatment in healthcare settings (e.g., primary care, mental health settings), specialty addiction/substance abuse disorder treatment settings, and criminal legal settings can significantly increase the number of people receiving MOUD (**Tool 7**). Example strategies include the following:

- **Adding or expanding MOUD treatment in healthcare settings** (primary care, behavioral or mental health treatment settings, general medical settings, addiction treatment programs).
- **Adding or expanding MOUD treatment in criminal legal settings** by working with local correctional facilities (e.g., jails, prisons).
- **Expanding access to MOUD treatment** through supporting healthcare providers in their capacity to provide telehealth prescriptions of buprenorphine, interim buprenorphine, or methadone, and through medication units. Please note that interim methadone or interim buprenorphine treatment and medication units are specific to licensed opioid treatment programs (OTPs).
  - **Interim methadone or buprenorphine treatment** at an OTP means that medication (methadone or buprenorphine) is dispensed to patients (*not* prescribed) for up to 120 days without comprehensive ancillary services. Interim treatment can only occur when there are waitlists and must be approved at the state level and by the Substance Abuse and Mental Health Services Administration (SAMHSA). After 120 days of interim treatment, the OTP must transition patients to comprehensive treatment.
  - **Medication units** are ancillary sites associated with a specific OTP where only medication is dispensed and urine is drug-tested.

Don'ts around MOUD prescribing

- **Don't** mandate counseling as a requirement for prescribing MOUD or continuing MOUD treatment (SAMHSA Treatment Improvement Protocol)
- **Don't** require a person to try abstinence-based treatment before prescribing MOUD (SAMHSA Treatment Improvement Protocol)
- **Don't** withhold MOUD from someone because they are also prescribed benzodiazepines (FDA guidance)

MOUD Treatment Guidelines

- SAMHSA Tip 63: Medications for Opioid Use Disorder
- SAMHSA: Clinical Use of Extended-release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide
- A Guide to DEA Narcotic Treatment Program Regulations
- SAMHSA Opioid Response Network

Tool 7: Expanding MOUD Treatment Availability Strategies

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Adding/expanding MOUD treatment in healthcare settings	• Where can people with OUD access MOUD treatment in your community? • What healthcare settings could offer MOUD but don't? • What do these settings require (i.e., trained staff, resources, anti-stigma training) to expand or offer MOUD treatment?	• **Identify barriers and opportunities** for implementing and expanding MOUD • **Identify potential settings** for MOUD integration and expansion • **Train staff** on MOUD • **Implement** an MOUD integration and expansion program	• Number of people receiving MOUD • Number of people receiving buprenorphine for treatment of OUD • Number of people receiving methadone • Number of people receiving naltrexone (injectable, combined injectable/oral) • Number of people with OUD receiving MOUD • Number of providers who prescribe buprenorphine for the treatment of OUD	• Search for providers using SAMHSA Buprenorphine Practitioner Locator • State level: National Survey of Substance Abuse Treatment Services, publicly available • IQVIA data (costs involved) • Electronic health record review from healthcare setting (requires permission/ access)
Adding/expanding MOUD treatment in criminal legal settings	• Can people experiencing incarceration access MOUD within local correctional facilities? • Are there limitations to who can receive treatment (e.g., pregnant women only, people previously prescribed or diagnosed with OUD)? • What would these settings require (i.e., trained staff, resources, anti-stigma training) to expand or offer MOUD treatment? • Are people with OUD linked to MOUD treatment within the community upon release?	• **Identify barriers** and opportunities for implementing or linking to MOUD • **Identify potential settings** for MOUD integration/linkage • **Train staff** on MOUD • **Implement** a MOUD integration and expansion program	• Number of people provided MOUD while incarcerated • Number of jails or prisons that will initiate MOUD treatment (for those who are not prescribed upon entry) • Number of inductions on buprenorphine during incarceration or immediately prior to release • Number of inductions on methadone or immediately prior to release • Number of inductions on naltrexone during incarceration or immediately prior to release • Number of criminal legal settings that link to MOUD upon release • Number of people released from prison and linked to MOUD within 14 or 28 days	• Contacts from local correctional facilities • Program data from linkage programs (if existent)

continued

Tool 7: Expanding MOUD Treatment Availability Strategies (continued)

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Expanding access to MOUD treatment through telemedicine, interim buprenorphine or methadone, or medication units	• Are there licensed opioid treatment programs (primary care or addiction treatment) with waiting lists where interim buprenorphine or methadone or telemedicine could expand access? • Are there programs or regions in your community with geographic barriers indicating that telemedicine or medication units could expand access? • Are providers trained on telemedicine prescription or interim buprenorphine and methadone?	• **Contact** local OTP programs offering to expand access to MOUD • **Train program staff** on procedures required to initiate interim buprenorphine or methadone or telemedicine • **Implement** a program to expand MOUD through interim buprenorphine/ methadone • **Implement** medication units as offshoots of OTPs • **Engage** telemedicine providers to prescribe buprenorphine	• Number of people receiving buprenorphine for treatment of OUD • Number of people receiving methadone	• Electronic health record review from OTP (requires permission/access) • State level: National Survey of Substance Abuse Treatment Services, publicly available • IQVIA data (costs involved)

Implementation resources for strategies expanding MOUD treatment availability by setting

General resources

» Providers Clinical Support System (PCSS) SUD 101 Core Curriculum: For healthcare providers spanning prevention, assessment, and treatment of substance use disorders and co-occurring mental health disorders; includes 22 modules (approximately 1 hour each) with free inter-professional continuing education credits.

» Brandeis Opioid Resource Connector: Helps communities in mounting a comprehensive response to the opioid crisis. It is a product of the Brandeis Opioid Policy Research Collaborative. The site provides a curated collection of community-focused programs, tools, and resources to help stakeholders choose, design, and implement essential interventions.

» AHRQ Six Building Blocks: A Team-Based Approach to Improving Opioid Management in Primary Care: A toolkit for organizations that have already completed opioid management improvement work or intend to engage in a more targeted effort. The website and corresponding materials describe the six building blocks that make up the program and how to implement them in a primary care setting.

» Buprenorphine Quick Start Guide: A six-page checklist for prescribing buprenorphine for OUD.

continued

Tool 7: Expanding MOUD Treatment Availability Strategies (continued)

Implementation resources for strategies expanding MOUD treatment availability by setting	
Primary care settings	» Boston University School of Public Health HRSA Integrating Buprenorphine Treatment for OUD in Primary Care: A 34-page document to aid clinicians who are implementing buprenorphine in a primary care setting. » Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings: This guide provides information to primary care providers and practices on how to implement opioid use disorder treatment using buprenorphine. Specifically, this resource documents step-by-step tactics to support buprenorphine implementation and how to identify and address barriers.
Addiction and recovery treatment programs	» Boston Medical Center OBAT Clinical Guidelines: A 167-page clinical guideline about the Nurse Care Manager Model of Office-Based Addiction Treatment (OBAT), broken into sections including (1) OBAT introduction and team requirements; (2) program requirements; (3) treatment agreement and policies; (4) treatment initiation, stabilization, and maintenance; (5) addressing substance use treatment; and (6) treating specific populations. » OBAT Clinical Tools and Forms (Boston Medical Center): This website offers a listing of various tools for providers in OUD. There are downloadable forms to aid with clinic visit documentation, such as patient forms and short informational videos. » MAT in Residential Treatment Facilities: A toolkit for residential treatment facilities.
Criminal legal settings	» Medication-Assisted Treatment (MAT) for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit: This toolkit, supported by funding from CDC and Bloomberg Philanthropies, provides correctional administrators and healthcare providers recommendations and tools for implementing MOUD in correctional settings and strategies for overcoming challenges. Informed by real-world practice, the toolkit provides examples from the field that can be widely applied and adapted. » Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings: This guide focuses on policies and practices that can be implemented to intervene during a person's time in the correctional system and upon release that moderate and mitigate the risk of overdose for people with OUD after release. This document contains five chapters: a brief of the field, an assessment of current evidence, some examples of MAT in justice settings, a discussion of how to identify and address the challenges of implementing programs in criminal justice settings, and resources to support the use of MAT in criminal justice settings. » Medication for Opioid Use Disorder (MOUD): Correctional Health Implementation Toolkit, August 2022: A 74-page document authored by the New York State Department of Health detailing how to implement an MOUD program in a correctional setting.
Telemedicine	» US Department of Health and Human Services: Telemedicine and Prescribing Buprenorphine for Treatment of OUD: This document discusses the Drug Enforcement Administration (DEA) statement concerning exemption from in-person medical evaluation if engaging the patient in the practice of telemedicine, a case example of effective use of this practice, and links to additional resources about telemedicine and regulations for general telemedicine. » Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders: This guide helps health care providers, systems, and communities support recovery from substance use disorders via employment mechanisms. It describes relevant research, examines emerging and best practices, identifies knowledge gaps and implementation challenges, and offers resources. » Telehealth for Opioid Use Disorder: Guidance to Support High-Quality Care: A 21-page toolkit focusing on real-time videoconferencing, buprenorphine, and adjunctive psychotherapy treatment.

continued

Tool 7: Expanding MOUD Treatment Availability Strategies (continued)

Implementation resources for strategies expanding MOUD treatment availability by setting	
Interim buprenorphine/ methadone	» Federal Guidelines for Opioid Treatment Programs – A 79-page document providing detailed rules, standards, and guidance regarding many facets of treatment for opioid use disorder. Pages 57–58 provide an overview of the rationale, requirements, and regulations governing interim treatment. » Code of Federal Regulations: Opioid Treatment Program Certification – Brief legal document that outlines requirements on how to become certified as a licensed OTP; Item G highlights who you need to contact and how to begin the process to seek approval to dispense buprenorphine or methadone to patients for up to 120 days.
Medication units	» Federal Guidelines for Opioid Treatment Programs – A 79-page document providing detailed rules, standards, and guidance regarding many facets of treatment for opioid use disorder. Pages 12–13 and 66–67 provide a general overview of Medication Units and how a licensed OTP can open one. » Code of Federal Regulations: Opioid Treatment Program Certification – A brief legal document that outlines requirements on how to become certified as a licensed OTP. Item I details how licensed OTPs can establish medication units, including what forms to complete.
Considerations for special populations	» Pregnant women: IHR Maternal Opioid Use During Pregnancy Toolkit » Co-occurring Disorders: – SAMHSA Tip 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders – American Psychological Association: The Opioid Guide » Multiple substances: SAMHSA EBP Guidebook on Treatment of Stimulant Use Disorder » Persons living with HIV: Integrating BUP treatment in HIV primary care settings

Interventions to Link to MOUD

People in need of MOUD are often located in the field or other service settings where MOUD is unavailable. This section outlines the associated resources and toolkits for linking those people to definitive addiction care (**Tool 8)**. The most basic, and least preferred, option is referral only. More advanced linkage support includes formal care coordination, often assisted by peer navigation, peer recovery support services, or provision of bridging MOUD medications in the time window between initial

identification and later engagement in care. Co-locating MOUD within a syringe service program (SSP) or harm reduction agency is another strategy to improve linkage to MOUD for people at higher risk of overdose. Example strategies include the following:

- **Linkage programs** in priority settings (SSPs, harm reduction agencies, emergency departments (EDs), post-overdose, recovery organizations)
- **Bridging MOUD medications** as a linkage adjunct in priority settings

Tool 8: Strategies to Improve Linkage to MOUD

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Linkage programs in priority settings	• What post-overdose outreach currently exists? • How can post-overdose outreach be improved or expanded? • Who can provide trainings on MOUD linkage to community outreach workers (including peers, first responders, law enforcement)? • Do local prisons/jails offer linkage to MOUD treatment following release? • What do these settings require (e.g., trained staff, resources) to offer linkage to MOUD?	• **Identify and engage peers** to be trained in MOUD outreach. • **Develop messaging and referral plan** with trained peer members. • **Implement or enhance** post-overdose outreach programs. • **Establish cross-sectoral communication and collaboration** involving law enforcement, harm reduction services, MOUD providers, and people who use drugs to support post-overdose outreach programs. • **Implement or enhance law enforcement trainings** to prevent adverse encounters and engage at-risk people and deflect them from criminal legal involvement.	• Number of people linked to MOUD following overdose • Number of opioid-related visits following linkage to MOUD post-overdose • Number of jails or prisons that link to MOUD upon release • Number of people released from prison and linked to MOUD within 14 or 28 days • Number of people linked to MOUD following an opioid-related ED visit • Number of people linked to MOUD following an opioid-related ED visit within 30 days • Number of withdrawal programs that initiate MOUD	• Electronic health record review from healthcare setting (requires permission/access) • IQVIA data (costs involved) • Contacts from local correctional facilities • Program data from linkage programs (if existent)

continued

Tool 8: Strategies to Improve Linkage to MOUD (continued)

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Bridging MOUD medications in priority settings	• Where can people quickly start MOUD? • What protocols are in place on quick start and linkage to MOUD treatment in priority settings in your community? • How can linkage to MOUD treatment from EDs or inpatients settings be improved? • Do local prisons/jails offer induction onto MOUD treatment? • What are medication aftercare protocols upon discharge from settings?	• **Develop medication quick start and linkage implementation protocols** (including evaluation measures and plan) • **Train staff** on quick start medication and linkage • **Implement or enhance** quick start medication or linkage program	• Number of people receiving MOUD following opioid-related ED visit • Number of people receiving MOUD during or following opioid-related inpatient stay • Number of jails/prisons that induct MOUD in the month prior to release • Number of jails or prisons that will initiate MOUD treatment (for those who are not prescribed upon entry) • Number of inductions on buprenorphine during incarceration or immediately prior to release • Number of inductions on methadone or immediately prior to release • Number of inductions on naltrexone during incarceration or immediately prior to release • Number of criminal legal settings that link to MOUD upon release • Number of people released from prison and linked to MOUD within 14 or 28 days	• Electronic health record review from health care setting (requires permission/access) • IQVIA data (costs involved) • Contacts from local correctional facilities • Program data from linkage programs (if existent)

continued

Tool 8: Strategies to Improve Linkage to MOUD (continued)

Implementation resources for strategies linking or bridging MOUD treatment by setting	
General overview of linkage programs	» Linking People with Opioid Use Disorder to Medication Treatment: A Technical Package of Policy, Programs, and Practices: Provides guidance for initiating OUD treatment and examples of linkage in primary care, ED, inpatient settings, SSPs, and prenatal and postpartum care. The technical document also includes best practices for linkage to OUD for people with justice-involvement, adolescents, people with past trauma, transgender and gender minority populations, sex workers, and tribal communities and indigenous people. » Police Assisted and Addiction Recovery Initiative (PAARI): This website is for law enforcement agencies to develop non-arrest pathways to treatment and recovery. It describes how PAARI was created in Massachusetts and includes links for technical assistance. » Innovative EMS Response to Overdoses: Beyond Naloxone: A webinar describing the nontraditional role of emergency medical services (EMS) agencies in the opioid epidemic and how Quick Response Teams can add to the care EMS provides and discusses the barriers to implementing these programs.
Bridging MOUD medications: Peer navigators	» PCSS Webinar: Collaboration in Crisis: Utilizing Peer Recovery Coach Support in the ED to Maximize Patient Outcomes: Webinar describing best practices for integrating Peer Support in the ED for Linkage to Treatment.
Bridging MOUD medications: EDs	» Yale School of Emergency Medicine EM: ED-Initiated Buprenorphine: This is a website that can be used for providers who wish to initiate a buprenorphine delivery program in the ED. There is a 43-slide presentation that describes buprenorphine in the ED, the clinical pathway, assessments for screening, interviewing, home induction information and how to set up a buprenorphine program. The website includes example assessments, algorithms for the ED and home induction one-pagers. » PCSS Webinar "Treatment of Opioid Use Disorder in the Emergency Department: Should it be a Choice?": A recorded webinar describing the role of the ED in treating OUD. » FAQ about Buprenorphine in the Emergency Department: Webpage of the Kentucky HEALing Communities Study that provides answers to Frequently Asked Questions about the use of buprenorphine in the ED.
Bridging MOUD medications: Inpatient settings	» CA Bridge: Blueprint for Hospital OUD Treatment: This blueprint provides step-by-step guidance on how to set up a MAT program in an acute care hospital following the CA Bridge model.
Bridging MOUD medications: Home induction	» NIDA Home Induction One-Pager: A one-page guide for reviewing when to start buprenorphine and dosing information for at-home induction.

Strategies to Improve MOUD Treatment Engagement and Retention

This section outlines strategies delivered in conjunction with MOUD to enhance implementation of MOUD and improve retention in care on MOUD (**Tool 9**). These include behavioral interventions such as Motivational Interviewing or Contingency Management, digital (web- or app-based) tools, the care coordination service delivery strategy, treating co-occurring psychiatric disorders, and reducing barriers to essential community resources such as housing, transportation, and childcare.

Tool 9: Strategies to Improve MOUD Treatment Engagement and Retention

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Enhancement of clinical delivery approaches that support engagement and retention	• What are the most reported clinical conditions that impair MOUD engagement and retention (e.g., psychiatric and other comorbidities)? • What clinical delivery approaches, including trauma-informed care, care navigation, case management, transportation and payment programs, and recovery support services, are currently offered in priority settings? • What barriers exist to enhancing clinical delivery approaches? • What approaches are most likely to be successful? • Who can provide trainings on clinical delivery approaches?	• **Identify** barriers and facilitators currently impacting service delivery. • **Develop strategy** to address identified factors impairing treatment retention (e.g., lack of robust recovery support, lack of transportation). • **Implement or enhance** a program to improve engagement and retention.	• Number of people with OUD receiving case management • Number of people with OUD receiving peer support • Number of people receiving buprenorphine for the treatment of OUD retained 6 months following initiation • Number of people receiving methadone retained 6 months following initiation • Number of people receiving naltrexone retained 6 months following initiation • Number of people receiving any MOUD retained 6 months following initiation • Number of person-months actively on MOUD over a set period of time (e.g., 6 months, 1 year)	• Electronic health record review from healthcare setting (requires permission/access) • IQVIA data (costs involved) • Programmatic data from priority setting (e.g., case management services, peer support services)

continued

Tool 9: Strategies to Improve MOUD Treatment Engagement and Retention (continued)

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Use of virtual retention approaches (mobile, web, digital therapeutics)	• What barriers currently exist for following up with patients with OUD who have been lost to care? • Are virtual approaches to enhance retention currently in place? • What would be the most acceptable virtual retention approach for the priority setting? • Who can provide support for developing the virtual retention approach?	• **Identify gaps** in current procedures to facilitate retention. • **Identify** the preferred virtual retention approach to implement. • **Implement** an enhanced virtual retention program.	• Number of people receiving buprenorphine for the treatment of OUD retained 6 months following initiation • Number of people receiving methadone retained 6 months following initiation • Number of people receiving naltrexone retained 6 months following initiation • Number of people receiving any MOUD retained 6 months following initiation • Number of person-months actively on MOUD over a set period of time (e.g., 6 months, 1 year)	• Electronic health record review from healthcare setting (requires permission/access) • IQVIA data (costs involved)
Use care coordinators	• Do priority settings offering MOUD have case management or peer support services available? • If not, what are the perceived barriers to offering case management or peer support? • What resources (trained staff, funding, etc.) are required to improve care coordination?	• **Identify gaps** in care coordination services • **Develop** clinical protocols for retention coordinators and evaluation measures • **Determine strategies** to use retention care coordinator services • **Implement or expand** a retention care coordinator program	• Number of people with OUD receiving case management • Number of people with OUD receiving peer support • Number of people receiving any MOUD retained 6 months following initiation • Number of person-months actively on MOUD over a set period of time (e.g., 6 months, 1 year)	• Programmatic data from priority setting (e.g., case management services, peer support services)

continued

Tool 9: Strategies to Improve MOUD Treatment Engagement and Retention (continued)

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Mental health and polysubstance use treatment integrated into MOUD care	• Do settings offering MOUD integrate mental health or polysubstance treatment into care? • If not, what are the perceived barriers to offering these services? • What resources (trained staff, funding, facilities) are required to offer integrated care? • What is the community capacity for existing mental health and polysubstance treatment providers that can be integrated into the MOUD care providers?	• **Identify gaps** and need to integrate MOUD, mental health, and polysubstance treatment. • **Develop new mental health** and polysubstance abuse treatment services for MOUD providers. • **Train MOUD providers** in integrated care. • **Implement** integrated care.	• Number of people with OUD receiving behavioral health treatment by treatment intensity: inpatient/American Society of Addiction Medicine (ASAM) levels 3-4, intensive outpatient/ level 2, outpatient ASAM level 1 • Number of people with OUD receiving case management • Number of people with OUD receiving peer support • Number of people receiving any MOUD retained 6 months following initiation • Number of person-months actively on MOUD over a set period of time (e.g., 6 months, 1 year)	• Programmatic data from priority setting (e.g., case management services, peer support services) • Electronic health record review from healthcare setting (requires permission/access) • IQVIA data (costs involved)
Reducing barriers to housing, transportation, childcare, and access to other community benefits for people with OUD	• What are the most significant barriers to MOUD retention (lack of housing, transportation, childcare, etc.) reported by persons with OUD? • What social services currently exist for persons with OUD? • What social services are most needed? • What resources are needed to expand these services?	• **Identify gaps and need** for housing, transportation, and childcare for people on MOUD. • **Determine existing capacity** for social services. • **Train MOUD provider**s on how to access existing services and implement new community services. • **Implement the integration** of these community benefits into existing MOUD treatment services.	• Number of people on MOUD receiving community benefits (housing, transportation, childcare, etc.) • Number of people receiving any MOUD retained 6 months following initiation • Number of person-months actively on MOUD over a set period of time (e.g., 6 months, 1 year)	• Programmatic data from priority setting (e.g., sharing community benefit information, case management services, peer support services) • Electronic health record review from healthcare setting (requires permission/access) • IQVIA data (costs involved)

continued

Tool 9: Strategies to Improve MOUD Treatment Engagement and Retention (continued)

Implementation resources for strategies linking or bridging MOUD treatment by setting	
Enhancement of clinical delivery approaches that support engagement and retention	» Developing a Behavioral Treatment Protocol in Conjunction with MAT (Revised): Providers Clinical Support System (PCSS) PowerPoint presentation covering four basic principles of empirically supported behavioral treatments for substance use disorders—coping skills, competing reinforcers, how people talk about their change plan, and using social supports. » Promoting Awareness of Motivational Incentives (PAMI): This online training program provides practical guidance on how to implement Motivational Incentives or Contingency Management, where rewards or prizes are awarded to patients, contingent on evidence of abstinence (drug-negative urine tests) or other desirable target behaviors such as attendance at treatment. The program is an outgrowth of two community-based, multisite trials of Motivational Incentives conducted in the NIDA-funded Clinical Trials Network.
Use of virtual retention approaches (mobile, web, digital therapeutics)	» The Center for Behavioral Health Technology: Program Reviews: This web-based review summarizes available technology-based programs for mental health, addiction, and dual diagnosis patients. Each technology-based program is reviewed in a page summarizing the intervention, the evidence of its efficacy, and a link to each program's site for further information about access.
Use care coordinators	» BMC SUD Continuum of Care ECHO: A 12-part telemonitoring training on SUD treatment for providers including but not limited to acute treatment services, opioid treatment programs, long-term residential programs, primary care, and psychiatry.
Mental health and polysubstance use treatment integrated into MOUD	» PCSS Webinars: The PCSS is made up of a coalition of major healthcare organizations dedicated to addressing the opioid overdose crisis. PCSS's mission is to increase health care providers' knowledge and skills in the prevention, identification, and treatment of substance use disorders with a focus on opioid use disorders. You do not have to be an member to create a new user account for free. » SAMHSA Treating Concurrent Substance Use Among Adults: The guidebook presents three evidence-based practices that can engage and improve outcomes for people with concurrent substance use disorders. » TIP 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders: This March 2020 TIP is intended to provide addiction counselors and other providers, supervisors, and administrators with the latest science in the screening, assessment, diagnosis, and management of co-occurring disorders.
Reducing barriers to housing, transportation, childcare, and access to other community benefits for people with OUD	» SAMHSA Homelessness Programs and Resources: A webpage with access to many articles, videos, trainings, webinars, and other resources with the intent to facilitate prevention and eradication of homelessness, particularly among patients with mental health and substance use conditions. » Substance Use Disorders Recovery with a Focus on Employment and Education: This guide helps healthcare providers, systems, and communities support recovery from substance use disorders via employment mechanisms. » Ryan White HIV/AIDS Medical Case Management: Resources on a core medical patient-centered service that links and engages patients living with HIV/AIDS to healthcare and psychosocial services. Medical case management aims to provide other services like housing and transportation for patients. It also includes routine assessment of service needs, development and implementation of the plan, patient monitoring to evaluate the efficacy of the plan, and periodic reevaluation and adaptation of the plan.

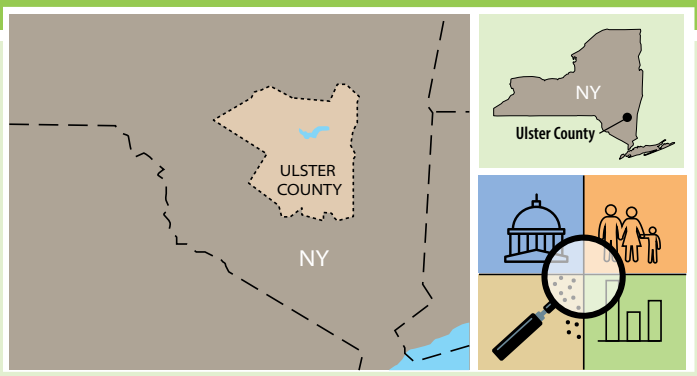
Cost Considerations and Resources

Communities, program planners, and providers considering these strategies will likely have questions regarding reimbursement, insurance coverage, and sample business plans. The following resources are recommended to provide information on these cost considerations (**Tool 10**).

Research is currently underway to estimate costs associated with specific strategies to enhance MOUD delivery (e.g., emergency department linkage program) implemented in HCS communities. These studies will be shared via the HCS Dissemination website (https://hcs.rti.org) over the coming months.

Tool 10: Implementation Resources for Considering Costs of MOUD Strategies

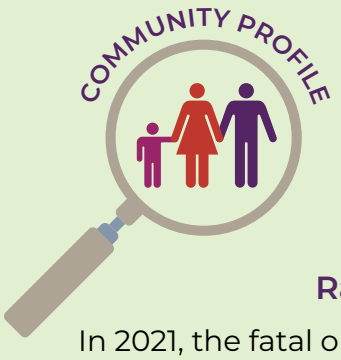
Implementation Resource	Description
2018 SAMHSA and National Council for Behavioral Health Report: Medicaid Coverage of MOUD for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose	This is a detailed report that outlines state-specific summary information on Medicaid coverage and financing of medications to treat alcohol and opioid use disorders.
PCSS and National Association of Community Health Centers: Business Plan for Medication-Assisted Treatment (MAT)	This report includes information on determining organizational readiness, a potential implementation timeline, and a financial plan, including information on billing and coding.
PCSS: Financing Factors for Implementing Medication-Assisted Treatment	A PowerPoint presentation addressing MOUD financing and overcoming financial barriers. Identifies financial considerations for successfully implementing and sustaining MAT in a primary or behavioral health practice setting and describes common models to implement and finance MAT in practice settings.
Billing and Coding Guidance for Treatment of OUD	A three-page summary from PCSS titled “Prescriber Billing for Office-based Treatment of Opioid Use Disorder” summarizing billing and diagnostic codes.
SAMHSA-funded Opioid Response Network (ORN), State Targeted Response (STR) Technical Assistance (TA), (STR-TA) Grant	Provides free training and technical assistance via local experts across the country around OUD prevention, treatment, and recovery support services.
American Society of Addiction Medicine Live and Online CME Trainings	Live and online continuing medication education (CME) opportunities for healthcare professionals focusing on the care and treatment of patients with substance use disorders.



STORIES FROM THE FIELD

Providing emergency housing to support entry into and reentry from treatment for opioid use disorder: A behavioral health and law enforcement crisis response team collaboration

ULSTER COUNTY, NEW YORK



Ulster County, New York

Ulster County in New York State sits along the Hudson River. With more than 182,000 residents. Ulster County's population is 87% White, 7% Black, and 6% other or two or more races, with 11% of the population reporting Hispanic ethnicity.[15]

Rate of Fatal Opioid Overdoses

In 2021, the fatal opioid overdose rate was 27 per 100,000, which was higher than the New York State (excluding New York City) average rate of 24 per 100,000.[21]

Authors: Jillian Nadiak-Bruck, Community Engagement Coordinator, Opioid Prevention, Ulster County Department of Health; Juanita Hotchkiss, Director of Community & Incarcerated Services, Ulster County Sheriff's Office; Kelly Perry, Data Surveillance Coordinator, Opioid Prevention, Ulster County Department of Health; Julianah Abimbola Ogundimu, Ulster County, Opioid Use Disorder System Specialist, HRMT/ORACLE; Tim Hunt, PhD, Co-Investigator & Intervention & Community Engagement Investigative Lead, Columbia University

HEALING COMMUNITIES STUDY (HCS) ULSTER COUNTY OPIOID STRATEGIC ACTION TEAM (OSAT)

Left to right: Left to right: Frankie Wright, Giff Liewa, Kevin Lundell, Julianah Abimbola Ogundimu (ORACLE), Michael Berg, Tamara Cooper, and Susan Carroll (Family of Woodstock) at the Roadway Inn Motel in Kingston, NY

A taskforce was formed in 2018 to provide strategic coordination, partnership, and resources to raise awareness about opioid misuse and harm reduction and to improve access to care for people experiencing opioid use disorder (OUD).

The taskforce is a coalition of 50 agencies and diverse community members. It has the full support of the Commissioners of the Departments of Health and Mental Health and the Ulster County Executive. The taskforce evolved into the HCS Ulster County OSAT and was tasked with implementing the Communities That HEAL intervention.

The coalition strives to mobilize the power of community members, organizations, and policymakers in finding solutions to the opioid use problems in the county. Its activities include

- providing education and training,
- establishing treatment and recovery options,
- developing data-driven strategies to identify areas of need,
- implementing evidence-based interventions, and
- evaluating progress toward achieving the stated goals.

Challenge: How to help individuals experiencing housing instability better cope with OUD

Access to safe and stable housing is one of the critical social determinants of health that can significantly impact a person's ability to cope with OUD. Navigating the complex system of care for individuals experiencing housing instability can present a significant challenge for individuals coping with OUD because they lack a safe place to store their belongings and find rest.

By providing temporary housing, individuals can concentrate on getting into treatment, connecting with necessary services, and achieving stability while preparing for the transition back into the community, as opposed to figuring out where they are going to find safety each night.

This housing solution serves as a critical support system after individuals complete the initial phases of treatment, and many work toward securing more permanent housing options.

When this strategy was developed, Ulster County was in the middle of a severe housing crisis. This problem was made worse by the sudden influx of people from New York City during the COVID-19 pandemic. Rents skyrocketed, as did the cost of purchasing a home. Consequently, we needed an immediate solution for individuals who did not meet the requirements from the Ulster County Department of Social Services (DSS) to get temporary housing.

Left to right: Tamara Cooper (Family of Woodstock), Frankie Wright, and Julianah Abimbola Ogundimu (ORACLE) showcase food items in a care package provided for every individual who stays at a motel through the housing voucher program.

Strategy Approach:
Use existing systems and collaborate with community pharmacy partners

Through the use of community impact funds, temporary housing was contracted and a voucher provided by the lead agency, Family of Woodstock, Inc. (FOW), for individuals in need of safe housing while seeking OUD treatment or awaiting inpatient treatment following release from incarceration.

FOW is a not-for-profit network of paid and volunteer individuals whose mission is to provide confidential and fully accessible crisis intervention, information, prevention, and support services to address the needs of individuals and families. Vouchers were also provided to individuals returning from inpatient treatment while they sought more permanent housing.

FOW worked with the Opioid Response as County Law Enforcement (ORACLE) initiative to set up response teams to address these housing challenges. The ORACLE initiative, selected by the Rural Justice Collaborative and the National Center for State Courts as one of the country's most innovative rural justice programs, is a crisis-intervention and recovery-response program based out of the Ulster County Sheriff's Office.

The response team includes crisis intervention officers, a mental health and substance use social worker, two peer-recovery advocates, and a care manager for people at high risk. Two individuals from this team were assigned as point persons for referrals in the strategy to be available Monday through Friday, 9:00 am to 9:00 pm. The point person worked with FOW to gather the information necessary to provide the best housing option. The referring agency was responsible for arranging transportation to the hotel and maintaining contact with the individual through the duration of their stay. Emergency referrals were accepted after hours and on weekends using the FOW hotline. Case reviews were conducted weekly during High-Risk Mitigation Team (HRMT) meetings, with required attendance for referring agencies.

Individuals who qualified for the program were

- individuals who are living with OUD (diagnosed or assessed) and experiencing housing instability, and
- individuals who are experiencing housing instability (with no other options) and are returning from inpatient treatment.

Referring agencies were responsible for certifying that individuals referred to this program did not currently have housing and did not qualify for DSS emergency housing assistance. Individuals could not use vouchers for more than 14 days upon return from treatment, and no more than 28 days total for the life of program participation.

OUTCOMES AND OTHER BENEFITS

From October 2020 through January 2023, a total of 1,221 vouchers (nights) were issued to 140 individuals.

Although demographics were not captured for recipients of housing vouchers, names were cross-referenced with the ORACLE HRMT database, which showed that 87 of the 140 individuals served were 37% female and 63% male, and that 87% were White, 9% Black, 3% mixed or other race, and 9% Hispanic.

> *The HEALing Community Program – Emergency housing has made an immense impact on individuals struggling with opioid use disorder by providing a safe place to transition into treatment programs and more importantly, integrating back into the community and accessing needed services.*
>
> —Julianah Abimbola Ogundimu, Ulster County, Opioid Use Disorder System Specialist, HRMT/ORACLE

HOW HAS THIS PROGRAM BRIDGED A GAP?

The program has helped bridge gaps by

- assisting with navigating clients with substance use disorder (SUD) for linkage to treatment programs;
- providing a safe place to locate clients for client-centered care;
- facilitating easy client communication and accessibility;
- helping address urgent housing and food needs, including unanticipated jail discharges;
- providing a reliable and consistent housing option; and
- providing access to peer support and navigation.

WHAT IMPACT HAVE YOU SEEN AS A RESULT?

