

**An Electronic Tool-Kit
for
Developing
Prevention Prepared Communities
in a
Recovery Oriented System of Care**

**Michigan Department of Community Health
Behavioral Health and Developmental Disabilities Administration
Bureau of Substance Abuse and Addiction Services
Prevention Workgroup of the Transformation Steering Committee**

October 2012

An Electronic Tool-Kit for
Developing Prevention Prepared Communities
in a Recovery Oriented System of Care

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FORWARD

Since 2009, Michigan's Bureau of Substance Abuse and Addiction Services has adopted the recovery oriented system of care (ROSC) concept as the core philosophy for the design and delivery of substance use disorder (SUD) prevention, treatment, and recovery services; and integration with primary care. The ROSC is being used as a roadmap on how to align SUD services and community-level partners. Prevention prepared communities (PPCs) are essential to the successful implementation of a ROSC.

A PPC is a community equipped to use a comprehensive mix of data driven prevention strategies, interventions, and programs across multiple sectors to promote emotional health and reduce the likelihood of mental illness, substance abuse (including tobacco), and suicide.

The focus of this electronic tool-kit is to help communities learn about ROSC and PPCs through an introductory PowerPoint presentation; and through a series of activities to conduct assessments of their community's readiness for change, capacity to become a PPC, and progress toward developing a ROSC. Also included are two frameworks for looking at community linkages; and SAMHSA's Collaborative for the Application of Prevention Technologies (CAPT) information sheets providing a behavioral health framework for prevention, important information about risk and protective factors, and a developmental framework. These materials may be used together in a formal training session or as individual pieces to help coalitions and other community groups move forward.

Michigan is making progress in its efforts to integrate SUD prevention, treatment, and recovery services with mental health promotion and primary care services. Creating PPCs throughout the state will be critical in the effort to reduce 1) underage and adult problem drinking, 2) prescription and over-the-counter drug abuse, 3) underage tobacco use, and 4) suicide attempts and deaths.

We appreciate your efforts to help us realize this vision.

Sincerely,

*Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services*

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TOOL-KIT INTRODUCTION AND DIRECTIONS FOR USE

Developing Prevention Prepared Communities in a Recovery Oriented System of Care

This tool-kit contains materials that were used in April 2012 trainings provided in the five coordinating agency (CA) regions that were part of the State Prevention Enhancement (SPE) project. The agencies were Bay Arenac Behavioral Health/Riverhaven Coordinating Agency, Kalamazoo Community Mental Health and Substance Abuse Services, Mid-South Substance Abuse Commission (now Community Mental Health of Clinton, Eaton, and Ingham Counties), Pathways to Healthy Living, and Western Upper Peninsula Substance Abuse Services. Trainings that used all of these materials entailed of five hours of training time, and granted five Michigan Certification Board of Addiction Professionals (MCBAP) credits to participants. Some of the trainings held did not include all of the activities; those lasted only four hours.

The trainings may be replicated and all of the activities offered to several community coalitions or groups at one time in the same location; or, all or some of the activities could be done for one coalition or group at their meetings over a period of time. The activities and resources as they are listed on the Tool-Kit Table of Contents page follow the order in which they were done in a five-hour training session. The activity worksheets are available in MS Word format so they can be modified to suit the group's needs.

- The introductory presentation (#3) is used to open the training. This contains many slides and is very comprehensive. Even though most groups are familiar with the Strategic Prevention Framework (SPF), this is included in some detail because it is the foundation for a PPC. If the group(s) are using SPF to guide their planning and activities these slides may not need very much attention. The presentation usually takes about 45 to 60 minutes. If a copy is being distributed – three slides to a page with note space is best, though slides sixteen and seventeen should be reproduced as full pages.
- A Case Study in Recovery (#4) could also be used as a warm-up activity at the beginning of the training. The goals for using this case study are that it helps to make the ROSC concepts real for participants and demonstrates the value of prevention, assessment, intervention, and support for recovery. This activity will take 30 to 45 minutes.
- Five CAPT Behavioral Health Sheets (#5) are included here as background for presenters; or, they may be sent out before the training or distributed at the end of the training.
- Directions for Completing the Local Community Readiness Assessment (#6) and the Local Community Readiness Assessment for ROSC and Prevention

Prepared Communities (#7) go together if doing this assessment in a workshop format. This activity requires a minimum of two hours and fifteen minutes to complete.

In preparation for this activity, it will need to be decided what option participants should do for the third column, titled "ROSC" (Recovery Oriented Systems of Care), of the assessment worksheet. There are two choices described on the Directions for Completing the Local Community Readiness Assessment (#6), column three:

1. The first option in this column asks participants to answer the following questions: "In what ways are we a healthy community that supports recovery? What are things we should have in place to support recovery? How can we become more healthy and in support of recovery?"

Unless an inventory has been done in the community, it may not be possible to know everything that is in place and all of the unmet needs. It takes a large diverse group of people to do a good job on this so use this with planning groups in the community. (30 min.)

2. The second option in this column asks participants to make a plan to complete the "Community Recovery Capital Needs Assessment" (#11). Take a few minutes to review this assessment and then come up with a plan for completing it in the community. (30 min.)

Once it is decided which of these two options will work best, modify both parts of the Local Community Readiness Assessment (#6 and #7) to include only the option chosen.

- If doing both parts of the Local Community Readiness Assessment (#6 and #7), Assessing Your Community's Readiness for System Transformation (#8) won't be needed because the information in #8 is already included in #7.
- The activity of Assessing Your Group's Community Linkages (#12) helps groups think about who they have relationships with and the nature of the relationships. There is a second framework provided (#13) that may also be reviewed.
- An evaluation (#14) is provided for use if these materials are offered as a workshop.

**DEVELOPING PREVENTION
PREPARED COMMUNITIES**
in a Recovery Oriented
System of Care

**Recovery Oriented System of Care
(ROSC) in Michigan**

Integrating services to support an individual's journey toward recovery and wellness by creating and sustaining formal and informal services and supports . . . through collaboration, partnership and a broad array of services for individuals, families and communities

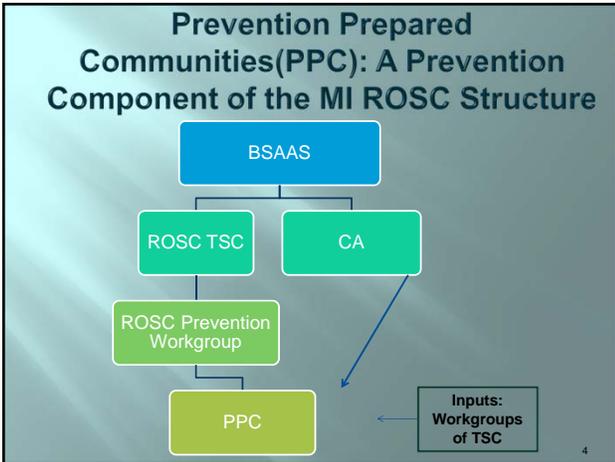
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**Recovery Oriented System of Care
(ROSC) in Michigan**

Example of an integrated system of care:

- Prevention Services (individuals, families, groups and communities)
- Behavioral Health Services (mental health & substance use disorders)
- Physical Health Services (primary & specialty)
- Medication
- Supports: housing, employment, education, child care, wellness, legal, crisis, support groups, etc.

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Prevention Prepared Communities (PPCs)

“Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse . . . and suicide” (SAMHSA).

- ### Prevention Prepared Communities (PPCs)
- Prevention services that use community collaboration and strategic partnerships to prevent and mitigate consequences of drug use, suicide, and other health problems affecting the community
 - Prevention services that draw on the strengths of the community to promote the health and well being of individuals and families in the community

Guiding Steps to Develop & Implement PPCs at the Local Level

- Use the data driven Strategic Prevention Framework (SPF) process
 - *Epidemiological data drives/guides decision and action*
- Include key community entities and stakeholders
 - *Multiple stakeholders encourage discussion, sharing, buy-in*

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Guiding Steps to Develop & Implement PPCs at the Local Level (cont.)

- Coordinate substance abuse prevention initiatives with other gov't health promotion efforts *(To plan & deliver specialized cost effective prevention services that promote social and emotional well being and align with healthcare reform outcomes)*
- Use evidence-based services & interventions
- Meet cultural and linguistic needs of diverse populations *(Cultural/Linguistic Competency)*

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Guiding Steps to Develop & Implement PPCs at the Local Level (cont.)

- Ensure focus on communities facing behavioral and physical health disparities:
 - *racial and ethnic minorities*
 - *lesbian, gay, bi-sexual, and transgendered (LGBT) people*
 - *people with disabilities*
 - *girls and transition-age youth*
 - *communities facing elevated levels of substance use disorders (SUDs) and higher suicide rates*

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**Prevention Prepared Community:
Priority Areas & Deliverables**

- a) Prevent/reduce consequences of underage drinking and adult problem drinking
- b) Reduce prescription (Rx) drug misuse and abuse
- c) Eliminate/reduce underage tobacco use

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**Prevention Prepared Community:
Priority Areas & Deliverables**

- d) Prevent and delay use, and reduce consequences of substance use disorders (*emerging local trends*)
- e) Promote behavioral & physical health
- f) Prevent suicides and attempted suicides

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**PPC: Operational & Conceptual
Goals and Priorities**

1. Prevent onset, mitigate consequences of substance use disorder & mental illness
2. Develop effective institutional collaboration of entities, individuals, & service functions that can provide and integrate services that address behavioral and health care needs

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PPC: Operational & Conceptual Goals and Priorities (cont.)

- 3. Develop workforce capacity to provide integrated services and deliver specialized substance abuse prevention services that promote health and wellbeing

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PPC: Operational & Conceptual Goals and Priorities (cont.)