The key impacts of the program include

- increasing successful admission into SUD treatment,
- improving open communication between clients and support services of the ORACLE team,
- addressing housing instability in Ulster County and supporting DSS,
- providing alternative and safe temporary housing for people with SUD who may not qualify for DSS temporary assistance, and
- increasing successful reentry and retention in care post inpatient treatment.

SUCCESS STORIES

Program successes include

- using housing vouchers for transitional housing for an individual following release from jail and prior to admission into long-term SUD treatment—the individual is currently engaged with a long-term treatment facility and making positive progress in recovery;
- using housing vouchers to provide a client safe housing until a detox bed at a treatment facility became available—the individual was housed for 3 nights in the motel, successfully picked up from the motel by Medicaid Transportation, and brought to treatment where they successfully completed and currently maintain recovery; and
- using a housing voucher for an individual who is a Veteran but could not connect with VA services in time to get safe housing the night they returned home from treatment—the individual contacted ORACLE requesting assistance with housing and we were able to place them in the motel for the night and get them connected to the VA the following day, who then connected them with long-term housing.

TIPS FOR YOUR COMMUNITY

- **Referrals.** Initially, organizations made their own referrals, but it was difficult to check each referral for eligibility against the voucher criteria. To simplify the process and collect data, we designated a point person within the organization to assess referrals for voucher criteria and link them to Family of Woodstock for voucher processing.
- **Partnership with DSS.** After someone completes their treatment program, emergency housing can typically be obtained from DSS. If we provide assistance for people in completing their application within a reasonable timeframe, DSS will cover housing costs.
- **Emergency housing vouchers.** Using an organization that already processes emergency housing vouchers through the county's DSS is efficient. Having a 24/7 hotline is important for off hours.
- **HRMT case review.** An HRMT case review meeting was useful to problem solve the barriers to getting individuals into treatment.
- **Transition to treatment.** Initially, there were no limits on the number of housing vouchers available to individuals. A specific time frame was introduced to encourage a speedier transition into treatment. If someone needed more time to prepare, they could apply for recertification to extend the time limit.
- **Care packages.** Individuals were leaving the motels because of lack of food and basic necessities. To prevent this from happening, care packages were provided to the individuals to help them settle in and avoid leaving, which could increase risks. These care packages were funded by HCS.

> *The HEAL Motel Voucher program has saved countless lives. When people do not feel safe, have food, shelter, and compassion, they are unlikely to work on their recovery. We have successfully linked 64 individuals to inpatient treatment in one year due to this incredible program!*
>
> —David McNamara, Executive Director, Samadhi

6. Evidence-based Strategies to Improve Prescription Opioid Safety

Rationale

The pharmaceutical opioid supply is a source of opioid exposure, contributing to OUD and the opioid overdose crisis. Specific prescribing practices, including excessive prescribing for acute or postoperative pain, prescribing high morphine-equivalent daily dose (e.g., ≥ 90 MME/day) for chronic pain, or co-prescribing opioids and benzodiazepines, increase the risk of opioid overdose. Promoting safer, more judicious opioid prescribing, dispensing, storage, and disposal practices can increase opioid safety, reduce the excess opioid supply in communities, and decrease the risk of overdose from prescribed opioids.

At the same time, there is increased recognition that misapplication of opioid prescribing guidelines (including sudden discontinuation of opioid prescriptions) can lead to significant harm. Therefore, strategies to improve prescription opioid safety should be mindful of current guidance on gradual, individualized tapering and evidence-based pain management guidelines.

Peer-reviewed literature to support prescription safety strategies

Key messages

- 8.7 million people misused prescription opioids in 2021 (NSDUH 2021)
- 45% of people who misused prescription opioids obtained them from a friend or relative (NSDUH 2021)
- Specific prescription features such as a high dose or long initial duration increase the likelihood of unintentional overdose and long-term use (Dowell et al., 2022)

Key citations

- Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022. MMWR Recomm Rep. 2022 Nov 4;71(3):1-95. doi: 10.15585/mmwr.rr7103a1.
- Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health. (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). 2022.

Goals: This menu is designed to:

1. Reduce high-risk opioid prescribing
2. Encourage appropriate opioid prescribing for acute conditions
3. Reduce opioid prescriptions from multiple prescribers or pharmacies
4. Increase appropriate medication disposal

Communities and healthcare facilities should carefully review state and local regulations before implementation of opioid prescribing, dispensing, and disposal strategies. State prescription drug monitoring programs (PDMPs) can provide prescribers with both patient-specific information regarding opioid use and aggregate prescribing data to assist both in clinical decision-making and development of safer prescribing practices and protocols.

Safer Opioid Prescribing for Acute and Chronic Pain

This section addresses safer opioid prescribing for acute and chronic pain and safer opioid dispensing **(Tool 11)**. Activities to encourage safer opioid prescribing include **offering an academic detailing service** (one-on-one education outreach visits and other engagement activities to improve prescriber decision-making and patient care) for healthcare professionals in primary care, urgent care/EDs, pharmacists, and dentists and **outreach to hospitals' opioid stewardship teams** and colleges of nursing, medicine, and pharmacy.

Other activities for improving opioid safety could include **continuing education** and **PDMP review**.

Pain Management Guidelines

2022 CDC Guideline for Prescribing Opioids for Pain

Tool 11: Strategies for Safer Opioid Prescribing

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Safer opioid prescribing for acute pain across settings (inpatient service, emergency/ urgent care, outpatient clinics, ambulatory surgery, dental clinics)	• What current protocols are in place around prescribing opioids for acute pain? • What could be improved (including use of PDMPs)? • What are the expressed goals around prescribing practices and patient education?	• **Obtain leadership support and identify a champion(s)** for opioid prescribing practices. • **Select and prioritize** guideline recommendations to implement. • **Establish protocol** to enhance providers' use of guidelines for opioid use. • **Train team** on best practices and new protocols. • **Implement** prescribing enhancement protocols and adapt as needed. • **Ongoing monitoring** of use and refresher training of new protocols.	• Number of new high-risk opioid prescriptions for acute pain (e.g., ≥ 90 MME/day) • Number of new opioid prescriptions for acute pain for over 31 days • Number of new prescriptions for acute pain using extended-release or long-acting opioids • Number of new prescriptions for an opioid with an overlapping benzodiazepine for at least 31 days • Percent of prescriptions limited to a 7-day supply of all new opioid prescriptions for acute pain • Number of opioid prescriptions from multiple prescribers or pharmacies	• PDMP data • Electronic health record review from healthcare setting (requires permission/ access) • IQVIA data (costs involved)
Safer opioid prescribing for chronic pain (adherence to Centers for Disease Control and Prevention (CDC) guidelines, patient-centered opioid tapering)	• What current protocols are in place around prescribing opioids for chronic pain? • What could be improved (including use of PDMPs)? • What are the expressed goals around prescribing practices and patient education?	• **Obtain leadership support and identify a champion(s)** for opioid prescribing practices. • **Select and prioritize** guideline recommendations to implement. • **Establish protocol** to enhance providers' use of guidelines for opioid use. • **Train team** on best practices and new protocols. • **Implement** prescribing enhancement protocols and adapt as needed. • **Ongoing monitoring** of use and refresher training of new protocols.	• Number of new high-risk opioid prescriptions for chronic pain (e.g., ≥ 90 mg/day) • Number of new prescriptions for chronic pain using extended-release or long-acting opioid • Number of new prescription for an opioid with an overlapping benzodiazepine for at least 31 days • Number of new prescriptions for an opioid with a naloxone co-prescription • Number of opioid prescriptions from multiple prescribers or pharmacies	• PDMP data • Electronic health record review from healthcare setting (requires permission/ access) • IQVIA data (costs involved)

continued

Tool 11: Strategies for Safer Opioid Prescribing (continued)

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Safer opioid dispensing (such as use of PDMPs and NARx score, improved communication with prescribers, and naloxone co-prescription)	• What settings can offer pharmacy education (e.g., schools of pharmacy, pharmacies within the community)? • What protocols are currently in place? • What could be improved (including use of PDMPs)? • What training is needed for pharmacists?	• **Develop pharmacist education** and outreach strategies to promote safe opioid dispensing practices. • **Develop patient education** materials on safer opioid use for pharmacists to use during counseling. • **Develop tools** for monitoring pharmacist outcomes and efficacy of materials. • **Train pharmacists**. • **Ongoing monitoring** and refresher trainings.	• Number of new prescriptions for an opioid with a naloxone co-prescription • Number of naloxone units distributed through pharmacies • Number of opioid prescriptions from multiple prescribers or pharmacies	• PDMP data • Review of pharmacy data (requires permission/access)

Implementation resources for strategies for safer opioid prescribing

Safer opioid prescribing for *acute* pain: **pain management guidelines**	» Guideline for Discharge Opioid Prescriptions after Inpatient General Surgical Procedures: A 2017 guideline for postoperative patients. Indicates that postdischarge opioid use is best predicted by usage the day before discharge and predicts that 85% of patients' postoperative home opioid requirements would be satisfied using their guideline. » Opioid-Prescribing Guidelines for Common Surgical Procedures: An Expert Panel Consensus): A 2018 guideline from the American College of Surgeons: Opioids After Surgery Workgroup. For 20 surgical procedures reviewed, the minimum number of opioid tablets recommended by the panel was 0. Ibuprofen was recommended for all patients unless medically contraindicated. The maximum number of opioid tablets varied by procedure (median 12.5 tablets), with panel recommendations of 0 opioid tablets for 3 of 20 (15%) procedures, 1 to 15 opioid tablets for 11 of 20 (55%) procedures, and 16 to 20 tablets for 6 of 20 (30%) procedures. » Dental Guideline on Prescribing Opioids for Acute Pain Management: A 2017 guidance developed by the Bree Collaborative and Washington State Agency for Medical Directors Group. An easy-to-use reference to help dentists and oral surgeons follow a set of clinical recommendations to align opioid prescribing with current evidence. » The Treatment of Acute Pain in the Emergency Department: A White Paper Position Statement Prepared for the American Academy of Emergency Medicine: A 2018 guideline that provides resources for the safe use of opioids in the ED and pharmacological and nonpharmacological alternatives to opioid analgesia. Emphasizes that care should be tailored to the patient based on their specific acute painful condition and underlying risk factors and comorbidities.

continued

Tool 11: Strategies for Safer Opioid Prescribing (continued)

Implementation resources for strategies for safer opioid prescribing	
Safer opioid prescribing for *acute* pain: **prescriber education**	» Opioid Prescribing Best Practices: Warning Signs, Tapering Strategies, and Alternatives. A two-part video interview with Dr. Arwen Podesta from Psych Congress Network. » Safer Post-Operative Prescribing of Opioids: This continuing medication education (CME) activity shares best practices in postoperative opioid prescribing to reduce the number of excess opioids left over following a surgery. » Education for Clinicians Treating Patients with Opioids for Chronic Pain: An animated video that focuses on four key strategies: Reducing Risk for Development of OUD and Avoidance of Misuse, Identification of Risk Factors, Safety Planning, and Overdose Rescue Preparation.
Safer opioid prescribing for *acute* pain: **academic detailing and consult services**	» Best Practices in Academic Detailing for Opioid Safety: Links to materials for conducting academic detailing campaigns generally and specifically targeting opioid safety. Developed at Brigham & Women's Hospital, Division of Pharmacoepidemiology. » Academic Detailing Service - Pain & Opioid Safety Initiative (OSI) Materials: U.S. Department of Veterans Affairs (VA): Pain resources for providers, including a pain management and opioid safety quick reference guide, dose and taper tools, and a chronic pain and suicide factsheet. Patient-facing resource related to risk of combining opioids and benzodiazepines. » PCSS Mentoring Program: National program connecting clinicians with one-on-one mentoring about pain management or addiction, or offers participation in clinical forums.
Safer opioid prescribing for *acute* pain: **patient education resources**	» Pain Education Toolkit for Patients: Patient handouts from Oregon Pain Guidance cover topics such as how pain works, sleep hygiene for pain, and videos that address questions like, "How does mood affect your pain?" "Why does activity help with pain?" and "Why should I think about reducing my pain medication?" Handouts are available in English, Spanish, Russian, Vietnamese, and Zhuang. » CDC Information for Patients: Information for patients about pain treatment, expectations for opioid therapy, and preventing misuse and overdose. Includes handouts and infographics about the CDC guideline, promoting safer and more effective pain management, and preventing overdose.
Safer opioid prescribing for *chronic* pain: **prescriber education**	» SCOPE of Pain Core Curriculum: A series of online or in-person CME activities designed to help practitioners safely and effectively manage patients with chronic pain, when appropriate, with opioid analgesics. » Safe and Competent Opioid Prescribing: Optimizing Office Systems: A CME activity to help clinicians reengineer office systems to reduce the potential for opioid misuse, addiction, or diversion while ensuring safe evidence-based care of patients with chronic pain. » SCOPE of Pain supplemental training: Includes online activities for opioid prescribing in special populations, naloxone co-prescribing, opioid tapering, and state-specific training for practitioners in New York and Massachusetts. » PCSS: Extensive resource provided by SAMHSA, including free CME and mentorship. A 13-module course "Management of Chronic Pain: A Core Curriculum for Primary Care Providers" covers key topics in chronic pain assessment and management, opioid risk assessment and management, opioid use disorder (OUD) in patients with chronic pain, and communication strategies.

continued

Tool 11: Strategies for Safer Opioid Prescribing (continued)

Implementation resources for strategies for safer opioid prescribing	
Safer opioid prescribing for *chronic* pain: **tapering guidelines and resources**	» CDC Pocket Guide for Tapering Opioids for Chronic Pain: A high-level overview of when and how to taper opioids for chronic pain. » Tapering Guidance & Tools: Includes a tapering flowchart and the BRAVO protocol for patient-centered opioid tapering. » VA Opioid Taper Decision Tool: A guide developed by VA to help clinicians determine when a taper is indicated and how to perform the taper and support patients throughout the taper. » RxFiles Opioid Tapering Template: Information for providers and patients to help guide opioid tapering, including a template for writing out a suggested opioid taper over time and managing symptoms of opioid withdrawal.
Safer opioid prescribing for *chronic* pain: **naloxone co-prescribing**	» PrescribetoPrevent.org: This website provides information for providers, pharmacists, and patients and families about how to prescribe, obtain, and use naloxone to prevent fatal opioid overdose.
Safer opioid prescribing for *chronic* pain: **pharmacist education**	» Scope of Pain: Series of online or in-person CME activities designed to help practitioners safely and effectively manage patients with chronic pain, when appropriate, with opioid analgesics.

KEY INSIGHTS

A qualitative study interviewing community members across the sites implementing the CTH intervention identified the following themes related to opioid prescribing practices:[22]

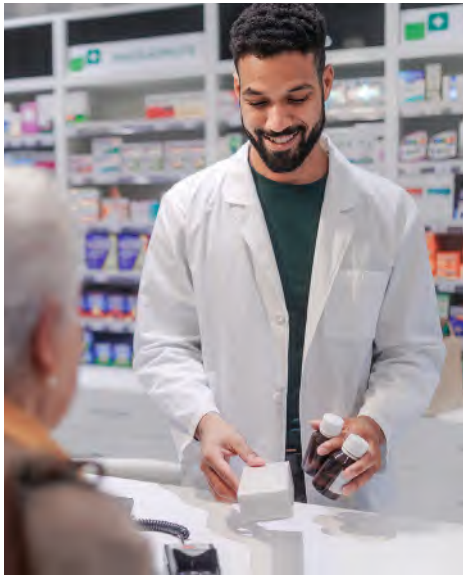
1. **Acknowledging progress** by recognizing that healthcare providers are part of the solution, provider educational opportunities, and use of PDMP.
2. **Emergent challenges** related to physician nonadherence to guidelines, difficulty identifying appropriate use of opioids, and concerns about accelerating the progression from opioid misuse to drug abuse.
3. **Opportunities for change** through patient, prescriber, and pharmacist education, changing expectations around completely eliminating pain, and expanding access and insurance coverage for non–opioid-based pain management.

Need to expand education to dentists and veterinarians:

> *We never really include dentists in the conversation. And we have been doing surveys with the community and asking people about like getting opiate prescriptions. And a lot of time they're saying they got them from their dentist. And I don't think that's a group that we often include in our conversation. And we've also heard from some rural residents that people are diverting medications that they receive from the vet for their animals. I feel like we don't think about dentists and veterinarians at the table when we're talking about reducing prescriptions."*
>
> —Community member within criminal legal sector in New York

Changing unrealistic expectations around pain:

> *I think the consequences of [over prescribing]...are lagged, they're gonna just be affecting us, I think, for a long time in terms of initiation of those behaviors because those are the broader challenges with prescribing universally and prescribing practices for opioids. Demand for them especially among, I think, older adults who are in pain, have been told for the last 30 years or so that they shouldn't be in pain, it's a vital sign, and that there's drugs to help. So I think [it's] the legacy of availability."*
>
> —Educator in New York



Safe Disposal Practices

Leftover (unused) prescription opioids are a potential source for opioid misuse and accidental poisoning. Providing safe, convenient, and environmentally appropriate options for disposing of unused prescription opioids can help reduce opioid supply within communities and prevent access by children, adolescents, and other vulnerable populations.

The three recommended means of drug disposal are

a. **Drug take-back events** sponsored by law enforcement agencies
b. **Permanent drug drop-box kiosks** in law enforcement, pharmacy, and other healthcare locations
c. **Take-home disposal mechanisms** such as mail-back envelopes, which are typically sold or provided by participating pharmacies

This section outlines the associated resources and toolkits for decreasing community opioid supply through more robust drug disposal programs **(Tool 12)**. Communities wishing to expand drug disposal options should identify current drug disposal locations, weigh the costs and benefits of each type of program, and review state and local regulations concerning drug disposal prior to implementation.

Tool 12: Strategies for Safe Disposal

Strategy	Key Considerations	Example Implementation Activities	Example Measures of Success	Example Data Sources for Measures
Drug take-back events, prescription drug drop-boxes, and mail-back programs	• Where in the community can people dispose of leftover opioids? • Are local pharmacies receptive to hosting a prescription drug drop-box? • What are potential barriers to implementing a safer disposal program (e.g., lack of community buy-in, lack of awareness)?	• **Establish partnerships** with key governmental officials, law enforcement, pharmacies. • **Identify** potential settings for prescription drug disposal. • **Implement** prescription drug disposal program and adapt as needed.	• Number of drug take-back events over 1 year • Number of prescription drug drop-boxes • Number of mail-back programs in place • Pounds of medication incinerated	• Local pharmacies • Law enforcement • Community organizations

continued

Tool 12: Strategies for Safe Disposal (continued)

Implementation resources for strategies linking or bridging MOUD treatment by setting	
Identification of current drug disposal locations	» DEA Controlled Substance Public Disposal Locations Search Utility: A public database contains locations that have registered with the Drug Enforcement Administration (DEA) for controlled substance disposal, searchable by ZIP code or city/state up to a 50-mile radius. Does not contain law enforcement–affiliated drug disposal locations. » NABP AwareRx Drug Disposal Locator: A public database of permanent U.S. drug disposal sites for consumers, searchable by ZIP code or city/state up to a 100-mile radius. Contains law enforcement–affiliated drug disposal locations; does not contain all DEA-registered facilities. Maintained by the National Association of Boards of Pharmacy. » National Drug Take Back Day: Information on DEA's national drug take-back day events in April and October. Includes a "Partnership Toolkit" with PSAs, posters, handouts, and other materials to promote National Prescription Drug Take-Back Day. » Safe Drug Disposal: A Guide for Communities Seeking Solutions: A 14-page guide written by Partnership for Drug-Free Kids to "help community officials and organizers design a safe drug-disposal program for their community." Focuses on three elements of drug disposal: collection, destruction, and promotion of the drug disposal service. Includes links to federal agencies involved in safe drug-disposal programs (DEA, FDA, EPA, and DOT). » Registrant for Drug Disposal: A website that includes link to get registered with DEA as a drug take-back receptor and to have receptacles installed at registered site.
Implementation of prescription drug disposal program	» National Drug Take-Back Day – Information on DEA's national drug take-back day events in April and October. – Includes a "Partnership Toolkit" with PSAs, posters, handouts, and other materials to promote National Prescription Drug Take-Back Day. » Safe Drug Disposal: A Guide for Communities Seeking Solutions – A 14-page guide written by Partnership for Drug-Free Kids to "help community officials and organizers design a safe drug-disposal program for their community." – Focuses on three elements of drug disposal: collection, destruction, and promotion of the drug disposal service. – Includes links to federal agencies involved in safe drug-disposal programs (DEA, FDA, EPA, and DOT). » How-to Guide for Drug Take-Back: Managing a Pharmacy-based Collection Program for Leftover Household Pharmaceuticals – A 40-page guide published by the Product Stewardship Institute to offer "step-by-step guidance" to pharmacies and other stakeholders wishing to set up a drug take-back program. – Provides details on modifying DEA registration to become a collector, selecting collection systems, setting up and operating the program, and promoting the service. – Appendix B includes a list of vendors to consider for take-back receptacles and disposal services. » Registrant for Drug Disposal – A website that includes link to get registered with DEA as a drug take-back receptor and to have receptacles installed at registered site

continued

Cost Considerations and Resources

Communities seeking to provide safer opioid prescribing education for healthcare providers and pharmacists can access free or low-cost educational trainings featured within the implementation resources shared above. Continuing education credits are often offered after completing these trainings, which can incentivize providers to participate. Free patient educational materials (e.g., posters, handouts) are available through CDC's Injury Center.

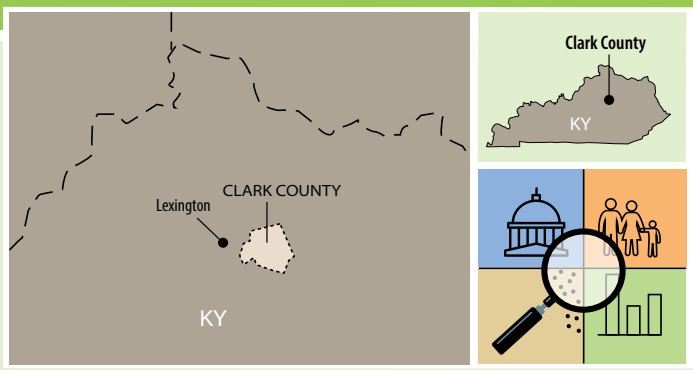
Costs associated with safe disposal strategies will vary depending on the approach used. This "Prescription Drug Take Back Toolkit" describes costs for a drug take-back event including hiring a law enforcement officer (~$30–$40/hour), costs of incinerating collected medications, and advertising. An alternative to organizing an event would be to publicize National Prescription Drug Take-Back Day and locations accepting leftover medications within the community.

Cost considerations for communities interested in establishing permanent drug disposal kiosks in law enforcement offices, pharmacies, and other healthcare settings are described in **Tool 13**. In a case study featured within the Product Stewardship Institute's How-to Guide for Drug Take-back, five rural pharmacies piloted a drug take-back program and calculated the total cost of promotion/outreach and collection materials (e.g., permanent drug drop-box, mail-back envelopes). The reported costs did not include employee time, which was determined to be minimal. The costs for the first year (i.e., pilot) of a drug take-back program for a pharmacy was $3,713 for independent pharmacies and $5,250 for a hospital-affiliated pharmacy. The five pharmacies collected around 300 pounds of leftover drugs.

The costs of implementing specific prescription drug safety strategies in HCS communities are still being researched and will be shared via the HCS Dissemination website (https://hcs.rti.org) over the coming months.

Tool 13: Permanent Drug Disposal Strategy Cost Considerations

Cost consideration	Estimated costs
Permanent drug drop-box kiosk (i.e., locking prescription drop-box)	~$300–$1,100 with varying sizes, available through medical supply websites
Drug deactivation and disposal pouch	~$2–$6 per pouch, available online
Raising awareness around permanent prescription drug take-back locations	This how-to guide includes in-pharmacy advertising strategies, social media guidance, and practical guidance on piloting a permanent drug drop-box



STORIES FROM THE FIELD

Using existing systems and collaborating with community pharmacy partners to create and promote medication drop-box/safe disposal locations

CLARK COUNTY, KENTUCKY

COMMUNITY PROFILE

Clark County, Kentucky

Clark County is a small, urban community in Central Kentucky that has been highly impacted by opioid overdose. Its systems, including the county jail and a syringe service program, could support adopting proven practices to reduce opioid overdose deaths.

Rate of fatal opioid overdoses

The 2020 age-adjusted opioid overdose death rate in Clark County was 73.5 per 100,000 residents,[23] which was higher than the national rate of 21.4 per 100,000.[24] Age-adjustment is a measure applied to rates that allows communities with different age structures to be compared.

Author: Laura K. Stinson, PharmD, HCS Academic Detailing Pharmacist

CLARK COUNTY COALITION

When looking at the Clark County community, there were no permanent pharmacy-based medication disposal options for controlled substances. These are drugs, such as prescription opioids, that are closely regulated by the government based on their potential for misuse and dependence. The nearest pharmacy with a place to dispose of these drugs was about 30 minutes away in a neighboring county. Because public transportation is not available to make this trip, this created challenges for people in Clark County without their own means of transportation.

Two local law enforcement agencies offered to dispose of controlled substances. But many people are not comfortable returning drugs—such as prescription opioids—to police departments or sheriff's offices. So these types of locations are not visited regularly by most people.

Information about the lack of disposal locations was shared with the Clark County Coalition. Pharmacists helped educate members of the coalition about the need for medication disposal for prescription opioid safety and options for increasing safe disposal to be available in their community.

Pharmacists highlighted the following:

- The number of prescription opioids that are not used
- The large portion of misused prescription pain relievers that are obtained from friends and relatives
- The increased chances of medication disposal when it is recommended by a healthcare provider, such as a pharmacist, and when the disposal site is in a convenient location, such as a community pharmacy

Challenge: How to create and promote medication drop-box/safe disposal locations

The Clark County Coalition saw the lack of convenient disposal options as a large gap with a high priority. Members also talked about medication take-back events held by law enforcement agencies. But low attendance at these events further emphasized the need for permanent disposal options for prescription opioids that are placed in convenient locations.

Based on the limited number of medication disposal locations and the fact that those available were associated with law enforcement, the community set a goal to increase the number of safe disposal locations within Clark County.

Strategy Approach:
Use existing systems and collaborate with community pharmacy partners

The Clark County Coalition identified possible priority community pharmacies as disposal sites based on their location and which patients they serve. Priority selection looked at people who are underserved and the convenience of locations. Coalition members who could help communicate with possible pharmacy partners were also identified.

Team members contacted all community pharmacies in Clark County—beginning with the priority locations—by phone, email, mail, virtual meeting, or in-person visit—with information about pharmacy-based disposal drop-boxes, an offer to provide a disposal drop-box and supplies, and instructions for ordering them. Team members worked closely with pharmacy owners, corporate offices, and pharmacy technicians to make the ordering process easier for all pharmacies that accepted. This included providing technical assistance when registering with the DEA to be able to collect controlled substances. Changing the DEA registration was a barrier in many locations, so team members worked with pharmacies to simplify the process.

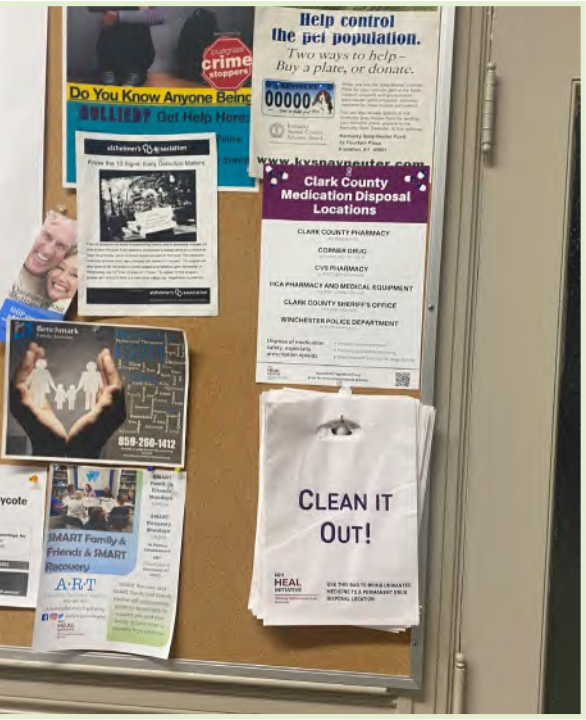
The following resources and support were also provided:

- Training on the disposal drop-boxes was offered to all pharmacy partners by virtual meeting, in person, or using a brief recorded video
- Follow-up calls or visits were made one month after the drop-box was installed and then every 3 months to identify challenges, report success, and offer assistance
- Public service radio announcements and ads in local publications promoted the importance of prescription opioid disposal and locations for disposal in the county
- Posters and bags encouraging medication disposal were placed in public locations, such as the public library, courthouse, and health department
- Community pharmacy partners reported new people visiting their pharmacy to use the disposal drop-box because of these efforts
- The Coalition looked at options for funding disposal drop-boxes over time and identified a local organization as a source for financial support
- Staff shared this information with pharmacy partners and also talked about the future costs and needs related to the drop-boxes, such as training, materials, and answering questions

> *It's a responsible thing to do for the community and there's always positive feedback from any patient who sees it.*
>
> —Local independent pharmacy owner and Clark County partner

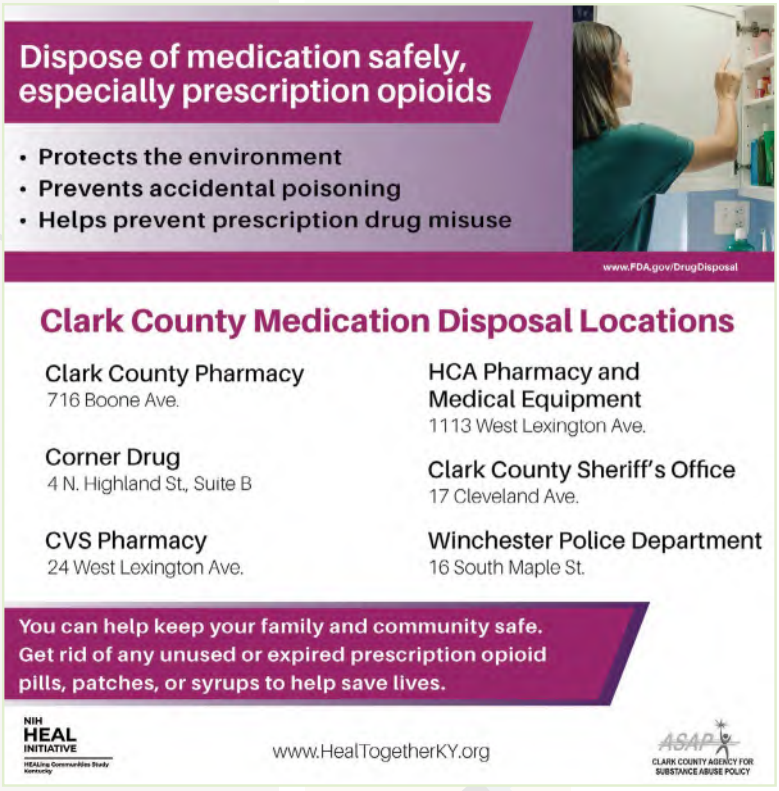
OUTCOMES AND OTHER BENEFITS

- We installed drop-boxes in four community pharmacies in Clark County (three independent pharmacies and one chain pharmacy). This exceeded our goal to have a permanent drop-box in about a third of community pharmacies in a county or one drop-box available for every 25,000 county residents.
- Two of the three priority locations identified by the coalition members agreed to install a drop-box. In interviews, participants reported that doing this did not create a big burden on pharmacy staff, the drop-box was convenient, and providing this service to their community was rewarding.
- The Coalition approved this approach in October 2020 and as of May 2023, the pharmacy partners in Clark County had returned 767 lbs. of medication to be incinerated, indicating that the approach is being sustained successfully.



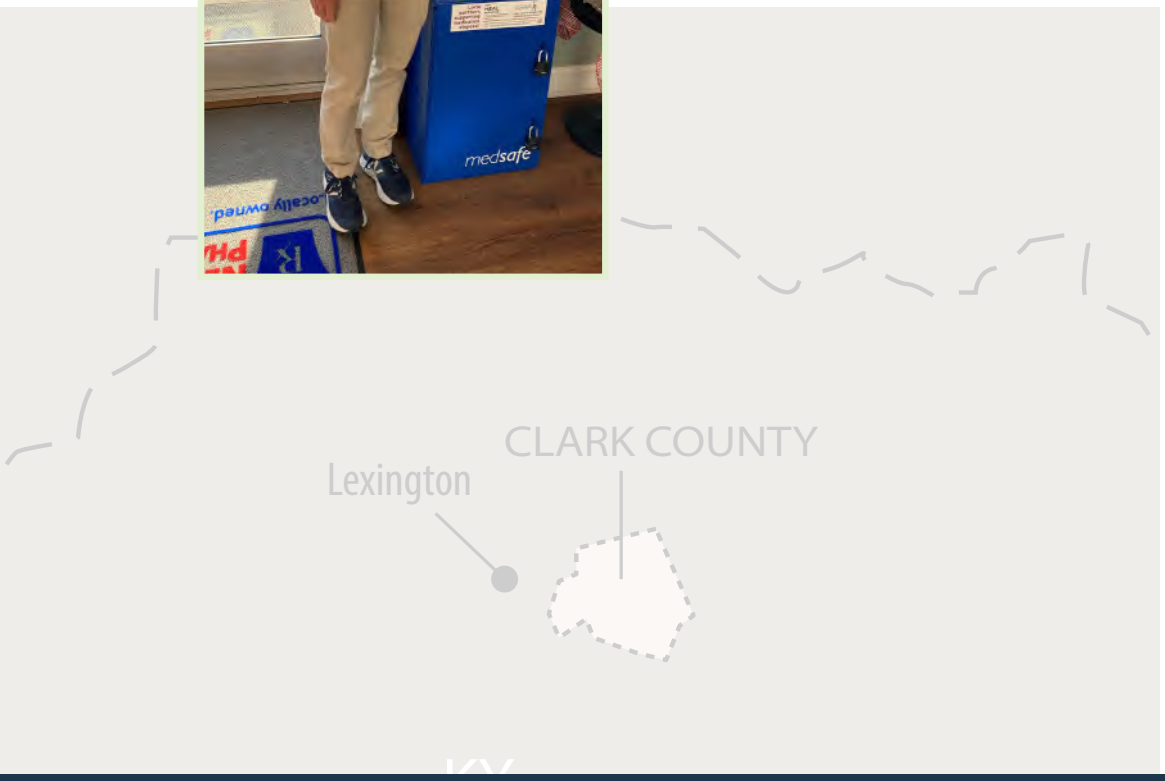
> *It's very user friendly, it's just been really great actually. It's very convenient for our customers.*
>
> —Clark County partner pharmacist

> *It's been really good … just being able to provide another service that people ask for so often.*
>
> —Clark County partner pharmacist



TIPS FOR YOUR COMMUNITY

- Overcoming barriers, such as cost and lack of information, increases acceptance of installing disposal drop-boxes in community pharmacies.
- The amount of medication that's been collected and destroyed from Clark County shows the previously unmet need for convenient disposal locations in this community.
- Community pharmacy partners can successfully carry out programs to increase prescription opioid safety when given the resources to overcome barriers.
- Promoting medication disposal and locations in a community using radio and newspaper ads can lead to increased use of disposal drop-boxes.