- 4. Develop creative and powerful collaborative efforts to address conditions that contribute to drug use & other risk behaviors
- 5. Ensure focus on groups that have been disproportionately affected by the consequences of behavioral and physical health, and by disparities in access to services

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Developing PPCs using the Strategic Prevention Framework (SPF) Process

- 1. Assessment/Community Profile
- 2. Building Capacity
- 3. Planning
- 4. Implementation
- 5. Evaluation

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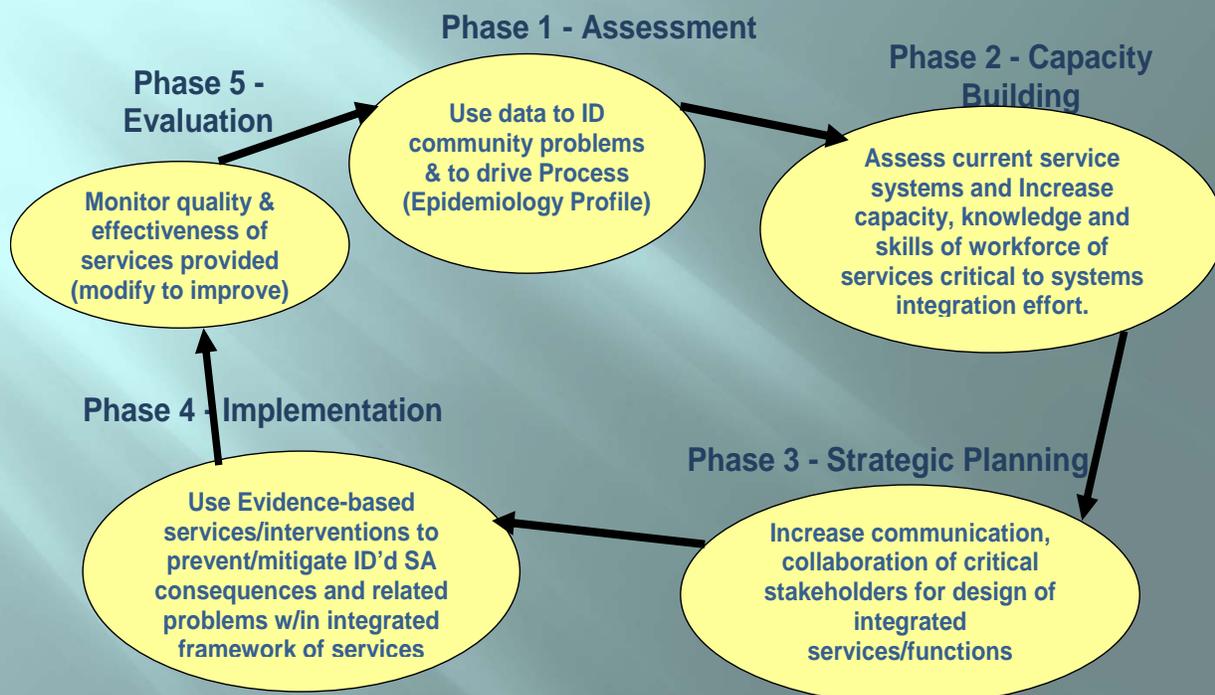
Five Infrastructure Steps

SAMHSA: The five SPF-PPC Phases



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Michigan's Planning Approach



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Strategic Prevention Framework/ Prevention Prepared Community

Preparing communities to ACT and to achieve wellness through:

- Comprehensive collaboration
- Joint assessment and planning efforts to address identified community needs
- Integrated systems approach to services

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Five steps to promote integration

Purpose of partnership and collaboration:

- Sharing relevant data
- Identifying mutual needs and strengths
- Developing complementary organizational processes and plans
- Integrating and/or linking services
(improving access to each other's services)
- Assessing effectiveness of actions

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PPCs: Michigan's Goals

- Use the five phase SPF process
- Use epidemiological data to identify needs, guide decisions and drive the process at the community level
- Assess capacity, identify gaps and improve access to health & behavioral services at the community level
- Enhance knowledge & skill of the workforce of service organizations that are part of collaborative or integrated service systems

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PPCs: Michigan's Goals (cont.)

- Expand scope of collaborative practice for services, projects and functions among service institutions at the community level
(State level: establish/ increase scope and terms of collaborative practice among key institutions)
- Increase effectiveness of initiatives and practices designed to prevent/reduce SUDs, underage drinking, Rx drug abuse, suicide, and underage tobacco use.

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PPCs: Michigan's Goals (cont.)

- Implement evidence-based practices and interventions in substance abuse prevention that foster use of collaborative functions and integrated functions to address substance abuse consequences
- Employ data to determine level of effectiveness of practices and make system realignments

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PPCs: Michigan's Goals (cont.)

- Develop projects, activities and initiatives focused on the following priority areas:
 - Reduce consequences of underage drinking
 - Reduce Rx drug misuse and abuse
 - Prevent/reduce consequences of SUDs(address local trends)
 - Prevent suicides among high risk populations*
 - Reduce underage tobacco use
 - Reduce obesity*
 - Prevent infant mortality*

*Aligned with the Governor's Dashboard and the DCH Strategic Plan

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Prevention Prepared Communities: A Call to Community Action

Lifting the Community Through
Partnerships & Collaborative Projects



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Guidance for Inclusion of Stakeholders & Community Partners

- Healthcare organizations (*health depts., hospitals, medical professionals, pharmacists, health promotion services*)
- Schools and education organizations
- Law enforcement, courts
- Multi-purpose collaborative
- Gov't service agencies (*ex. DHS*)
- Ethnic/tribal leaders
- Behavioral health providers
- Families, parents, parent groups
- Business



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Guidance for Inclusion of Stakeholders & Community Partners (cont.)

- Media
- Youth, student groups, services for youth
- Faith-based, fraternity organizations
- Members of the recovering community
- Civic, volunteer groups
- Suicide prevention groups/services
- Other gov't agencies (*ex. DEA, FDA*)
- Organizations involved in reducing SA (*Prevention Network, Mich. Coalition to Reduce UAD, MADD, etc*)
- Older adult organizations

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PPC: Integrated service approaches supporting Recovery and Wellness

Prevention Prepared Community, a community-based integrated prevention initiative designed to support recovery and wellness by:

1. Preventing/reducing use of drugs
2. Mitigating consequences of substance use disorders to individuals, families and communities
3. Forging partnerships that can foster collaborative efforts and develop an integrated service system able to sustain persons in recovery & their families
4. Promoting good quality of life and improving health and wellness of the community

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Helping build a PPC Structure – State Prevention Enhancement Grant

Strategic Prevention Enhancement (SPE) grant awarded to the Bureau of Substance Abuse and Addiction Services (BSAAS)

- One-year planning grant to implement SAMHSA's strategic initiative #1 (Prevention of SA and mental illness)
- Purpose: Design a state-wide comprehensive plan to develop a prevention infrastructure that uses a multidisciplinary collaborative approach to prevention
- Priority Areas:
 - Reduce underage drinking and adult problem drinking
 - Prevent suicide/attempted suicides (high risk populations)
 - Prevent Rx drug misuse and abuse

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Helping build a PPC Structure – State Prevention Enhancement Grant

Approach: Targeted planning effort with five high-need regions selected based on epidemiological data related to the priority areas to participate in the development of statewide model for:

- Data driven identification of community-level prevention needs, goals, objectives, and strategies
- Collaborative initiatives between public and private sectors to facilitate delivery of care services (health, behavioral, etc) in a more integrated environment at the community level
- Identification of strategies and practices that help develop and implement structures for Prevention Prepared Communities (PPCs)

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ROSC Prevention Workgroup Contact

Michigan Department of Community Health,
Bureau of Substance Abuse and Addiction
Services

mdch-bsaas@michigan.gov or (517) 373-4700

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After reading the following case study, ask what interventions might have been used in addition to those actions that were taken. What services and supports should the community now have in place to help someone like Ashley?

A Case Study in Recovery

As a child, Ashley vowed never to be like her mother who was an alcoholic. Her mother had many boyfriends and never spent any time with Ashley. Ashley had plans to graduate from high school, get married, and have children that she would love and spend time with.

Ashley was exposed to her mother's boyfriends and often left alone with them, one day one of her mother's boyfriends raped Ashley. She was upset and began having problems at school. She confided in a teacher about what happened. The teacher reported the incident to social services and Ashley was removed from the home.

Ashley's grandmother took Ashley in to prevent her from being in foster care. Ashley lived with her grandmother for some time and things appeared stable. Ashley's mother had gone into a treatment facility and had been clean for a year when she decided she wanted Ashley to come and live with her. She arrived one day and told the grandmother she had come to get Ashley back. Ashley was reluctant to leave her grandmother, but her grandmother said Ashley's mother had legal custody. She said Ashley had to go live with her mother. Ashley was unhappy about this.

In her new home with her mother, Ashley became involved in unhealthy and risky behaviors. She hung out with the wrong crowd and got drunk every now and then. She had sex with a guy at a party and became pregnant. It was the first time Ashley had sex. The father of the child didn't want anything to do with Ashley, once she was pregnant. Ashley had her baby when she was 16 years old. She had fallen behind in school and dropped out that year. She intended to go back but thought she needed a break.

Now Ashley has a baby and she is feeling all alone. She parties and drinks and smokes marijuana to make herself feel better. She found some work over the next couple of years but nothing consistent. She can't keep a job. She goes out at night to party when her kid goes to sleep. She leaves her child alone at night to get high and party every Friday. A neighbor noticed Ashley is high all of the time and was concerned about her child. She called Protective Services. A social worker came to the home and removed Ashley's child.

Ashley was crushed mentally by years of torment and unfulfilled dreams and promises. The worker called the Women and Families Specialist at the coordinating agency to get Ashley in treatment so that Ashley could keep her child. Ashley was admitted into treatment. During the intake process, Ashley tested positive for HIV.

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Information Sheet 1: A Behavioral Health Lens for Prevention

While many of us working in the substance abuse field have long-recognized the value of prevention, placing this work in the context of overall behavior health requires a critical shift in perspective. Applying a behavioral health lens to our current prevention efforts helps us to see the connections between substance abuse and related problems and to take the necessary steps to address these problems in a comprehensive and collaborative way.

What is Behavioral Health?

Behavioral health is a state of mental/emotional being and/or choices and actions that affect wellness. Substance abuse and misuse are one set of behavioral health problems. Others include (but are not limited to) serious psychological distress, suicide, and mental illness (SAMHSA, 2011). Such problems are far-reaching and exact an enormous toll on individuals, their families and communities, and the broader society. Consider these statistics:

- By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide.
- The annual total estimated societal cost of substance abuse in the United States is \$510.8 billion, with an estimated 23.5 million Americans aged 12 and older needing treatment for substance use.
- Each year, approximately 5,000 youth under the age of 21 die as a result of underage drinking.
- More than 34,000 Americans die every year as a result of suicide, approximately one every 15 minutes.
- Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24—in 2008, an estimated 9.8 million adults in the U.S. had a serious mental illness.

Overlapping Problems, Collaborative Solutions

In the past, practitioners and researchers saw substance abuse prevention as distinct from the prevention of other behavioral health problems. But mounting evidence indicates that the populations affected by these problems overlap significantly, as do the factors that contribute to these problems. Consequently, improvements in one area often have direct impacts on the other.