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Appendices

APPENDIX A. TOOLS FOR DATA-DRIVE STRATEGY SELECTION

Strategies to Increase Opioid Overdose Prevention Education and Naloxone Distribution (OEND)						
Strategy and Venue	**Current Activity**	**Size of Gap (Current Activity vs. Need)**	**Feasibility in <12 Months**	**Impact on Overdose Deaths**	**Potential reach with underserved populations**	**Priority Score**
From the ORCCA menu, brainstorm possible strategies to meet the community OEND goals. Record all strategies in this column.	Briefly summarize current activity in your community.	0. None 1. Small 2. Medium 3. Large	0. Extremely low 1. Low 2. Medium 3. High	1. Low 2. Medium 3. High	1. Low 2. Medium 3. High	Add previous four columns. If any column contains 0, priority score is 0.
Strategies to Enhance Delivery of MOUD Treatment, Including Agonist/Partial Agonist Medication						
Strategies to Improve Prescription Opioid Safety						

ORCCA Strategy Selection Tool

From your community assessment, what is the most urgent priority in your community regarding opioid overdose prevention?	
List a potential strategy from the ORCCA menu that your community wants to implement.	
Higher risk population prioritized:	
Setting engaged:	
What resources within this practice guide would be helpful as you plan and advance implementation?	
What data do you have to inform your choice?	
What data do you need to inform your choice?	
What technical assistance and training resources do you think may be needed?	
Who should be at the table to plan and advance this strategy?	

APPENDIX B. HEALing COMMUNITIES STUDY

NIH HEAL INITIATIVE
HEALing Communities Study

The National Institutes of Health and the Substance Abuse and Mental Health Services Administration launched the HEALing Communities Study to test the immediate impact of an integrated set of evidence-based interventions across healthcare, behavioral health, criminal legal, and other community-based settings to prevent and treat opioid misuse and opioid use disorder within highly affected communities.[25] The HCS tests the impact of the Communities that HEAL (CTH) intervention, which seeks integration of prevention efforts, overdose treatment, and medication-based treatment in select communities hard hit by the opioid crisis. The CTH contains three components: (1) a community-engaged coalition and data-driven process to facilitate the implementation of evidence-based practices;[26] (2) the ORCCA menu of strategies;[27] and (3) communication campaigns to address stigma and increase knowledge of, and demand for, evidence-based practices.[28] This comprehensive treatment model was tested in a coordinated array of settings, including primary care, emergency departments, and other community settings.

The goal of the HCS is to reduce opioid-related overdose deaths by 40 percent over the course of 3 years. Research sites partnered with 67 communities highly affected by the opioid crisis in four states to measure the impact of these efforts. The study looks at the effectiveness of coordinated systems of care designed to increase the number of people receiving medication to treat OUD, increase the distribution of naloxone, and reduce high-risk opioid prescribing. The study also supports harm reduction research to investigate the effectiveness of rapid-acting fentanyl test strips in modifying drug use behaviors and exploring drug checking needs in clinical settings.

Within the HCS study, community coalitions were required to select at least five ORCCA menu strategies with a minimum of (1) one strategy involving active OEND; (2) three strategies involving MOUD expansion, linkage, or retention; and (3) one strategy on safer opioid prescribing/dispensing practices. In addition, the study protocol required coalitions to implement

at least one EBP strategy in three key sectors (behavioral health, criminal legal, and healthcare). Coalitions were encouraged to consider EBP strategies focused on those most vulnerable to opioid overdose (e.g., people with a prior opioid overdose, people who inject drugs) and priority settings (e.g., correctional settings, syringe service programs). Additional detail on the development of the ORCCA menu can be found in Winhusen et al.[27]

Research grant awards were issued to the University of Kentucky in Lexington; Boston Medical Center in Boston; Columbia University in New York City; and Ohio State University in Columbus. The HCS is a multiyear study under a cooperative agreement supported by the National Institute on Drug Abuse, part of the National Institutes of Health. The study launched in 2019 and results will be shared in the summer of 2023. Technical details and specifics about study design and how intervention success was evaluated can be found in this overview of the HEALing Communities Study Consortium.[25]

APPENDIX C. ACKNOWLEDGMENTS

Technical Expert Panel Members

- **Laura Fanucchi**, MD, MPH, Associate Professor of Medicine, Division of Infectious Disease, University of Kentucky College of Medicine
- **Fernando González**, MD, MPH, Manager, EMS Opioid Prevention Program, UTHealth San Antonio/Project Vida
- **Chase Holleman**, LCSW, LCAS, Public Health Analyst, SAMHSA Center for Substance Abuse Prevention
- **Edward V. Nunes**, MD, Professor of Psychiatry, Columbia University Irving Medical Center
- **Richa Ranade**, MPH, Senior Director, Overdose Prevention, Association of State and Territorial Health Officials
- **Angelia Smith-Wilson**, EdD, MSW, Executive Director, Friends of Recovery-New York
- **Jessica Taylor**, MD, Assistant Professor of Medicine, Boston University School of Medicine, Boston Medical Center
- **John T. Winhusen**, PhD, Professor, Vice Chair of Addiction Sciences, University of Cincinnati, College of Medicine

HEALing Communities Study

- Continuum of Care Work Group
- Community Engagement Work Group

Substance Abuse and Mental Health Services Administration

- **Yngvild K. Olsen**, MD, MPH, Director of the Center for Substance Abuse Treatment
- **Karran Phillips**, MD, MSc, Deputy Director of the Center for Substance Abuse Treatment
- **Carter Roeber**, PhD, MA, Social Science Analyst, National Mental Health and Substance Use Policy Laboratory
- **Humberto Carvalho**, MPH, Project Officer, Center for Substance Abuse Treatment

National Institute on Drug Abuse

- **Redonna K. Chandler**, PhD, Director of the HEALing Communities Study
- **Jennifer Villani**, PhD, MPH, Associate Director of the HEALing Communities Study
- **Andrea Czajkowski**, MBA, PMP, Program Analyst, HEALing Communities Study

RTI Data Coordinating Center

- **Joëlla W. Adams**, PhD, MPH, Research Epidemiologist
- **Lauren Farmer**, BA, Project Management Specialist
- **LaShawn Glasgow**, DrPH, MPH, Senior Director, Center for Program and Policy Evaluation to Advance Community Health
- **Craig LeFebvre**, PhD, MS, Communications Scientist
- **Emmanuel Oga**, MD, MPH, Senior Research Epidemiologist
- **Megan Hall**, MPH, Research Clinical Study Specialist
- **Beth Linas**, PhD, MHS, Research Epidemiologist
- **Mia Christopher**, MPH, Research Epidemiologist

RTI Editing and Design

- **Vivien Arnold**, MA, Senior Graphic Designer
- **Ally Elspas**, BA, Senior Graphic Designer
- **Rebecca Hipp**, BS, Senior Project Management Specialist
- **Claire Korzen**, BA, Editor
- **Shari Lambert**, BFA, Senior Graphic Designer
- **Michelle Myers**, BS, Senior Editor

APPENDIX D. TECHNICAL EXPERT BIOGRAPHIES

Laura Fanucchi, MD, MPH, FASAM, is Associate Professor of Medicine at the University of Kentucky in the Division of Infectious Diseases and the Center on Drug and Alcohol Research. Dr. Fanucchi graduated from Emory University School of Medicine and completed a residency and chief residency in Internal Medicine at New York – Presbyterian Hospital/Weill Cornell. Dr. Fanucchi is board-certified in Internal Medicine and Addiction Medicine and is the founding Director of the University of Kentucky inpatient Addiction Consult and Education Service. Her research is focused on developing innovative approaches to current clinical problems in the treatment of opioid use disorder that translate to improved outcomes. Dr. Fanucchi is an NIH/NIDA-funded clinical researcher and has received support from AIDS United and the Kentucky Opioid Response Effort for clinical service expansion and improvement in addiction medicine. She is a Co-Investigator on the HEALing Communities Study – Kentucky, providing clinical expertise, training, and technical assistance to support increasing access to medications for treatment of opioid use disorder in communities highly impacted by the opioid epidemic.

Fernando González, MD, MPH, has more than 37 years of experience in Public Health work in the United States and Mexico, with emphasis in the United States-Mexico border. He graduated from medical school at the University of Juarez, Mexico and received an MPH degree from the UTHealth Houston School of Public Health. Dr. González currently serves as manager for the EMS Opioid Prevention Program at UTHealth San Antonio/Project Vida in El Paso, Texas. The program provides peer support and clinical response services and develops predictive analytic models for optimal resource allocation. For more than 16 years, Dr. González has collaborated as senior consultant for Links Global based in Rockville, MD. The company provides worldwide solutions across many sectors, including public health. He has developed ample professional experience in global health, working and collaborating in both the United States and Mexico with federal, state, and international agencies such as Ministry of Health, Mexico; Pan American Health Organization; CDC; Texas Department of Health; U.S.-México Border Health Commission, U.S.; and Mexico Border Health Association. Dr. González has publications on maternal and child health, tuberculosis, public health services, and infectious diseases and has received awards and recognition from several agencies in the United States and Mexico.

Chase Holleman, LCSW, LCAS, serves as a Public Health Advisor in the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention. As part of the Office of Prevention Innovation, Mr. Holleman serves in a lead role supporting harm reduction efforts within the Center and across the Agency as a subject matter expert. In his previous role as Assistant Professor at UNC-Greensboro, he cofounded and directed GCSTOP, a novel harm reduction services program that doubles as a clinical training site for undergraduate and graduate social work students.

Edward "Ned" Nunes, MD, is a Professor of Psychiatry at Columbia University Irving Medical Center and Research Psychiatrist at New York State Psychiatric Institute. He is an internationally recognized leader in research on treatments for opioid use disorder and other substance use disorders and on co-occurring psychiatric and substance use disorders. For the past 30 years with continuous funding from NIH, mainly National Institute on Drug Abuse (NIDA), including a series of Career Development Awards, he has led clinical trials on medication and behavioral treatments for cocaine and opioid use disorders.

Richa Ranade, MPH, leads the overdose prevention department of the Association of State and Territorial Health Officials (ASTHO). In this role, she oversees ASTHO's technical assistance and capacity building related to overdose prevention, preparedness, mortality data, and surveillance. These technical assistance and capacity-building efforts regularly convene public health agencies, behavioral health agencies, public safety partners, harm reduction professionals, and others to collectively advance the public's health and well-being. Prior to joining ASTHO, Ms. Ranade was a health policy advisor for the Maryland Department of Health, where she managed multiple maternal and child health training and technical assistance programs. Earlier in her career, she supported and led qualitative and quantitative public health research efforts that aimed to describe the role of social determinants of health in health disparities. She completed her Master of Public Health at the George Washington University and a Bachelor of Science degree at the Pennsylvania State University. Ms. Ranade is passionate about facilitating partnerships, implementing evidence-based programs, and supporting the public health workforce.

Angelia Smith-Wilson, EdD, MSW, brings over 20 years of human service and addiction experience to Friends of Recovery-New York. Her career spans across working with human service agencies that have served people with mental health, substance use, residential, and homeless issues. She has worked as an intensive case manager, a primary therapist, a director of client services and eventually progressing to level of vice president throughout the greater Rochester and Albany NY area. Dr. Smith-Wilson has centered her career around improving recovery and treatment outcomes for those in recovery and exploring research designed at substance use counselor development. Her doctoral dissertation, "Examining the Relationship between the Substance Abuse Counselor Knowledge of the Models of Disability and their self-assessment of cultural competence working with the Deaf Sign Language User," afforded her the opportunity to learn and study addictions from the counselor's perspective. Her research further led her to develop trainings centered around cultural humility and its application to working with people in recovery. Dr. Smith-Wilson has a BS in Psychology from SUNY Brockport, MSW from Roberts Wesleyan College, and EdD from St. John Fisher College. Dr. Smith-Wilson is adjunct

faculty at the School of Social Welfare, Graduate MSW Program, University of Albany, where she teaches Macro Practice Social Work in the MSW program and a variety of undergraduate courses. She is currently a member of Black Faces, Black Voices, and on the CAPRRS Advisory Committee for Faces and Voices of Recovery, and a founding board member of Girls Beyond Inc.

Jessica L. Taylor, MD, is an Assistant Professor of Medicine in General Internal Medicine at the Boston University School of Medicine (BUSM) and Boston Medical Center (BMC) and a board-certified Addiction Specialist. She attended Mount Sinai School of Medicine and completed internal medicine residency training at Beth Israel Deaconess Medical Center and Harvard Medical School, where she also served as a Chief Resident. Dr. Taylor's clinical work focuses on the care of patients with substance use disorders, HIV, and viral hepatitis. Her research interests include HIV prevention among people who inject drugs, HIV pre-exposure prophylaxis implementation, low-barrier substance use disorder treatment models, and overdose prevention. She is Co-Director of the Care Continuum Core for the Massachusetts site of the NIDA-funded Healing Communities Study, which aims to reduce fatal opioid overdose by 40 percent. Dr. Taylor is the Medical Director of Faster Paths to Treatment, Boston Medical Center's innovative, low-barrier substance use disorder bridge clinic and she codirects clinical services in a former hotel that offers low-threshold, transitional housing for people experiencing homelessness. She directs HIV Prevention Programs at BMC. Her educational roles include directing the HIV Pathway for internal medicine residents and serving as core faculty in BUSM's Addiction Medicine fellowship program.

John Winhusen, PhD, is a Professor and Vice Chair of Addiction Sciences in Psychiatry, and the Director for the Center for Addiction Research at the University of Cincinnati College of Medicine. He has been a continuously funded NIDA investigator for over 20 years with much of his career focused on conducting clinical trials evaluating medication and psychosocial interventions in "real-world" clinical settings. Most of this work has been accomplished through his roles as both a lead investigator (national PI) of multisite clinical trials and node PI in the National Drug Abuse Clinical Trials Network (CTN). The research that Dr. Winhusen conducts has the goal of improving public health by improving addiction treatment outcomes and has been largely influenced by the two "epidemics" that have occurred during his career—the crack cocaine epidemic and the opioid epidemic. Since 2014, he has led or co-led eight NIDA-funded opioid-focused studies. As co-chair of the NIDA CTN Prescription Opioid Task Force, Dr. Winhusen played a critical role in developing the CTN Opioid Research Task Force Report, which outlined research priorities for addressing the opioid use epidemic. He serves as the Co-PI for the Ohio Healing Communities Study (HCS) and leads the national HCS Care Continuum workgroup.

ENGAGING COMMUNITY COALITIONS TO DECREASE OPIOID OVERDOSE DEATHS

PRACTICE GUIDE 2023

NIH National Institute on Drug Abuse

SAMHSA Substance Abuse and Mental Health Services Administration

Engaging Community Coalitions to Decrease Opioid Overdose Deaths Practice Guide

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NIH HEAL INITIATIVE
HEALing Communities Study

Released 2023

Contents

Key Terms

TERM	DEFINITION
Addiction	Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases. See American Society of Addiction Medicine Definition of Addiction
Behavioral Health	The term "behavioral health" means the promotion of mental health, resilience, and well-being; the treatment of mental health conditions and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.
Continuum of Care	An integrated system of care that guides and tracks a person over time through a comprehensive array of health services appropriate to the individual's need. A continuum of care may include prevention, early intervention, treatment, continuing care, and recovery support.
Evidence-Based Practice (EBP)	Evidence-based practices are interventions that are guided by the best research evidence with practice-based expertise, cultural competence, and the values of the persons receiving the services, that promote individual-level or population-level outcomes.
Harm Reduction	Harm reduction is a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (and their families) with the choice to live healthy, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of people who use drugs, especially those in underserved communities, in these strategies and the practices that flow from them. See SAMHSA–Harm Reduction
Intersectionality	The complex, cumulative intertwining of social identities that result in unique experiences, opportunities, and barriers. People may use "intersectionality" to refer to the many facets of our identities, and how those facets intersect. Some use the term to refer to the compound nature of multiple systemic oppressions.
Justice-Involved	This descriptor indicates past or current involvement in the criminal legal system, typically indicating the person has experienced one or more of the following: an arrest, prosecution, incarceration in a jail or prison, and/or community supervision.
Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex + (LGBTQI+)	Lesbian, gay, bisexual, transgender, queer, those who are questioning their sexual orientation or gender identity, and others who are not cisgender or straight/heterosexual. LGBTQI+ is used interchangeably with "sexual and gender minority."

TERM	DEFINITION
Medication for Opioid Use Disorder (MOUD)	This term refers to the class of medications that are FDA-approved for the treatment of opioid use disorder (OUD). They are often used in combination with counseling and other behavioral therapies to provide a whole-patient approach to the treatment of OUD. This class of medications includes buprenorphine, methadone, and naltrexone in different formulations. See SAMHSA Medications, Counseling, and Related Conditions
Peer Distribution	Peers are people with lived experience from the community. In a peer distribution program, peers distribute naloxone to others within the community outside of formal settings (e.g., medical offices, harm reduction agencies).
Peer Support Workers	Peer support workers are people with lived or living experience who help others experiencing similar situations.
Peer Recovery Support Services	Services provided by peer support workers may include emotional (e.g., mentoring), informational (e.g., parenting class), instrumental (e.g., accessing community services), and affiliational (e.g., social events) support. See SAMHSA Peer Support Workers for those in Recovery
People with Lived Experience (PWLE)	People who currently use or formerly used opioids, or their family members.
Recovery	Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. There are four major dimensions that support recovery: • Health: overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being. • Home: having a stable and safe place to live. • Purpose: conducting meaningful daily activities and having the independence, income, and resources to participate in society. • Community: having relationships and social networks that provide support, friendship, love, and hope. See SAMHSA Recovery and Recovery Support
Social Determinants of Health	Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The Social Determinants of Health cover five domains: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context. See Healthy People 2030: Social Determinants of Health
Stigma	Stigma arises from the negative feelings that many individuals harbor against people struggling with mental and/or substance use disorders, and their beliefs that poor personal choices, "moral failing," and defects of character are to blame for the disease. Stigma can reduce willingness of policymakers to allocate resources, reduce willingness of providers in non-specialty settings to screen for and address mental health conditions and substance use disorders, impact a person's standing in their community, limit access to employment or housing, and may limit willingness of individuals with these conditions to seek treatment. Some people object to this term as it may perpetuate a negative connotation. Others favor "prejudice and discrimination" as the societal attitudes and actions that reinforce negative stereotypes and policies.

TERM	DEFINITION
Telehealth	Telehealth is usually used as a broader term. Telehealth typically includes not only telemedicine but also other forms of telecommunication, including asynchronous or "store and forward" systems, which transfer a patient's data or images for a physician or practitioner at another site to access at a later time. With these systems, the patient and provider do not have to be present at the same time. See SAMHSA CCBHCs Using Telehealth or Telemedicine
Telemedicine	"Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment… [Medicaid] does not recognize telemedicine as a distinct service." See SAMHSA CCBHCs Using Telehealth or Telemedicine
Trauma	SAMHSA describes individual trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." See SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach
Trauma-Informed Approach	A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. Referred to variably as "trauma-informed care" or "trauma-informed approach" this framework is regarded as essential to the context of care. See SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Acronyms

ASAP	Agency for Substance Abuse Policy
BIPOC	Black, Indigenous, and people of color
CBPR	Community-Based Participatory Research
CE	Continuing Education
CME	Continuing Medical Education
CTH	Communities That HEAL
DEI	Diversity, Equity, and Inclusion
HCS	HEALing Communities Study
KY-ASAP	Kentucky Agency for Substance Abuse Policy
LC	Learning Collaboratives
LGBTQI+	Lesbian, gay, bisexual, transgender, queer, those who are questioning their sexual orientation or gender identity, and others who are not cisgender or straight/heterosexual
LMDC	Louisville Metro Department of Corrections
MOUD	Medications for Opioid Use Disorder
NIH	National Institutes of Health
OEND	Overdose Education and Naloxone Distribution
ORCCA	Opioid-Overdose Reduction Continuum of Care Approach
OUD	Opioid Use Disorder
PTTC	Prevention Technology Transfer Center Network
PWLE	People with Lived Experience
PWUD	People Who Use Drugs
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SUD	Substance Use Disorders
TTC	Technology Transfer Centers
WIC	Women, Infants, and Children

1. Overview

This publication is a product of the HEALing Communities Study (HCS) informed by the Communities That HEAL (CTH) Intervention Manual and integral contributions from research and community partners across four research sites. This guide was developed in recognition of the need to center community engagement throughout the efforts to address the opioid overdose crisis. This guide exists to help communities decrease opioid overdose deaths; it includes tools and real-world examples that can be used to build and strengthen community coalitions that work to reduce opioid overdose deaths.

Care continuum is the span of care across prevention, diagnosis, engagement, and retention in OUD treatment.

Harm reduction is a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (and their families) with the choice to live healthy, self-directed, and purpose-filled lives. (SAMHSA).

Recovery is a "process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential" (SAMHSA).

WHO IS THIS GUIDE FOR?

The guide was developed for the Substance Abuse and Mental Health Services Administration (SAMHSA) Technology Transfer Centers (TTC) program and other providers of technical assistance as a resource for individuals working to end the opioid crisis. These individuals include community coalition members, professional treatment providers, recovery support specialists, people with lived experience, policymakers, recovery program administrators, and many others working to prevent, treat, and support recovery from substance use disorders. This guide is particularly designed for individuals who can help create new coalitions, or support and encourage opportunities to potentially re-envision existing coalitions, to address the opioid crisis in their communities.

HOW WAS THIS GUIDE DEVELOPED?

This guide leverages insights from the community engagement approach deployed through the Communities That HEAL (CTH) intervention of the HCS. In deploying the CTH, researchers partnered with community coalitions to create data-informed action plans for selecting evidence-based interventions to reduce opioid overdose. As part of the development of this publication, an eight-person technical expert panel reviewed the community engagement elements of the CTH and recommended useful ways to share CTH insights and tools with the TTC network. The panel included experts from recovery and harm reduction agencies, SAMHSA, the National Institute on Drug Abuse, and the HCS. HCS researchers contributed case examples based on their experiences working with community coalitions to respond to the opioid overdose crisis. All experts provided input on the guide and reviewed all content. See **Appendix G** for a full list of contributors. A companion practice guide, *Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) Practice Guide*, features a menu of evidence-based practices for reducing opioid overdose deaths and real-world tips for implementing these practices.

WHAT IS IN THIS GUIDE?

This guide consists of six sections.

1. Guide Overview

Section 1 briefly describes the purpose of this guide, including who it is for and how it was developed.

2. Community Engagement Fundamentals

Section 2 defines community engagement and its principles, describes how coalition building is a key element of community engagement, and provides a brief overview of how coalitions were central to the CTH intervention.

3. Building a Community Coalition

Section 3 provides guidance on defining your community, conducting a community assessment, identifying potential coalition members, and assessing coalition representativeness.

4. Maintaining and Strengthening a Community Coalition

Section 4 reviews the importance of providing bidirectional training opportunities, the importance of developing goals and a shared vision for the coalition, and how to improve coalition efficiency.

5. Assessing Community Engagement and Coalition Functioning

Section 5 provides guidance on how to measure the quality and implementation of community engagement activities and insights on how to improve community engagement within an existing coalition.

6. Appendices

Appendices include tools that can be used to support coalition building and maintenance, biographies of the technical expert panel, and additional information on the HCS study and guide development.

See **Appendix F** and the HCS website for more information: hcs.rti.org

2. Community Engagement Fundamentals

INTRODUCTION

The opioid overdose crisis has had a generational-defining impact on the United States. From mountain towns in remote Appalachia to bustling cities in the Northeast to the West Coast, no community has been spared. The scale of suffering and loss of life is difficult to grasp. For context, in 2020, one person died of an opioid overdose approximately every 8 minutes. In the same year, more Americans died from a drug overdose than from a motor vehicle accident.[1; 2]

From parents who have lost children to small business owners, practitioners, and policy makers, engaged community members have united to make it their collective responsibility to find local solutions to address the opioid overdose crisis. These efforts are bolstered by experts whose lived experiences help inform strategies to protect the lives of people who use drugs and ultimately to strengthen our communities.

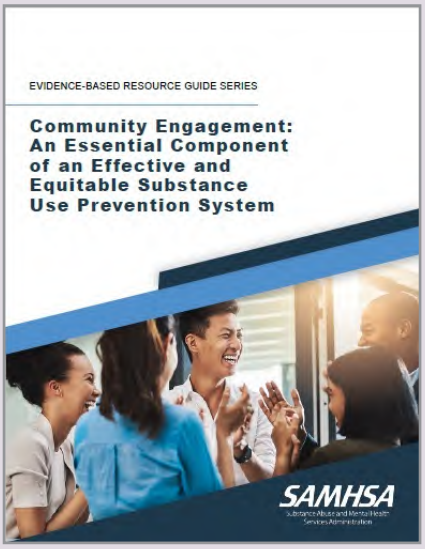
Infused with stories from the field and insights from more than 67 community coalitions across four states participating in the HEALing Communities Study (HCS) and a panel of experts, this guide includes strategies for people and groups committed to ending the opioid overdose crisis. Our focus is on **community coalitions**—groups of people, organizations, community groups, or other bodies who undertake a joint effort to achieve an agreed-upon goal[3]—who are working to end the opioid overdose crisis. Although we share some general fundamentals of community engagement to inform coalition building, our primary focus is on sharing guidance for overcoming some of the unique challenges that may arise when responding to the opioid crisis. These challenges range from addressing stigmatizing beliefs that community members hold about medications for opioid use disorder (MOUD), to ensuring that the coalition is authentically representing the community, to facilitating coalition meetings that bring people who use drugs and law enforcement into the same space. Throughout this guide, we highlight "Stories from the Field," in-depth examples of the challenges coalitions implementing the Communities That HEAL (CTH) intervention faced, their solutions, and their lessons learned. We hope that these insights will inspire you and your coalition to create and sustain effective, community-led change.

WHAT IS COMMUNITY ENGAGEMENT?

Community engagement is defined by the World Health Organization as a "process of developing relationships that enable participants to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes." Community engagement is an ongoing process, not a set of steps to follow and then mark as completed. Genuine engagement seeks to bring together the skills, knowledge, and experiences of the community to create solutions that work for all its members. It aims to ensure that people who are most affected by challenges and inequities have a voice in creating and implementing solutions to accelerate change. For those working to end the opioid overdose crisis, this means working with community members who are most affected by the crisis, including, but not limited to, people with lived experience, service providers, law enforcement, and emergency medical services personnel. We describe exactly who might be at this table and potential ways of engaging them in coalition work within the "Building a Coalition" section.

CORE PRINCIPLES OF COMMUNITY ENGAGEMENT

Community engagement can improve health outcomes, lead to more-tailored programs (i.e., programs that are intended to reach a certain audience), decrease stigma and discrimination, help communities maximize scarce resources, and improve a sense of representation within marginalized communities. The Substance Abuse and Mental Health Services Administration's (SAMHSA's) resource, *Community Engagement: An Essential Component of an Effective and Equitable Substance Use Prevention System*, notes that successful community engagement can take many forms, but shares the following core principles:



Transparency and trust: Community engagement should create an environment where all ideas are respected and considered.

Careful planning and preparation: Community engagement is a rigorous process of organizing around a specific issue.

Inclusion and demographic diversity: Community engagement involves leaders from different sectors of the community, as well as community members themselves. It is important for coalition members to represent the community's diversity.

Collaboration and shared purpose: Community engagement brings together organizations and people around a common purpose or vision.

Openness and learning: Participants should be open to information and ideas from all types of experts.

Impact and action: Community engagement focuses on making a difference and having an effect on the identified topic.

Sustained engagement and participatory culture: Community engagement is ongoing. All participants are valued for their contribution.

COALITION BUILDING AND COMMUNITY ENGAGEMENT

Coalition building is a common approach to community engagement. This guide focuses on engaging communities through building and maintaining coalitions to decrease opioid overdose deaths. The goals of a coalition can be wide ranging, from advocating for specific policy change (e.g., take-home methadone) to sharing resources (e.g., community-based distribution of naloxone).

Coalitions are effective because they can accomplish what would be difficult for an individual to accomplish alone, and they contribute to the community engagement process in several ways. Coalitions can help maximize the influence of people and organizations. Think of a peaceful protest—a group of protestors will most likely be more influential than just one or two. Coalitions can also create new collective resources and connect people to them. Two minds are better than one; in other words, a group working together often creates new ideas and creates them more quickly. And each coalition member brings their own network of connections to the group, therefore creating a larger network for deploying resources and ultimately effecting change.[3]

Evidence-based practices are approaches that have been shown, through research and evaluation, to be effective in decreasing opioid overdose deaths.

COALITION BUILDING AS A PART OF THE CTH INTERVENTION

The CTH intervention engaged communities through coalition building.[4] As part of the intervention, new community coalitions were established, or existing coalitions were enhanced, to support the selection of evidence-based practices for decreasing opioid overdose deaths. These coalitions included members with lived or living experience; representatives from healthcare, behavioral health, and criminal legal systems; policymakers; and other community members. Members worked together using data to prioritize, implement, and monitor evidence-based practices. This guide shares lessons learned and tools from the coalition building work of the CTH to help other communities build and strengthen coalitions committed to addressing the opioid crisis.

COMMUNITY ENGAGEMENT DOS AND DON'TS

Do

☐ **Make time and embrace the process**

Make time to think critically about how you are engaging the community, checking your biases and assumptions, sharing power, and taking the community's lead. Community engagement success lies in the process.

☐ **Be inclusive**

Ask, "Who is in the room and who is not?" Having diverse perspectives is about creating the clearest possible picture of strengths, needs, and solutions.

☐ **Build trust and deeper relationships**

Make sure that roles and responsibilities are clear and decision-making processes are agreed upon.

Engaging community requires bringing ourselves and our identities to the table to build trusting relationships where engagement can thrive. Be vulnerable; share yourself.

☐ **Co-create with shared power and decisions**

Work with communities and share the power of decision-making. The community has expertise that is critical to the success of the program. Listen to what community members want and why before providing input and guidance.

☐ **Be a universally great communicator**

Really, really listen. Be clear and don't use jargon. Use "I" statements. Be present.

☐ **Keep perspective and mess up gracefully**

Remember we are here to save lives together and do less community harm by working with community. You're bound to mess up … try to do so with grace.

☐ **Cultivate the space**

Create spaces where marginalized voices are welcome, disagreement is embraced, and unspoken power dynamics are named.

Don't

☐ **Ignore community engagement and give into stress**

When we are stressed, we are prone to bad decisions and community engagement can take a back seat. But times that can cause stress are often the times to focus most on thoughtful engagement and process.

☐ **Force your agenda**

Don't leverage your expertise over community experience. Check your assumptions, preconceived notions and solutions, and entitlement at the door. Show up to listen and understand before offering guidance.

☐ **Take the path of least resistance**

Confrontation and conflict are key aspects of growth and moving forward. Don't avoid them for the sake of your comfort. Ask tough questions of yourself, your team, and coalitions. Be okay with being asked tough questions.

☐ **Ignore important dynamics**

Keep structural and institutional lenses in mind when working to solve problems and check yourself. Don't try and fix things or people. Don't take up too much space, and don't ignore power dynamics in the room.

Adapted from material developed by

NIH HEAL INITIATIVE

HEALing Communities Study Massachusetts

3. Building a Community Coalition

FRAMEWORK FOR COALITION BUILDING

Understand your community ▶ **Identify potential coalition members** ▶ **Orient members to OUD and EBPs** ▶ **Develop rules of coalition engagment**

1. Understand Your Community

The first step in building a community coalition is gaining a deeper understanding of your community through a community assessment. This assessment should preferably be led by, but at a minimum must involve, those who live in the community and who are intimately familiar with the community's strengths and weaknesses related to the opioid overdose crisis.

Define your community. Before the community assessment, it is important to define the community you are seeking to reach and serve. Specifically, what does community mean to you and potential coalition members? Is it a geographic entity like a town or county, or a sociocultural grouping like a shared faith or cultural background?

Does this community change over time, or is it stable? Could you draw bounds around your community? Who represents the community? Who should speak for the community, even if they are not currently empowered to? Who is most affected by the opioid overdose crisis in your community?

Coalition builders can draft an initial definition of their community to guide community assessment work and coalition member recruitment. However, as members are recruited, the coalition should review and work together to refine their definition of their community.

Engage community experts. You can work with a core group of experts to identify and recruit coalition members and find resources to support coalition efforts. Think beyond academic or technical training—expertise can be deep knowledge of a community or lived experiences relevant to the coalition's work. Ensuring that people most affected by the opioid overdose crisis and those at higher risk of opioid overdose have an active role in building the coalition and goal-setting will maximize the impact of your coalition. Involving these people from the very beginning, before the first coalition meeting is even held, will set the stage for meaningful and thoughtful involvement throughout the coalition's work. Start by reaching out to people you know who are working on addressing the opioid overdose crisis in your community or work in agencies serving people at higher risk of opioid overdose. Share your thoughts about creating a coalition and ask whether they are willing to help by being part of this initial core group.

People to include are:

- **People with lived experience** (i.e., people who currently use or formerly used opioids, or their family members) who can provide key insights on treatment experiences, community-held beliefs that might affect coalition activities, and anticipated challenges and facilitators for implementing evidence-based practices to decrease opioid overdose deaths.