Many young people have more than one behavioral disorder. These disorders can interact and contribute to the presence of other disorders, leading to concurrent diagnosable disorders or “comorbidity”. An estimated 37% of alcohol abusers and 53% of other drug abusers also have at least one serious mental illness.

Despite extensive research documenting strong associations between multiple problems, it’s not always clear what leads to what. For example, can substance abuse lead to thoughts of suicide, or can thoughts of suicide lead to substance abuse? Or are they both the product of a third, unknown causal factor?

Mental and physical health is also connected. Good mental health often contributes to good physical health. Similarly, the presence of mental health disorders, including substance abuse and dependence, is often associated with physical health disorders (O’Connell, 2009). A large number of studies provide strong evidence that drinking alcohol is a risk factor for primary liver, breast, and colorectal (colon) cancer. Positive lifestyle adjustments, however—like sleep, diet, and activity and physical fitness—can also significantly strengthen mental health (O’Connell, 2009).

“One in five individuals with a diagnosable mental health disorder also suffer from a substance abuse disorder.”

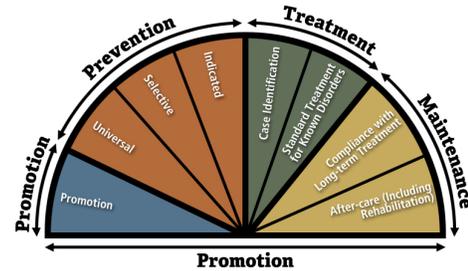
(O’Connell, 2009)

As prevention practitioners, our responsibility is to be mindful of these linkages and see our work as part of a broader effort to improve overall health. Recognizing these linkages can help us identify opportunities to address health in a more comprehensive way—by working across disciplines, pooling resources, and reaching people in those settings and during those times in their lives where and when services are most likely to have an impact.

Prevention as Part of a Continuum of Care

A comprehensive approach to behavioral health also means seeing prevention as part of an overall continuum of care. The *Behavioral Health Continuum of Care Model* helps us recognize that there are multiple opportunities for addressing behavioral health problems and disorders. Based on the *Mental Health Intervention Spectrum*, first introduced in a 1994 Institute of Medicine report, the model includes these components:

- **Promotion:** These strategies are designed to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of behavioral health services.
- **Prevention:** Delivered prior to the onset of a disorder, these interventions are intended to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use, prescription drug misuse and abuse, and illicit drug use.
- **Treatment:** These services are for people diagnosed with a substance use or other behavioral health disorder.
- **Maintenance:** These services support individuals' compliance with long-term treatment and aftercare.



Keep in mind, however, that interventions do not always fit neatly into one category or another. For example, consider co-morbidity. If some disorders (like substance use) are risk factors for other disorders (like depression)—does that mean that all treatment can be seen as prevention? Each prom season, communities across the nation implement safe driving campaigns—are they promoting healthy lifestyles or preventing potential substance use?

Working Across the Continuum

The *Continuum of Care* model reminds us to think, more explicitly, about the relationships between promotion, prevention, and treatment. All too often these relationships are overlooked opportunities for collaboration are missed, and outcomes are compromised. Consider this example:

To address increasing rates of underage drinking, the anti-drug task force of a small New England town decided to strengthen enforcement of its underage drinking laws. Police began arresting youth they found attending underage drinking parties. The arrested youth were required to receive an assessment of their substance use and attend a 6-week education program provided by the local substance abuse and mental health agency. The intervention was effective on the prevention end: knowing that the threat of arrest was real, fewer youth attended underage drinking parties and underage drinking decreased.

But what about its affects on related treatment services? The increased enforcement efforts produced an increase in the *number* of referrals to the local substance abuse and mental health agency, as well as a change in the *type* of referrals. Prior to the increased enforcement, most of the youth referred to the agency were at high risk for substance use. These youth received selective interventions tailored to their needs. Now most of the

referrals were youth who were at much lower risk; their needs were significantly different.

Recognizing the potential impact of its new enforcement policy, the task force worked closely with administrators of the treatment agency to prepare. Knowing what was coming down the pike, the agency was able to more appropriately allocate resources and address the diverse needs of all its referrals. Thus, collaboration and a more comprehensive approach to the problem of underage drinking produced a better outcome overall.

Sources

- Compton, M. T. (2009). *Clinical Manual of Prevention in Mental Health* (1st ed.). American Psychiatric Publishing, Inc.
- O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. National Research Council and Institute of Medicine of the National Academies. Washington, D.C.: The National Academies Press.
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Information Sheet 2: Levels of Risk, Levels of Intervention

Prevention practitioners have long targeted risk and protective factors as the “influences” of behavioral health problems. The 2009 report *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities* defines risk and protective factors as follows:

- **Risk factor:** a characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes
- **Protective factor:** a characteristic associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes

Some risk factors are causal: cigarette smoking, for instance, has been closely linked to lung cancer. Others act as proxies (e.g., living in an area with a high prevalence of cigarette smoking) or markers of an underlying problem (e.g., having a smoker’s cough).

Some risk and protective factors, such as gender and ethnicity, are *fixed*: they don’t change over time. For instance, at a population level being a boy is a risk factor for substance abuse because boys develop substance abuse problems more quickly than girls. Other risk and protective factors are considered *variable*: these can change over time. Variable risk factors include income level, peer group, and employment status.

Many factors influence an individual’s likelihood to develop a substance abuse or related behavioral health problem. Effective prevention focuses on reducing those risk factors, and strengthening those protective factors, that are most closely related to the problem being addressed.

Prevention: Universal, Selective, and Indicated

Not all people or populations are at the same risk of developing behavioral health problems. Preventive interventions are most effective when they are appropriately matched to their target population’s level of risk. The Institute of Medicine defines three broad types of prevention interventions:

1. **Universal preventive interventions** take the broadest approach, targeting “the general public or a whole population that has not been identified on the basis of individual risk” (O’Connell, 2009). Universal prevention interventions might target schools, whole communities, or workplaces.

Examples: community policies that promote access to early childhood education, implementation or enforcement of anti-bullying policies in schools, education for physicians on prescription drug misuse and preventive prescribing practices, social and decision-making skills training for all sixth graders in a particular school system

2. **Selective preventive interventions** target “individuals or a population sub-group whose risk of developing mental disorders [or substance abuse disorders] is significantly higher than average”, prior to the diagnosis of a disorder (O’Connell, 2009). Selective interventions target biological, psychological, or social risk factors that are more prominent among high-risk groups than among the wider population.

Examples: prevention education for new immigrant families living in poverty with young children, peer support groups for adults with a history of family mental illness and/or substance abuse

3. **Indicated preventive interventions** target “high-risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing mental, emotional, or behavioral disorder” prior to the diagnosis of a disorder (O’Connell, 2009). Interventions focus on the immediate risk and protective factors present in the environments surrounding individuals.

Examples: information and referral for young adults who violate campus or community policies on alcohol and drugs; screening, consultation, and referral for families of older adults admitted to emergency rooms with potential alcohol-related injuries

Individual vs. Population Risk

It's simplest to think about risk on an individual level. Consider this example:

Sandra is a 12-year-old girl with a family history of alcoholism and mental illness. Sandra's mother is a functioning alcoholic and her father suffers from undiagnosed depression. Over the past 5 years, Sandra's family has moved four times: she now lives in low-income neighborhood with high crime and many abandoned buildings. At night, neighborhood youth use the corner park to drink and use drugs. Sandra is bussed across town to attend school but lives close to her grandparents, with whom she has a close relationship. She attends an after-school program at the local Girls, Inc. where she is the lead scorer on her basketball team.

- *What is Sandra's level of risk?*
- *What are some of the risk and protective factors in her life?*
- *Which of these factors are fixed and which are variable?*

But it's important to realize that every community includes many Sandras: Adolescents who live in conditions and experience combinations of risk and protective factors that place them at risk for substance abuse and other related behavioral health problems. As prevention practitioners, we focus not only on individuals but on whole populations, looking for ways to address risk and protective factors that contribute to problems on the population level.

Sources

- Compton, M. T. (2009). *Clinical Manual of Prevention in Mental Health* (1st ed.). American Psychiatric Publishing, Inc.
- Mrazek, P. J., & Haggerty, R. J. (Eds.). (1994). *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. Washington, D.C.: The National Academies Press.
- O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. National Research Council and Institute of Medicine of the National Academies. Washington, D.C.: The National Academies Press.
- Substance Abuse and Mental Health Services Administration. (2011). *Leading change: A plan for SAMHSA's roles and actions 2011-2014*. SAMHSA.

Information Sheet 3: Key Features of Risk and Protective Factors

The 2009 report *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities* presents four key features of risk and protective factors for practitioners to consider when designing and evaluating prevention interventions, each described below:

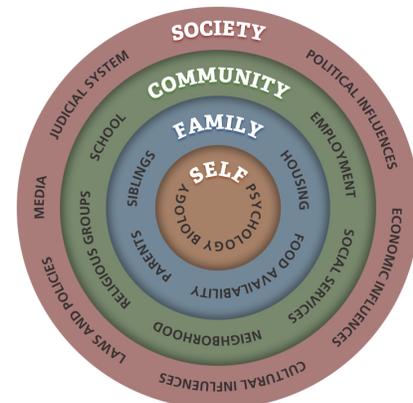
1. Risk and protective factors can be found in multiple contexts.
2. Effects of risk and protective factors can be correlated and cumulative.
3. Some risk and protective factors have specific effects, but others are associated with multiple behavioral health problems.
4. Risk and protective factors influence each other and behavioral health problems over time.

1. Risk and Protective Factors Exist in Multiple Contexts

Individuals come to the table with **biological and psychological** characteristics that make them vulnerable to, or resilient in the face of, potential behavioral health problems. Individual-level risk factors include genetic predisposition to addiction or exposure to alcohol prenatally; protective factors might include positive self-image, self-control, or social competence.

But individuals don't exist in isolation. They are part of families, part of communities, and part of society. A variety of risk and protective factors exist within each of these contexts. For example:

- In **families**, risk factors include parents who use drugs and alcohol or who suffer from mental illness, child abuse and maltreatment, and inadequate supervision; a protective factor would be parental involvement
- In **communities**, risk factors include neighborhood poverty and violence; protective factors might include the availability of faith-based resources and after-school activities
- In **society**, risk factors can include norms and laws favorable to substance use, as well as racism and a lack of economic opportunity; protective factors include policies limiting availability of substances or anti-hate laws defending marginalized populations, such as LGBTQ youth



Practitioners must look across these contexts to address the constellation of factors that influence both individuals and populations: targeting just one context is unlikely to do the trick. For example, a strong school policy forbidding alcohol use on school grounds will likely have little impact on underage drinking in a community where parents accept underage drinking as a rite of passage or where alcohol vendors are willing to sell to young adults. A more effective—and comprehensive—approach might include school policy plus education for parents on the dangers of underage drinking, or a city ordinance that requires alcohol sellers to participate in responsible server training.

2. Risk and Protective Factors are Correlated and Cumulative

Risk factors tend to be positively correlated with one another, and negatively correlated with protective factors. That is to say, young people with some risk factors have a greater chance of exposure to still more risk factors—they are also less likely to have protective factors.

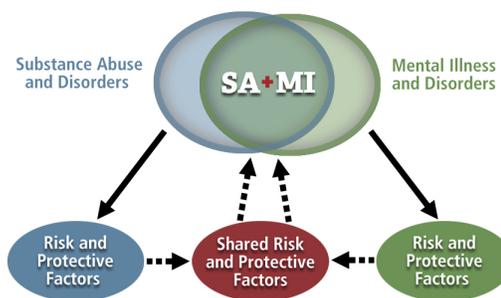
Risk and protective factors also tend to have a cumulative effect on the development—or reduced development—of behavioral health problems. Young people with multiple risk factors have a greater chance of developing a problem, while young people with multiple protective factors are at reduced risk.

Understanding how risk and protective factors influence one another—that they *do*, in fact, influence one another—underscores the importance of (1) intervening early, and (2) developing interventions that target multiple factors, rather than addressing individual factors in isolation.

3. Individual Factors Can be Associated with Multiple Problems

Though preventive interventions are often designed to produce a single outcome, research shows that some risk and protective factors are associated with multiple outcomes. For example, negative life events, such as divorce or sustained neighborhood violence, are associated not only with substance abuse but also with anxiety, depression, and other behavioral health problems.

What this tells us is that preventive efforts targeting a particular set of risk and protective factors have the potential to produce positive effects in multiple areas. Interventions with multiple benefits can lead to broad improvements in health and are a cost-effective investment for society.



4. Risk and Protective Factors are Influential Over Time

Risk and protective factors can strengthen or limit the presence of other factors and disorders over a lifetime. For example, risk factors such as poverty and family dysfunction, can contribute to later psychosocial problems and behavioral disorders, such as risky sexual behavior and depression. Moreover, risk and protective factors within one particular context—such as the family—may also influence or be influenced by factors in another context. For example, effective parenting has been shown to mediate the effects of multiple risk factors, including poverty, parental divorce, parental bereavement, and parental mental health problems.

The more we understand about how risk and protective factors interact, the better prepared we will be to develop appropriate interventions. In the past, prevention practitioners typically focused on a select group of factors that they thought contributed to a specific issue or produced a single outcome. Today, practitioners have begun broadening their lens—to look at connections *between* risk factors and implement effective programs strategically to address multiple outcomes.

Sources

- Compton, M. T. (2009). *Clinical Manual of Prevention in Mental Health* (1st ed.). American Psychiatric Publishing, Inc.
- O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. National Research Council and Institute of Medicine of the National Academies. Washington, D.C.: The National Academies Press.
- Rutter, M. (1987). Psychosocial Resilience and Protective Mechanisms. *American Journal of Orthopsychiatry*, 57(3), 316-331.
- Substance Abuse and Mental Health Services Administration. (2011). *Leading change: A plan for SAMHSA's roles and actions 2011-2014*. SAMHSA.

Information Sheet 4: The Developmental Framework

A developmental approach to prevention helps to ensure that interventions have the broadest and most significant impact. The developmental framework organizes risk and protective factors and their potential consequences and benefits according to defined developmental periods. This enables practitioners to match their prevention and promotion efforts to the developmental needs and competencies of their audience. It also helps planners align prevention efforts with key periods in young peoples' development, when they are most likely to produce the desired, long-term effects.

Stages of Development

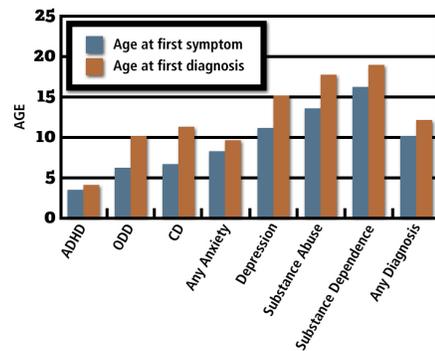
Preventing behavioral problems begins with an understanding of how young people develop and how the challenges they face and overcome interact to produce changes in their mental and physical health over their lifetimes. As children grow, they progress through a series of developmental periods. Each of these periods is associated with a set of developmental competencies: cognitive, emotional, and behavioral abilities children need to adapt to new challenges and experiences. Developmental competencies are "essential as a young person assumes adult roles and the potential to influence the next generation of young people" (O'Connell, 2009).

The likelihood of individuals gaining these competencies depends on (1) their foundation of other competencies; and (2) the risk and protective factors they encounter at each developmental stage. *Information Sheet 5* maps out some of the core competencies and the contextual risk and protective factors for substance abuse associated with each developmental period.

Windows of Opportunity

When addressing risk and protective factors, timing is critical. Half of all behavioral disorders appear during adolescence. While the average age of diagnosis varies by disorder, the first symptoms of most behavioral health disorders typical occur two to four years before diagnosis. In the case of substance abuse disorders, for example, initial symptoms appear around age fourteen—about four years before these symptoms progress to the point of a diagnosable disorder.

If we can intervene during these windows of opportunity—during the period between the time when symptoms can be first detected and disorders can be diagnosed—we are more likely to prevent the onset of the disorder and produce lasting and long-term impacts. And if we can intervene even sooner, to promote healthy lifestyles, our potential for reducing the toll of behavioral health problems on individuals, communities, and society is even greater.



Matching Interventions to Developmental Phase

Certain risk and protective factors are more common and influential during particular developmental periods. The developmental framework helps practitioners match their prevention and promotion efforts to the developmental needs and competencies of their audience. It's important to note that many actors affect more than one phase, as do the corresponding interventions. Consider the following scenarios:

- **Scenario 1:** A prevention and wellness committee of an urban elementary school reviews recent efforts to reduce substance abuse and improve behavioral health. The committee decides to address

identified gaps in programming for kindergartners by implementing a program that focuses on healthy decision-making and critical thinking skills.

- **Scenario 2:** A community-wide substance abuse coalition identifies underage drinking as a primary focus for its prevention efforts; coalition members are concerned about alcohol being served at community events and that adults buy alcohol for minors. To address these problems, the coalition decides to implement *Across Ages*, an evidence-based intervention designed to increase protective factors for high-risk students by matching youth with older adult community mentors.

In both scenarios, the intentions are good but the developmental-appropriateness of the selected interventions is questionable: neither intervention matches the developmental phase of the target audience or addresses the risk and protective factors most influential during that phase. In the first scenario, the intervention addresses competencies that children develop later in life, during their middle-childhood and adolescence. A more appropriate intervention might be one that targets kindergarten teachers, helping them to provide better support for their students' behavioral health. In the second scenario, the intervention targets individual-level behavior change. A more effective approach might be to reduce social access to alcohol—by enforcing bans on serving and selling alcohol to minors.

Matching Interventions to Setting

It's also important to consider the "where" of an intervention. Children develop competencies in a range of settings. In just one day, a child might move from his home to school, then to after-school day-care, then on to a neighborhood park to play with friends. Each of these settings plays a role in a child's development. As individuals progress through their youth and into adulthood, the significance of setting in shaping behavioral health evolves. For example, when individuals are very young, immediate family members play a key role in shaping development. But as children mature their friends and peers become significantly more influential, which introduces new risk and protective factors in- and out-of-school.

Sources

- Compton, M. T. (2009). *Clinical Manual of Prevention in Mental Health* (1st ed.). American Psychiatric Publishing, Inc.
- O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. National Research Council and Institute of Medicine of the National Academies. Washington, D.C.: The National Academies Press.
- Substance Abuse and Mental Health Services Administration. (2011). *Leading change: A plan for SAMHSA's roles and actions 2011-2014*. SAMHSA.

Information Sheet 5: Developmental Competencies and Associated Risk & Protective Factors by Context

Infancy and Early Childhood

Competencies: Infants begin understanding their own and others' emotions, to regulate their attention, and to acquire functional language

Risk Factors	Protective Factors
<ul style="list-style-type: none"> • <i>Individual:</i> difficult temperament • <i>Family:</i> parental drug/alcohol use, cold and unresponsive mother behavior 	<ul style="list-style-type: none"> • <i>Individual:</i> self-regulation, secure attachment, mastery of communication and language skills, ability to make friends and get along with others • <i>Family:</i> reliable support and discipline from caregivers, responsiveness, protection from harm and fear, opportunities to resolve conflict, adequate socioeconomic resources for the family • <i>School/community:</i> support for early learning, access to supplemental services such as feeding and screening for vision and hearing, stable and secure attachment to childcare provider, low ratio of caregivers to children, regulatory systems that support high quality of care

Middle Childhood

Competencies: Children learn how to make friends, get along with peers, and understand appropriate behavior in social settings

Risk Factors	Protective Factors
<ul style="list-style-type: none"> • <i>Individual:</i> poor impulse control, sensation-seeking, lack of behavioral self-control, impulsivity, early persistent behavior problems, attention deficit/hyperactivity disorder, anxiety, depression, antisocial behavior • <i>Family:</i> permissive parenting, parent-child conflict, low parental warmth, parental hostility, harsh discipline, child abuse/maltreatment, substance use among parents or siblings, parental favorable attitudes toward alcohol and/or drug use, inadequate supervision and monitoring, low parental aspirations for child, lack of or inconsistent discipline • <i>School/community:</i> school failure, low commitment to school, peer rejection, deviant peer group, peer attitudes toward drugs, alienation from peers, law and norms favorable toward alcohol and drug use, availability and access to alcohol 	<ul style="list-style-type: none"> • <i>Individual:</i> mastery of academic skills (math, reading, writing), following rules for behavior at home and school and in public places, ability to make friends, good peer relationships • <i>Family:</i> consistent discipline, language-based rather than physically-based discipline, extended family support • <i>School/community:</i> healthy peer groups, school engagement, positive teacher expectations, effective classroom management, positive partnering between school and family, school policies and practices to reduce bullying, high academic standards