- **Members of local organizations** that deliver services to people at higher risk of opioid overdose (e.g., syringe service programs, addiction treatment organizations) in your community who can share information about how different approaches to decreasing overdose deaths have worked or might work in their settings.

Conduct a community assessment. A community assessment helps answer the question, ***"what is currently being done to address the opioid crisis in my community, and what more can be done?"*** Understanding your community's existing resources to address opioid overdose deaths, gaps in services, and barriers to care is critical for planning an appropriate response to the opioid crisis. This assessment should document the availability of overdose education and naloxone kits and locations treating opioid use disorder (OUD), including medication for opioid use disorder (MOUD). The assessment should also determine whether services are reaching people who are at higher risk for overdose. Speaking with community members, particularly those with lived experience, and with service providers can help identify existing gaps. You can also search online, using Google or another search engine, to identify existing services or organizations in your community.

When seeking community expertise, consider your community's

- **sociodemographic** characteristics (race, ethnicity, age distribution, gender and sexual orientation, etc.);
- **sociocultural** characteristics (political climate, religion, country of origin, languages spoken); and
- **history** of opioid-overdose-related work within the community and key leaders.

The most-successful efforts will establish buy-in and build trust among community members and community leaders and thoughtfully seek out and engage underserved populations.

Tool 1: Guiding Questions For A Community Assessment

Focus	Guiding Questions	Information Sources
Existing Services	• What are existing services for people at higher risk of opioid overdose in your community? • What substance use treatment services are available? – Recovery support? – Social services?	• Speak with community members about available services, including the following members: – People with lived experience, including people who use drugs (PWUD) – Recovery support service providers – Staff at harm reduction agencies – Treatment providers • Search online for community resources • Search for providers using SAMHSA's Buprenorphine Practitioner Locator
Service	• What are the most pressing gaps between existing services and those needed? • What services have people at higher risk of overdose sought out and haven't been able to locate? • What are the greatest needs expressed by community experts? • What populations are underserved?	• Speak with community members about service needs • Recovery support service providers • Staff at harm reduction agencies • Treatment providers

Another approach to a community assessment is **asset mapping**.

Asset mapping is systematic process of cataloging individual-level and organizational resources in a community. Assets may include people trained to provide peer support services to people in recovery, community-based harm reduction programs, or organizations that provide space and support for community outreach. Assets can be marked on a map of your community. Mapping resources helps you "see" available resources for addressing the opioid crisis, as well as areas where more resources are needed.

This type of assessment leads a community to look within for solutions and resources to solve problems. As a result, asset-based mapping fosters a sense of independence, pride, and possibility as the community discovers and appreciates its own resources. Asset-based mapping can empower residents to realize and use their abilities to build and transform their community and to develop self-reliance.

Examples of individual assets

Skills, talents, and experience of residents, individual businesses, and home-based enterprises; social capital; human capital

Examples of organizational assets

Community members' organizations (service clubs, fraternal organizations, athletic clubs), business associations, financial institutions, cultural organizations, communications organizations, and religious organizations

Example questions

- What is something good that happened to your community recently?
- What personal talents or skills can community members contribute?
- What issues or concerns related to opioid use is your community willing to address?
- Who in your community is working to reduce opioid overdose?

Coalition builders can also engage in a **needs-based assessment**. This type of assessment is based on a community need or a problem that concerns the community. This approach looks at gaps and deficiencies and determines needed improvements. Be aware that this type of assessment can lead to the coalition seeking outside assistance rather than looking for community change agents. Because a needs-based assessment focuses on communities' weakness and inabilities, it can discourage community members, who may begin to believe that only outsiders can "fix" them.

Example questions:

- What is the problem we are trying to solve?
- What needs to be accomplished to reach our goals?
- What are the gaps within existing services in our community for people at high risk of opioid overdose?

Other community assessment approaches to consider: Speak with your community experts to decide on the right approach for your coalition. Additional approaches include the following:

- **Community walks**: A physical walk through a neighborhood of interest to map out and collect information about the neighborhood's resources and dynamics. This method provides a firsthand view of the community, its people, and assets. These assets can be placed on your asset map. Consider having people with lived experience (PWLE), peer champions, or other coalition members representative of the community who are familiar with your community's many people and assets lead this walk.
- **Listening tours**: A talk with community experts. Use descriptive and open-ended questions about the community and its potential assets to allow the interviewee to speak freely.
- **Focus groups**: A focus group is a small-group discussion guided by a trained leader. It is used to learn about opinions on designated topics/ assets.
- **Inventories of individual and organizational capacities**: A technique for collecting information about a community through observation. It works best when conducted at a community meeting or gathering. Consider adding inclusion criteria around this task for larger communities (for example, size, service area, or type of service provided).
- **Visioning**: A collaborative, creative process that results in a blueprint for a shared community vision and values. A shared community vision is an overarching goal for the community now and in the future.

More-formal approaches (asset mapping, focus group) can be useful if sharing information with potential funders or with governmental officials. Less-formal approaches (interviews, visioning) may be particularly useful for generating excitement and buy-in from potential coalition members. Feel free to mix and match approaches to gain deeper understanding of the community content.

Additional resources for conducting a community assessment:

- Community Toolbox: Assessing Community Needs and Resources: Features information on how to assess local needs, including how to conduct public forums and listening sessions, needs assessment surveys, and other approaches to community assessment
- CDC Community Health Improvement Navigator: Features tools such as Vulnerable Populations Footprint, Community Need Index, and CDC Community Health Status Indicators

Should I work with an existing coalition? There may already be a coalition in your community that is working to address opioid overdose deaths or on a related issue, such as other substance use. These existing groups may function as a task force, advisory board, working group, or citizens' committee. Existing groups may have been started by community members or established by government officials.

When deciding whether to work with an existing coalition, consider the following:

- Does the mission/purpose of the existing coalition align with reducing opioid overdose deaths?
- What geographic region does it serve?
- What population(s) does it serve?
- How was it established?
- How long it has been in existence?
- Does it have any organizational or government affiliations?
- How is it funded?
- What is its membership size and composition? Does it represent different types of organizations and diverse community members?

Benefits of working with an existing coalition can include avoiding duplication by coordinating efforts, pooling resources and networks, and starting off with a deeper understanding of previous efforts in the community. An important consideration is whether there is bandwidth and interest in addressing specific goals important to the priorities that the core group of your coalition builders named. Existing coalitions may be established in approach, have a fixed way of operations, and possibly be less open to expansion of mission and change. If there is not perfect alignment, but there remains interest in engaging the coalition, it might help to have a memorandum of understanding that sets out expectations and allows your priorities to be addressed.

2. Identify Potential Coalition Members

Who will be invited to join the coalition, and how will you approach them? Before recruiting coalition members, think through the recruitment process and how to best prepare for sustained engagement over time.

How will you reach out to potential coalition members? Develop a recruitment plan that outlines the steps you will take to recruit potential members. For example:

- Develop a 30-second "elevator pitch" describing the local overdose crisis and potential solutions that the coalition could pursue.
- Share the pitch with your core group of community experts and incorporate their input.
- Ask your community experts to recommend potential coalition members (also referred to as "snowball" recruitment) and use the networking capacity of your core group to the fullest.
- Create a tracking form to document outreach and avoid duplication.
- Decide on the method of outreach. Potential methods include face-to-face meetings, phone calls, email, personal letters, mass mailings, flyers, and posters.
  - Note that not all outreach methods are inclusive. Not everyone has a mailing address or a cell phone; therefore, these should not be exclusively relied upon.
  - Carefully craft messaging included on flyers or posters. Avoid stigmatizing language. We do not recommend publicizing that the coalition is recruiting people who use drugs (PWUD) to serve on the coalition; rather, work through personal networks to reach out. More guidance is shared later within this section.
- Plan for one-on-one meetings, preferably face-to-face, with potential coalition members to gauge views on OUD and interest in participating in the coalition.

See **Appendix A** for a Coalition Checklist

Who should be at the table? Who will be most affected by the coalition's work? Who can help move the coalition's work forward? Informed by your community experts and the community assessment, think about the sectors of community life that will need to be at the table and how best to ensure that those sectors are represented. How will you engage the perspectives of those who are most affected (i.e., those who stand to gain or lose) in coalition decision-making?

Who should be at the table:	
People with lived experience	» People who currently use or formerly used opioids, or their family members, who can speak to the needs, challenges, and preferences related to their firsthand experience
Addiction treatment and recovery facilities	» Opioid treatment programs » Settings providing medically managed withdrawal treatment or socially managed withdrawal
Behavioral health	» Providers who are likely to implement evidence-based practices to decrease opioid overdose deaths
Health systems, agencies, and healthcare providers that are likely to implement evidence-based practices to treat with medications for opioid use disorder and to reduce overdose deaths	» Hospitals (emergency departments and other divisions) » Federally qualified health centers » Primary care practices » Pain management clinics » Maternal health practices (OBGYN, Planned Parenthood, etc.) » Pharmacies
Emergency response units from municipal sub-units or geographical areas	» Emergency management services » Fire departments
Local law enforcement and criminal legal organizations	» Jail/prison administrators » Sheriffs » District attorneys » Narcotics squads » Police (can also be considered first responders) » Drug or treatment courts » Family courts » Community supervision » Probation/parole
Harm reduction services	» Syringe exchange programs » Mobile units » Naloxone programs

Continued

Who should be at the table (continued):	
Organizations that address social determinants of health, including social services and entitlement service providers	» Housing service providers (public and private, hotels, etc.) » Transportation outlets/providers » Food insecurity organizations (food pantries, WIC, etc.) » Employers (large and small) » Education (public school administrators, representatives from local colleges, etc.)
Local service organizations, civic leaders, and other potential influencers	» County administrators and supervisors » Legislators » Prevention resource centers and providers
Other potential partners	» Clergy and faith-based organizations serving affected areas of the community » Media and health messaging resources and outlets » Local advocacy organizations (including previously existing local coalitions) » Victim services » Local businesses, Chamber of Commerce » Veterans and organizations serving veterans » Different municipal subunits or geographic areas of the community
Organizations that support specific demographic groups experiencing OUD-related disparities	» Specific age groups (youth, seniors, etc.) » Black, Indigenous, and people of color (BIPOC) communities » Lesbian, gay, bisexual, transgender, queer (LGBTQI+), and other communities supporting individuals who are not cisgender or straight/heterosexual

How can I ensure that the coalition reflects the community? Coalitions should evaluate membership to determine whether the right people, organizations, and voices are included in its operations and decisions. Diversity of membership should be considered in terms of age, gender identity, sexual orientation, race, ethnicity, class, and ability to reflect the underlying demographic makeup of the community. Geographic diversity is also important, including diversity in municipal subunits or geographic areas of the community.

Communities of color have been and remain disproportionately affected by opioid overdose and premature mortality caused by substance use, exclusion from access to high-quality care, and criminalization. Incorporating a health equity lens into recruitment processes can improve the reach and impact of the coalition's work.

Diversity, Equity, and Inclusion (DEI)

Many community-driven organizations have begun insisting on DEI frameworks when partnering with community coalitions. As discussed within this guide, it's important to include PWUD and PWLE. It's equally important to ensure there are others at the table who may have been traditionally overlooked. For example, there are many Black and Brown communities in addition to organizations that serve Black and Brown communities. When building and growing coalitions, it's important to ensure these people and organizations are involved in your work. To do that, you must be deliberate in inviting them to join you. Consider drafting an equity statement to ground your coalition's DEI efforts and sharing it with community members and organizations during outreach.

Sample Equity Statement

Our coalition is committed to promoting and prioritizing racial equity for Black, Brown, and Indigenous people and other people of color. We will strive to ensure equity, diversity, inclusion, and belonging when setting coalition goals and recruiting peer champions to be involved in or lead our efforts. We will be intentional about including Black, Brown, and Indigenous people and other people of color in developing and executing our plans to ensure all voices in our community are heard and all community members have equitable access to any resources our coalition develops.

Prioritizing health equity

Some best practice tools for integrating equity into coalition recruitment and retention include the following:

- The Opioid Crisis and the Black/African American Population: An Urgent Issue
- Racial Equity and Social Justice Process Guide
- Equitable Hiring Tool
- Fast Track Equity Analysis Tool
- Comprehensive Equity Analysis Tool

Should recruitment involve a screening and interview? Consider meeting with potential coalition members one-on-one to share information on the local OUD crisis, discuss potential solutions, and learn more about the potential member informally to determine fit. Determine their availability to participate in coalition meetings and their interest in potential coalition goals.

How to gauge views on OUD and prevention? Recruitment is also an opportunity to better understand a potential member's views about OUD and evidence-based practices to reduce overdose deaths. Does the member hold beliefs relevant to the coalition's work that may need to be considered? For example, a parent who has lost a child to overdose may not be as receptive to harm reduction approaches such as naloxone distribution and prefer to engage in work more focused on prevention of opioid use. A person in recovery may hold certain beliefs regarding different types of treatment and feel uncomfortable working on efforts to expand the use of MOUD vs. other OUD treatment approaches. Listen to their perspective. Think through how best to leverage their experiences to further the work of the coalition. Note any potentially stigmatizing beliefs, and discuss these beliefs further during coalition training opportunities. Is the potential member open to hearing different perspectives? Be up-front from the outset that although a range of perspectives will be represented within the coalition, stigmatizing language will not be acceptable, and respect for all persons, including those actively using, will be a coalition norm. If the member's views do not seem compatible, be clear and forthright to avoid mismanaged expectations.

How to recruit people with lived experience in a way that protects their well-being? As coalitions tasked with prioritizing our community's needs, we must listen to those in the community most committed to and affected by our work. For initial recruitment, consider complementing existing efforts with a focus on engaging with and recruiting PWLE:

- Leverage existing community workgroups and coalitions not only to increase membership but also to learn how they recruited members with lived experience or members who actively use drugs.
- Relevant groups may be referred to as task forces, community advisory boards, working groups, citizens' committees, or something else.

Prioritizing the Voices of PWLE/ PWUD

Harm reduction, considered a social policy and public health model, was born out of grassroots efforts by PWUD and community activists. PWUD play a critical role in identifying emerging issues, particularly in the evolving drug supply as well as associated health behaviors and outcomes.

PWUD are the only population at risk for overdose and, therefore, the very people our work as a community coalition must prioritize and protect. We need their expertise and lived experience to be successful.

- When deciding what groups to prioritize for potential partnerships, consider what's most important for your members and your work to ensure a good fit. For example, your coalition may prioritize racial equity. It will be important to have candid conversations with potential partners to ensure they, too, are committed to equity for community members who have been systematically underserved and discriminately affected by fatal overdose. (See also the Sample Equity Statement.)
- Work with your local brick-and-mortar harm reduction services, syringe service programs, and opioid treatment programs to learn about their experiences and ask for their help. They most likely know of an individual or a group that is well-connected within the community and can be the voice of those your coalition aims to support (e.g., a community peer or community champion). (See also Coalition Roles: Chairs and Champions.)
- Work with your local leaders to generate a list of existing initiatives, coalitions, or community workgroups who prioritize PWLE membership.

Making these connections and building these relationships takes time. Take small steps. Start with what you know and who you know. Next, supplement that knowledge with information publicly available online. You can be confident in knowing that you are not starting at zero, but rather, building on the successes and lessons learned of those in your community committed to a similar cause. You'll also have the opportunity to pay it forward to the next group looking for *your* advice.

When speaking with potential coalition members with lived experience, consider the following best practices:

> *"The emphasis here is on inclusion. Not representation, not membership. We are not checking a box. We should focus on the process or the processes of inclusion instead of representation or membership. Using a phrase like 'PWLE membership is required/not required' is actually the antithesis of our coalition's efforts to be inclusive."*
>
> —Coalition Inclusion Champion

- Emphasize that participation in the coalition or coalition work will not be connected to any criminal legal purpose, particularly when including law enforcement representation within the coalition.
- Recognize publicly and privately that their knowledge is valuable.
- Allow people to decide on how to introduce themselves and their story. Accept that "PWUD" or "PWLE" may not be what these experts want to be called.

- Do not require people to share their story or disclose their experience. Offer to keep documentation related to personal experiences at a minimum if documentation presents a barrier.
- Avoid tokenism, or only inviting an individual from an underrepresented group to participate to give the appearance that the coalition is diverse and inclusive. Be intentional about inviting PWLE and PWUD to participate in the coalition and creating a coalition culture where they are welcomed, empowered to engage, and valued.
- Don't assume that one individual or a few people can speak for an entire group of people. Seek out multiple perspectives.
- Emphasize that the knowledge and insights of PWLE will be incorporated meaningfully into coalition decision-making.
- Consider reimbursing people for transportation costs or time related to attending coalition meetings, if funding is available, and share this information during recruitment.

Peer Bill of Rights

Consider asking your peer champions to create a bill of rights for your coalition. This not only empowers your peer champions to take ownership but also ensures that all coalition members and community partners maintain respect for all people (i.e., treat one another fairly, with dignity and equity, and support each other to develop your full potential).

Some example rights from the Peer Network of New York's Peer Bill of Rights include the following:

- "Every Peer has the right to be included in the process of making decisions about POLICY and ADVOCACY efforts that impact Peers"
- "Every Peer has the right to be supported in fighting the fear, shame, and stigma that keeps us from participating in our communities and from accessing health services"
- "Every Peer has the right to be supported in developing our skills and knowledge so we can become better harm reduction educators and advocates, and eventually lead and run professional organizations"

Additional resources for engaging people who are actively using drugs

- International Network of People who Use Drugs (INPUD)
- National Harm Reduction Coalition
- National Harm Reduction Technical Assistance Center: offers access to free help in providing or planning to provide harm reduction services
- Hazelden Betty Ford is a national organization offering peer-run training and technical assistance focused on keeping peer integrity first with strength-based delivery

How to achieve buy-in from agencies working to address the opioid overdose crisis? Informed by your community assessment, reach out to organizations that serve people at higher risk of overdose (e.g., harm reduction services, treatment providers, social services, local community groups). Request a brief meeting to share the initial coalition vision (e.g., reducing opioid overdose deaths in your community). Gauge interest in participating by asking whether they would like to send a representative to the initial coalition meeting. Emphasize that participation is voluntary.

If there is a long list of potential members, how will you narrow down the list? Engaging in initial one-on-one meetings with potential members can help determine their fit, availability, and interest in serving on the coalition. Note that there is no one ideal coalition size, and meeting attendance will likely fluctuate over time (see call-out box).

Insights from the implementation of the Communities That HEAL Intervention

Coalition membership, meeting frequency, and attendance

- **No one coalition size fits all communities**: Across the 67 coalitions, coalitions had between 17 and 44 members, reflecting 9 to 23 different organizations per community.
- **Expect meeting attendance to fluctuate over time**: Coalitions held monthly meetings that, on average, were attended by 9 to 19 coalition members. Over a 30-month period, coalition members attended an average of 6.5 meetings. Approximately 30% of coalition members only attended 1 meeting, 50% attended 2 to 11 meetings, and 22% attended 12 or more meetings over the 30 months.

3. Orient Potential Members to the Opioid Crisis in Their Community and Possible Solutions

Local OUD epidemiology. To have the biggest impact, your potential members must first understand the local opioid overdose epidemic. Seek to answer the following questions:

- Who is overdosing (e.g., age, race, ethnicity)?
- Where is overdose occurring (e.g., which neighborhoods)?
- In what settings are people overdosing (e.g., shelters, public restrooms, motels, residential settings)?

Use public health surveillance data, mortality data from the medical examiner's office, data from emergency medical services, or conversations with local harm reduction agencies to answer these questions. Examining your community's local overdose data enables you to better understand which people should be prioritized for receiving services and what solutions might work best.

> *When discussing data among coalition or community members, remember that in smaller circles, small numbers may be identifiable as lost or impacted loved ones. Encourage your teams to acknowledge this prior to discussing data.* ***We never want to lose sight that each data point represents a human life.***

Potential solutions. It can be overwhelming to navigate the literature to search for evidence-based practices related to OUD. Equally challenging is orienting potential coalition members to available solutions in an accessible, easy-to-understand manner. However, during initial meetings with potential coalition members, it is useful to discuss the potential activities the coalition could engage in. Remember that your goal is not to make every potential coalition member an expert in all possible strategies the coalition might pursue. Rather, your goal is to introduce the "toolbox" of different approaches that have a strong base of evidence to support their implementation. Refer to our companion practice guide, *Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) Practice Guide*, for a menu of evidence-based strategies proven to decrease opioid overdose deaths, along with tips and case examples from coalitions.

This initial discussion with potential coalition members is to think through the type of work that the coalition could perform, informed by the local OUD crisis and findings from the community assessment. What kind of work could the coalition do? This is also a chance to get excited about the things that a coalition could accomplish and highlight why the coalition is needed. For example, if your community assessment identifies that there are few or no locations for people to pick up a naloxone kit (i.e., overdose education and naloxone distribution [OEND]), you might discuss identifying a local medical provider who could assist in training and hosting a booth at a community event giving out free naloxone kits and information on overdose prevention.

We recommend providing in-depth training on evidence-based practice to decrease opioid overdose deaths for coalition members following the first coalition meeting (see Potential training topic: Scope of opioid overdose crisis).

4. Develop rules of coalition engagement

Plan and hold the first meeting. After working with your core group of community experts to conduct a community assessment and recruit potential coalition members, it is time to plan and hold your first meeting. Ideally, this meeting will be collaborative and have an energy and momentum that will inspire action. While acknowledging that the opioid overdose crisis is a serious topic and many have suffered and lost, cultivating a sense of hope and action will help people come back for future meetings with the enthusiasm and drive to work on the issue.

An agenda for this initial meeting could include the following:

- **Introduce all attendees**: Ask people to give a brief statement of who they are and what issue they are most excited to work on. If appropriate, consider adding a neutral easy-to-answer icebreaker question like "What is your favorite hobby?/What is your favorite local treat?/What is your favorite movie?" to encourage connections and bring energy to the meeting.
- **Orient attendees to the local OUD crisis and community assessment findings**: In a focused, brief presentation, share findings related to the community assessment and the local OUD crisis. Consider showing a short slide presentation displaying maps or main findings to walk through as a group. Ideally, have one of the core community experts share these findings.
- **Agree on coalition goal and purpose**: What is the coalition's overarching goal? It can be as simple as "reduce opioid-related overdose deaths." However, leave enough time and space to engage all members in this discussion. Spending time early on will avoid misunderstanding and conflict later. Note that setting specific goals related to this overarching goal will be a continuous process.
- **Discuss coalition operations**: Using a draft charter (see Draft a Charter) and draft coalition operations, walk through decisions regarding how the coalition will be run and ensure that all attendees feel involved.

Working with a pre-existing coalition?

- The initial meeting can focus on introductions and reviewing a summary of coalition activities to date as well as the community assessment.
- This first meeting provides an opportunity for existing coalitions to get a "fresh start" and become energized by a new way to function.
- Note that not all coalition members will welcome change, and there can be confusion about roles and responsibilities. Therefore, a coalition and community assessment before this first meeting is critical to diffuse some of the skepticism that may arise.

Encourage members to speak up regarding their preferences and aim for consensus. OUD and treatment can be polarizing topics, so it is important that the group establish a process for making decisions when there are disagreements.

- **Decide on initial coalition roles**: Typical coalition roles include a chair and co-chair. Consider holding an election or a nominating process to select a chair. Champions can be coalition members who champion specific issues or coalition activities; the "champion" role is further described below in the section titled Coalition Roles: Chairs and Champions.
- **Establish coalition norms**: To ensure all coalition members feel safe in the meeting environment and to foster a culture of respect, discuss and establish coalition norms. Some suggested norms for consideration are described in Decide on Coalition Norms.
- **Review action items and responsible members**: Decide on actions to be taken before the next coalition meeting and who will accomplish them. This can include things like sharing the charter for final review and approval, sharing meeting notes, following up on questions regarding the local OUD presentation, or reaching out to additional potential coalition members. If known, share the next meeting date so attendees are aware.

Make sure to follow up with attendees promptly with meeting notes and any action items. Request that attendees think about others who might be interested in participating in the coalition and continue recruitment efforts, if needed. Celebrate the success of the first meeting!

Draft a charter (for a new coalition) or memorandum of understanding (for partnering with an existing coalition). It's important to decide how the coalition will function and operate and to document these decisions in writing. For example, how often will the coalition meet? How will decisions be made? These details can be documented in a charter or in operating procedures that should be easily accessible for all coalition members.

See **Appendix B** for a Charter Template

Operating principles and protocols can be documented in a charter, membership agreement, or similar document. **Table 1** lists key elements to cover in a charter and operating procedures. See **Appendix B** for an example coalition charter template. Elements to consider including within coalition operating procedures are presented under Draft Coalition Operating Procedures.

Drafting a document for the coalition to discuss, rather than generating one from scratch during a meeting, will be more efficient and allows the coalition to engage in decision-making regarding coalition activities (rather than logistics) from the start. Before the first coalition meeting, start a draft charter that can be used to guide the coalition through determining how the coalition will function.

The purpose of a charter is to guide coalitions. Charters standardize the procedures of the coalition and create a set of norms that allow the coalition to orient new members to the coalition's culture. The charter development process should involve everyone, be engaging, and generate ideas from all members of the coalition. It is important to spend enough time on the charter so that coalition members fully understand it and agree that the structure and processes are fair, balanced, and legitimate.

Generally, charters will include the following elements:

Table 1. Elements of coalition charter

Element	Brief Description	Key Considerations
Goals and purpose	A high-level summary of what the coalition is aiming to do	Clearly state the impact the coalition hopes to have on the opioid crisis.
Member responsibilities and membership	• Attendance and participation expectations • Term limits • Procedure for new members joining the coalition (Who orients members? What training is provided?) • Procedure for existing members (Is there a debrief? How do you ensure continuity of activities?)	• Incorporate membership targets that relate to the goals of the coalition (e.g., ensure representation of healthcare providers, criminal legal system, people with lived experience). • State membership targets around community representation.
Equity statement	A statement of the coalition's commitment to equity, diversity, and inclusion	See Diversity, Equity, and Inclusion (DEI) for more information.
Coalition structure	• Description of key leadership positions (e.g., coalition chair, co-chair, champions) and responsibilities • Description of any committees and process of creating or disbanding	Suggested champion roles and committees are at Determine Coalition Roles: Chairs and Champions.

Continued

Element	Brief Description	Key Considerations
Decision-making process	• Approach taken to making coalition decisions (democratic process vs. consensus building vs. another approach) with specifics (for example, XX percent of membership must be present for a vote to take place) • Clarification of who can vote for coalition decisions • Build in options for electronic voting • Include a time limit on voting	Carefully consider how to encourage engagement in decision-making for marginalized populations and people with lived experience. Coalition leadership should be sensitive to the fact that coalition members have likely had experiences of not being included within decisions that affected them directly. Ensure power sharing.
Fiscal management and budgeting	• Details of how fiscal decisions will be recorded, monitored, and reported back to the coalition	Ensure that any funding requirements from grants or government partners are considered.
Meeting operations	• Description of meeting frequency (quarterly, monthly, etc.), platform (in person, Zoom), facilitation, communication (notes, slides shared, etc.), and documentation	Consider including relevant protocols for sharing sensitive content (e.g., no personal identifiers when disclosing past or current substance use, incorporating notices before sharing potentially distressing information).
Privacy and confidentiality	• Clarification of whether information shared during coalition meetings is confidential or public • Plans for recording meetings or opening the meetings to the public	Set expectations regarding any recording or photos. For example, coalition members will be notified at least 24 hours ahead of time if the meeting will be recorded.
Compensation	• Description of protocol and expectations related to reimbursing members for meeting attendance	Reimbursement can be used to help offset expenses related to participating in coalition meetings (e.g., transportation, childcare costs), Note that this amount should correspond with the time commitment required to fill the role, and it should not be coercive.

Note that charters are dynamic and can change over time, but changes should follow processes developed by the coalition, which can be outlined in the charter.

Draft coalition operating procedures. Coalition operating procedures should cover the following elements:

Timelines: Most coalitions need rapid progress, so procedures must orient coalitions to necessary timelines. If your coalition has received any sort of external funding (e.g., grants, awards), it is important to have transparent and open communication around the tasks that need to be completed on time to meet your funders' requirements.

Organization of meetings: Meetings should be scheduled in advance at regular times and intervals. When working with existing coalitions, the structure of existing meeting schedules and meeting frequency should be honored. It may be useful to develop a standing agenda that is distributed ahead of and at the meeting. Respecting your members' time is helpful for maintaining engagement.

Meeting locations: Face-to-face meetings are preferable. If desired, meetings may be held in different locations to make the burden of travel more equitable. Coalition members may decide to allow video or audio participation.

Documentation of meetings: Meetings may be recorded to facilitate generation of minutes. Meeting minutes and decisions should be documented using a structured meeting minutes form.

Communication among coalition members: Coalitions may establish ways to maintain contact with one another, local/county leadership, and outside groups. Be sure to consider equity when determining how best to reach all members. Some may have access to email while others don't.

Like charters, operating procedures are dynamic and change over time. Building in a regular review process to update them can help ensure your coalition functioning is thoughtfully considered and updated over time.

Determine coalition roles: chairs and champions. Establish roles needed to manage and run the coalition.

These roles can include the following:

- A **chair and co-chair for the overall coalition**. These people are responsible for overall leadership and decision-making of the coalition. This leader organizes the monthly meeting agendas, ensuring they align with the coalition's goals; meets with the community as needed; and reviews action items, decisions, and minutes.

See **Appendix C** for a sample role description of a potential full-time employee focused on community coalition coordination

See **Appendix D** for a coalition assessment tool

- **Champions**. People who are particularly driven to work on a particular issue may be interested in serving as a champion. Champions can agree to report back to the coalition on their issue of focus or perform actions related to the issue. If enough coalition members are interested, a committee (led by the champion) can be formed. Champion roles could include the following:
  - ***Peer Champion:*** Brings their lived experience from the community. Peer champions can lead recruitment efforts, advise coalition leadership, and provide trainings.
  - ***Community Engagement Champion:*** Leads recruitment efforts and new member orientation; coordinates community engagement training for coalition members.
  - ***Community Data Champion:*** Updates coalition with recent information on the local OUD epidemic.
  - ***Criminal Legal Champion (or Liaison):*** Assesses availability of and accessibility to community resources for people experiencing incarceration (e.g., access to naloxone and MOUD within local prisons and jails).
  - ***Harm Reduction and Outreach Champion***: Assesses availability of and accessibility to harm reduction resources and coordinates outreach with agencies (e.g., syringe service programs, OEND programming).
  - ***Housing and Community Benefits Champion:*** Assesses availability of and accessibility to social services, such as access to safe, temporary housing for PWUD.
  - ***Communication Champion:*** Develops and disseminates communication (e.g., social media posts, newsletters, local news pieces) regarding coalition activities.

Prioritizing the Voices of PWLE/ PWUD

Consider nominating a Peer Champion for your workgroup. This Peer, or Community, Champion will work with their peer networks outside of the coalition while reporting insights to the workgroup to ensure anonymity and safety to peers and current and future coalition members. You may also want to consider forming smaller working groups or subcommittees to foster a safe space and open dialog for your PWUD Peer Champions to share important insights from the community.

Decide on coalition norms. It is critical to establish a set of coalition norms that help create an environment where all members feel comfortable participating and different perspectives are respected. This is particularly important for marginalized groups, such as PWUD, BIPOC, and LGBTQI+. Clear norms can also help foster a safe and welcoming

environment for people who may be triggered by coalition discussions and work, such as people in recovery or people who have lost loved ones to opioid overdose.

These norms can be discussed and decided upon during the first coalition meeting. The following questions can help guide this conversation:

- How can we ensure that everyone has time to voice opinions and concerns?
- How do we want to handle differences in opinion?
- How can we ensure that everyone understands the discussion, without using unfamiliar terms, technical jargon, or acronyms?
- How will we handle discussions that we do not have time to complete during coalition meetings?

Welcome discussion about these norms and, as a group, decide how the coalition will strive to handle these issues.

Be clear about what type of behavior will not be tolerated (for example, use of stigmatizing language or personal insults).

Essential Element: Ensuring PWLE Are Empowered to Engage

What should we do if someone uses stigmatizing language during a coalition meeting?

Coalition norms should empower coalition members to point out any use of stigmatizing language. Understandably, this can be awkward and can make people feel uncomfortable. The following are some tips or suggestions for how to address the use of stigmatizing language:

- Orient coalition members to person-first language and preferred terms related to OUD (e.g., use “patient,” “person with OUD,” or “person in recovery” rather than “addict” or “user”) at initial meetings. These resources can be helpful in guiding this orientation.
- Let people choose how they are described. Terminology may shift.
- Foster an environment of learning together. Even the most well-meaning person can say the wrong thing or state something that can perpetuate stigma. With the goal of educating others, challenge inaccuracies and guide people to the preferred terminology.
- On the other hand, it can be frustrating to feel responsible for educating others and doing so can lead to people feeling burned out. Allow people to share their thoughts, anonymously, with the coalition chair during or after a meeting so the responsibility doesn’t fall only on certain people to advocate for change.

How can we ensure that people with lived experience feel safe and comfortable participating in coalition meetings?

- Foster an environment of listening and open-mindedness.
- Model respectful, person-first language and discuss impact of stigmatizing terms.
- Identify a meeting place that accommodates the needs and requests of people to ensure everyone feels comfortable and safe participating.
- Collectively decide on expectations. For example:
  - If someone uses substances on site, do they want intervention?
  - Any recording, written, audio, or video, will be clearly announced to all.
- Have a plan in place for if and when discussion becomes triggering or distressing. Is there a physical space set aside where coalition members can have a private moment? Is there an easily sharable resource list that might assist in immediate needs (e.g., safe housing, bridge treatment, mental health resources)?
- Understand that it is likely that many coalition members have experienced stigma from healthcare providers, law enforcement, and others represented within the coalition. Interactions may step outside previous relational boundaries. Be willing to take this journey together, knowing it could be vulnerable for all parties. Don't mistake passion for anger.
- Advocate that everyone deserves health and wellness, including those actively using drugs.
- Be willing to have tough conversations with everyone, including people with lived experience.
- Understand that people who are actively using, unhoused, or experiencing

Engaging PWLE Through a Peer Recovery Coach and Peer Champion with Lived Experience

Boston, Massachusetts

Our Community Advisory Board (CAB) encouraged inclusion and engagement with people who were current and former users of drugs. Some people disclosed this information; others did not. **Paul Bowman**, a prominent advocate dedicated to reducing opioid overdose deaths, served as one of our CAB's experts.