Adolescence

Competencies: Adolescents focus on developing good health habits, practice critical and rational thinking, and seek supportive relationships

Risk Factors	Protective Factors
<ul style="list-style-type: none"> • <i>Individual:</i> emotional problems in childhood, conduct disorder, favorable attitudes toward drugs, rebelliousness, early substance use, antisocial behavior • <i>Family:</i> substance use among parents, lack of adult supervision, poor attachment with parents • <i>School/community:</i> school failure, low commitment to school, not college bound, aggression toward peers, associating with drug-using peers, societal/community norms about alcohol and drug use 	<ul style="list-style-type: none"> • <i>Individual:</i> positive physical development, academic achievement/intellectual development, high self-esteem, emotional self-regulation, good coping skills and problem-solving skills, engagement and connections (in school, with peers, in athletics, employment, religion, culture) • <i>Family:</i> family provides predictable structure with rules and monitoring, supportive relationships with family members, clear expectations for behavior and values • <i>School/community:</i> presence of mentors and support for development of skills and interests, opportunities for engagement within school and community, positive norms, clear expectations for behavior, physical and psychological safety

Early Adulthood

Competencies: Individuals learn to balance autonomy with relationships to family, make independent decisions, and become financially independent

Risk Factors	Protective Factors
<ul style="list-style-type: none"> • <i>Individual:</i> lack of commitment to conventional adult roles, antisocial behavior • <i>Family:</i> leaving home • <i>School/community:</i> attending college, substance-using peers 	<ul style="list-style-type: none"> • <i>Individual:</i> identity exploration in love and work and developing a world view, subjective sense of adult status, subjective sense of self-sufficiency, making independent decisions, becoming financially independent, future orientation, achievement motivation • <i>Family:</i> balance of autonomy and relatedness to family, behavioral and emotional autonomy • <i>School/community:</i> opportunities for exploration in work and school, connectedness to adults outside of family

Source

- O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. National Research Council and Institute of Medicine of the National Academies. Washington, D.C.: The National Academies Press.

Directions for Completing the Local Community Readiness Assessment for ROSC and Prevention Prepared Communities

This ROSC Readiness Assessment is designed for use by a group of people from the same community who have some knowledge of its services, needs, and prevention and treatment providers. This is not an activity that can be completed in the time available during this workshop but a good start can be made and the tool can be used with a larger planning group when you return home. Someone should use their form to make notes for the group. Time guidelines are provided in parenthesis for today's activity.

In the middle of the worksheet, you are asked to define the community about which you are doing this assessment and planning. Even though some of you work with many communities or clients from many communities this exercise asks you to focus on one. It can be a city, an identifiable population within a county or city, a Native American Tribe, or any community whose members recognize and identify as a group. Write your community name on the line. (5 Min.)

In column one, titled "Attitude toward System Transformation," is an adaptation of Prochaska and DiClemente's *Stages of Change Model* (1983). Think of the people you know who are actively involved in prevention and treatment in your community. Read through these descriptions and decide which one best fits your collective attitude toward **developing effective institutional collaboration of entities, individuals, and service functions that can provide and integrate services that address behavioral and health care needs.** (10 min.)

Included in your packet is a list of strategies for transformation that can be used at each level of readiness for change, "Core Strategies for Transformation based on Readiness for Change." Read through the strategies that match the level of readiness you have identified. Check the ones that might be most useful in your community. (30 min.)

Column two is titled "Prevention Prepared Communities." In this part of the workshop, you are asked to assess ways that you are a Prevention Prepared Community (PPC). You are also asked to record ideas for what can/should be done to become more of a PPC. A separate handout provides a page for writing down ideas about each of the guiding steps of a PPC. Spend 5-10 minutes on each step or goal. (60 min.)

Column three is titled "ROSC" (Recovery Oriented System of Care). There are two choices:

1. You are asked to answer the following questions: "In what ways are we a healthy community that supports recovery? What are things we should have in place to support recovery? How can we become more healthy and in support of recovery?"

Unless you have done an inventory of your community, you may not know everything that is in place and all of the unmet needs. It takes a large diverse group of people to do a good job on this so you may want to use this with planning groups in your community. (30 min.)

2. You are asked to make a plan to complete the "Community Recovery Capital Needs Assessment." Take a few minutes to review this assessment and then come up with a plan for completing it in your community. (30 min.)

Local Community Readiness Assessment for ROSC and Prevention Prepared Communities

Attitude Toward System Transformation	Prevention Prepared Communities	ROSC		
<p>After reading through these stages of change, decide which best describes your community. If your community is not in the “Action” stage of transformation, use the handout labeled “Core Strategies for Transformation based on Readiness for Change” for ideas of strategies will help move your community forward.</p> <p><u>1. Pre-contemplation</u> Treatment works sufficiently. We are just under-resourced. We need more money to provide an expanded service array but we don’t see the need for a philosophical shift of any kind. We already provide recovery oriented care. There’s no real urgency around increasing the coordination and integration of prevention and treatment services.</p> <p><u>2. Contemplation</u> There are significant problems with the current design of the system but the obstacles to addressing them seem insurmountable. Alter-natively stakeholders see the need for change but are not sure what to change and how to go about it. Recovery related practice changes are considered but commitment to move in this direction may be diminished amidst concerns about low funding, system crises, and lack of clarity about how to proceed. There may be an awareness of the need to further coordinate prevention and treatment services in order to meet common goals, but minimal efforts have occurred to date.</p>	<p>Our community is _____</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p style="text-align: center;"><i>“Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse...and suicide” (SAMHSA)</i></p> </div> <p>In what ways are we a Prevention Prepared Community?</p> <ul style="list-style-type: none"> □ We use the data-driven Strategic Prevention Framework (SPF) process. This includes: <ul style="list-style-type: none"> • Assessment – Use data to identify community problems and to drive process (epidemiology profile) • Capacity Building – Assess current service systems and increase capacity, knowledge, and skills of workforce of services critical to systems integration effort. • Strategic Planning – Increase communication, collaboration of critical stakeholders for design of integrated services/functions. • Use evidence-based services/interventions to prevent/mitigate identified substance abuse consequences and related problems within integrated framework of services. • Monitor quality and effectiveness of services provided (modify to improve). <table border="1" style="width: 100%; margin: 10px 0;"> <tr> <td style="text-align: center; width: 50%;">What We Do</td> <td style="text-align: center; width: 50%;">What We Need to Do</td> </tr> </table> <ul style="list-style-type: none"> □ We include key community entities and stakeholders in joint assessment and planning efforts to address identified community needs. This means <ul style="list-style-type: none"> • Sharing relevant data • Identifying mutual needs and strengths • Developing complementary organizational processes and plans • Integrating and/or linking services • Assessing effectiveness of actions 	What We Do	What We Need to Do	<p>Answer these questions:</p> <p><i>In what ways are we a healthy community that supports recovery?</i></p> <p><i>What are things we should have in place to support Recovery?</i></p> <p><i>How can we become more healthy and in support of recovery?</i></p> <hr/> <p style="text-align: center;">OR</p> <p style="text-align: center;">Complete the Community Recovery Capital Needs Assessment.</p>
What We Do	What We Need to Do			

Attitude Toward System Transformation	Prevention Prepared Communities	ROSC						
<p><u>3. Preparation</u> We have decided and are going to make major changes in service philosophy and practices. Diverse stakeholder groups are being engaged in planning efforts. Concrete goals are being set to begin the process with the coming year. The role of both prevention and treatment within a ROSC are being explored. We are seeking support to help guide and sustain the process.</p> <p><u>4. Action</u> We are actively making changes in philosophy, and policies at all levels of the system. Stake-holders may perceive the process as energizing, chaotic and challenging. Prevention efforts are leveraged to promote community wellness and increased general community and recovery supports. Lessons learned in different parts of the system are being disseminated to increase the momentum.</p> <p><u>5. Maintenance</u> We have come a long way. We are implementing recovery oriented care throughout the system and the administrative structure has shifted to support this, but we recognize the need for continued improvement.</p>	<p>Who is represented at your table and to what degree do they participate in joint assessment and planning efforts as described above? Healthcare organizations like health departments, hospitals, medical professionals including dentists and dental hygienists, pharmacists, health promotion services? Multi-purpose collaborative? Law enforcement, courts? Schools, and education organizations? Employee assistance programs? Government service agencies like DHS? Other social service agencies? Other government agencies like DEA and FDA? Ethnic/tribal leaders? Behavioral health providers? Families, parents, parent groups? Business? Media? Youth, student groups, services for youth? Faith-based organizations? Fraternity organizations? Local government officials? Recovery organizations, members of the recovery community? Civic, volunteer groups? Suicide prevention groups/services? Older adult organizations? Organizations involved in reducing substance abuse like Prevention Network, Michigan Coalition to Reduce Underage Drinking, and MADD?</p> <table border="1" data-bbox="741 764 1606 875"> <tr> <td data-bbox="741 764 1173 875">Who Do We Now Include and How?</td> <td data-bbox="1173 764 1606 875">Who Else Do We Need to Include and Who Needs to Participate in What Other Ways?</td> </tr> </table> <p><input type="checkbox"/> We coordinate substance abuse prevention initiatives with other government health promotion efforts. We plan and deliver specialized cost effective prevention services that promote social and emotional well-being and align with healthcare reforms.</p> <table border="1" data-bbox="741 1086 1606 1154"> <tr> <td data-bbox="741 1086 1173 1154">What are we doing?</td> <td data-bbox="1173 1086 1606 1154">What else can we do?</td> </tr> </table> <p><input type="checkbox"/> We use evidence-based programs, services, and interventions: (schools, parent programs, after-school programs, courts, healthcare services, student groups, suicide prevention groups/services, treatment services, prevention programs and services).</p> <table border="1" data-bbox="741 1349 1606 1446"> <tr> <td data-bbox="741 1349 1173 1446">Programs, Services, & Interventions Being Used</td> <td data-bbox="1173 1349 1606 1446">Programs, Services, & Interventions to Explore Using</td> </tr> </table>	Who Do We Now Include and How?	Who Else Do We Need to Include and Who Needs to Participate in What Other Ways?	What are we doing?	What else can we do?	Programs, Services, & Interventions Being Used	Programs, Services, & Interventions to Explore Using	
Who Do We Now Include and How?	Who Else Do We Need to Include and Who Needs to Participate in What Other Ways?							
What are we doing?	What else can we do?							
Programs, Services, & Interventions Being Used	Programs, Services, & Interventions to Explore Using							

Attitude Toward System Transformation	Prevention Prepared Communities	ROSC								
	<p data-bbox="716 256 1629 378"> <input type="checkbox"/> We prevent onset, mitigate consequences, of substance abuse and mental illness. Consider each of life's stages: infancy, 1-3 years, pre-school, early elementary, 4th-6th grades, middle school, high school, young adults (18-29), middle-age (30-49), older adults (50-62), and seniors. </p> <table border="1" data-bbox="741 407 1593 464"> <tr> <td data-bbox="741 407 1167 464">Programs & Activities in Place</td> <td data-bbox="1167 407 1593 464">Ideas for Programs or Activities</td> </tr> </table> <p data-bbox="716 518 1612 607"> <input type="checkbox"/> We develop workforce capacity to provide integrated services and deliver specialized substance abuse prevention services that promote health and wellbeing. </p> <table border="1" data-bbox="741 631 1614 691"> <tr> <td data-bbox="741 631 1167 691">Programs & Activities in Place</td> <td data-bbox="1167 631 1614 691">Ideas for Programs or Activities</td> </tr> </table> <p data-bbox="716 745 1635 867"> <input type="checkbox"/> We focus on populations facing behavioral and physical health disparities: racial and ethnic minorities; lesbian, gay, bisexual, and transgendered people; people with disabilities; girls and transition-age youth; groups facing elevated levels of substance use disorders and higher suicide rates. </p> <table border="1" data-bbox="741 886 1614 946"> <tr> <td data-bbox="741 886 1167 946">What We Do</td> <td data-bbox="1167 886 1614 946">What We Need to Do</td> </tr> </table> <p data-bbox="716 1013 1625 1102"> <input type="checkbox"/> We are increasing the effectiveness of initiatives and practices designed to prevent/reduce substance use disorders, underage drinking, prescription drug abuse, suicide, and underage smoking. </p> <table border="1" data-bbox="741 1127 1614 1187"> <tr> <td data-bbox="741 1127 1167 1187">What We Do</td> <td data-bbox="1167 1127 1614 1187">What We Need to Do</td> </tr> </table>	Programs & Activities in Place	Ideas for Programs or Activities	Programs & Activities in Place	Ideas for Programs or Activities	What We Do	What We Need to Do	What We Do	What We Need to Do	
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What We Do	What We Need to Do									

Assessing Your Community's Readiness for System Transformation

After reading through these stages of change, decide which best describes your community. If your community is not in the "Action" stage of transformation, use the handout labeled "Core Strategies for Transformation based on Readiness for Change" for ideas of strategies that will help move your community forward.

1. Pre-contemplation

Treatment works sufficiently. We are just under-resourced. We need more money to provide an expanded service array but we don't see the need for a philosophical shift of any kind. We already provide recovery oriented care. There's no real urgency around increasing the coordination and integration of prevention and treatment services.

2. Contemplation

There are significant problems with the current design of the system but the obstacles to addressing them seem insurmountable. Alternatively, stakeholders see the need for change but are not sure what to change or how to go about it. Recovery related practice changes are considered but commitment to move in this direction may be diminished amidst concerns about low funding, system crises, and lack of clarity about how to proceed. There may be an awareness of the need to coordinate further prevention and treatment services in order to meet common goals, but minimal efforts have occurred to date.

3. Preparation

We have decided and are going to make major changes in service philosophy and practices. Diverse stakeholder groups are being engaged in planning efforts. Concrete goals are being set to begin the process with the coming year. The role of both prevention and treatment within a ROSC are being explored. We are seeking support to help guide and sustain the process.

4. Action

We are actively making changes in philosophy, and policies at all levels of the system. Stakeholders may perceive the process as energizing, chaotic, and challenging. Prevention efforts are leveraged to promote community wellness and increased general community and recovery supports. Lessons learned in different parts of the system are being disseminated to increase the momentum.

5. Maintenance

We have come a long way. We are implementing recovery-oriented care throughout the system and the administrative structure has shifted to support this, but we recognize the need for continued improvement.

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Core Strategies for Transformation based on Readiness for Change

1. Pre-contemplation

Implement awareness raising activities to establish the need for change.

- Host conference with national or state leaders to challenge the status quo.
- Hold community meetings to explore the state of the system.
- Identify and develop a cadre of people in recovery who can effectively share their recovery stories in a manner that supports and reaffirms the need for the desired changes (e.g. Storytelling Trainings).
- Create opportunities to bring diverse stakeholders together to dialogue about their perspectives. Incorporate recovery stories in these dialogues and ask participants to focus on what helps and what hurts.
- Conduct system and community assessments using focus groups and surveys to examine the strengths and limitations in the current system.
- Utilize national (or state) data to underscore national (or state) challenges and reduce defensiveness about the need for change locally.
- Disseminate relevant information and data about the effectiveness and gaps of the current system.
- Articulate how some current treatment models are not consistent with what research and people in recovery are suggesting works.
- Increase awareness of national efforts around recovery transformation.

2. Contemplation

In addition to the above, implement strategies to increase the sense of urgency.

- Conduct community meetings and focus groups to assess and clearly identify the concerns regarding recovery transformation (e.g., limited resources, concerns regarding complexity or clarity of vision, burnout, uncertainty around how-to proceed, and anxiety about change).
- Conduct a pro vs. con analysis with stakeholder input.
- Develop strategies strategically targeted at community/system concerns about moving in this direction.
- Mobilize the recovering community to increase the demand for change.
- Leverage critical incidents in the system to underscore the need for change.
- Highlight the efforts of other systems with an emphasis on benefits and the reality that system transformation is possible.

- Explore with stakeholders the importance of community health in helping people to sustain their recovery and examine how treatment and prevention efforts can support one another.
- Identify recovery champions in all parts of the system and begin to build a network of potential early adopters.
- Highlight and support existing recovery oriented practices.
- Conduct trainings that challenge current thinking and practices.

3. Preparation

In addition to the above, increase understanding of how a ROSC is different from traditional systems and develop implementation plan.

- Identify a point person.
- Develop a guiding coalition.
- Develop participatory processes for all planning activities.
- Develop a shared vision and guiding principles for the system that encompass both prevention and treatment efforts.
- Develop a strategic plan to guide the implementation process.
- Communicate the vision x 10.
- Clarify the approach to developing a ROSC (additive, selective, transformative).
- Identify relevant recovery oriented treatment practices, prevention efforts, and potential barriers to implementation.
- Prioritize the implementation of these recovery oriented activities.
- Conduct initial policy and fiscal alignment to support the implementation of different services and supports.
- Address perceived loss by facilitating new ways to engage stakeholders (e.g., planning groups).
- Ensure that people in recovery and community members are in leadership roles.
- Organize training efforts to increase stakeholder understanding.
- Obtain community support through community meetings where the need for change, recovery stories, and strategies are highlighted.
- Identify initial targets and potential short-term wins.

4. Action

In addition to the above, take action.

- Examine the implications that new practices have for all levels and aspects of the system.
- Increase prevention/treatment collaboration around building community and recovery supports.
- Conduct relevant baseline assessments to document impact.
- Provide resources to assist with implementation, (e.g., training, technical assistance, self-assessments, implementation guidelines, and technology-based resources.)
- Identify the early adopters and highlight their efforts.
- Develop learning communities where stakeholders share challenges, successes, and strategies.
- Identify obstacles to practice alignment and share with state/federal entities.
- Align system-level administrative functions with recovery orientation in partnership with stakeholders (e.g., monitoring, outcome evaluations, policy alignment, and fiscal).
- Communicate how transformation efforts connect to other initiatives (e.g., NIATx and evidence-based practices) to reduce fragmentation.
- Streamline operations to reduce load on providers (e.g., paperwork).
- Summarize emerging lessons learned and share with system.
- Identify short-term wins and celebrate successes.
- Explore implications for other systems and align collaborative efforts (e.g., criminal justice).

5. Maintenance

- Implement processes for continued practice alignment.
- Evaluate and monitor efforts to identify areas for ongoing improvement.
- Disseminate outcome data broadly to demonstrate the benefits of system changes.
- Identify ongoing challenges.
- Address policy and fiscal alignment for long-term sustainability.
- Strengthen the community.
- Link the transformation to other political and community agendas to promote sustainability.

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In What Ways are We a Prevention Prepared Community?

Our community is _____

“Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse...and suicide” (SAMHSA)

- We use the data-driven Strategic Prevention Framework (SPF) process. This includes:
 - Assessment – Use data to identify community problems and to drive process (Epidemiology Profile).
 - Capacity Building – Assess current service systems and increase capacity, knowledge, and skills of workforce for services critical to systems integration effort.
 - Strategic Planning – Increase communication; collaborate with critical stakeholders for design of integrated services/functions.
 - Evidence-based services/interventions – Use these to prevent/mitigate identified substance abuse consequences and related problems within integrated framework of services.
 - Monitor – Check quality and effectiveness of services provided (modify to improve).

What we do.	What we need to do.

- We include key community entities and stakeholders in joint assessment and planning efforts to address identified community needs. This means:
 - Sharing relevant data
 - Identifying mutual needs and strengths
 - Developing complementary organizational processes and plans
 - Integrating and/or linking services
 - Assessing effectiveness of actions

Who is represented at your table and to what degree do they participate in joint assessment and planning efforts as described above? Healthcare organizations like health departments, hospitals, medical professionals including dentists and dental hygienists, pharmacists, health promotion services? Multi-purpose collaborative? Law enforcement, courts? Schools and education organizations? Employee assistance programs? Government service agencies like DHS? Other social service agencies? Other government agencies like DEA, FDA? Ethnic/tribal leaders? Behavioral health providers? Families, parents, parent groups? Business? Media? Youth, student groups, services for youth? Faith-based organizations? Fraternity organizations? Local government officials? Recovery organizations, members of the recovery community? Civic, volunteer groups? Suicide prevention groups/services? Older adult organizations? Organizations involved in reducing substance abuse like Prevention Network, Michigan Coalition to Reduce Underage Drinking, and MADD?

Who do we now include and how?	Who else do we need to include and who needs to participate in what other ways?

- We coordinate substance abuse prevention initiatives with other government health promotion efforts. We plan and deliver specialized cost-effective prevention services that promote social and emotional well-being and align with healthcare reform.

What are we doing?	What else can we do?

- We use evidence-based programs, services, and interventions: schools, parent programs, after-school programs, courts, healthcare services, student groups, suicide prevention groups/services, treatment services, prevention programs and services.

Programs, services, & interventions now being used.	Programs, services, & interventions to explore using.