He leveraged his lived experience with recovery and substance use disorder to help ensure a safe space for all coalition members to engage and share stories to inform our work. He kept us on our toes by bringing up the most important issues that people who were using drugs were facing, what support they needed, who wanted to elevate their voices, and who preferred to provide insight anonymously. He did not shy away from anything; he made sure we were facing issues head-on and in real-time.

> *He was really a hero for all of us, and we have been able to ensure his influence and legacy is part of our work.*
>
> —Erin Gibson, HCS-MA

significant challenges may have difficulty seeing the coalition's bigger picture because of their immediate present challenges. Be able to bring in the vision and convey, with compassion, that certain actions or statements might not be appropriate if you are seeking to build bridges.

- Ground discussion in an understanding that the coalition is about "us" as a community and not "them" as people with lived experience.
- Emphasize at every meeting: "Nothing about us, without us".

What if the coalition loses a coalition member or peer to overdose?

Many of us have experienced loss or death in our lives. Given the work we do, these experiences may include the death of a loved one to opioid overdose. If a coalition member, peer champion, or any individual you work with loses their life to overdose, it is important to be prepared to come together to support one another while honoring your colleague's life.

You may want to address this possibility in case it occurs. Consider discussing how your coalition would choose to act in this situation. It will be important to sufficiently acknowledge the loss with respect to both the individual who has died and all coalition or community members who knew them.

Consider drafting a plan for meetings following loss. Create time and space for a moment of silence. You may want to ask whether coalition members want to share stories. Offer an opportunity to create a mural or another type of memorial to honor the person who passed away.

It will be helpful to establish open dialog around trauma, mental health, and coping strategies as a norm. Consider having a professional grief counselor attend this meeting, and ensure that coalition members are aware that the counselor is available. Learn to Cope and Support After a Death by Overdose are two existing agencies that can assist and even provide services following a substance-use-related death. Remember that we all react differently to different situations, and coalition members may be re-traumatized by an overdose death. Acknowledge and embrace all emotions and focus your time together as much as possible. Allow for open dialog and consider focusing on the core actions (see below).

Core Actions

The following suggestions are from Coping with Overdose Fatalities: Tools for Public Health Workers and based on work from Hobfoll et al.:

1. Promote **safety**
   - Ensure basic needs are met (food, water, medical care, etc.)
   - Advise on the risks of using substances to cope
   - Respond decisively if coalition members express an intent to harm themselves or others
2. Promote **calm**
   - Only share information you know is accurate
   - Listen calmly and without judgement
   - Normalize the sharing of difficult-to-process and intense emotions
3. Promote **connectedness**
   - Find a way for people who have shared the experience to be together to process emotions
   - Establish a norm that members can avoid being in situations or around people that are not healing
   - Have resources and support at hand
4. Promote **hope**
   - Share simple messages of hope. For example, "As hard as this is, I believe we are doing a good job," or "I just believe in helping the next person if we can."
   - Stay away from cliché phrases such as "This too shall pass."
   - Invite coalition members to discuss the reasons why they do this work.

Source: Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., ... Ursano. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry, 70*(4), 283–315

Challenges and Solutions

The previous section outlined the initial steps in building a coalition and some key considerations. This next section addresses some potential challenges that might arise in the process of building a coalition.

Challenge: Avoiding an "us vs. them" mentality

An "us vs. them" mentality can hurt coalitions. The "us" and "them" can range widely, from housed vs. unhoused, experiences with using drugs vs. no drug use, or those who want local treatment vs. those who do not want treatment in their neighborhood.

Solution: Build diverse membership[5]

Why this is important: Involving people who represent the community increases the impact of your coalition's strategy planning and implementation. Including diverse sectors promotes collaboration, builds stronger bridges to the target populations, pools resources, and builds your influence in the community.

> *If you are working in a community where a foreign language is predominantly used and all your materials are in English, this signals 'this information is not for you.'*
>
> —Pedro Alvarez, Assistant Director of Urban Drug User Health & Outreach, MA

Potential solutions: Find people with lived experience, publicly recognize that their knowledge is valuable, and help them feel empowered. The coalition should consider and use their experiences to inform the coalition's actions. Remember that experts who have worked for a long time in the community aren't necessarily enough. Engage people who are actively living in the communities affected by the opioid crisis. Help community members get involved, and consider compensating people for their time and contributions. Be willing to have tough conversations and build bridges. Lastly, understand that language matters, as it can be stigmatizing and harmful.[6] Do think about the language used when recruiting coalition members and understand what language stigmatizes your community. Signal respect and a desire to work together.

Challenge: "The coalition can't agree on anything" or "Members don't feel like they are part of the coalition"

Without cohesion, a lack of engagement can arise, and this can hinder decision-making. Additionally, a lack of cohesion can hurt the efficiency of the coalition.

> *It almost felt like coalition members were just there to be part of the show. They were just there to do what they were told to do. They were getting things done but there was no sense of cohesiveness.*
>
> —Community Engagement Project Manager, OH

Solution: Build coalition cohesion

Why this is important: Feelings of unity, trust, and belonging are a few common features of a cohesive coalition. Cohesion among members appears as strong interpersonal relationships and effective collaboration strategies. Organizational cohesion leads to member satisfaction, commitment, and retention. A cohesive coalition has a positive work environment where members develop trust with each other and are capable of resolving conflicts.

Potential solutions: Cohesion is built through membership. Who are you engaging? Who is represented? Evaluate the signs of cohesion: did a charter result from a collaborative process? Is everyone's voice being heard? Has everyone signed onto one shared goal? Shared goals help ensure cohesion. Cohesion needs to be maintained and addressed in every meeting. Review the decided-upon process of working through disagreements.

Challenge: Coalition members don't feel like they are accomplishing much

For the coalition to run smoothly, members need to be encouraged to take on a variety of roles and responsibilities. These roles can be tied to the members' expertise, abilities, and interests.

Solution: Provide opportunities for member participation

Why this is important: Recruiting members into the coalition can be easy, but if opportunities for participation are not available or provided, they may not feel like they are accomplishing anything, and retention may become an issue. Research has shown that coalition members taking on significant roles creates an empowering environment.[7] Additionally, providing a range of opportunities to members not only supports the coalitions' goal but also helps build members' skills and competencies.

Potential solutions: Empower and educate members to be champions or create and serve on sub committees. These roles empower people to engage and help others engage. Be explicit about the goals of your coalition and ensure members goals align. For example, during meetings, share a list of questions for discussion, form smaller focused groups for specific questions, and have people rotate groups to ensure everyone can share their perspective.

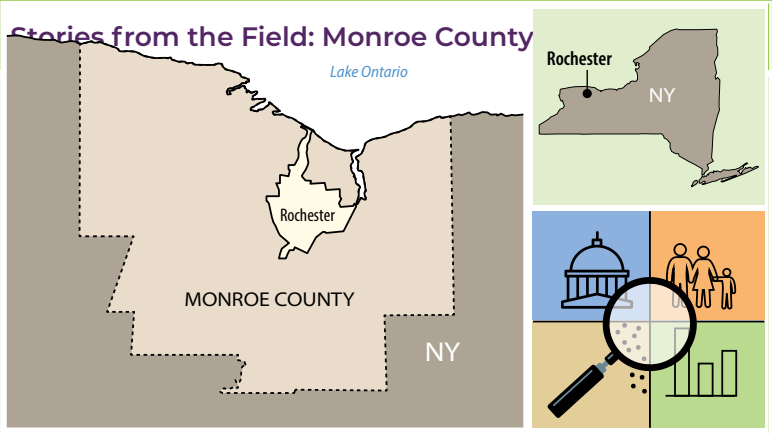
Additional resources for coalition building:

Creating Inclusive Prevention Organizations and Coalitions – Webinar

Building Strong Prevention Coalitions – Webinar

Coalition Building: Recruitment and Retention – Webinar

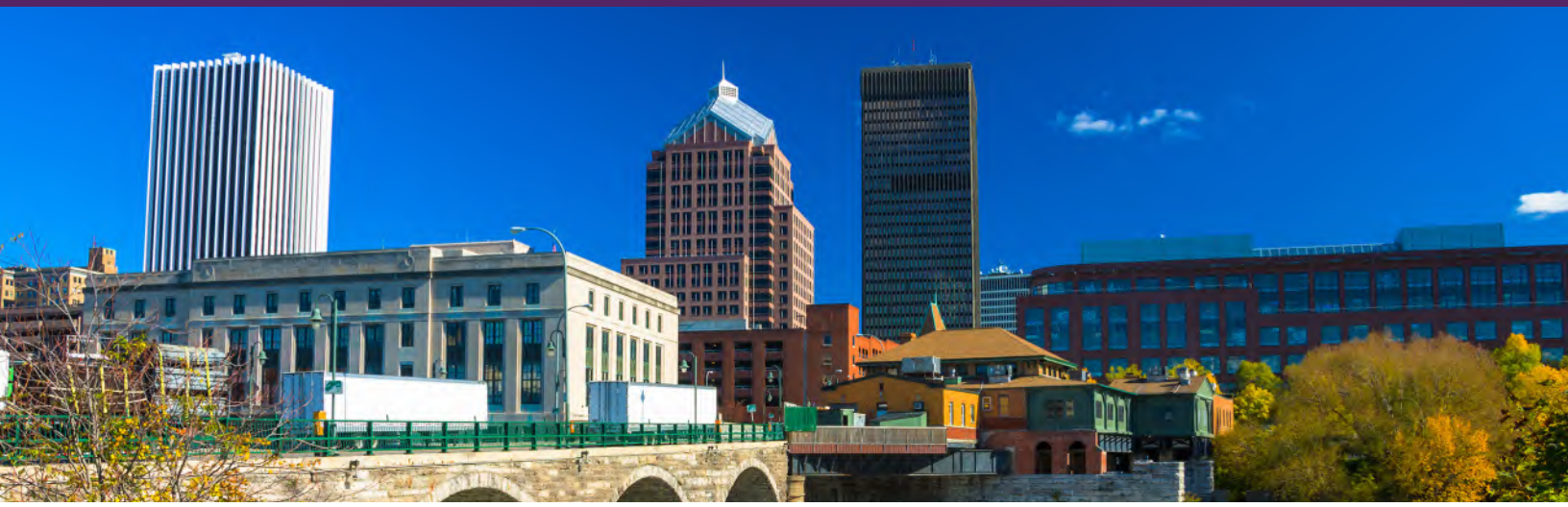
Coalition Building: Coalition Design & Member Engagement – Webinar



STORIES FROM THE FIELD

Utilizing a **readiness assessment** and **coalition membership checklist** to build and engage a coalition that aligns with the community's priorities, experience, and capacity for **opioid overdose prevention in Rochester, New York.**

ROCHESTER · MONROE COUNTY, NEW YORK



Rochester is a large urban community in Western New York covering 35 square miles. With a population of more than 210,000, it is the third most populated city in New York and one of the most racially and ethnically diverse, with nearly 49 percent African American/Black and 19 percent Latino residents.

The median household income is $40,083. Almost a third of the population (about 29 percent) is living in poverty.[8]

Major employers in this community include the University of Rochester, Wegmans, Rochester Regional Health, and Xerox.

Rochester is known for its historical buildings and colleges. It also has a social justice legacy, as the home of historical figures Fredrick Douglass, Harriet Tubman, and Susan B. Anthony.

Authors: Tim Hunt, PhD, Co-Investigator & Intervention & Community Engagement Investigative Lead, New York HEALing Communities Study; Emma Rodgers, MPH, Director of Community Engagement, New York HEALing Communities Study; Frankie Sampson, LMSW, Program Manager, Rochester HEALing Communities Study, Monroe County Department of Public Health.

SUBSTANCE USE AND THE OPIOID CRISIS

- In the early 2000s, Eastman Kodak, Bausch and Lomb, and Xerox downsized
- The community's economic system and the Rochester City School District began experiencing a rise in poverty, crime, and substance use
- In response, local county leaders and partner organizations began enhancing efforts to combat the rise in substance use and opioid overdose deaths
- The Finger Lakes Prevention Resource Center of the National Council on Alcoholism and Drug Dependence-Rochester and the Monroe County Heroin Task Force partnered with local substance use treatment providers, advocacy agencies, and people with lived experiences to provide education and resources with a goal of decreasing unnecessary deaths

RATE OF FATAL OPIOID OVERDOSES IN MONROE COUNTY (31.2 PER 100,000) IN 2020[9]

In 2020, opioid overdose deaths increased 38 percent nationally and 44 percent in New York. Drug overdose death rates increased across all racial and ethnic groups, nearly five-fold for Black New Yorkers, quadrupling for Hispanic or Latino New Yorkers, and tripling for White New Yorkers.[10]

MONROE COUNTY COALITION

The Monroe County Coalition shares workgroup updates during their monthly coalition meeting and engages attendees in ideas sharing and decision-making.

Uplift Irondequoit, Helio Health, Rochester Police Department, Hope Dealers Anonymous, Catholic Ministries, and members of the Monroe County Coalition, work together during Drug Take Back Day in Rochester.

Monthly community naloxone training where community members were invited to become part of the coalition.

Local event hosted by the Monroe County Coalition at a library in Rochester to provide Naloxone education and trainings and information on overdose awareness and the dangers of fentanyl in the community.

Solution: Create a local and racially/ethnically diverse coalition focused on local issues

> *Developing a uniform and culturally competent approach to community engagement is vital in providing an all-encompassing plan of care to African American, Black, Latino individuals, and other minorities in need of substance use treatment, while addressing racial inequalities will prompt positive change.*
>
> — Frankie M. Sampson, LMSW, Program Manager, Rochester HEALing Communities Study, Monroe County Department of Public Health

Challenge: How to successfully engage a community around opioid overdose prevention

- How do we build a multisector and diverse coalition with members who represent our community and have a good understanding of its assets and needs?
- How do we accurately define the problem(s), choose and implement appropriate strategy to effectively address the problem(s), and sustain our efforts?
- Although many county-wide coalitions have focused on reducing opioid overdose deaths, few have targeted the city of Rochester or represented people of color and the organizations that serve them.

STEP 1 We completed a readiness assessment.

The readiness assessment aimed to ensure that our coalition had a deepened understanding of the opioid crisis in Rochester. The tool included questions about

- community demographics;
- overdose rates;
- resources and programs—past and present—for medications for opioid use disorder (MOUD) and overdose education and naloxone distribution (OEND);
- the history and composition of existing coalitions in Rochester and Monroe County focused on the opioid crisis; and
- a list of MOUD, OEND, and Safer Prescribing and Dispensing strategies and communications campaigns currently or formerly implemented in the community.

The tool would help us understand our ability to obtain and share local data and how best to create and sustain relationships with the medical examiner and county coroner.

The readiness assessment is a valuable tool to help coalitions better understand the current climate in their communities and current and previous work to address the opioid crisis. Through the assessment, coalitions may engage with local leadership to solicit feedback on gaps and opportunities to successfully **address the opioid crisis at the local level.**

See **Appendix E** for Coalition Readiness Assessment

Example Questions

- Describe the community. Is it a rural or urban community? What is the population? How many people overdosed in the previous year (fatal and non-fatal)? How many MOUD providers are there? How much naloxone was distributed and by whom?
- What is the history and structure of current coalitions? The perspective and role of county leadership on the opioid crisis?
- What evidenced-based practices are currently being implemented in the community to address the opioids crisis? What was implemented in the past?

STEP 2 We developed a coalition membership checklist.

The coalition membership checklist was used to identify and recruit coalition members who could help with selecting and adopting evidence-based practices within and among Monroe County's healthcare, behavioral health, and criminal justice sectors and settings. The checklist built on information gathered in the readiness assessment and provided detailed information on organizations and people from those organizations who would be active members of the coalition. People with lived experience (PWLE), including people who use drugs (PWUD), and organizations that support specific demographic groups and geographic areas were seen as the priorities for recruiting key coalition partners.

- The coalition membership checklist provided clear guidance on which organizations and individuals the coalition needed to recruit. Recruitment informed by the checklist inspired important discussions about who has been missing from the table historically, how PWLE and PWUD should be not only involved but also in leadership roles, and **the level of influence each coalition member has within their organization to champion and effect change.**

Both the readiness assessment and the **coalition membership checklist** helped us identify the need for building ongoing relationships with community members, partner organizations, and local leaders. With knowledge gained from these tools, we were able to design our community forums to address barriers, including lack of knowledge of local overdose data, that African American/Black and Latino/Latina people were facing.

See **Appendix A** for Coalition Membership Checklist

Sample Questions

- Are there people with living and lived experience who can speak to needs, challenges, and preferences in their community?
- Are there organizations that support specific demographic groups, including specific age groups (youth, seniors, etc.), Black, Indigenous, and people of color (BIPOC) communities, and LGBTQI+?
- How does your implementation and leadership team reflect the communities that this coalition is engaging?
- Are there people who represent health systems, agencies, and health providers that are likely to implement evidence-based practices to treat with MOUD and to reduce overdose deaths?

TIPS FOR YOUR COMMUNITY

> *It is extremely vital to have the presence and buy-in of leadership and community partners to support creative implementation backed by evidence based-practices to increase progress in reducing opioid fatalities and to get buy-in from the community.*
>
> —Monroe County Coalition member

- **The readiness assessment is most useful when the data are current and information is gathered from multiple sources**—for example, beyond a basic Google search. Better data lead to more-accurate and more-detailed information about a community's current and past work and readiness to implement strategies. Data empower coalition members to ask questions to better understand the people who the programs are trying to reach.

- Beyond the initial phases of building a coalition, the **coalition membership checklist can be used to check that all sectors and demographic groups are continuously represented and have leadership roles** as strategies are implemented and evolve. It is an ongoing process and not one point in time.

- **The readiness assessment and coalition membership checklist can help identify gaps and opportunities for community engagement**, such as the need for new coalitions. However, building a diverse, multisector coalition with organizations and people that truly represent their community and can effect real change may not always be easy. Politics and power dynamics, departmental leadership differences, racism, and limited capacity are among the challenges communities face when doing this work. Try to identify and address these challenges early and often.

- **Engaging and providing leadership opportunities for PWLE and PWUD is vital for addressing the opioid crisis locally, but it can be challenging**. Consider partnering with peer organizations, offering stipends to people for coalition contributions and activities, and creating workgroups led by and focused on PWLE who are well versed in client-centered and harm reduction approaches. State partnerships and funding mechanisms are needed to support grassroots organizations with low threshold requirements for sustainability.

4. Maintaining and Strengthening a Community Coalition

Once the coalition is up and running with membership and operations established, it is important to think about how to maintain the momentum. Development of new skills for coalition members through training opportunities, goal-directedness, fostering a culture of hope, and improving efficiency can help maintain and strengthen a coalition.

Training opportunities

Shared Vision

Culture of Hope

Improved Efficiency

PROVIDE TRAINING OPPORTUNITIES FOR COALITION MEMBERS

Collaboration ensures power sharing and the equitable distribution of resources while acknowledging and embracing the many different forms of knowing and knowledge generation. You'll want to try to meet members where they are and try to remember that learning is not always a linear process.

Prioritizing the Voices of People with Lived Experience (PWLE)/ People Who Use Drugs (PWUD)

Coalition members are knowledge holders and experts on their own experiences and environments. Ask questions. Be curious. Listen. Listen again. Together, coalition members can co-produce knowledge and ideas while working across similarities and differences to achieve the shared goal of reducing opioid overdose deaths in your community.

Trainings are an excellent opportunity not only to engage and potentially evaluate coalition members' competencies but also to promote bidirectional learning and knowledge-sharing. There will often be opportunities for your coalition to debrief after trainings for critical reflection and capacity building to encourage continuous development for all members regardless of title, role, or experience and whether they are founding members or new recruits. Conflict may arise. Embrace it. Use conflict management and resolution skills for transparent participatory facilitation. Out of challenges come opportunities.

Dedicate time during a coalition meeting to select training topics. Open discussion with the following prompt:

> *"We want to be sure that (1) we are offering you training related to our coalition's activities, and (2) we are able to learn from your expertise. Please let us know if there are any topics you would like to hear more about or if there are training resources you would like to share with the team."*

Work with coalition members to draft an initial training plan based on shared priorities. This plan should be updated over time, account for changes relevant to the field (for example, the availability of over-the-counter Narcan), and take the formats (e.g., in-person workshops, live webinars, self-study guides) that the coalition members request.

Opportunities for skill building can improve the coalition's impact and promote member retention. Consider tapping into local expertise through community organizations for trainings and developing train-the-trainer models to facilitate sustainability. Trainings may be a mix of in-person, video conference, and recorded formats, which may include asynchronous and synchronous activities, self-paced learning, coaching, learning collaboratives, retreats, facilitated

discussion, training the trainers, and leadership development. Find what works for your coalition. Remember to meet people where they are and be agile. Training formats, funding opportunities, and members preferences for learning and debriefing all may evolve.

Below, we offer some key modules that you may want to consider as you seek to enhance individual and collective knowledge and skills across all coalition members.

Table 2. Potential modules and learning objectives for coalition member trainings

Module Topics	Brief Description	Learning Objectives
Gauging pre-existing facilitation and community engagement skills	Assess community engagement skill; understand community engagement through personal narratives and experiences	Team-building; the development of a shared understanding of community engagement and assessment
Introduction to community engagement and Community-Based Participatory Presearch (CBPR)	Develop an understanding of the critical importance of community engagement and CBPR to the overall success of your coalition	To clearly articulate CBPR principles and why your coalition is using them
Relationship and coalition building	Develop the community organizing skills to effectively orchestrate and carry out meetings; recruit and retain coalition members; develop community relationships; and learn about community strengths, needs, and context	Build relationships and work across similarities and differences toward a shared goal
Deep listening and communication	Develop communication skills, particularly those related to deep and active listening. Gain an understanding of how best to apply these skills to facilitating meetings and having successful one-on-ones	
Cultural humility	» Understand substance and opioid use disorders in the context of inclusion, equity, diversity, and belonging » Gain a deeper understanding of your own, your coalitions', and your community partners' position compared to others within the community and power » Build an appreciation for others' expertise, knowledge, and leadership » Gain an understanding of public health, healthcare, and substance use through common/mainstream frames and narratives; learn how to incorporate a social justice framework into these narratives » Gain an understanding of your community's specific health equity information and how it relates to success and barriers of your coalition	Exhibit a fundamental knowledge of one's self, identity, and positionality, and how all of these aspects can affect one's relationship with other coalition members and community partners

Continued

Module Topics	Brief Description	Learning Objectives
Facilitating great meetings	» **Participatory Facilitation**: Gain an understanding of the theory behind participatory facilitation and develop skills associated with participatory facilitation, inclusive consensus building, and collaborative decision-making » **Co-creating Great Meetings**: Build knowledge and skills related to co-designing and facilitating great, accessible meetings (i.e., shared power and values-driven agenda making, accessibility, open and iterative feedback practices, community agreements, centering relationship building, navigating power dynamics, power sharing, recognizing success and sharing gratitude, tracking and following up on tasks) » **Embracing Conflict**: Unpack and understand our relationship to conflict; build skills to embrace and harness conflict as opportunities for growth » **Role of the Facilitator**: Deeply understand the role of a facilitator and develop skills to better coordinate collective progress, respectively delegate, and ask for help » **Practice, Practice, Practice**: Develop skills related to co-designing and facilitating meetings through role plays, planning practice activities, etc.	Ask questions and acknowledge community members as knowledge holders or experts of their own experience and environment

CE training resources

- Doing the Work Together: Authentic Partner Engagement in Prevention—Webinar
- Community Toolbox—Collection of resources and trainings

The work we do is difficult. Your coalition may want to consider forming a task force that addresses things like self-care and support for one another. Consider bringing together coalition and community members to (1) create a culture of self-care and personal sustainability and (2) develop strategies that aim to support maintaining coalition membership and community partnerships to address substance and opioid use and stigma long into the future.

Potential training topic: Scope of opioid overdose crisis

Providing specialized training on the opioid overdose crisis for coalition members will ensure they have a foundation of information that will allow them to participate in all types of discussions and decisions. These trainings can take place during regular coalition meetings or online.

Specific topics to consider:

- **Understanding the Opioid Crisis**: Causes and consequences of opioid use disorder (OUD); background on the local epidemiology of OUD; medications for opioid use disorder (MOUD); social determinants of health
  - Addiction 101
  - Overview of Substance Use Disorders—Continuing education (CE)/continuing medical education (CME) credits available
- **Treatment of OUD**: Understanding evidence-based MOUD and nonmedical approaches; state of the delivery system for MOUD—practices and policies
  - Medications for Opioid Use Disorder—CE/CME credits available
  - Screening, Assessment, and Treatment Initiation for Substance Use Disorders (SUD)—community engagement/CME credits available
- **Emergency Management of Opioid Overdoses**: Crisis response and emergency care; distribution of naloxone: rationale and barriers
  - Integrating Opioid Use Disorder Treatment in Clinical Care—CE/CME credits available
  - Naloxone: The Opioid Reversal Drug that Saves Lives
- **Opioid Use and the Criminal Justice System**: The role of law enforcement; opioid use during incarceration and reentry
  - Introduction to the Criminal Justice System and MOUD—CE/CME credits available
- **Preventing SUD**: Evidence-based prevention interventions; prevention in community settings
  - Selecting Prevention Strategies that Work
- **Social Determinants of Health & SUD**
  - Social Determinants of Health & Substance Misuse: Implications for Prevention Planning - Session 1

Potential training topic: Stigma

Think through the beliefs that those within the coalition or community members express regarding OUD. Are there beliefs that have hurt the community? For example, are there community-held beliefs about OUD being a choice rather than a disease? Stigma can stall community engagement, hinder coalition cohesion, and complicate the delivery of evidence-based practices. Therefore, offering coalition members a training on stigma related to substance use or OUD is highly recommended.

The following are some recommended messages to counter some commonly held stigmatizing beliefs:

- OUD is a medical disease
- Anyone can develop an OUD
- MOUD can be an essential part of someone's recovery from OUD
- MOUD improves lives
- Naloxone saves lives

Coalition training materials can share information on these concepts. This will empower coalition members to counter stigmatizing beliefs and can help guide the coalition's activities.

Suggested training materials:

- **The language of addiction**: Why outdated terminology can cause confusion or perpetuate stigma around substance use disorders
  - Changing the Language of Addiction
- **A pledge to use less-stigmatizing language when discussing substance use disorder**
  - Words Matter
- **SUD and stigma reduction**: Practical information to enhance your capacity to engage in effective stigma reduction efforts.
  - Anti-Stigma Toolkit: A Guide to Reducing Behavioral Health Disorder Stigma
- **Cultural understanding of addiction**: Approaches to help reduce stigma and discrimination
  - CCE Dismantling Stigma: Addiction, Treatment, and Policy—CE/CM credits are available
- **Individually held vs. community-held stigma**:
  - Community Perceptions of Opioid Overdose: Brains, Bias, and Best Practices—CE/CME credits are available

After this training, engage in a discussion about where coalition members notice stigma affecting the coalition's work in the community. Are there steps the coalition can take to counter this stigma?

> *The coalition discussed how stigma prevents many in the community from accessing Naloxone. They also mentioned barriers and regulations that dictate which organizations can distribute Naloxone and how that needs to be tracked. The coalition considered these factors when brainstorming interventions, and they were leaning towards expanding Naloxone. A coalition member shared that their agency has been trying to get NaloxBoxes for a while and COVID-19 put a halt on that effort. They added that it is difficult to get places to put out the boxes in public because of stigma, people say that the boxes 'invite those people here.'* (June 2020)[11]

Potential training strategy: Learning Collaboratives or Communities of Practice

Learning collaboratives (LCs) or communities of practice (i.e., "groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly")[12; 13] may be tailored to specific community issues and may target specific community groups (e.g., local hospitals, law enforcement, first responders, housing service providers, harm reduction specialists, and bridge clinic providers).

LCs enable community coalitions, champions, and partner organizations (within or across communities) to learn from each other, share strategies, and problem-solve. They should be developed in response to coalitions' and partner organizations' needs.

LCs may take several forms. They can be designed to provide opportunities for all coalition members to share ideas, discuss barriers, and problem-solve. They may also be designed to share with your community partners and other agencies to increase visibility of your coalition and its goals. LCs can also be made up of subcomponents tailored to smaller, more focused groups (e.g., a group of peer champions, a committee working on a funding application, or coalition members planning a community listening tour).

Ultimately, coalitions' and partner organizations' information sharing needs should drive both the structure of LCs and the topics covered. When planning LCs, ensure your coalition explicitly identifies and commits to its purpose and learning objectives (i.e., how does the content shared support your coalition).

When possible, your coalition should collect some data (e.g., number of participants and their community sector) to inform future planning and sustainability. You may also want to encourage attendees to share their names and contact information, if they are comfortable.

For example, Northeast Ohio Medical University Ohio Opiate Continuing Education TeleECHO is a LC open to buprenorphine prescribers and meets virtually every Friday from 3 to 4 p.m. EST. Providers sign up with an email address. The meetings follow a similar structure each week: half of the teleconference/webinar is dedicated to didactic presentations (e.g., motivational interviewing in an emergency room setting), and the other half is dedicated to case reviews with a panel of experts.

KEEP FOCUS ON A SHARED VISION

A major challenge that many coalitions face is maintaining focus on a shared vision. Coalition members may have "pet" issues that they feel need priority, members may disagree about how to accomplish the coalition's mission, and setbacks or challenges can lead to frustration. Anticipate that these challenges will arise and have a plan in place with the coalition's leadership.

Early wins are particularly important for those who are action-oriented. Are there strategies that can be quickly deployed?

How will the coalition maintain focus on a shared vision? One strategy is reminding coalition members of the agreed-upon vision statement at the start of coalition meetings. Building off this vision can inform and facilitate decision-making. The coalition may choose to capture their vision in terms of SMART goals: Specific, Measurable, Achievable, Relevant, and Time-Bound. To work toward the coalitions' overall goal, short-term goals may need to be met along the way. Another potential approach is guiding the coalition through a Strengths, Weaknesses, Opportunities, and Threats analysis related to the shared mission of the coalition. Elucidating opportunities can re-invigorate members to focus on how the coalition can work toward their goals.

What helps coalitions stay goal-oriented?

- Smaller workgroups
- Shared accountability
- Balance of short- and long-term goals
- Celebrating coalition wins
- Meeting frequently to keep people informed
- Review real-time local OUD data frequently
- Pre-established regular meetings with external contacts (e.g., public health officials, governmental officials) to report on progress
- Being community-driven and community-owned; being accountable to the community

Specific goals that further the overall coalition vision may include selecting and implementing evidence-based practice strategies to reduce opioid overdose deaths. Coalitions could select evidence-based practices within the *Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) Practice Guide*, which include the span of care across prevention, diagnosis, engagement, and retention in treatment.

Goal-directedness is important because it is easy to get sidetracked by smaller issues that surround the coalition's central goals. Thus, task focus is critical in achieving goals.

Example goal from a New York HEALing Communities Coalition:

Vison:
Provide naloxone training and naloxone distribution to people with a SUD upon release from the county jail
Why:
• In the county jail, 75% currently have a SUD. • Within the first 2 weeks of release, people are 40 times more likely to die of an opioid overdose compared to people without a history of incarceration.[14] • To facilitate rapid access to a naloxone kit upon release. • To standardize the process for a jail clinician to train all people with a SUD in jail and provide them with naloxone.
How:
• Jail clinician becomes a trainer and trains willing people in jail. – Upon release, a dose of naloxone is picked up at [Program], or – Upon release, naloxone is received through the mail.
Goal:
• 100% of people with SUD provided with training and a naloxone kit upon release
Technical Assistance, Needed Resources, or Potential Challenges:
• Clinician needed to train people on naloxone administration • Need a process to distribute naloxone upon release • How to afford mailing naloxone

FOSTER A CULTURE OF HOPE

Celebrating successes will strengthen relationships, build trust between coalition members, and foster a culture of hope. Moments of celebration can occur when coalition members

- tell a personal story and further healing from sharing,
- recognize growth in skills and training,
- learn new skills in engagement or collaboration,
- help change a community,
- work within a system to improve it,
- listen and act upon stories shared to change a culture or community-held belief, and
- engage with others in a positive and powerful way.

Adapted from *Engaging Individuals with Lived Experience: A Framework*

Welcome coalition members to share these moments of celebration during meetings and consider reserving set-aside time during coalition meetings to share coalition member wins and achievements.

IMPROVE COALITION EFFICIENCY

Efficiency is critical to a coalition's success. Coalition efficiency refers to the work ethic and task focus of the coalition as well as its ability to effectively use its resources to implement change. People and organizations form coalitions to accomplish together what they cannot alone. However, members and community organizations are very busy and must consider how much time they can give to the cause. How well-organized the coalition is and the clarity of the coalition's goals may factor into their decision to participate. A lack of efficiency can hinder coalition retention, accomplishments, and even efforts to maintain a diverse coalition.

The leaders of the coalition set the tone for coalition efficiency. Having clear agendas with timelines, taking and sharing notes, and being prepared to lead helps others stay committed themselves. Efficiency can prevent duplication of efforts and helps the coalition stand out from other efforts.

It is important for coalition leadership to remain adaptable to how coalition members view efficiency. Some coalition members may prefer a more-authoritative style, while others may prefer more discussion-based decision-making.

As a coalition builds, acquiring and fostering new knowledge and skills can increase the coalition's efficiency and effectiveness. Skills-building opportunities can not only improve the coalition's impact but also promote member retention and self-efficacy.

CHALLENGES AND SOLUTIONS

What If Our Coalition Has Very Limited Resources?

We asked Dr. Tisha Smith from the Monroe County Department of Public Health in Rochester, New York, to tell us about her work on the Opioid Taskforce focused on Monroe County and the Finger Lakes Region and the newly formed Monroe Coalition—the first coalition of its kind in Rochester solely focused on opioids in Black and Brown communities. Specifically, we asked her what advice she would give to other coalitions who may lack resources and how they might work within their means.