- We prevent onset, mitigate consequences of substance use disorders and mental illness. Consider each of life's stages: infancy, 1-3 years, pre-school, early elementary, 4th-6th grades, middle school, high school, young adults (18-29), middle-age (30-49), older adults (50-62), and seniors.

Programs & activities currently in place.	Ideas for programs or activities.

- We develop workforce capacity to provide integrated services and deliver specialized substance abuse prevention services that promote health and wellbeing.

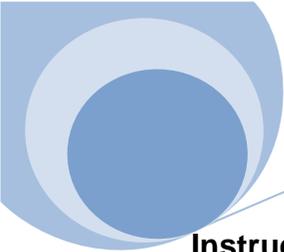
Programs & activities in place.	Ideas for programs or activities.

- We focus on populations facing behavioral and physical health disparities: racial and ethnic minorities; lesbian, gay, bisexual, transgendered people; people with disabilities; girls and transition-age youth; and groups facing elevated levels of substance use disorders and higher suicide rates.

What we do.	What we need to do.

- We are increasing the effectiveness of initiatives and practices designed to prevent/ reduce substance use disorders, underage drinking, prescription drug abuse, suicide, and underage smoking.

What we do.	What we need to do.



Community Recovery Capital Needs Assessment

Instructions: Recovery Capital are those internal and external resources an individual may utilize to initiate and sustain recovery. This Community Recovery Capital Needs Assessment is designed to help identify what recovery supports currently exist in the community. This information allows communities to work towards enhancing recovery supports by identifying and prioritizing known service gaps and other weaknesses in the recovery support system. In answering these questions, please consider the public and private, including faith-based resources in your communities, and other ancillary supports that assist and support individuals and their families/significant others on their path toward recovery. Moreover, as always, please consider and respect the anonymous nature of many recovery networks.

The Community Recovery Capital Needs Assessment is structured in such a way that no one assessment method will be able to answer all of the questions. Various methods including focus groups, brief surveying of specific populations, and web-based surveying may be necessary to complete this assessment. The goal of the Community Recovery Capital Needs Assessment document is to simply begin the conversation around recovery capital. The format is flexible and can be reformatted or expanded to fit the needs of the individual or team completing it or in consideration of what information you are interested in or how you would like this information to be shared or presented to others.

1. What support groups are held in the communities within your county?

The purpose of this question is to find out the range of programs available in your county. The results might indicate the community may need support groups other than 12-step focus in order to reach those individuals who are uncomfortable with the spirituality focus of the 12-step groups.

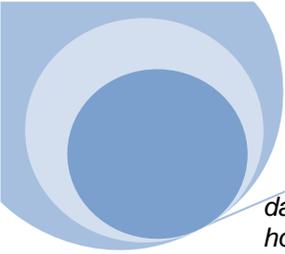
- Alcoholics Anonymous
- Chemically Dependent Anonymous
- Cocaine Anonymous
- Narcotics Anonymous
- Secular Organizations for Sobriety
- SMART Recovery
- Women for Sobriety
- Double Trouble in Recovery
- Dual Recovery Anonymous
- Al-Anon/Alateen
- Co-Anon
- Families Anonymous
- Nar-Anon

Additional comments surrounding support groups in your county:

2. Of the different support groups, how many meetings per week are available?

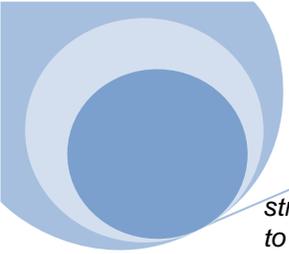
- a. On what days of the week?
- b. At what time of the day?

This question is designed to find out the frequency of support group meetings in your county. There may be a need to offer meetings at different times of the day or evening than what is traditionally offered. The suggested layout for the information gathered is to provide a grid with the



days of the week across the top and the names of the support group down the side, then indicate how many and at what times for each day.

3. Are there any support groups for youth (ages 14-17)? **Yes/No**
4. Does the area need support from the SUD treatment providers and prevention coalition to develop support groups for teens? **Yes/No**
5. Are there any support groups for young adults (ages 18-26)? **Yes/No**
6. Does the area need support from the SUD treatment providers and prevention coalition to develop support groups for young adults? **Yes/No**
The purpose of these questions is to focus on the younger population needing recovery support. Most often there are very few that are specific for the younger age demographic. This may be where the treatment providers and/or the coalition will need to support a group by hosting it and maybe having a designated "leader" for the group as it grows.
7. Are there any gender-specific support group meetings in the county?
The purpose of this question is similar to the ones regarding youth and young adults; having groups that are gender-specific allows for both genders to focus on issues necessary for recovery without having to be guarded.
8. Are the local support groups welcoming to diverse populations? In other words, do people of color, or non-English speaking, or the LGBT populations feel welcomed at the local support groups and in the recovery community? Provide examples of how support groups, and the recovery community welcome diverse populations. An example of a welcoming and supportive community would be if there are meetings specifically for these diverse populations.
The purpose of this question is to determine how welcoming the recovery community is to diversity. In larger communities there are dedicated meetings for the LGBT community, Spanish-speaking groups, etc. Is there a need for this kind of diversity in the community and are these needs being met?
9. Provide geographic areas where meetings are held.
The purpose of this question is to find out if the meetings are primarily located in the urban center of the county, making it difficult for those who live in the suburban and/or rural areas to attend meetings. This is particularly important for those involved in drug/sobriety/DWI courts, as they may not have a valid driver's license making it difficult to attend meetings. This may be an area of focus for peers to take on to develop meetings in these areas or be aware there will be transportation needs for meetings.
10. In the community, is there a dedicated location for AA/Al-Anon/Alateen meetings? (They are usually called Alano Clubs.) **Yes/No**
11. If the answer to #7 is yes, what are the hours of operation?
 - a. Is it open in-between meetings so people in recovery can meet, have coffee, and talk?
 - b. Does it have paid and/or volunteer staffing?
The purpose of these questions is determine if there is a safe place for people in early recovery to go to talk with others in recovery, meet their sponsors, or just sit and be safe if the urge to use is



strong. If there isn't somewhere for those in recovery to go, or if hours of availability are limited due to its being a volunteer operation, this may be something the recovering community needs support in developing and maintaining.

12. Where are the various group meetings held?

- Churches (you may want to list the different churches)
- Homes (sometimes the less well-known groups meet at someone's home)
- Local hospital
- Offices (such as doctors, therapists)
- SUD treatment providers
- Recovery clubs such as an Alano club

The purpose of this question is to find out where the different support groups are meeting and depending on where meetings are located may make a difference in how easily new people access them.

13. Inter-area groups are a loosely formed collection of local support group meetings that come together for the "good of the groups." They publish meeting directories, disseminate public information about recovery, and sponsor recovery-focused activities, such as summer picnics and New Year's Eve parties. The meetings are usually held monthly. Are there inter-area groups for any of the support groups identified? **Yes/No**

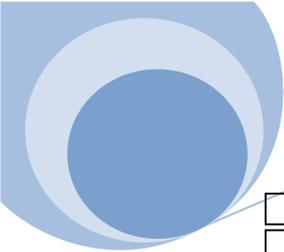
If so, for which support groups?

- Alcoholics Anonymous
- Chemically Dependent Anonymous
- Cocaine Anonymous
- Narcotics Anonymous
- Secular Organizations for Sobriety
- SMART Recovery
- Women for Sobriety
- Double Trouble in Recovery
- Dual Recovery Anonymous
- Al-Anon/Alateen
- Co-Anon
- Families Anonymous
- Nar-Anon

14. Are the different support groups in your county listed with 2-1-1? **Yes/No**

If so, which ones are listed?

- Alcoholics Anonymous
- Chemically Dependent Anonymous
- Cocaine Anonymous
- Narcotics Anonymous
- Secular Organizations for Sobriety
- SMART Recovery
- Women for Sobriety
- Double Trouble in Recovery
- Dual Recovery Anonymous



- Al-Anon/Alateen
- Co-Anon
- Families Anonymous
- Nar-Anon

15. Do any of the support groups have a hotline number listed in the various phone books? **Yes/No**

a. If so, which ones?

- Alcoholics Anonymous
- Chemically Dependent Anonymous
- Cocaine Anonymous
- Narcotics Anonymous
- Secular Organizations for Sobriety
- SMART Recovery
- Women for Sobriety
- Double Trouble in Recovery
- Dual Recovery Anonymous
- Al-Anon/Alateen
- Co-Anon
- Families Anonymous
- Nar-Anon

b. Indicate the hours of operation for those that do have a hotline number listed in the various phone books and/or with 2-1-1.

The purpose of questions 12-15 is to find out how easily people can find the groups when they need them. Are there phone numbers to contact so they can talk with someone from the support group before they go to a meeting to find out more about them? When someone is in treatment, the therapist usually gives some information, or the recovery coach, but if someone is "cold" calling, having this level of support in the community is important.

16. Do the treatment providers in county have alumni groups? **Yes/No**

If no, are they willing or interested in re-energizing an alumni group and involving them in supporting the agency or existing clients? **Yes/No**

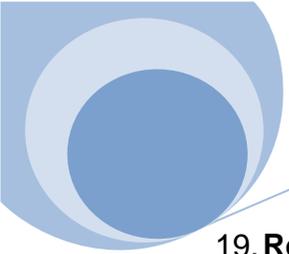
17. Are there any peer supports/recovery coaching type activities occurring within the publicly funded treatment providers in your county? **Yes/No**

If yes, provide status of effort to date.

18. Are there any peer supports/recovery coaching type activities occurring outside of the publicly funded treatment provider arena in your county? **Yes/No**

If yes, could those efforts be aligned or connected in the future with the publicly funded treatment providers' exploration of peer supports/recovery coaching?

The purpose of questions 16-18 is to determine how active individuals in the recovery community are with supporting people in early recovery and in SUD treatment. This is different activity than being a sponsor. Alumni groups are excellent avenues for advocacy, fund-raising activities, and recruiting peer supports/recovery coaches. However, maintaining alumni groups and peer supports/recovery coaches as a group of volunteers is time consuming for most providers, depending on the size of the county, the number of providers, and how involved the recovery community wants to be in this process.



19. Recovery Residences: This is new terminology for the field as it moves toward the recovery management model and chronic care as opposed to an acute care model of service delivery. Recovery housing is the basic service provided by recovery residences that includes, at a minimum, recovery peer support(s). Recovery residences is an all-encompassing term that accurately describes the residential modality of recovery support. Recovery residences provide a vital bridge from residential SUD treatment to recovery communities and independent living. The National Association of Recovery Residences (NARR) has recently been formed and has developed standards for recovery residency levels of support. These levels of supports more or less align with the more common terminology for recovery housing supports.

Transitional Housing is Level III under NARR's standards and definitions. The primary distinction of a transitional housing residence is the level of supervision provided. There usually is a resident facility manager and the residents are still in SUD treatment in the community.

½ Way House is Level II under NARR's standards and definitions. The primary distinction of a ½ way house is the level of monitoring is less than in the transitional home. The residents do not have to be in SUD treatment but do have to participate in mutual aid/support group meetings. The participants need to be working or actively looking for work.

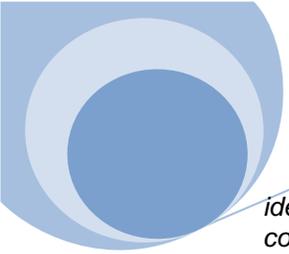
¾ Way House is Level I under NARR's standards and definitions. The primary distinction is the level of monitoring is the least restrictive of any other the recovery residences. It is primarily peer-run.

Question: Is there any sober housing in the various communities in the county?
Yes/No

If so, list by community in which the housing is located.

- Transitional Housing
 - For men
 - For women
 - For women with children
- ½ way homes
 - For men
 - For women
 - For women with children
- ¾ way homes
 - For men
 - For women
 - For women with children

Sober housing is important for individuals in early recovery but is difficult to find in most communities. It is important to survey just what is available within the community in order to begin working with other community agencies. This issue is bigger than what the SUD network can develop, nor should it be done by the field alone. This is a community-wide concern. Having some



idea as to what is available and/or what is needed is an important first step to bring to the community.

20. Stigma is still a major barrier to individuals and their families/significant others getting the help they need to begin and maintain recovery. Do the other community agencies (such as the hospital, public health department, community mental health, community action agency, housing authority, and primary health care providers) support recovery in tangible ways? Please describe the ways each community agency demonstrates its support of recovery.

The purpose of this question is to determine how someone needing help appears at any other agency would be treated (i.e. with respect?). In addition, would they be referred for the appropriate help or would their addiction just be ignored?

21. Does the county have any drug/sobriety/DWI courts within its court system?
Yes/No

If yes, could they utilize additional support from the publicly funded treatment providers, recovering community, and/or county SUD coalition and its networks?

22. Are there any underage programs for youth charged with minor in possession within the court system, such as a Minor in Possession Program or First Time Offender Program? **Yes/No**

Questions 21 and 22 are concerned with how the criminal justice system interacts with those individuals needing addiction treatment. Are they given opportunities for help, support, and treatment, or are they simply put in jail and then on probation? You may provide more information by way of a narrative regarding the various types of courts, their goals and objectives, specific processes, and level of interaction with the SUD service system.

Additional comments, opinions, and feedback surrounding the recovery capital of your county may be added to enhance the utility of this report. Counties may also add questions to this survey or tailor it to their own local concerns, issues, etc., surrounding other traditional and non-traditional recovery supports/recovery capital identified in your community. Examples include access to basic needs (clothing, shelter, food assistance), healthy, drug-free, and barrier-free recreational activities, and other community resources that support improved health and wellbeing for individuals and families, and the movement towards a recovery oriented system of care.

Recommendations: Please list any identified recommendations and/or next steps to improve upon or enhance the current resources and recovery supports that exist in your county.

- 1.
- 2.
- 3.
- 4.
- 5.

<p>This instrument was developed and graciously shared by Joel Hoepfner, Program Services Manager, of Mid-South Substance Abuse Commission – now with Community Mental Health Authority of Clinton, Eaton, and Ingham Counties.</p>

Assess Your Group's Community Linkages

Study the handout labeled "Five Levels of Collaboration." Then identify the groups that are part of your coalition/group and the groups to which your coalition/group belongs. Write their names in the first column. Using the handout decide what level of collaboration your coalition/group has with each group listed. Do you have a formal link with a written agreement? What steps can be taken to strengthen the relationship with each group listed? What about the relationships between the groups listed? Are all groups equal participants? How much do groups share resources?

Names of Groups	Level of Collaboration	Memorandum of Understanding?	Steps that can be Taken to Strengthen the Relationship

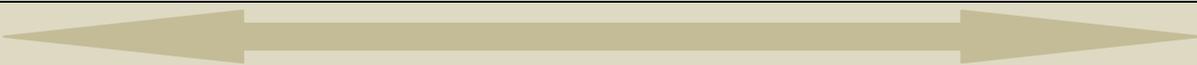
Names of Groups	Level of Collaboration	Memorandum of Understanding?	Steps that can be Taken to Strengthen the Relationship

Five Levels of Collaboration

Levels	Purpose	Structure	Process
Networking	<ul style="list-style-type: none"> • Dialog and common understanding • Clearinghouse for information • Create base of support 	<ul style="list-style-type: none"> • Non-hierarchical • Loose/flexible link • Roles loosely defined • Community action is primary link among members 	<ul style="list-style-type: none"> • Low key leadership • Minimal decision making • Little conflict • Informal communication
Cooperation or Alliance	<ul style="list-style-type: none"> • Match needs and provide coordination • Limit duplication of services • Ensure tasks are done 	<ul style="list-style-type: none"> • Central body of people as communication hub • Semi-formal links • Roles somewhat defined • Links are advisory • Group leverages/ raises money 	<ul style="list-style-type: none"> • Facilitative leaders • Complex decision making • Some conflict • Formal communications within the central group
Coordination or Partnership	<ul style="list-style-type: none"> • Share resources to address common issues • Merge resource base to create something new 	<ul style="list-style-type: none"> • Central body of people consists of decision makers • Roles defined • Links formalized • Group develops new resources and joint budget 	<ul style="list-style-type: none"> • Autonomous leadership but focus in on issue • Group decision making in central and subgroups • Communication is frequent and clear
Coalition or Partnership	<ul style="list-style-type: none"> • Share ideas and be willing to pull resources from existing systems • Develop commitment for a minimum of three years 	<ul style="list-style-type: none"> • All members involved in decision making • Roles and time defined • Links formal with written agreement • Group develops new resources and joint budget 	<ul style="list-style-type: none"> • Shared leadership • Decision making formal with all members • Communication is common and prioritized
Collaboration	<ul style="list-style-type: none"> • Accomplish shared vision and impact benchmarks • Build interdependent system to address issues and opportunities 	<ul style="list-style-type: none"> • Consensus used in shared decision making • Roles, time and evaluation formalized • Links are formal and written in work assignments 	<ul style="list-style-type: none"> • Leadership high, trust level high, productivity high • Ideas and decisions equally shared • Highly developed communication
<p>Source: Community Based Collaborations – Wellness Multiplied 1994, Teresa Hogue, Oregon Center for Community Leadership http://crs.uvm.edu/ncco/cd/subfra.htm.</p>			

PACER Center, Inc. 2004
 Building Program Capacity to Serve Youth with Disabilities Session #7: Interagency Collaboration

Community Linkages Grid: Defining Connections

Range of Connections			
Linkage Types → and Areas ↓	Networking groups and Cooperatives are mostly aligned w/ this category	Alliances and Partnerships are mostly aligned w/ this category	Coalitions, Collaborations, Advisory Boards are mostly aligned w/ this category
Leadership	Few key leaders, facilitative leaders	Independent/ad-hoc/issue driven leadership	Shared and defined leadership with high level of trust and responsibility
Decision Making/Potential for Conflict	Minimal decision making, not sought for opinions or stances on issues collectively, low level of conflict or controversy	Complexity of decision making grows to include committees that report to leadership structure; decisions may be by consensus. Potential for conflict increases with nature of issue.	More decision making tasks; formalized structure and responsibility is defined for levels of decisions. Conflict of interest parameters for participants are commonly defined. Potential for controversy is high and needs to be mitigated.
Communication	Informal participation, optional communication	Lines of communication are set and managed, with participation expected	Communication has a structure, formality and protocol. There is an expectation for accuracy (vetted, shared information) and involvement by members.
Purpose/Function	<ul style="list-style-type: none"> * Dialog and common understanding * Clearinghouse for information * A base of support * Share resources to address common issues * Merge resource base to create something new 	<ul style="list-style-type: none"> * Match needs and provide coordination * Limit duplication of services * Accomplish tasks that require multiple voices and perspectives to further policy and system level changes * Share ideas and be willing to pull resources from existing systems 	<ul style="list-style-type: none"> * Commitments from participants required for a minimum of time * Accomplish shared vision and impact benchmarks; typically a strategic plan and/or goals and objectives developed for group * Build interdependent system to address issues and opportunities * By-laws in place * Links to formal structures for running programs and applying for and receiving funding in place.
Structure	Loose and flexible with lightly defined roles. Central body of regular participants. Participation on individual, organizational/agency level acceptable.	May play unofficial advisory role. Participants may have to meet certain requirements and commitment. Scope of work may be developed to address issues. Minimal resource development.	May have official advisory role or ability to approve decisions on a broader scale. Roles are defined by professional affiliation or agency/organizational representation. Resource development a regular and important focus.

Adapted from "Collaboration Framework: Addressing Community Capacity" (found at ncoinfo@extension.umn.edu <http://www.cyfernet.org/>) by the Center for Applied Research Solutions www.cars-rp.org

Developing Prevention Prepared Communities Training Evaluation

The following statements relate to your evaluation of the Developing Prevention Prepared Communities training. For each statement, please indicate whether you strongly agree, agree, disagree, or strongly disagree with the statement.				
	Strongly Disagree	Disagree	Agree	Strongly Agree
1. The goals of the meeting were clear to me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I learned more about Recovery Oriented System of Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I learned more about Prevention Prepared Communities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. The Developing PPC presentation helped me to see the link between ROSC and PPCs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Completing the Readiness Assessment helped me see our strengths and challenges	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. The Community Readiness Assessment is a useful tool for our organization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. The discussion on PPCs gave me ideas about how to bring new collaborative partners to the table	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. The materials presented were easy to understand	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. The speakers provided good examples	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. There was enough time for questions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. The meeting was long enough to cover all the information	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. Which information do you think you will most likely use in your prevention work?

13. Provide two examples of how you will use the information:

14. What did you like best about the meeting?

15. What did you like least about the meeting?

16. What other type of training/education do you need...

...regarding Recovery Oriented System of Care?

...regarding Prevention Prepared Communities?

...regarding any other prevention topics?

Thank you for your participation in this survey. We appreciate your feedback!