> *In thinking about how to gather more people in the room, I think back to an example from years ago. There was a woman who had lost her child here in Rochester to an overdose. She was struggling. She reached out to another mother who had a son that was actively using [drugs]. And the two of them kind of just shared [their experiences] with other people who were going through some things and then other people in the community said, 'hey, yeah, me too.' And from there, they were able to create this kind of bereavement group.*
>
> *It just takes a dynamic person who can pull in other people who are willing to dedicate their time to [address the opioid crisis] and from there, they might know somebody who might know somebody who might know somebody.*
>
> *It's about going out and talking to people about what's going on and them realizing they can help make some change. I don't think it's really an issue of resources. It just takes people that are willing to get involved and getting them together.*
>
> *It's about who you know. Maybe you know somebody who has a radio station that can do free advertising. Maybe there's a free newspaper in your community where you can advertise. It's about involving the people who say they want to be involved and letting them know what you need and what issues you are trying to address.*
>
> *Use social media. Talk with veterans. Make phone calls, lots of phone calls.* ***You can create a movement with just one person—that's all it really takes****. It's that great smile and having the gift for gab to motivate others to assist. When in doubt, talk with your government officials and tell them you need their support and ask them what resources they can provide.*

Coalition Wishlist

Consider creating a coalition wish list and sharing it with organizations in your community. You might need a computer or a printer or maybe some tables and chairs. Add these items to your wish list. Use social media or the local newspaper to share your wish list. Not only might you get some of the things your coalition needs, but you might also create a pathway for partnership. You are increasing your coalition's visibility in your community, letting others know that you are an organization committed to addressing the opioid overdose crisis.

What if power dynamics within the coaliton make it difficult to stay on task or lead to members feeling left out of decision-making?

It is important to consider who feels included and excluded during coalition meetings and in carrying out a coalition activity. This includes when agendas and tasks are being set. There will likely be members who engage in and encourage discussion (planners) and others who are more comfortable with action-directed steps (doers). Empowering both planners and doers is necessary for coalition efficiency. When one group feels discounted or unheard, it can lead to poor power dynamics within the coalition.

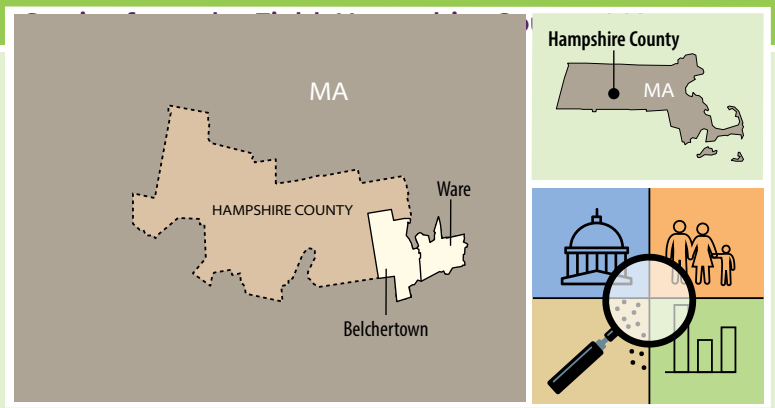
How to address power dynamics

- Consider holding action-focused and planning-focused meetings separately and have a member from each group report out to the larger coalition. This will keep the momentum moving forward.
- Think about the reputation of the coalition as well as who gets credit. It will take deliberate effort to ensure that all coalition members share in coalition victories.

Case study

Efficiency can affect the diversity of a coalition through member retention.

A prominent Black leader within the faith community was engaged early on in coalition efforts. However, inefficient meetings and a lack of progress led him to stop attending coalition meetings. Because he no longer attended meetings or responded to emails, the remaining members of the coalition became increasingly frustrated. As a result, the coalition became divided. This led to negative feelings all around. Inefficient meetings can be detrimental to coalition member retention—particularly for lower-income people who may have care demands or limited time outside of work. It is also a challenge for people representing vulnerable populations who are balancing the needs of the coalition with many other needs of their community. Efficiency signals to coalition members that you respect and value their time.



STORIES FROM THE FIELD

Engaging People with Lived Experience of Opioid Use through **Photovoice** in Belchertown and Ware, Massachusetts

BELCHERTOWN and WARE · MASSACHUSETTS

Belchertown and Ware are two small, rural communities near each other in Western Massachusetts. They are in some of the more remote areas in the state. The median household income is much higher in Belchertown ($77,431) than in Ware ($43,783), and both are lower than the overall state median income ($89,645).[2]

Ware is a historic mill town that experienced severe economic decline when the textile mill closed in 1984 and more recently when the local Mary Lane Hospital closed in 2021. In Belchertown, the economy is driven by the education because there are several colleges in the area. In Ware, the economy is based mostly on healthcare.

Most of the people who live in these communities are non-Hispanic White (89.9 percent), followed by Hispanic (4.4 percent) and Asian (2.4 percent).[1]

Authors: Peter Balvanz, MPH, Associate Director of Informatics, Massachusetts HEALing Communities Study, and Alyssa Curran, Community Coordinator for Belchertown and Ware Coalition.

RATE OF FATAL OPIOID OVERDOSES

Fatal opioid overdoses were higher in these communities (51 per 100,000) than the state average (33.1 per 100,000). Also, the total number of fatal opioid overdoses among residents in 2021 was 14, which doubled from 7 in 2020, with most occurring in Ware.[15]

BELCHERTOWN AND WARE COMMUNITY COALITION

Challenge: How to learn about what's driving opioid use in these communities from the perspective of people with lived experience (PWLE) to help prevent overdose

Despite our community coalition being highly engaged in discussions around opioid overdose and gaps in harm reduction services, we have had limited insight from PWLE.

Solution: Engage PWLE in a Photovoice project to better understand their views on the local opioid epidemic and what they think can be done to address it.

WHAT IS PHOTOVOICE?

Photovoice is a type of participatory research that involves researchers and participants collaborating to understand social issues and take actions to bring about social change. Specifically, Photovoice uses photography and focus group discussion.

WHAT ARE THE GOALS OF PHOTOVOICE?

- Record and reflect community strengths and issues
- Promote critical discussion on the causes of the issues and how they may be addressed
- Reach policymakers and decision-makers with the results and encourage them to adopt policies that promote health

> *The opposite of addiction is not recovery—it is connection.*
>
> *—Community Coordinator reflecting on themes from their Photovoice project while speaking at the 2023 Human Service Forum Legislative Reception*

Through four Photovoice sessions with 12 PWLE in Ware, our coalition aimed to generate insights into what's causing the opioid epidemic locally and how to protect against it.

The **Photovoice project** provided unique insight into participants' experiences and what they think is causing the opioid epidemic locally. These ranged from direct links, such as starting at a young age to take opioids to manage pain, to indirect links, including social determinants of health (SDOH). SDOH are the nonmedical factors that influence health outcomes, such as lack of transportation to healthcare services.

Photovoice participants discussed how the declining local economy has eroded recreational opportunities and that the few remaining social outlets center around alcohol. Partly because of the resulting lack of social connection and few positive social outlets in the community, adults are more likely to use substances and young people begin to use substances at an early age. This increases their risk for substance use disorder and limits their opportunities in the future.

Photovoice participants also shared that the lack of transportation severely limits not only recreation but also economic opportunities and options for recovery from opioid use because treatment facilities are far away.

OUTCOMES

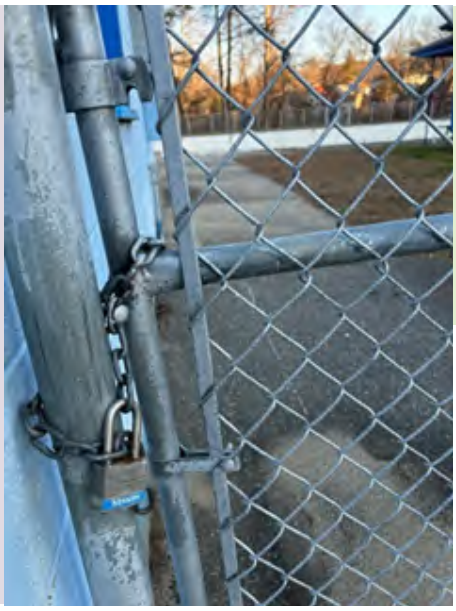


Image of a swimming pool, no longer maintained, that has been closed and locked (photo credit: Ware Photovoice Participant)

> *It's so easy to get distracted and lose touch with other people in recovery when there's nowhere for us to go and do anything. And then once we lose connection with those people, we're more vulnerable to making poor decisions because we don't feel a part of anything.*
>
> —Ware Photovoice Participant

> *I've had this Jeep, but have needed to fix it. But without a way to get to a job, I can't make the money I need to fix it, and it keeps me in this cycle of never being able to get my feet under me.*
>
> —Ware Photovoice Participant

Photovoice participants valued the opportunity to

- reflect on what enables and what protects against opioid use,
- suggest potential solutions, and
- continue to work with their community partners to implement proposed solutions.

For example, the recognized lack of recreational opportunities inspired a plan for Recovery Center of Hope clients to lead a park clean-up day to pick up trash and empty alcohol mini-bottles. Photovoice participants recognized their ability to create change in their community, which brought our community and coalition together.

For another example, concerns about the harmful impact of the lack of transportation influenced our coalition to implement a mobile methadone clinic, a transportation program, and gas cards to help people with opioid use disorder who were leaving incarceration travel to appointments with medications for opioid use disorder service providers.

HUMAN SERVICE FORUM LEGISLATIVE RECEPTION

In January 2023, our coalition shared the Photovoice group's vision to revitalize their community with state representatives at the Human Service Forum Legislative Reception.

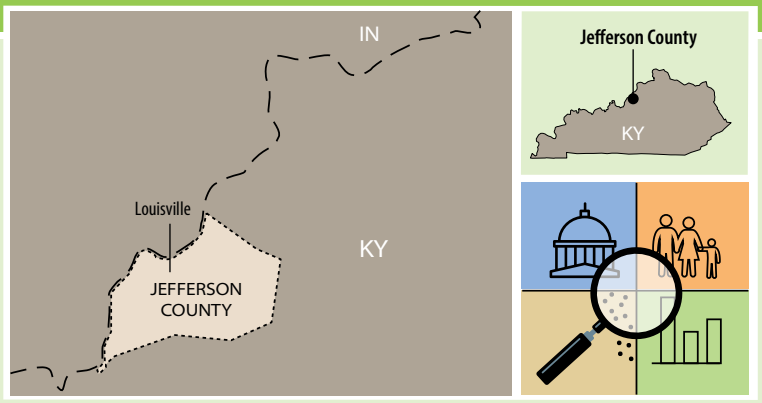
For instance, our Community Coordinator explained that there are few opportunities to connect in person in Ware. The lack of transportation adds to **social isolation**, which has led to a **300 percent increase in overdose death rates** in Ware. The coordinator was able to successfully lobby for state representatives to visit Ware and hear directly from our Photovoice participants, who are the experts.

At the conclusion of the project, our experts expressed a desire to continue Photovoice as a way to further explore what's driving opioid use and mobilize around potential solutions. As a result of the impact of this project, the local District Attorney's office provided funding to continue Photovoice at a new recovery center in the community.

TIPS FOR YOUR COMMUNITY

- Photovoice is a creative tool that helps communities gain insights to address the opioid epidemic from people with lived experience of opioid use.
- The findings from these activities can help shape a community's strategy to address the opioid epidemic. They can also be used to apply for funding to support community engagement around the opioid crisis.
- With permission, photos and quotes from Photovoice projects can be used as communications materials from the local community.
- Photovoice is an effective tool to engage and learn from groups that have been economically and socially marginalized and to mobilize groups to implement change.

Photovoice participants and facilitators meet at the Ware Recovery Center



STORIES FROM THE FIELD

How a **community listening tour** helped build a **diverse and representative coalition** committed to **reducing overdose deaths** in Jefferson County, Kentucky

LOUISVILLE · JEFFERSON COUNTY, KENTUCKY

Jefferson County is next to the Ohio River near Kentucky's border with Indiana. More people live in Jefferson County than in any other county in Kentucky.

The county has more racial and ethnic diversity than the rest of the state. For example, nearly 23 percent of people who live in Jefferson County are Black or African American, and about 9 percent were born outside the United States.

Jefferson County has a slightly smaller percentage of residents who live below the federal poverty level as compared with the whole state. But there are real social and economic disparities within the county. For example, the average income of the top 20 percent of Jefferson County residents is nearly 16 times greater than the average income of the bottom 20 percent of residents.[17] Also, Jefferson County residents are segregated by race, with most of its Black residents living west of Louisville's Ninth Street Divide.[16; 19]

Authors: Kacey Byczek and Amanda Fallin-Bennett

SUBSTANCE USE AND THE OPIOID CRISIS

Jefferson County has many strengths that can help address the opioid crisis. For example, it has 11 syringe service program sites, five opioid treatment programs, several buprenorphine prescribers, and a willingness to try new strategies to reduce opioid overdoses.

Jefferson County's jail, Louisville Metro Department of Corrections (LMDC), is among the first jails in the United States to install naloxone in every one of its dorms and offer buprenorphine treatment to people already prescribed the medication and to people who are pregnant (regardless of whether they were previously prescribed the medication).[18] Overall, the county has demonstrated support for harm reduction services and a readiness to implement progressive approaches to providing medications for opioid use disorder (MOUD).

RATE OF FATAL OPIOID OVERDOSES IN JEFFERSON COUNTY

Drug-overdose deaths in Kentucky rose 14.6 percent in 2021. Jefferson County reported 569 overdose deaths, an 11 percent increase from the 512 overdose deaths reported in 2020. The county's overdose death rate was 77 per 100,000, well above the statewide rate of 52.9 per 100,000.[20]

JEFFERSON COUNTY HEALING COMMUNITIES STUDY COALITION

A mock-up of a purple coffee sleeve featuring Shameka Parrish-Wright, a Black woman who resides in Louisville's West End. Ms. Parrish-Wright is a former Louisville mayoral candidate and the Executive Director of VOCAL-KY (Voices of Community Activists and Leaders Kentucky), a statewide grassroots membership organization that builds power among low-income people directly impacted by HIV/AIDS, substance use, incarceration, and homelessness. Beside her photo is a quote from Ms. Parrish-Wright, which reads, "I want our people prepared. Naloxone saves lives" in blue text.

Photo Credit: Kacey Byczek, Jefferson County co-Community Coordinator, and Jennifer Reynolds, HCS Communications Manager

Challenge: How to ensure that a community coalition implementing strategies to reduce opioid overdose deaths reflects the community's unique diversity and includes a broad group of local leaders and partners

In 2000, the Kentucky Agency for Substance Abuse Policy (KY-ASAP) was created to look at substance use and its related harms. Across the state, KY-ASAP works with 79 local ASAP coalitions. Each one has a community-based strategy and plan for prevention, treatment, and law enforcement.

Local ASAP coalitions distribute funding on the local level for initiatives that address substance use. They also recommend policies at the local and state levels. Jefferson County is part of a regional ASAP partnership that includes six counties. These counties vary in how rural they are, their social and economic status, and the level of opioid overdose they have.

Jefferson County needs highly local input to help successful implementation of overdose reduction initiatives. That includes people who represent its racial, economic, and geographic diversity.

Solution: Conduct listening tours to gather insights from the many people and groups in the community committed to a common goal

We conducted a listening tour to meet with local leaders and community members familiar with our community's unique needs.

Among the first to participate in the listening tour were the Jefferson County KY-ASAP and HCS Community Advisory Board representatives. In this and all future meetings, we asked for additional recommendations for other people with whom we should speak, thus helping our team's network of community connections "snowball" over time.

> *It's been an honor and a privilege to be a part of the Jefferson County HCS Coalition. One of the most meaningful things that I've been able to witness from the coalition itself is the level of collaboration that was organically forged [between coalition members and partner agencies], which has been an extreme asset. Traditionally, Louisville has been very siloed, and more of a competitive landscape. Since the coalition was built, I've seen so much consistent, continual collaborations outside of the HCS meetings and beyond the HEAL Initiative. Really being able to look at the data the HCS team was able to provide to see where everyone was working in the city and where the service delivery gaps were, and then watch the coalition go into action because they had information to make informed decisions about overdose reduction strategies for Jefferson County has been amazing. Another amazing aspect of the coalition...are all of the educational resources that the HCS has created and disseminated—now providers and practitioners have an agreed-upon best practice and agreed upon language, which is key because communication between providers, between patients, and between the public is one way we reduce stigma.*
>
> —Jeremy Byard, Jefferson County HCS Coalition Chair

We looked online for local MOUD providers, opioid treatment programs, and leaders in the recovery community. We also reviewed reports from the local health department on health and resource gaps to understand the local context and identify additional partners, such as champions and thought leaders.

Listening tour participants each had their own views about Jefferson County's ability to address the opioid overdose crisis. However, several common ideas came to light:

- Lack of resources in the mostly Black West End of Louisville
- Transportation issues that prevent people from starting and staying on MOUD
- Separate and isolated harm reduction services

We focused on building a coalition of people who are familiar with these issues and with Jefferson County's racial, geographic, and social and economic diversity. The listening tour included 36 champions working in the healthcare, harm reduction, and criminal legal systems and community organizers and people with lived experience. Ultimately, 26 champions joined our coalition.

COALITION SUCCESSES AND OTHER BENEFITS

- As of April 6, 2023, more than **3,500 units of naloxone** have been distributed throughout Jefferson County. This has been done through direct delivery of opioid overdose education and naloxone distribution (OEND) and naloxone distributed through local partner agencies and organizations.
- As recommended by our coalition champions, we prioritized OEND at places in the West End and in programs that serve people with a high risk of opioid use disorder—such as Feed Louisville, which does daily outreach to people experiencing housing instability and manages a hotel for people transitioning to housing.

> *"As a prevention specialist in Jefferson County, it has been refreshing seeing the impact of OEND in our community. When we set up a booth with a sign that says, "Free Narcan available here," we never know what reactions we may get. However, in Jefferson County, we are met with a lot of people thanking us for being there.... One time in front of a local trailer park, a woman drove by and saw me conducting OEND. When she got close enough, she rolled her window down and said, "God bless you for being here!" and proceeded to tell me she was three years into recovery. Many of the connections we have made have been at events where people see what we do, and either want their place of business to participate, or recommend places where they feel OEND is needed. We are consistently recognized by community members as providers of a much-needed service, in areas that otherwise may feel neglected or underserved. I consider myself lucky to be a part of this life-saving initiative.*
>
> —Bennett Becherer, Jefferson County Prevention Specialist

Coalition members from the local health department and LMDC helped us foster a connection with, to our knowledge, the first incarcerated individual in Kentucky to use naloxone to reverse an overdose in a jail. The coalition shared this story in a local communications campaign focused on naloxone and fentanyl awareness, highlighting the importance of making naloxone readily available to people facing incarceration.

TIPS FOR YOUR COMMUNITY

- Get insights from local leaders and community members.
- Build partnerships and communication with different types of allies, such as faith leaders, journalists, people who work in substance use fields, and people with lived experience.
- Include a diverse group of service providers and people with lived experience to help bridge gaps between local organizations and to broaden services.

Overdose Education and Naloxone Distribution Outreach Manual

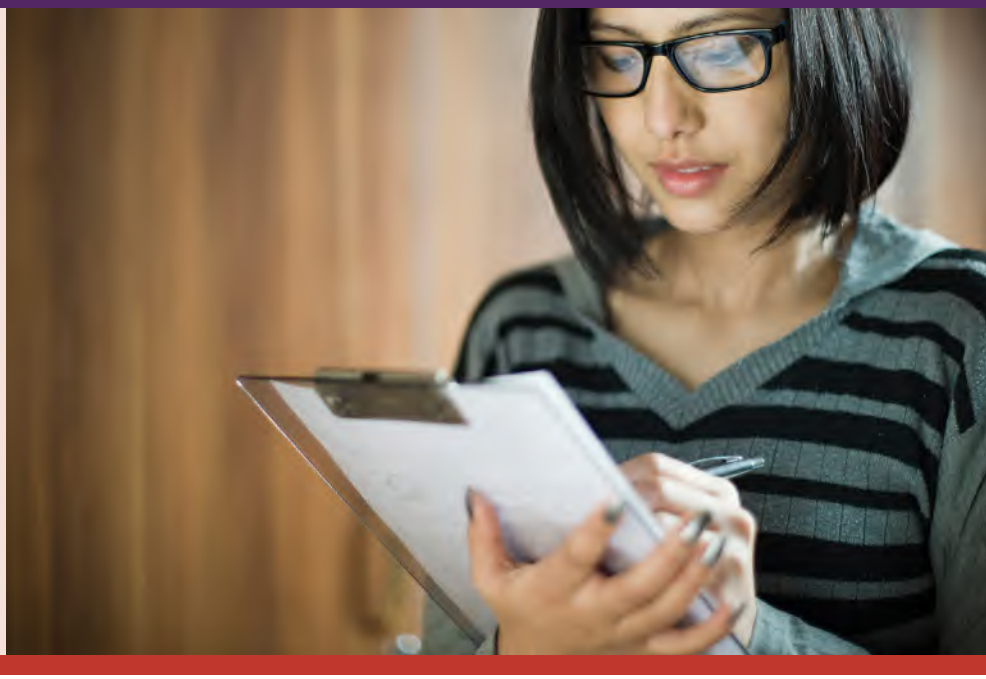
HCS-KY staff at the State Capitol for Overdose Awareness Day in Franklin County, Kentucky

This manual provides a blueprint for sustaining or launching successful OEND outreach programs based on lessons learned from the HEALing Communities Study in Kentucky.

Among its many features are venue outreach and scheduling ideas, a supply checklist, and a breakdown of program costs.

You can download the manual from this website: https://fw.uky.edu/HEALKYResources

5. Assessing Community Engagement and Coalition Functioning



Is your coalition successfully engaging the community? Could coalition functioning be improved? Are coalition activities reaching those at greatest risk of opioid overdose death? These questions should be asked regularly over time to prevent stagnation, reduce disengagement among coalition members, and retain perspective into the coalition's relationship with the community.

Evaluation can be used to gain insight on participants' needs and wants and improve how things are done in your coalition.

EVALUATE THE RELATIONSHIP BETWEEN THE COALITION AND COMMUNITY ORGANIZATIONS

Evaluating and measuring the relationship between the coalition and community organizations can improve a coalition's impact, function, and longevity. This can be done through formative evaluation, active listening, conversations with community members or partner organizations, and surveys of coalition members.

Refer back to your community assessment and work with your champions to think through different community organizations in your community. Are they represented within your coalition? Do you have coalition members who might facilitate improved communication between the coalition and organization? What have been barriers to a better relationship, and can these barriers be addressed?

For example, one coalition had a representative from an opioid use disorder (OUD) treatment provider attend the first several coalition meetings. Over time, that representative moved on to a new position, and no one else from the treatment center was sent as a replacement. Now the coalition no longer hears updates from the treatment center, and the work the representative engaged in—facilitating a linkage program for people leaving incarceration and entering treatment—has stalled. By going back to the initial community assessment, coalition leadership identified this gap and reached out to the treatment center to ask whether they would like to continue involvement with coalition work.

The PARTNER Tool

This tool can be used to assess the strengths (and gaps) of relationships among coalition members, how members perceive trust and value in partnerships, the creation of member relationships, and how they have evolved, as well as to identify needs and gaps related to outcomes and success at reaching coalition goals.

Resource for more information: Varda, D. M., & Sprong, S. (2020). Evaluating Networks Using PARTNER: A social network data tracking and learning tool. In A. W. Price, K. K. Brown, & S. M. Wolfe (Eds.), *Evaluating Community Coalitions and Collaboratives. New Directions for Evaluation, 165*, 67–89.

To examine the relationships within and between the coalition's agencies and organizations, consider the following:

- Use your initial community assessment or coalition checklist (**Appendix A**) to identify the organizations and entities that do work related to opioid overdose in your community.
- Assess the *current* relationship between each organization and your coalition. What is the quality of the relationship? How connected are they to coalition activities? Are there goals that you share that you can leverage to further your relationship?
- Think through the organization's power, influence, and trust within the community. Are they an essential member to have at the table? How can you successfully engage with them?

With this information, the coalition can discuss the strengths, challenges, and possible solutions to strengthen the relationship between organizations and coalitions.

How can we increase engagement with potentially resistant sectors?

When evaluating the coalition's engagement with community organizations and sectors, coalitions may find less engagement with certain sectors. Perhaps these sectors are represented within the coalition through meeting attendance, but engagement is minimal. Perhaps schedules are very busy, and members have limited time or energy to commit. Perhaps other coalition members express stigma or resistance when members from this sector try to engage in conversations or relationship building. Ideally, the coalition can recognize this as an opportunity to build bridges and improve the interaction.

Commit to understanding what barriers your coalition members face. For example, one coalition chair would personally reach out to any coalition members with attendance gaps. They would discuss barriers to meeting attendance and use this information to consider other options: changing the meeting times, offering hybrid attendance options to avoid travel, and allowing members to provide asynchronous input (e.g., via email) if they were unable to attend because of work schedules. This was most needed for coalition members who were employed within the healthcare sector.

After conducting a coalition evaluation, one coalition recognized that law enforcement was not very engaged in coalition work. Although a law enforcement officer attended every coalition meeting, they weren't involved with coalition conversations and activities. The coalition decided to share findings from the evaluation during a coalition meeting. Without making law enforcement feel "called out," the coalition presented suggestions about how to improve engagement. Coalition leadership also engaged the law enforcement representative in a one-to-one conversation about the law officer's perception of coalition functioning and activities. Additional representation from the criminal legal system was requested to provide more than one perspective at coalition meetings, and specific programs (anti-stigma trainings for officers, naloxone leave-behind programs) were introduced that provided a bridge to a more-engaged relationship.

Although the evaluation process presents a chance to address these potential barriers, from the beginning, coalition members should check whether organizations that assign representatives to the coalition are assigning the "right" representatives. Too often, members are "voluntold" to attend and represent but may not have motivation or interest. Being clear about the role and responsibilities of coalition membership can help avoid this challenge.

The following are some additional tips for working with law enforcement:

- Ensure all coalition members recognize these people as coalition partners committed to addressing the opioid crisis and not as law enforcement agents.
- Leverage champions (e.g., Criminal Legal Champion) to further relationships.
- Provide additional training opportunities on naloxone and medications for opioid use disorder (MOUD) to improve engagement and reduce stigma.
- If needed, the interaction may be influenced (or enforced) via funding requirement. For example, a grant specifying the required level of participation from the criminal legal sector.

EVALUATE THE COALITION'S ENGAGEMENT WITH THE COMMUNITY

Consider dedicating a coalition meeting to critically (but constructively!) evaluate how successful the coalition has been in engaging with the community. Potential questions to guide this discussion:

- **Are the right community members at the table?**

  This is a good assessment question, as it can be asked repeatedly over time as coalition members enter and leave the coalition. Think through your local OUD data: are people at greatest risk of opioid overdose represented?

- **Can new members easily join?**

  Has the coalition developed an inclusive culture? Are new members welcomed and oriented? How can you make the coalition more welcoming to the community?

- **Does the process and structure of coalition meetings allow all voices to be heard and equally valued?**

  Where and when do meetings take place, and who leads them? How are decisions made, and how are conflicts handled? Do members feel able to share their insights, and have those insights inform the coalition's actions? Revisit coalition procedures over time and account for changes.

- **Are community members aware of coalition activities?**

  Think through any public-facing activities the coalition has engaged in (naloxone trainings, safe medication disposal events or locations, etc.). Are people aware? How have you shared information about these events (e.g., social media, flyers, word of mouth), and are there other ways that might be better suited for specific populations? Consider asking coalition members to reach out to friends and acquaintances and ask about their level of awareness.

- **In what ways have community members been involved in coalition activities?**

  Beyond awareness, gauge how community members were engaged in the development and involvement with coalition plans and activities. Can you quantify community members' engagement? For example, how many pounds of leftover medication were dropped

off at a safe disposal event? How many people picked up free naloxone kits at a coalition event? Use metrics like this to evaluate how successfully these activities are reaching the community. Report these metrics back to the coalition members so they can understand the reach of coalition activities and brainstorm new approaches to increase reach.

- **Do you have demographic information on community participation in coalition activities? Is your community represented?**

  If possible, evaluate how community participation aligns with the demographics of your community. Is there a way to make events or activities more inclusive? Examples include hosting an event in a location with easily accessible public transportation or offering materials in languages spoken in your community.

- **What lessons has your coalition learned?**

  This assessment is an excellent time to celebrate any successes the coalition has made. Celebrate accomplishments in building connections within the community while learning from any mistakes made. Focus on a growth mindset and admit when things could have been done better. Community engagement is an ongoing process.

Case study

Assessing Community Engagement and Coalition Functioning in Ross and Brown Counties, Ohio

In Ohio, a coalition's efforts occurred alongside pre-existing coalitions and assessing coalition functioning was seen as critical. An assessment was done to identify the critical partners and to assure buy-in and response from the organizations within the coalitions. It was designed to assess various aspects of the network, including aspects of coalition structure and function.

Although these insights are critically important for coalitions to address complex problems faced by their communities, collecting these data and making them available often requires resources not available to community coalitions. In addition, coalitions often do not reflect on their own structure and function even though these play a significant role in coalition effectiveness. Therefore, the coalition leadership chose to gather insights directly from coalition members to inform strategic planning.

Continued

Working with each coalition's leadership, the coalition developed and conducted a survey using the PARTNER tool. They collected data regarding the resource contributions, desired outcomes, and perceived success of our coalition. In addition, the survey compiled data on the relational ties, trust, and value among coalition members. Response rates ranged from 52 percent to 91 percent with 7 out of 9 counties having a response rate of 70 percent or higher. Survey responses informed a report to each coalition for reflection and review. The survey results are being reviewed as part of a larger strategic planning process that includes a focus on sustainability.

Counties recognized various takeaways from the findings. For example, the coalition has discussed both the connections among coalition members (both as a positive and as a challenge) and identifying sector involvement (or lack thereof) have been discussed by the coalition. Lessons learned from this process include the importance of having coalition leadership as champions for the surveys, the need for ongoing processes to support community coalitions in understanding and using data on how the coalition functions, and the importance of focusing on the long-term "life" of the coalition to successfully sustain the coalition's mission and work.

EVALUATE COALITION MEMBERS' EXPERIENCES

How do your coalition members feel about the coalition? Regularly checking in with coalition members can help gauge how people are feeling about the coalition's activities and direction. Welcoming members to provide input, even anonymously, can help get a sense of how people are feeling about their involvement. Consider conducting a more-formal survey at regular intervals (e.g., every 6 months) to assess your members' feelings comprehensively.

Below are potential survey questions:

Thinking about your work in this community coalition, please rate your level of agreement with the following statements.					
I am committed to the work of the coalition	1	2	3	4	5
I can influence decisions that this coalition makes	1	2	3	4	5
This coalition is effective in achieving its goals	1	2	3	4	5
This coalition can influence decisions that affect the community	1	2	3	4	5
I am satisfied by the amount of influence I have over the decisions that this coalition makes	1	2	3	4	5

When the term "leaders" is used in this section, we mean the leadership of this coalition. Thinking about your work in this opioid coalition, please rate your level of agreement with the following statements.					
I am satisfied by the amount of influence I have over decisions that this coalition makes	1	2	3	4	5
The coalition leaders are able to guide the coalition toward the accomplishment of its goals	1	2	3	4	5
The leaders run effective meetings	1	2	3	4	5
The leaders articulate the vision of the coalition	1	2	3	4	5
The leaders encourage commitment to the coalition from coalition members	1	2	3	4	5

1. Strongly disagree **2.** Disagree somewhat **3.** Agree somewhat **4.** Agree strongly **5.** Prefer not to answer

Understanding how coalition members perceive the value of their involvement and the coalition's efforts to date can help the coalition more effectively engage members. For example:

- If members feel like they are not able to influence decisions, consider dedicating a coalition meeting to goal-setting and agenda-setting. Make efforts to acknowledge the voices of all members. Engage coalition members in choosing new board members and deciding on strategies to achieve consensus and voting.
- If members feel like the coalition has not been effective, consider reviewing progress to date with the coalition and inviting critical but constructive input on how these efforts could be more successful. Sharing a report to an external partner or to community partners can be another way to highlight successes made to date.

- If members say that leaders don't run effective meetings, consider reviewing operating procedures with coalition leadership and share with coalition membership to update any needed components.
- If members feel uninformed, consider sending more-frequent updates to coalition members or revisit the method of communication used.

As with most coalition work, improving how coalition members experience their role within the coalition will be an ongoing process that requires consistent and collective review, recognition of achievements, and recommendations for improvement. Coalition leadership should share their intention to reflect and respond to what is shared and highlight a commitment to ensuring meaningful participation for all.

Additional resources on coalition evaluation

- Community Toolbox—free resources, including a section on evaluating community programs and initiatives
- Prevention Technology Transfer Center Network (PTTC) Resources on Evaluation

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Appendices

APPENDIX A. COALITION MEMBERSHIP CHECKLIST

Type of Organization/Individuals
People with lived experience who can speak to needs, challenges, and preferences in their community
☐ People who are in recovery from opioid use disorder and/or other substance use disorders
☐ People who are actively using opioids or other substances with potential for lethal consumption e.g. methamphetamine or cocaine mixed with fentanyl
☐ Family and network members of individuals who overdosed because of opioids
☐ Peer organizations
Addiction treatment and recovery facilities
☐ Opioid treatment programs
☐ Settings providing medically managed withdrawal treatment or socially managed withdrawal
Behavioral health treatment providers that are likely to implement evidence-based practices to reduce overdose deaths
☐ Behavioral health treatment facilities
Health systems, agencies, and health providers that are likely to implement evidence-based practices to treat with MOUD and to reduce overdose deaths
☐ Hospitals (ER and other divisions)
☐ Federally qualified health centers
☐ Primary care practices
☐ Pain management clinics
☐ Maternal health practices (OBGYN, Planned Parenthood, etc.)
☐ Pharmacies
Emergency response units from municipal sub-units or geographic areas
☐ EMS services
☐ Fire departments
Local law enforcement and/or criminal legal organizations
☐ Jail/prison administrators
☐ Sheriffs
☐ District attorneys
☐ Narcotics squads
☐ Police (can be considered first responders)

Continued

Type of Organization/Individuals
☐ Drug or treatment courts
☐ Family courts
☐ Community supervision
☐ Probation/parole
Harm reduction services
☐ Syringe service programs
☐ Mobile units
☐ Naloxone programs
Organizations that address social determinants of health, including social services and entitlement service providers
☐ Housing providers (public and private, hotels, etc.)
☐ Transportation outlets/providers
☐ Food insecurity organizations (food pantries, WIC, etc.)
☐ Employers (large & small)
☐ Education (public school administrators, representatives from local colleges, etc.)
Local service organizations, civic leaders, and other potential influencers
☐ County administrators and supervisors
☐ Legislators
☐ Prevention resources centers and providers
Other key partners
☐ Clergy and/or faith-based organizations serving affected areas of the community (behavioral health sector)
☐ Media and health messaging resources and outlets
☐ Local advocacy organizations (including outside local coalitions)
☐ Victims services
☐ Local businesses, Chamber of Commerce
☐ Veterans and/or organizations serving veterans
☐ Different municipal sub-units or geographic areas of the community
Organizations that support specific demographic groups
☐ Specific age groups (i.e., youth, seniors, etc.)
☐ BIPOC communities
☐ LGBTQI+ communities

APPENDIX B. COALITION CHARTER TEMPLATE

For communities to successfully address the opioid crisis, they need implementation strategies that take their unique local needs and resources into account. Coalitions can help develop a community-driven change process that will enable communities to be more effective in preventing deaths from opioids.

Coalition Goal

The overarching aim of this coalition is to reduce opioid-related overdose deaths.

Coalition Priorities

This coalition will use the following priorities to guide decision-making:

- Elevating local expertise.
- Building on existing community assets.

Membership

List coalition members, committee members (if applicable), and member contact.

Roles & Responsibilities

Describe the roles and responsibilities of people in the coalition.

Committee Structure and Duties

If applicable, describe committees that will support the work of the coalition. List each of the committees, their makeup, and the goals of the committee.

Finances and Budgeting

How will financial decisions be made, recorded, monitored, and reported back to the coalition?

Meeting Operations

- Meeting frequency: The coalition meetings will be held _____.
- Meeting platform: Meetings will be held [*in person, online, both*].
- Agenda: An agenda is distributed at least _____ hours in advance of the meetings by the chair.
- Facilitation: Meetings will be facilitated by _____.

- Documentation: Notes will be taken at all meetings to ensure follow-up and shared via _____ within _____ [*timeframe*].
- Decision-making: The coalition will make decisions and approve actions that are consistent with the coalition's strategic priorities. The coalition will use _____ decision-making strategy.

Communication Procedures

The group will agree upon operational protocols with respect to communication and interactions. *The coalition engages its members through communication protocols, which include the following: …*

Schedule of Meetings

Add a list of monthly coalition and subcommittee meetings. Note whether the meeting is in person, over phone, over Zoom, or other.

Timeline and Milestones

Add a timeline and milestones.

Privacy and Confidentiality

Is information shared within coalition meetings confidential?

APPENDIX C. COMMUNITY COALITION COORDINATOR JOB DESCRIPTION

Summary: The Community Coalition Coordinator will help build the local community coalition's capacity and prepare the coalition to sustain community-led efforts. The coalition's overarching goal is to reduce opioid use disorder and opioid overdose mortality by adopting evidence-based practices. An ideal Community Coalition Coordinator candidate should believe strongly in the value of harm reduction for preventing deaths and the importance of having voices of people with lived experience at the table.

Suggested Duties and Responsibilities

- ☐ Serve as the community organizer of the community coalition.
- ☐ Collaborate with members to enhance coalition building and community engagement.
- ☐ Responsible for agenda development, training needs, planning, and other coalition-related tasks as needed.
- ☐ Help identify a diverse and representative set of key people to serve on the coalition, including content area champions related to naloxone, medications for opioid use disorder, opioid prescription safety, data, and communications.
- ☐ Work constructively with a diverse group of key people, including community leaders, addiction treatment providers, law enforcement, medical and mental health providers, and recovery programs.
- ☐ Facilitate the development of a charter and meet expectations set by the charter.
- ☐ Facilitate coalition meetings.
- ☐ Aid in conducting a needs assessment, selecting evidence-based practices, and monitoring and evaluation.
- ☐ Create plans to promote sustainability of coalition activities.
- ☐ Partner with champions to prepare and disseminate information to coalition, partners, and the public.
- ☐ Promote the inclusion of people who use drugs, people with lived experience, families, people of color, unhoused people, and other key populations.
- ☐ Support diverse perspectives, constructive dialogue, and consensus-building among coalition members with a variety of backgrounds.
- ☐ Other duties as necessary.

Suggested Qualifications

- ☐ Flexibility and willingness to work as part of a team
- ☐ Local expertise, relationships, and knowledge of community history and dynamics; preference for residents
- ☐ Strong meeting planning, scheduling, and facilitation skills
- ☐ Experience building and coordinating coalitions of diverse people
- ☐ Capable of communicating among many partners in organized and clear manner
- ☐ Strong writing and public speaking skills
- ☐ Alignment with cultural humility and the tenets of harm reduction
- ☐ Experience with research and working to address opioid use disorders a plus

Suggested Education or Equivalent Experience

- ☐ Professional training in public health, social work, community health, or similar field in human services OR equivalent years of experience and service
- ☐ Multilingual skills highly recommended

APPENDIX D. COALITION COMPOSITION ASSESSMENT TOOL

The following are recommended for members in a coalition to address opioid overdose deaths.

- ☐ People with lived experience with opioid use disorder (OUD), particularly those that have experience with medications for OUD as a pathway to remission and recovery (e.g., peer support specialists, attendees of recovery meetings supportive of medications for opioid use disorder [MOUD], and those identified as key opinion leaders that support harm reduction efforts).
- ☐ People employed in the criminal legal sector (e.g., local jail employee, community supervision programs, drug court and law enforcement).
- ☐ People employed by agencies providing medication for OUD (e.g., prescribing providers, case workers/care navigators in MOUD providing agencies).
- ☐ People familiar with safe opioid prescribing, dispensing, and disposal (e.g., opioid-prescribing MDs, PA, and APRNs; pharmacists; pharmacy technicians and members of regulatory or prescription drug monitoring boards or programs).
- ☐ People familiar with local challenges and opportunities related to naloxone (e.g., local harm reduction staff, quick response teams, pharmacists, pharmacy technicians, and health department employees).
- ☐ People who are local opinion leaders and influential in local and organizational decision-making (e.g., local coalition chairs, local governmental leaders, and organizers of local community events and trainings).
- ☐ People involved in providing ancillary services relevant to remission and recovery from OUD (e.g., social support services and assistance programs).
- ☐ People involved in local emergency response (e.g., emergency management services, fire departments, police, quick response teams, and social work teams).
- ☐ Family and friends of people with OUD.
- ☐ People involved in monitoring or collecting local data relevant to OUD.
- ☐ Leaders and providers from healthcare settings.
- ☐ Members of faith-based communities.
- ☐ Members of cultural and traditional community groups.

How might the current makeup of this coalition influence decision-making?

Does the coalition reflect county demographics with respect to age, gender, sexuality, race, and ethnicity?

☐ Yes ☐ Somewhat ☐ No

If no or only somewhat, what groups do you feel are missing and how may we reach them with invitations?

After reviewing the list above, do you feel that the coalition in _____ (location) has/had adequate representation from every sector on the *priority list? ☐ Yes ☐ No

If not, who is missing, and who might we consider inviting?

Name	Organization/role	Contact information
Name	Organization/role	Contact information
Name	Organization/role	Contact information

After reviewing the lists above, do you feel that the coalition in _____ location has/had adequate coverage for the areas listed that were not marked with *s? ☐ Yes ☐ No

If not, who is missing, and who might we consider inviting?

Name	Organization/role	Contact information
Name	Organization/role	Contact information
Name	Organization/role	Contact information
Name	Organization/role	Contact information

Continued

Do the people that currently make up the coalition have the necessary time to commit to meaningfully serving on the coalition?

☐ Yes, all do ☐ Some do, but others may not ☐ No

If no or only some do, who does or may not?

Name	Organization/role	Contact information
Name	Organization/role	Contact information
Name	Organization/role	Contact information

Who might we consider/have considered inviting in their place? You may want to consider one of their staff or colleagues, or a person from a different but similar organization.

Name	Organization/role	Contact information
Name	Organization/role	Contact information
Name	Organization/role	Contact information

Source: Kentucky HEALing Communities Study

APPENDIX E. COALITION READINESS ASSESSMENT

Instructions: You must download and save the file to your computer before filling it out. Completing the form within your web browser will not save your work.

OVERVIEW OF COMMUNITY	
County	
Geography (Rural/Urban)	
Population	
Total Population	
AA/Black Pop (%)	
Latino/Hispanic Pop (%)	
Overdoses (#/Rates per 100,000 population)	
Fatal Opioid Overdoses	
Non-Fatal Opioid Overdoses	
Fentanyl-Related	
MOUD	
MOUD Providers	
MOUD Prescriptions	
OEND	
EMS	
Law Enforcement	
Overdose Prevention Specialists	
Local Prevention, Treatment, and Recovery Resources	
PWUD Peer Champions and Community Experts	

Source: New York HEALing Communities Study

Continued

APPENDIX E. COALITION READINESS ASSESSMENT

COALITION HISTORY & STRUCTURE	
Coalition	
Name of Coalition Lead	
Name of Coalition	
Year Established	
Fiscal Agent	
Anchor/Lead Agency/Organization	
Coalition Staff	
Program Manager	
Data Coordinator	
Workgroups & Champions	
Coalition Charter or Mission	
Meeting Frequency	
Funders (Current & Past)	

Source: New York HEALing Communities Study

Continued

APPENDIX E. COALITION READINESS ASSESSMENT

COMPOSITION OF CURRENT COALITION	
County	
Criminal Justice	
Jail/Prison	
Courts	
Police	
Probation/Parole	
Healthcare	
Behavioral Health	
SUD Treatment Providers	
MOUD Providers	
Hospitals	
Primary Care	
Maternal Health	
Pharmacies	
Emergency Response (EMS, Fire Dept, etc.)	
Peer Organization	

Source: New York HEALing Communities Study

Continued

APPENDIX E. COALITION READINESS ASSESSMENT

COMPOSITION OF CURRENT COALITION	
People with Lived Experience & Loved Ones	
PWLE	
PWUD	
Family & Friends of People with OUD	
BIPOC Communities	
BIPOC Individuals	
BIPOC Organizations	
Gov't Agencies	
Local Prevention, Treatment, and Recovery Resources	
Elected Officials	
Faith-Based Organizations	
Housing	
Communications	
Local Media	
Staff with Communications Experience (social media, PR, campaigns, etc.)	
Local Businesses	
Veterans	

Source: New York HEALing Communities Study

Continued

APPENDIX E. COALITION READINESS ASSESSMENT

CURRENT & PAST EVIDENCED-BASED PRACTICES IMPLEMENTED IN THE COMMUNITY TO ADDRESS THE OPIOIDS CRISIS	
County	
Overdose Education and Naloxone Distribution	
Medications for Opioid Use Disorder	
Safer Prescribing, Dispensing & Disposal	

COMMUNICATIONS CHANNELS, CAMPAIGNS & PRESS COVERAGE (EARNED MEDIA)	
County	
Website (URL)	
Social Media Channels	
Facebook	
Instagram	
Twitter	
Current & Past Media Campaigns	
Earned Media Received (examples)	

Source: New York HEALing Communities Study

Continued

APPENDIX E. COALITION READINESS ASSESSMENT

COALITION'S ACCESS TO DATA & ABILITY TO SHARE WITH THE PUBLIC	
County	
Relationship with Medical Examiner? (Yes/No)	
Relationship with County Coroner? (Yes/No)	
Utilize ODMAP? (yes/no)	
Existing Dashboard (on website, internal site, etc.)	

Source: New York HEALing Communities Study

Additional Questions:

Does the coalition reflect county demographics with respect to age, gender identification, sexual orientation, race, and ethnicity, and class? □ Yes □ Somewhat □No

If no or only somewhat, what groups do you feel are missing and how may we reach them with invitations?

Does the coalition reflect different municipal sub-units or geographic areas of the community?

If not, who is missing and who might we consider inviting?

APPENDIX F. HEALing COMMUNITIES STUDY

The National Institutes of Health and the Substance Abuse and Mental Health Services Administration launched the HEALing Communities Study (HCS) to test the immediate impact of an integrated set of evidence-based interventions across healthcare, behavioral health, criminal legal, and other community-based settings to prevent and treat opioid misuse and opioid use disorder within highly affected communities. The HCS tests the impact of the Communities That HEAL (CTH) intervention, which seeks to integrate prevention efforts, overdose treatment, and medication-based treatment in select communities hard hit by the opioid crisis. The CTH intervention contains three components: (1) a community-engaged coalition and data-driven process to facilitate the implementation of evidence-based practices; (2) the Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) menu of strategies; and (3) communication campaigns to address stigma and increase knowledge of, and demand for, evidence-based practices. This comprehensive treatment model was tested in a coordinated array of settings, including primary care, emergency departments, and other community settings.

The goal of the HCS is to reduce opioid-related overdose deaths by 40 percent over the course of 3 years. Research sites partnered with 67 communities highly affected by the opioid crisis in four states to measure the impact of these efforts. The study looks at the effectiveness of coordinated systems of care designed to increase the number of people receiving medication to treat opioid use disorder (OUD), increase the distribution of naloxone, and reduce high-risk opioid prescribing. The study also supports harm reduction research to investigate the effectiveness of rapid-acting fentanyl test strips in modifying drug use behaviors and exploring drug checking needs in clinical settings.

Because implementation of evidence-based practices to reduce opioid overdose deaths within communities remains suboptimal, community engagement strategies were employed to improve the uptake and sustainability of those practices. Community coalitions were required to select at least five ORCCA menu strategies with a minimum of (1) one strategy involving active OEND; (2) three strategies involving medications for opioid use

disorder (MOUD) expansion, linkage, and retention; and (3) one strategy on safer opioid-prescribing/dispensing practices. In addition, the study protocol required coalitions to implement at least one evidence-based practice strategy in three key sectors (behavioral health, criminal legal, and healthcare). Coalitions were encouraged to consider evidence-based practice strategies focused on those most vulnerable to opioid overdose (e.g., people with a prior opioid overdose, people who inject drugs, etc.) and priority settings (e.g., correctional settings, syringe service programs, etc.). Additional detail on the development of community coalitions can be found in the article Community engagement to implement evidence-based practices in the HEALing communities study.

Research grant awards were issued to the University of Kentucky in Lexington; Boston Medical Center in Boston; Columbia University in New York City; and Ohio State University in Columbus. The HEALing Communities Study is a multiyear study under a cooperative agreement supported by the National Institute on Drug Abuse, part of the NIH. The study launched in 2019, and results will be shared in the summer of 2023. Technical details and specifics about study design and how intervention success was evaluated can be found in the article The HEALing (Helping to End Addiction Long-term SM) Communities Study: Protocol for a cluster randomized trial at the community level to reduce opioid overdose deaths through implementation of an integrated set of evidence-based practices.

APPENDIX G. ACKNOWLEDGMENTS

Technical Expert Panel Members

- **Pedro Alvarez**, Assistant Director of Urban Drug User Health & Outreach, Tapestry
- **Lawrence Bryant**, PhD, MPH, Assistant Professor, Kennesaw State University
- **Judy Harness,** RN, MS, Community Engagement Project Manager, HEALing Communities Study Ohio
- **Tim Hunt**, PhD, MSW, Associate Director, Columbia University School of Social Work
- **Ben Riker**, Director of Government Alliances, Velocity BioGroup
- **Clayton Ruley,** MLSP, MSS; Director of Diversity, Equity, Inclusion and Harm Reduction; Community Liver Alliance
- **Reyna Saures**, Administrative Services Manager, Commonwealth Healthcare Corporation: Community Guidance Center
- **Hilary Surratt**, PhD, Associate Professor, University of Kentucky

HEALing Communities Study

- Continuum of Care Work Group
- Community Engagement Work Group

Substance Abuse and Mental Health Services Administration

- **Yngvild K. Olsen**, MD, MPH, Director of the Center for Substance Abuse Treatment
- **Karran Phillips**, MD, MSc, Deputy Director of the Center for Substance Abuse Treatment
- **Carter Roeber**, PhD, MA, Social Science Analyst, National Mental Health and Substance Use Policy Laboratory
- **Humberto Carvalho**, MPH, Project Officer, Center for Substance Abuse Treatment

National Institute on Drug Abuse

- **Redonna K. Chandler**, PhD, Director of the HEALing Communities Study
- **Jennifer Villani**, PhD, MPH, Associate Director of the HEALing Communities Study
- **Andrea Czajkowski**, MBA, PMP, Program Analyst, HEALing Communities Study

RTI Data Coordinating Center

- **Joëlla W. Adams**, PhD, MPH, Research Epidemiologist
- **Megan Hall**, MPH, Research Clinical Study Specialist
- **Beth Linas**, PhD, MHS, Research Epidemiologist
- **LaShawn Glasgow**, DrPH, MPH, Senior Director, Center for Program and Policy Evaluation to Advance Community Health
- **Craig LeFebvre**, PhD, MS, Communications Scientist
- **Emmanuel Oga**, MD, MPH, Senior Research Epidemiologist
- **Lauren Farmer**, BA, Project Management Specialist

RTI Editing and Design

- **Vivien Arnold**, MA, Senior Graphic Designer
- **Ally Elspas**, BA, Senior Graphic Designer
- **Rebecca Hipp**, BS, Senior Project Management Specialist
- **Claire Korzen**, BA, Editor
- **Shari Lambert**, BFA, Senior Graphic Designer
- **Michelle Myers**, BS, Senior Editor

APPENDIX H. TECHNICAL EXPERT BIOGRAPHIES

Pedro Alvarez is the Assistant Director of Urban Drug User Health & Outreach at Tapestry. Mr. Alvarez started his career at Tapestry in January 2016 as a Harm Reduction Counselor providing direct service to active injection drug users and their immediate social networks. Within his new role, he oversees HIV prevention programs that service drug users, with a specific focus on harm reduction services centered in heavily concentrated urban areas. Mr. Alvarez is fortunate enough to work in his hometown community for a community-based organization that truly cares about its residents. He is passionate about community education and awareness surrounding topics of harm reduction and the intersection of healthcare and innovation. He serves on the Board of Directors as Vice President of The Consortium, which works to create conditions in which people with lived experience can fully participate in decision-making processes related to their and their community's needs. He is also a member of the Department of Public Health's Latinx advisory group and numerous community-based efforts related to social justice and the Latinx population.

Lawrence Bryant, PhD, MPH, brings a plethora of experiences and knowledge dealing with substance use disorders (SUD), HIV/AIDS prevention, cultural responsiveness, and issues related to race and sexual orientation. He has successfully developed and implemented a statewide strategic plan for Georgia in response to the opioid and prescription drug overdose epidemic. As a result of this formative work, Dr. Bryant received a grant to do a multicultural needs assessment among vulnerable populations in support of the Statewide Strategic Plan from the Georgia Department of Public Health. Dr. Bryant has also published more than 20 peer-reviewed articles in the areas of HIV/AIDS, homophobia, racism, and tobacco use prevention. He has been a registered respiratory therapist for more than 45 years, most recently fighting on the front lines of the COVID-19 pandemic. As a part-time Assistant Professor at Kennesaw State University and Capella University, Dr. Bryant teaches SUD, health, and wellness courses and does research and training in SUD prevention, treatment, and recovery. Dr. Bryant is a sought-after speaker and presenter at the national and international levels, and on August 16th, 2022, celebrated 30 years in recovery.

Judy Harness, RN, MS, has proudly served the HEALing Communities Study for Ohio as Project Director of Community Engagement since 2020. For her, responding to the call to get involved in the work of the opioid crisis is an opportunity to serve those most in need. Having family members impacted by the devastation of addiction was the doorway to working on the HEAL study. She has worked in the field of community health as a Clinical Nurse Specialist for the past 20 years. Primarily working in the field of tobacco cessation research, she has managed various projects in the Appalachian communities of Ohio. She has been a nurse since 1985 and has a passion for people! Although she loves caring for those in the hospital, she is happy to devote herself to promoting positive health initiatives in communities across Ohio and

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beyond. She is active in her local community, married to her best friend for 35 years, mother of four, and Grandma to eight beautiful children, not including two lovely pups who think they are children. A two-time graduate of The Ohio State University, she is a proud Buckeye! O-H.....I-O!

Timothy Hunt, PhD, MSW, is an Associate Research Scientist and Associate Director with the Social Intervention Group, the Global Health Research Center of Central Asia, and Columbia's Center for Healing of Opioid and Other Substance Use Disorders-Enhancing Intervention, Development and Implementation (CHOSEN) at the Columbia University, School of Social Work. Dr. Hunt has provided trauma-informed family therapy, substance abuse treatment, and HIV prevention and care for more than 33 years. His global and domestic research includes (1) designing, testing, and disseminating HIV/sexually transmitted infection prevention and health promoting interventions; (2) studying the effectiveness of capacity-building strategies and methods to support evidence-based interventions and core competencies of the healthcare workforce in Europe, Central Asia, and the Middle East; and (3) the adaptation and translation of evidence-based interventions aimed at reducing harm caused by addictions, reducing harm caused by intimate partner violence, and promoting wellness. He is co-investigator for the HEALing Communities Study, co-designing and leading the community-engaged intervention, and for the New York State engagement of the criminal legal sector aimed at reducing overdose deaths in 16 New York State counties, in collaboration with 67 counties from Ohio, Massachusetts, and Kentucky. Dr. Hunt is an international trainer in Motivational Interviewing and a CDC Master Dissemination Trainer.

Ben Riker is a father of two, a person in recovery, and a passionate advocate for data-driven, evidence-based policy surrounding education, treatment, and recovery from SUDs. His professional background includes all aspects of organizational peer-professional integration and programming, including training, coaching, and supervision as well as community and professional education and outreach. Ben has experience as a Friends of Recovery-New York Best Practice Trainer; is a member of the Agency for Substance Abuse Policy—New York City Board Trainer Registry; and serves on the Partnership to End Addiction's FIRST Research Network National Advisory Board, Faces and Voices of Recovery's National Public Policy Committee, and the NY Association of Substance Abuse Provider's Harm Reduction Committee.

Clayton Ade-Andrew Ruley, MLSP, MSS, is a social worker by trade and currently the Director of Diversity, Equity, Inclusion, and Harm Reduction at the Community Liver Alliance (CLA). Before his work with CLA, Clayton worked for 12 years at Prevention Point Philadelphia serving in a host of official (and unofficial) leadership roles, from coordinating free medical clinics in the Street-side Health

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Project, the Stabilization Treatment and Engagement Program (STEP), directing the Harm Reduction Service Center, to leading the Community Engagement and Volunteer Services Department. Clayton graduated from Bryn Mawr Graduate School of Social Work and Social Research (GSSWSR) in 2010 with a dual MSS and MLSP. While at GSSWSR, Clayton was a 2009 Ruth Mayden Scholar, first Annual Kevin J. Robinson awardee, and a 2010 Fellow with the Black AIDS Institute's African American HIV University program. He earned his undergraduate degree from Bloomsburg University, where he majored in political science and mass communications. A social worker coming from a family of social workers (mom, dad, brother, sister-in-law, godfather), Clayton is a harm reductionist, social justice advocate, and avid user of media who loves to inform and be informed. Clayton is a lifelong Philadelphia resident.

Reyna Malone Saures, a resident of the Commonwealth of the Northern Mariana Islands (CNMI), has been engaged in behavioral health in different facets. From May 2013 to May 2015 and again from March 2019 to January 2022, she served as the Director of Behavioral Health (Community Guidance Center) under the Commonwealth Healthcare Corporation (CHCC)—the Single State Authority for Behavioral Health services in the CNMI. Currently, she serves in the Director's office as the Administrative Services Manager working with CHCC behavioral health programs across the continuum of care and across service and age populations, as well as in areas that promote strategic planning, data-driven systems, evaluation, and quality assurance. Most notably, she is mother to a son on the spectrum for autism and family member and friend to individuals with lived experience. Both her personal and professional experiences in the field fuel her passion to advocate for and engage in policies, best practices, and activities that promote hope, healing, and health among those she loves, is surrounded by, and serves in her community.

Hilary L. Surratt, PhD, is Associate Professor in the Department of Behavioral Science at the University of Kentucky and Director of Evaluation at the Center for Clinical and Translational Science. Her research interests include SUD and infectious disease, with a focus on optimizing behavioral and structural interventions to improve care for people who use drugs. As a Kentucky native with a passion for working in underserved communities, she has forged successful bidirectional partnerships with rural Appalachian County health departments to undertake critical harm reduction research in areas of the state that have been devastated by the opioid epidemic. She has embraced the opportunity to contribute to rural community-engaged substance use research with the goal of informing effective practice and promoting equitable access to evidence-based treatment and care for underserved rural populations. Dr. Surratt has published more than 150 peer-reviewed articles and book chapters; her recent work has appeared in *Drug and Alcohol Dependence, Frontiers in Psychiatry, Therapeutic Advances in Infectious Disease*, and *Journal of Clinical and Translational Science*.

Recovery from Substance Use and Mental Health Problems Among Adults in the United States

SAMHSA
Substance Abuse and Mental Health Services Administration

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Contents

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I. ABSTRACT

This brief report presents self-reports of recovery among adults aged 18 and older in the United States who thought they ever had a problem with their use of drugs or alcohol and/or mental health. Recovery for substance use or mental health problems differed by age, family income, education, marital status, and importance of religious beliefs. Adults who participated in at least one government assistance program, had a lower level of education, or had a lower family income relative to the federal poverty level tended to have a higher prevalence of substance use recovery, but a lower prevalence of mental health recovery. The percentage of adults in mental health recovery tended to be higher among those who were insured, had better overall health, were heterosexual, or were never arrested or booked for breaking the law. Further, the percentage of adults in recovery tended to be lower among those with past-year serious psychological distress, substance use disorder (SUD), co-occurring mental illness and SUD, alcohol use, marijuana use, or cocaine use. Substance use recovery was more prevalent among adults who received lifetime or past-year substance use treatment. Similarly, mental health recovery was more prevalent among adults who received past-year mental health treatment. These findings provide a clearer characterization of the factors associated with recovery among adults and how future efforts can foster a whole-health approach to sustain recovery from mental health and substance use conditions.

II. INTRODUCTION

Substance use and mental health conditions impact individuals from all walks of life, and across all age groups. While these conditions are common, recurrent, and often serious, they are preventable and treatable; and many individuals do recover. In 2022, the Substance Abuse and Mental Health Services Administration (SAMHSA) reaffirmed its definition of *recovery* as "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential" (SAMHSA, 2012). The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. A better understanding of those who self-identify as in recovery, particularly during the COVID-19 pandemic, is crucial if data-driven efforts are to foster recovery through expanded access to treatment and recovery services. This report summarizes perceived recovery, hereafter referred to as "recovery," among U.S. adults. The following sections present the prevalence of substance use and mental health recovery among adults who perceived that they ever had a problem with their substance use or mental health, stratified by population characteristics related to sociodemographic factors, substance use, SUD, mental health, and treatment.

III. METHODS

Data Source

The National Survey on Drug Use and Health (NSUDH) is an annual survey sponsored by SAMHSA, an agency within the U.S. Department of Health and Human Services. NSDUH's data collection protocol was approved by the U.S. Office of Management and Budget and the institutional review board at Research Triangle Institute International. Informed consent was obtained from each NSDUH participant.

NSDUH collects information from residents of households and noninstitutional group quarters (e.g., shelters, rooming houses) and from civilians living on military bases. The

survey excludes unhoused people who do not use shelters, military personnel on active duty, and residents of institutional group quarters, such as jails and hospitals. The 2021 NSDUH used multimode data collection, in which respondents completed the survey via the web or in person in eligible locations. The weighted household screening response rate was 22.2%, and the weighted interview response rate was 46.2% for 2021. Additional details about the NSDUH methods are provided in the 2021 Methodological Summary and Definitions report (Center for Behavioral Health Statistics and Quality [CBHSQ], 2022).

A total of 69,850 respondents aged 12 or older completed the survey in person or via the web in 2021. This brief report utilized the 2021 NSDUH restricted-use file to examine data from adults aged 18 years and older who reported that they ever had a problem with their drug use, alcohol use, or mental health.

IV. MEASURES

Respondents aged 18 or older were asked whether they thought they ever had a problem with their use of drugs or alcohol or whether they thought they ever had a problem with their mental health. Respondents who reported that they ever had a problem with their drug or alcohol use were asked whether they considered themselves (at the time they were interviewed) to be in recovery or to have recovered from their drug or alcohol use problem. Similarly, respondents who reported that they had a problem with their mental health were asked whether they considered themselves (at the time they were interviewed) to be in recovery or to have recovered from their mental health problem. Additional measures were created to demonstrate the presence of a perceived substance use and/or mental health problem and recovery from a substance use and/or mental health problem.

Additionally, NSDUH collected information on:

- Sociodemographic characteristics: Sex, age, race and ethnicity, health insurance coverage, participation in a government assistance program, family income relative to the federal poverty level, marital status, sexual identity, veteran status, educational attainment, employment status.
- Other social determinants of health: Overall health, importance of religion, criminal justice system involvement.
- Perceived COVID-19 pandemic impact: Mental health, amount of alcohol or drug use.
- Substances used in the past year: Tobacco, alcohol, marijuana, cocaine, hallucinogens, prescription pain relievers, prescription tranquilizers, prescription sedatives, prescription stimulants.
- SUD in the past year, using diagnostic criteria from the *Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition)*.
- Treatment for illicit drug or alcohol use in the past year.
- Mental health in the past year: Serious thoughts of suicide, psychological distress, mental illness.
- Mental health treatment in the past year.

V. STATISTICAL ANALYSIS

Recovery was examined among respondents aged 18 years and older who perceived that they ever had a substance use or mental health problem. Prevalence estimates of recovery from substance use or mental health problems were stratified by population characteristics (i.e., sociodemographic characteristics, other social determinants of health, perceived COVID-19 impact, substances used, SUD, SUD treatment, mental health, mental health treatment). Descriptive analyses using Pearson's chi-square test examined whether the prevalence of recovery differed by population characteristics. For each analysis, a 2-tailed *p* value of less than 0.05 was considered statistically significant. In cases where overall chi-square tests identified significant differences in the prevalence of recovery between multiple levels of a variable (for example, across the five age groups), observed patterns based on the prevalence estimates were examined. Statistical tests for trends or pairwise comparisons were not conducted to formally assess which groups had higher or lower recovery prevalence. SUDAAN 11.0.4 was used for all data analyses to account for NSDUH's complex sample design and sample weights. Unreliable estimates were not published in accordance with NSDUH suppression criteria (CBHSQ, 2022).

VI. RESULTS

In 2021, 70.0 million adults aged 18 or older perceived that they ever had a substance use and/or mental health problem, 72.1% (or 50.2 million) of whom considered themselves to be in recovery or to have recovered from their substance use and/or mental health problem. For substance use specifically, of the 29.0 million adults who perceived that they ever had a substance use problem, 72.2% (or 20.9 million) considered themselves to be in recovery or to have recovered from their drug or alcohol use problem. For mental health, of the 58.7 million adults who perceived they ever had a mental health problem, 66.5% (or 38.8 million) considered themselves to be in recovery or to have recovered from their mental health problem.

VII. SOCIODEMOGRAPHIC CHARACTERISTICS

Among adults with perceived substance use and/or mental health problems, the percentage who were in recovery differed by age, marital status, poverty level, participation in at least one government assistance program, and education. Adults who participated in at least one government assistance program, had lower levels of education, or had a lower family income relative to the federal poverty level were generally more likely to be in substance use recovery, but less likely to be in mental health recovery. Additionally, mental health recovery tended to be more common among adults who were insured or heterosexual. While not statistically significant, recovery from substance use problems was more often reported among veterans.

VIII. OTHER SOCIAL DETERMINANTS OF HEALTH

The percentage of adults in recovery from substance use and/or mental health problems significantly differed by importance of religious beliefs. In general, the prevalence of recovery tended to increase with the level of importance that adults placed on their religious beliefs. Additionally, the percentage of adults who were in mental health recovery

significantly differed by their perceived overall health and whether they were arrested or booked for breaking the law. Mental health recovery tended to be more common among adults with higher levels of perceived overall health and among those who had never been arrested or booked.

IX. PERCEIVED COVID-19 PANDEMIC IMPACT

Among adults who used alcohol or drugs in the past year, the prevalence of substance use recovery significantly differed depending on the extent to which they perceived that the COVID-19 pandemic impacted their substance use. Similarly, the prevalence of mental health recovery significantly differed depending on the extent to which adults perceived that the COVID-19 pandemic negatively impacted their mental health. Among adults who used alcohol or drugs in the past year, substance use recovery was generally more common among those who reported that they used alcohol or drugs less than they did before the pandemic. Similarly, mental health recovery tended to be less common among adults who perceived that the pandemic negatively affected their health "quite a bit" or "a lot."

X. SUBSTANCE USE IN THE PAST YEAR

Adults who had an SUD in the past year were significantly less likely to be in recovery. The prevalence of substance use recovery was lower among adults who used alcohol, marijuana, cocaine, or a hallucinogen in the past year, while the prevalence of mental health recovery was lower among adults who used tobacco, alcohol, marijuana, cocaine, or prescription tranquilizers in the past year. While not statistically significant, the percentage of adults in recovery from substance use and/or mental health problems was lower among those who used prescription stimulants in the past year.

XI. SUBSTANCE USE TREATMENT IN THE PAST YEAR

The prevalence of recovery from substance use was higher among adults who had ever received substance use treatment in their lifetime or in the past year. While not statistically significant, the prevalence of recovery from mental health problems was higher among adults who had received substance use treatment in the past year. The percentage of adults in recovery from either substance use or mental health problems was lower among those who needed treatment for substance use and did not receive treatment in the past year.

XII. MENTAL HEALTH IN THE PAST YEAR

The percentage of adults in recovery from either substance use or mental health problems was significantly lower among those who had experienced serious psychological distress, mental illness, or comorbid mental illness and SUD in the past year. The percentage of adults in recovery from mental health problems was also lower among those who had serious thoughts of suicide in the past year.

XIII. MENTAL HEALTH TREATMENT IN THE PAST YEAR

The percentage of adults in mental health recovery was significantly higher among those who received any mental health treatment in the past year, including inpatient, outpatient, prescription, or virtual care. The percentage of adults in recovery from either substance use or mental health problems was also lower among those who felt that they needed mental health treatment but did not receive it in the past year.

The Appendix summarizes the prevalence of recovery, stratified by population characteristics.

XIV. DISCUSSION

An estimated 72.1% of adults who considered themselves to have ever had substance use and/or mental health problems reported that they were in recovery from such problems. Recovery for substance use or mental health problems differed by age, family income, education, marital status, and importance of religious beliefs. Adults who participated in at least one government assistance program, had a lower level of education, or had a lower family income relative to the federal poverty level tended to have a higher prevalence of substance use recovery, but lower prevalence of mental health recovery. The percentage of adults in mental health recovery tended to be higher among those who were insured, had better overall health, were heterosexual, or were never arrested or booked for breaking the law. Furthermore, the prevalence of recovery was lower among adults with past-year substance use, SUD, and serious psychological distress. Such findings are largely consistent with previous work (Jones et al., 2020; Kelly et al., 2017; Salzer et al., 2018).

These data reveal that recovery, from the perspective of those impacted by mental health and substance use conditions, is real and possible for the majority, and that there are many adults in the U.S. who identify as being in recovery. Recovery is also clearly supported by a range of factors, including social, spiritual, and somatic, thus calling for a whole-health approach to facilitating recovery.

Notably, these results demonstrated that individuals who received mental health treatment in the past year were more likely to self-identify as being in recovery from a mental health problem, and people who received substance use treatment in the past year were more likely to self-identify as being in recovery from a substance use problem. Those individuals were also less likely to need but not receive substance use treatment, or to perceive unmet need for and not receive mental health treatment. These findings highlight the importance of treatment and recovery-oriented systems of care so that when individuals with mental health and/or substance use problems seek help, they are met with the knowledge and belief that anyone can recover, and that they can successfully manage their conditions.

During the COVID-19 pandemic, adverse mental health symptoms and substance use increased due to factors such as worry and stress over the coronavirus, social isolation, and economic downturns (Czeisler et al., 2020; Haydon & Salvatore, 2022; Panchal et al., 2020). However, adults who reported that COVID-19 had stronger detrimental effects on their mental health or substance use were less likely to be in mental health or substance use recovery, respectively. This finding suggests that those in recovery may exhibit higher resilience, and as a result, experience reduced impact from COVID-19 due to their ability

to adapt, cope, and maintain healthier habits. This emphasizes resilience being a key component of recovery. Recovery is characterized by continual growth and improvement in one's health and wellness while managing setbacks, which are a natural part of life.

It is important to implement policies that leverage the positive aspects of protective factors among individuals in recovery to promote their overall well-being and successful reintegration into society. Some policy recommendations, grouped in the four dimensions that SAMHSA identifies as supporting recovery, include:

- **Health**
  - Primary Health Care – Expand access to affordable, high-quality health care, including health insurance coverage.
  - Mental Health and Substance Use Treatment Accessibility: Improve access to affordable and high-quality mental health and substance use treatment services to ensure early intervention and ongoing support for those in recovery.
  - Resiliency: Recognize and build on the strengths and capacities of individuals, families, and communities to overcome challenges and thrive.
- **Home**
  - Affordable Housing Initiatives: Create affordable housing options—including supported housing and recovery housing—to support individuals in recovery, fostering a sense of community and social support.
- **Purpose**
  - Supportive Employment Programs: Implement initiatives that promote job opportunities and vocational training for individuals in recovery, helping them access stable employment and higher incomes.
  - Collegiate Recovery: Expand efforts to provide campus-based supports to assist individuals to attain higher education.
  - Financial Counseling and Education: Offer financial literacy programs to help individuals in recovery manage their income effectively and build financial stability.
- **Community**
  - Community Outreach and Support Networks: Establish community-based support networks and peer-led programs that provide social support and mentorship to individuals in recovery.
  - Anti-Discrimination and Stigma Reduction Efforts: Develop campaigns to combat stigma surrounding mental health and substance use, fostering a more inclusive society that supports individuals' reintegration into the workforce and society.
  - Spirituality: Engage faith communities in supporting people in recovery.
  - Equity: Provide focused efforts to expand recovery opportunities to under-served and under-resourced populations, including people of color, LGBTQI+ populations, and others.

- Criminal Justice Diversion: Implement alternatives to arrest and incarceration.
- Family Support Services: Provide resources for families of individuals in recovery, acknowledging the vital role they play in providing social support.

The current report leverages SAMHSA's NSDUH data to characterize recovery from substance use and mental health problems more clearly. Through this effort, SAMHSA can better achieve its vision that people with, affected by, or at risk for mental health and substance use conditions receive care, achieve well-being, and thrive.

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XVI. APPENDIX: PERCEIVED RECOVERY FROM SUBSTANCE USE AND/OR MENTAL HEALTH PROBLEMS AMONG ADULTS WITH PERCEIVED SUBSTANCE USE AND/OR MENTAL HEALTH PROBLEMS

	Perceived Ever Had Substance Use or Mental Health Problems	In Recovery from Drug or Alcohol Use Problems		In Recovery from Mental Health Problems		In Recovery from Drug/Alcohol or Mental Health Problems	
	N = 70,033 (In Thousands)	Yes n = 20,936 (In Thousands)		Yes n = 38,787 (In Thousands)		Yes n = 50,172 (In Thousands)	
		%	*p*	%	*p*	%	*p*
		72.2		*66.5*		*72.1*	
Sociodemographics							
Gender			*0.74*		*0.35*		*0.95*
Male	32,129	72.0		65.7		72.0	
Female	37,905	72.7		67.1		72.1	
Age Groups			*<.01*		*<.01*		*<.01*
18–25 Years	12,787	67.0		63.0		66.5	
26–34 Years	14,312	73.4		63.9		69.9	
35–49 Years	18,914	69.9		66.2		72.7	
50–64 Years	15,542	70.7		67.5		72.3	
65 or Older	8,478	81.1		78.5		82.5	
Race/Ethnicity			*0.47*		*0.55*		*0.53*
Non-Hispanic White	50,337	73.5		66.9		72.8	
Non-Hispanic Black/ African American	6,335	69.2		63.6		69.4	
Non-Hispanic American Indian or Alaska Native	490	*[1]		*		*	
Non-Hispanic Native Hawaiian or Other Pacific Islander	*	*		*		*	
Non-Hispanic Asian	2,177	*		71.1		71.5	
Non-Hispanic More Than One Race	1,868	*		61.7		71.6	
Hispanic or Latino	8,644	67.6		66.2		70.2	
Health Insurance Coverage			*0.07*		*<.01*		*<.01*
No Health Insurance	6,448	66.0		58.0		63.9	
Any Health Insurance	63,586	73.0		67.3		72.9	
Participated in at Least 1 Government Assistance Program			*<.01*		*<.01*		*0.63*
Yes	16,262	78.0		62.0		72.7	
No	53,771	70.3		67.9		71.9	
Poverty Level[1]			*0.04*		*<.01*		*0.42*
Living in Poverty	10,862	77.0		60.9		70.9	
Income Up to 2X Federal Poverty Threshold	13,599	74.9		62.9		71.0	
Income More Than 2X Federal Poverty Threshold	45,545	70.3		69.0		72.7	

[1] * = low precision.

	Perceived Ever Had Substance Use or Mental Health Problems	In Recovery from Drug or Alcohol Use Problems		In Recovery from Mental Health Problems		In Recovery from Drug/Alcohol or Mental Health Problems	
	N = 70,033 (In Thousands)	Yes n = 20,936 (In Thousands)		Yes n = 38,787 (In Thousands)		Yes n = 50,172 (In Thousands)	
		%	*p*	%	*p*	%	*p*
		72.2		*66.5*		*72.1*	
Marital Status			*<0.01*		*<.01*		*<.01*
Married	26,686	74.5		70.1		74.3	
Widowed	2,536	*		73.6		77.6	
Divorced or Separated	12,312	75.7		69.0		76.7	
Never Been Married	28,500	67.2		62.1		67.5	
Sexual Identity			*0.13*		*<.01*		*<0.01*
Heterosexual	57,749	72.3		68.0		73.0	
Lesbian or Gay	3,227	66.2		61.2		67.6	
Bisexual	8,304	76.2		59.9		68.3	
Ever Been in the U.S. Armed Services			*0.09*		*0.81*		*0.23*
Yes	5,459	77.2		65.8		74.9	
No	64,564	71.6		66.5		71.8	
Education			*0.03*		*<.01*		*0.71*
Less Than High School	5,574	77.2		60.5		71.4	
High School Graduate	15,486	73.0		63.6		70.9	
Some College/Associate Degree	24,767	73.8		65.7		72.2	
College Graduate	24,207	67.8		70.1		72.9	
Employment Status in the Past Week			*0.12*		*0.25*		*0.36*
Employed Full Time	32,329	71.0		67.1		71.7	
Employed Part Time	10,794	68.0		67.6		70.3	
Unemployed	4,450	71.4		61.1		71.5	
Other[2]	22,460	75.7		66.1		73.6	
Other Social Determinants of Health							
Overall Health			*0.42*		*<.01*		*<.01*
Excellent	8,496	73.6		76.8		77.2	
Very Good	23,608	69.9		70.9		74.1	
Good	24,434	73.5		66.3		72.7	
Fair/Poor	13,438	73.0		53.0		64.2	
My Religious Beliefs Are Important			*<.01*		*<.01*		*<.01*
Strongly Disagree	18,176	68.5		62.2		68.2	
Disagree	13,218	67.3		61.2		66.4	
Agree	20,724	71.9		67.3		72.6	
Strongly Agree	17,404	81.0		74.4		80.1	

[2]*Other employment includes students, people keeping house or caring for children full time, people who are retired or disabled, or other people not in the labor force.*

	Perceived Ever Had Substance Use or Mental Health Problems	In Recovery from Drug or Alcohol Use Problems		In Recovery from Mental Health Problems		In Recovery from Drug/Alcohol or Mental Health Problems	
	N = 70,033 (In Thousands)	Yes n = 20,936 (In Thousands)		Yes n = 38,787 (In Thousands)		Yes n = 50,172 (In Thousands)	
		%	*p*	%	*p*	%	*p*
		72.2		*66.5*		*72.1*	
Ever Arrested and Booked for Breaking the Law			*0.15*		*<.01*		*0.14*
Yes	18,104	73.9		61.7		73.7	
No	51,770	70.9		67.7		71.5	
Perceived COVID-19 Impact							
Perception of How COVID-19 Negatively Affected Mental Health			*0.02*		*<.01*		*<.01*
Not at All	12,156	76.0		68.6		74.0	
A Little or Some	36,616	73.1		69.9		74.5	
Quite a Bit or a Lot	20,727	67.6		60.2		66.8	
Perception of How COVID-19 Negatively Affected Amount of Alcohol Drank[3]			*<.01*		*0.37*		*<.01*
Used Alcohol a Little Less or Much Less Than Before the Pandemic	13,486	81.1		66.2		74.3	
Used Alcohol About the Same as Before the Pandemic	25,628	65.9		65.5		69.5	
Used Alcohol a Little More or Much More Than Before the Pandemic	10,947	49.6		63.2		64.5	
Perception of How COVID-19 Negatively Affected Drug Use[4]			*0.02*		*0.04*		*0.10*
Used Drugs a Little Less or Much Less Than Before the Pandemic	12,488	75.2		63.5		72.8	
Used Drugs About the Same as Before the Pandemic	23,193	70.7		64.7		70.8	
Used Drugs a Little More or Much More Than Before the Pandemic	6,211	63.1		58.6		67.4	
Substance Use in the Past Year							
Drug or Alcohol Use Disorder			*<.01*		*<.01*		*<.01*
No	46,303	84.6		70.4		74.9	
Yes	23,730	60.1		58.6		66.6	
Tobacco Use			*0.127*		*<0.01*		*0.78*
No	45,885	73.9		68.3		72.2	
Yes	24,149	70.6		62.7		71.8	

[3]*Among past-year alcohol users only.*
[4]*Among past-year drug users only.*

	Perceived Ever Had Substance Use or Mental Health Problems	In Recovery from Drug or Alcohol Use Problems		In Recovery from Mental Health Problems		In Recovery from Drug/Alcohol or Mental Health Problems	
	N = 70,033 (In Thousands)	Yes n = 20,936 (In Thousands)		Yes n = 38,787 (In Thousands)		Yes n = 50,172 (In Thousands)	
		%	*p*	%	*p*	%	*p*
		72.2		*66.5*		*72.1*	
Alcohol Use			*<.01*		*<0.01*		*<.01*
No	18,886	87.5		70.4		78.7	
Yes	51,147	65.3		65.2		69.6	
Marijuana Use			*<.01*		*<.01*		*<.01*
No	45,102	75.5		69.4		73.8	
Yes	24,932	67.9		61.4		69.1	
Cocaine Use			*<.01*		*0.01*		*0.06*
No	67,108	73.3		67.0		72.3	
Yes	2,926	59.6		55.2		66.5	
Hallucinogen Use			*<.01*		*0.20*		*0.04*
No	65,528	73.3		66.7		72.4	
Yes	4,505	61.2		63.7		67.7	
Prescription Pain Reliever Use			*0.01*		*0.25*		*0.04*
No	46,338	70.0		67.1		71.1	
Yes	23,695	75.5		65.3		73.9	
Prescription Tranquilizer Use			*0.27*		*0.05*		*0.38*
No	54,610	71.6		67.3		71.8	
Yes	15,424	74.4		63.9		73.1	
Prescription Stimulant Use			*0.70*		*0.29*		*0.82*
No	62,231	72.4		66.8		72.1	
Yes	7,803	71.3		64.6		71.7	
Prescription Sedative Use			*0.25*		*0.62*		*0.13*
No	63,863	71.9		66.6		71.8	
Yes	6,171	75.9		65.3		75.1	
Substance Use Treatment							
Received Treatment at Any Location for Illicit Drug or Alcohol Use in Lifetime			*<.01*		*0.25*		*<.01*
No	57,535	67.3		66.1		69.7	
Yes	12,498	79.9		68.7		83.0	
Received Treatment at Any Location for Illicit Drug or Alcohol Use in Past Year			*<0.01*		*0.05*		*<.01*
No	66,820	71.0		66.2		71.4	
Yes	3,214	83.1		72.9		86.4	

	Perceived Ever Had Substance Use or Mental Health Problems	In Recovery from Drug or Alcohol Use Problems		In Recovery from Mental Health Problems		In Recovery from Drug/Alcohol or Mental Health Problems	
	N = 70,033 (In Thousands)	Yes n = 20,936 (In Thousands)		Yes n = 38,787 (In Thousands)		Yes n = 50,172 (In Thousands)	
		%	*p*	%	*p*	%	*p*
		72.2		*66.5*		*72.1*	
Needed Treatment for Substance Use but Did Not Receive Treatment in a Specialty Facility in Past Year[5]			*<.01*		*<.01*		*<.01*
No	49,609	84.3		69.9		75.2	
Yes	20,425	55.6		58.0		64.4	
Mental Health Status							
Serious Thoughts of Suicide in Past Year			*0.13*		*<.01*		*<.01*
No	59,869	72.8		69.8		74.3	
Yes	10,165	67.9		50.2		59.3	
Past-Year Serious Psychological Distress Indicator			*<0.01*		*<.01*		*<.01*
No	43,894	74.2		75.3		77.6	
Yes	26,139	67.4		54.8		62.9	
Mental Illness (MI) Category in Past Year			*0.41*		*<.01*		*<.01*
No Past-Year MI	30,617	73.9		79.8		79.1	
Past-Year Mild MI	14,800	69.8		67.6		72.1	
Past-Year Moderate MI	11,680	69.5		58.2		65.4	
Past-Year Serious MI	12,937	71.9		50.4		61.4	
Comorbid MI and SUD in Past Year			*<.01*		*<.01*		*<.01*
Yes	15,454	63.1		53.4		65.9	
No	54,580	76.2		70.7		73.8	
Mental Health Treatment							
Received Inpatient, Outpatient, Prescription, or Virtual Mental Health Treatment in Past Year			*0.78*		*<.01*		*<.01*
Yes	32,757	71.9		68.5		74.2	
No	37,118	72.5		64.2		70.3	
Perceived Unmet Need/ Did Not Receive Mental Health Treatment in Past Year			*<.01*		*<.01*		*<.01*
Yes	16,883	66.1		49.3		59.1	
No	52,985	73.8		73.2		76.2	

[5]*Specialty facilities for substance use treatment include hospitals (inpatient only), rehabilitation facilities (inpatient or outpatient), or mental health centers.*

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SAMHSA

Substance Abuse and Mental Health
Services Administration

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.

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Key questions to ask when **selecting outcome measures:** a checklist for allied health professionals

Author:
Allied Health Professions (AHP) Outcome Measures UK Working Group

November 2019

Next

Appraising the impact and effectiveness of our interventions and services, and how they are perceived by the people who access them, is an integral part of professional practice.

A health outcome can be defined as 'a change in the *health status* of an individual, group or population which is attributable to a planned intervention or series of interventions' (World Health Organization 1998, p10.). Outcome measures allow us to evaluate whether such changes have occurred over time, and therefore play an important role in helping us deliver safe and effective interventions/services, which are valued by the people who access them. They can be used to:

- Identify meaningful change for the person accessing our services (e.g. in wellbeing/quality of life)
- Evaluate the effect of our interventions
- Demonstrate the impact and value of our services (e.g. to people who access them, colleagues and funders/commissioners)
- Identify areas for improvement
- Benchmark against other organisations/services/standards

Whilst the value of using outcome measures is well recognised, deciding upon an appropriate measure can be a somewhat daunting prospect. This checklist has been developed by a cross-disciplinary group of professional bodies, to help individual allied health professionals (AHPs) or teams select an appropriate outcome measure for their practice setting.

The checklist consists of three sections:

1. **Initial considerations when selecting an outcome measure** – helps to identify the type of outcome and how it will be measured.

2. **Acceptability and utility** – focusses on whether the outcome measure is user-friendly and relevant, and its feasibility within the practice setting.

3. **Measurement properties** – outlines key measurement properties, including validity, reliability and responsiveness/sensitivity to change.

This checklist is not intended to be exhaustive; it is a tool to aid discussion, reasoning and decision-making. A list of further reading is provided at the end of the document.

<table>
<tr><th colspan="4">1. Initial considerations when selecting an outcome measure</th><th>✓</th></tr>
<tr><td rowspan="5">What do I want to measure?</td><td colspan="3">People's experience of accessing care/satisfaction with service</td><td></td></tr>
<tr><td colspan="3">People's perception of their health/wellbeing</td><td></td></tr>
<tr><td colspan="3">Activity/function/participation</td><td></td></tr>
<tr><td colspan="3">Effectiveness/safety of intervention</td><td></td></tr>
<tr><td colspan="3">Service-level outcomes</td><td></td></tr>
<tr><td rowspan="5">How will I measure it?</td><td rowspan="3">Self-report</td><td colspan="2">Self-reported outcome measure
(e.g. Patient Reported Outcome Measure [PROM])</td><td></td></tr>
<tr><td colspan="2">Self-reported experience measure
(e.g. Patient Reported Experience Measure [PREM])</td><td></td></tr>
<tr><td colspan="2">Satisfaction measure</td><td></td></tr>
<tr><td colspan="3">Report by, or measure designed to be administered by, relevant others (e.g. parent, teacher, caregiver)</td><td></td></tr>
<tr><td colspan="3">Therapist/clinician administered measure</td><td></td></tr>
<tr><td colspan="3">Service data (e.g. length of hospital stay, number of appointments/sessions, grade of staff delivering the intervention)</td><td></td></tr>
<tr><td rowspan="4">Is there already a recommended outcome measure for this population/area of practice?

N.B. Population can, for instance, relate to age, gender, health condition, culture and/or geographic region.</td><td rowspan="3">Yes</td><td colspan="2">Name of outcome measure:</td><td></td></tr>
<tr><td rowspan="3">Does it have an evidence base for use with this population/area of practice?

N.B. Information about the evidence base may be found in the manual/on the website for the outcome measure, or by carrying out a literature search for relevant research papers.</td><td>Yes
Continue to section 2.</td><td></td></tr>
<tr><td>Not sure
Check manual, relevant literature etc.</td><td></td></tr>
<tr><td>No
Consider alternative outcome measure(s). Please refer to the 'further reading' section.</td><td></td></tr>
<tr><td>No/I am not aware of one</td><td colspan="3">Consider potential outcome measure(s)
Please refer to the 'further reading' section for resources.</td></tr>
</table>

2. Acceptability and utility		Comments
Is the outcome measure acceptable and meaningful to the people who will be using it?	Is it user-friendly?	
	Is it meaningful/does it add value (for the person accessing the service, and the department where it is to be used)?	
	Is it in a format that is appropriate for the individual? (e.g. are easy-read, translated or braille versions available?)	
What are the practical implications?	Is a current version of the outcome measure available?	
	Are there any cost/licensing implications?	
	Is any special training required to administer the outcome measure?	
	How is it administered? (e.g. face-to-face, questionnaire, app)	
	Where can it be administered? (e.g. individual's home, clinic setting)	
	Is any specialist equipment required?	
	How long does it take to administer?	
	How is information recorded and stored? Does use of the outcome measure comply with information governance/data protection requirements, including the General Data Protection Regulation?	
	How often can/should it be administered? *N.B. some outcome measures should not be re-administered within a certain period of time.*	

3. Measurement properties

When selecting an outcome measure, it is important to consider its measurement properties, which can broadly be considered in terms of:

- Validity
- Reliability
- Responsiveness/sensitivity to change

This section of the checklist asks some key questions about measurement properties, to help you ascertain whether the outcome measure can be expected to produce accurate and consistent results (when used with the people you are working with) and is responsive/sensitive enough to detect meaningful change.

N.B. You will usually be able to find details of measurement properties in the manual, on the relevant website and by exploring the evidence base (e.g. through a literature search).

<table>
<tr><td rowspan="7">VALIDITY</td><td rowspan="2">What population(s) has the outcome measure been validated against?</td><td rowspan="2">Population(s):

N.B. Population can, for instance, relate to age, gender, health condition, culture and/or geographic region.</td><td rowspan="2">Is this applicable to the people I am working with?
For example, if an outcome measure was developed and its properties tested with a population of Canadian school children, it may not be valid when used with British school children.</td><td>Yes</td><td></td></tr>
<tr><td>No</td><td></td></tr>
<tr><td colspan="2">Comments:</td></tr>
<tr><td rowspan="5">Does it accurately measure what it intends to measure?</td><td>Face validity</td><td>Whether, on the face of it, the content of the outcome measure adequately reflects that which it is designed to measure.
For example, does an outcome measure about fear of falling ask questions about this?</td><td colspan="2">Comments:</td></tr>
<tr><td>Content validity</td><td>The extent to which the content measures what it is intended to measure, has sufficient breadth/ depth, and is lacking in bias.</td><td colspan="2">Comments:</td></tr>
<tr><td>Construct validity</td><td>The extent to which an outcome measure explores the construct (such as ‘quality of life’) that it intends to measure.</td><td colspan="2">Comments:</td></tr>
<tr><td rowspan="2">Criterion validity</td><td>Concurrent validity
The extent to which the scores/results are consistent with those produced by a known outcome measure with good validity.
For example a new test of muscle function produces scores that are consistent with those achieved in an existing test.</td><td colspan="2">Comments:</td></tr>
<tr><td>Predictive validity
The extent to which the outcome measure can accurately predict an outcome, result or relationship.
For example, a test of balance that can predict risk of falls.</td><td colspan="2">Comments:</td></tr>
</table>

RESPONSIVENESS	Is it able to adequately detect change over time? (responsiveness/ sensitivity to change)	Floor effect	Occurs when an outcome measure lacks the sensitivity to change to produce scores below a certain level. *For example, if an individual's muscle strength is less than that represented by the lowest score on the test.*	Comments:
		Ceiling effect	Occurs when an outcome measure lacks the sensitivity to change to produce scores above a certain level. *For example, if an individual's muscle strength is greater than that represented by the highest score on the test.*	Comments:
RELIABILITY	Does it produce consistent results?	Internal consistency	The extent to which features within the outcome measure (such as items in a questionnaire) produce consistent results.	Comments:
		Intra-rater reliability	The extent to which a single rater (person administering/scoring the outcome measure) will produce consistent results.	Comments:
		Inter-rater reliability	The extent to which two or more raters will produce consistent results.	Comments:
		Test-retest reliability	The extent to which the outcome measure produces consistent results over time *(i.e. when re-administered and other variables have not changed).*	Comments:
		Measurement error	The difference between what is measured and its 'true' value. All outcome measures have the potential for small amounts of error. *For example, when weighing an individual with calibrated scales, there will still be a degree of variation.*	Comments:

It is important that you administer, use and score the outcome measure as intended. Adapting an outcome measure to suit your own clinical needs will invalidate its measurement properties.

Further Reading

This checklist is intended to help professionals select an appropriate outcome measure for use in their area of practice. It is not intended for academic or research use, and does not seek to be an exhaustive source of information. If you would like to carry out further reading, the publications and websites listed below may be of interest. Many of these have been used to inform the development of this checklist.

Publications

Asher IE (2014) *Asher's occupational therapy assessment tools: an annotated index*. 4th ed. Bethesda, MD: American Occupational Therapy Association.

Cappelleri JC, Zou KH, Bushmakin AG, Alvir JMJ, Alemayehu D, Symonds T (2014) *Patient-reported outcomes: measurement, implementation and interpretation*. Boca Raton, FL: CRC Press/Taylor and Francis.

Kamudoni P, Johns N, Salek S (2018) *Living with chronic disease: measuring important patient-reported outcomes*. Singapore: Adis/Springer Nature.

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Laver Fawcett A (2007) *Principles of assessment and outcome measurement for occupational therapists and physiotherapists: theory, skills and application*. Chichester: John Wiley.

McDowell I (2006) *Measuring health: a guide to rating scales and questionnaires*. 3rd ed. Oxford: Oxford University Press.

Mokkink LB, Terwee CB, Patrick DL, Alonso J, Stratford PW, Knol DL ... de Vet HCW (2010) The COSMIN study reached international consensus on taxonomy, terminology, and definitions of measurement properties for health-related patient-reported outcomes. *Journal of Clinical Epidemiology, 63(7),* 737–745.

Stokes EK (2011) *Rehabilitation outcome measures*. 1st ed. Edinburgh: Churchill Livingstone.

Streiner DL, Norman GR, Cairney J (2015) *Health measurement scales: a practical guide to their development and use*. 5th ed. Oxford: Oxford University Press.

Thornicroft G, Tansella M eds (2010) *Mental health outcome measures*. 3rd ed. London: RCPsych Publications.

Websites

COMET (Core Outcome Measures in Effectiveness Trials) Initiative. *http://www.comet-initiative.org*

COSMIN (COnsensus-based Standards for the selection of health Measurement INstruments). *https://www.cosmin.nl*

UKROC (UK Rehabilitation Outcomes Collaborative). *http://www.ukroc.org*

SSNAP (Sentinel Stroke National Audit Programme). *https://www.strokeaudit.org*

All websites accessed on 23.09.19.

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Contributors

This resource has been developed by representatives from the following AHP professional bodies and membership organisations:

ROYAL COLLEGE OF SPEECH & LANGUAGE THERAPISTS	Kathryn Moyse (Chair) Outcomes and Informatics Manager Royal College of Speech and Language Therapists **www.rcslt.org**
Document endorsed by BDA The Association of UK Dietitians	Eleanor Johnstone Policy Officer The British Dietetic Association **www.bda.uk.com**
CHARTERED SOCIETY OF PHYSIOTHERAPY	Dr Denise Ross Research and Innovation Lead for Physiotherapy and Clinical Specialist Physiotherapist Neurological Rehabilitation Leeds Teaching Hospitals NHS Trust Representing the Chartered Society of Physiotherapy **www.csp.org.uk**
The COLLEGE of PODIATRY	Katie Collins Professional Support Officer The College of Podiatry **www.cop.org.uk**
iO THE INSTITUTE of OSTEOPATHY	Dr Carol Fawkes Senior Research Officer National Council for Osteopathic Research Representing the Institute of Osteopathy **www.iosteopathy.org**
Royal College of Occupational Therapists	Pauline McDonald Research and Development Officer Royal College of Occupational Therapists **www.rcot.co.uk**

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Community-Based Prevention and Strategies for the Opioid Crisis

Howard K. Koh, MD, MPH

Solving the unrelenting opioid crisis has become a pressing national priority. As evidence, the President's Commission on Combating Drug Addiction and the Opioid Crisis recently urged President Trump to declare "a national emergency under either the Public Health Service Act or the Stafford Act." Critical to future progress will be leveraging the full resources of the community—in partnership with health professionals—to prevent misuse, addiction, and death.

Evidence-Based Prevention of Addictive Behaviors

National experience demonstrates that prevention initiatives have contributed to past or ongoing reductions in cocaine use, underage drinking, and youth cigarette smoking. The exhaustive global report *Prevention of Addictive Behaviours* describes theories of addiction prevention, applies strength-of-evidence ratings to high-quality studies (including randomized trials, meta-analyses, and Cochrane reviews), and ranks universal and selective interventions (for average- or high-risk populations) for various settings and substances.

One oft-cited study, from Communities That Care (CTC), tailored evidence-based interventions to families and school-aged youth, including training to reduce risk factors, such as delinquency, and boost protective factors, such as decision-making skills for problem solving and resisting peer pressure. Involving more than 4000 youth (in grade 5 at the beginning of the study) in 7 states, this study matched 12 pairs of small towns, randomly assigning one from each pair to the intervention. By grade 12, those in intervention towns were 18% more likely to avoid delinquent behavior and 31% more likely to abstain from gateway drug use (alcohol, cigarettes, or marijuana) than their counterparts in matched control towns.

Such studies not only provide the foundation for addiction prevention recommendations by the White House Office of National Drug Control Policy National Drug Control Strategy (2016), the Office of the Surgeon General, and the National Institute on Drug Abuse but also inform the ongoing work of the President's Commission on Combating Drug Addiction and the Opioid Crisis, established in March 2017. Meanwhile, organizations are encouraging prevention strategies in communities nationwide. The Center for Substance Abuse Prevention of the Substance Abuse and Mental Health Services Administration (SAMHSA) supports implementing effective prevention practices, focusing on their fidelity and sustainability. The Community Anti-Drug Coalitions of America (CADCA) promotes drug-free communities via youth education and training. The National Association of State Alcohol and Substance Abuse Directors fosters prevention and treatment through every state. Yet, to date, such prevention practices have currently reached only about 10% of youth.

Prevention of Addictive Behaviors: Opioids

Identifying evidence-based preventive measures for opioids remains a work-in-progress that will require more documentation of how prevention strategies can best ameliorate the current crisis. For example, although the Iowa Strengthening Families Program showed that brief universal interventions in adolescents implemented by community-university partners reduced self-reported prescription opioid misuse and lifetime prescription drug misuse overall, generalizability of these results awaits replication in additional populations.

Developing stronger prevention measures also requires recognizing specific challenges of opioids. The 33 000 opioid-related deaths in 2015 arose from misuse of illegal drugs (including heroin or illicitly manufactured synthetic opioids such as fentanyl), legal prescription drugs, or multiple additional substances. The average age of initiation was about 25 years, and median age of overdose death ranged from 35 years to 44 years. Of those misusing heroin, 75% to 83% reported starting with a prescription drug. Of those misusing prescription opioid painkillers, 41% to 57% obtained them from friends or relatives. In 2015, 91.8 million (37.8%) US adults reported using prescription opioids, 11.5 million (4.7%) misused them, and 1.9 million (0.8%) had use disorders. Misuse and use disorders were most common among those who were uninsured or unemployed, were low-income individuals, or had behavioral health problems.

Howard K. Koh, MD, MPH

These data highlight the urgent need to address addiction broadly—and opioids in particular—and to reduce access to both illegal and legal drugs. Prevention can encompass a continuum of activities. This ranges from educational efforts that frame the crisis as a medical issue (as opposed to solely a criminal justice issue) to multifaceted policies and practices that can complement treatment. Across the country, multisector coalitions (including, for example, patients, families, educators, health leaders, law enforcement officials, and policy makers) are tailoring opioid-specific interventions to their own communities. Online toolkits from CADCA and from SAMHSA document case studies of some of these efforts in areas hardest hit by the crisis.

Harvard T.H. Chan School of Public Health

Community-Level Interventions

Current community-level interventions can include public education, clinician-patient partnerships, and community-based medication disposal programs.

Public Education. Major national momentum to teach lay bystanders to reverse overdoses with naloxone has now reached 50 states and the District of Columbia, aided in 40 by Good Samaritan laws providing liability protections. A systematic review of 19 studies showed increased knowledge and administration rates, as well as some early evidence of decreased deaths in Massachusetts and in North Carolina. Such education can also raise public understanding of harm reduction through syringe service programs and catalyze collaborations with criminal justice officials committed to expanding their role beyond traditional law enforcement.

Other efforts include the New York State health education curriculum, which now requires information about opioids as part of an overall prevention strategy. Heightened community-wide dialogue emphasizing use of nonstigmatizing language could change societal perceptions about people with addiction and lend support to the estimated 25 million in recovery nationally.

Clinician-Patient Partnerships. Before starting opioids for medical reasons, patients are increasingly asked to partner with clinicians to disclose risk factors (such as a family history of substance use disorders) and reach explicit understanding, sometimes contractual, about goals and expectations. Despite recent declines, per capita opioid prescriptions remain high, having tripled between 1999 and 2015.

Community-Based Medication Disposal Programs. Collection sites and "drop boxes" for unused prescription opioids have arisen in sites including hospitals, fire departments, and pharmacies. For example, Walgreens' safe medication disposal kiosks populate over 500 stores across 43 states, and the Drug Enforcement Agency's National Prescription Drug Take-Back Days involve over 5000 collection sites. Further evaluation awaits.

Prevention always constitutes a hard sell: it lacks the glamor of treatment, can entail years of implementation, and when successful, is usually invisible. The first major federal addiction legislation in 40 years, the 2016 Comprehensive Addiction and Recovery Act, authorized education campaigns but did not appropriate funds for them. Furthermore, although the 2016 21st Century Cures Act authorized nearly a billion dollars to state and territories and noted universal prevention strategies as a priority, to date they have been underemphasized and largely overlooked.

Considerable efforts notwithstanding, the national burden of opioid-related suffering remains unacceptable. Accelerating action in research, evaluation, and practice of effective community-based prevention could bring a measure of relief for a nation in need. ■

Author Affiliation: Howard K. Koh, MD, MPH, is the Harvey V. Fineberg professor of the practice of public health leadership at the Harvard T. H. Chan School of Public Health and the Harvard Kennedy School.

Corresponding Author: Howard K. Koh, MD, MPH (hkoh@hsph.harvard.edu).

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