ENGAGING COMMUNITY COALITIONS TO DECREASE OPIOID OVERDOSE DEATHS

PRACTICE GUIDE 2023

NIH National Institute on Drug Abuse

SAMHSA Substance Abuse and Mental Health Services Administration

Engaging Community Coalitions to Decrease Opioid Overdose Deaths Practice Guide

Acknowledgments
This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under federal award number UM1DA049394-01S4 with the National Institute on Drug Abuse. The HEALing (Helping to End Addiction Long-term℠) Communities Study (HCS) was supported by the National Institutes of Health through the NIH HEAL Initiative under award numbers [UM1DA049394, UM1DA049406, UM1DA049412, UM1DA049415, UM1DA049417].

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Electronic Access
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Recommended Citation
Substance Abuse and Mental Health Services Administration: *Engaging Community Coalitions to Decrease Opioid Overdose Deaths Practice Guide*. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2023.

Originating Office
National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857. Published 2023.

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NIH HEAL INITIATIVE
HEALing Communities Study

Released 2023

Contents

Key Terms

TERM	DEFINITION
Addiction	Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases. See American Society of Addiction Medicine Definition of Addiction
Behavioral Health	The term "behavioral health" means the promotion of mental health, resilience, and well-being; the treatment of mental health conditions and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.
Continuum of Care	An integrated system of care that guides and tracks a person over time through a comprehensive array of health services appropriate to the individual's need. A continuum of care may include prevention, early intervention, treatment, continuing care, and recovery support.
Evidence-Based Practice (EBP)	Evidence-based practices are interventions that are guided by the best research evidence with practice-based expertise, cultural competence, and the values of the persons receiving the services, that promote individual-level or population-level outcomes.
Harm Reduction	Harm reduction is a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (and their families) with the choice to live healthy, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of people who use drugs, especially those in underserved communities, in these strategies and the practices that flow from them. See SAMHSA–Harm Reduction
Intersectionality	The complex, cumulative intertwining of social identities that result in unique experiences, opportunities, and barriers. People may use "intersectionality" to refer to the many facets of our identities, and how those facets intersect. Some use the term to refer to the compound nature of multiple systemic oppressions.
Justice-Involved	This descriptor indicates past or current involvement in the criminal legal system, typically indicating the person has experienced one or more of the following: an arrest, prosecution, incarceration in a jail or prison, and/or community supervision.
Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex + (LGBTQI+)	Lesbian, gay, bisexual, transgender, queer, those who are questioning their sexual orientation or gender identity, and others who are not cisgender or straight/heterosexual. LGBTQI+ is used interchangeably with "sexual and gender minority."

TERM	DEFINITION
Medication for Opioid Use Disorder (MOUD)	This term refers to the class of medications that are FDA-approved for the treatment of opioid use disorder (OUD). They are often used in combination with counseling and other behavioral therapies to provide a whole-patient approach to the treatment of OUD. This class of medications includes buprenorphine, methadone, and naltrexone in different formulations. See SAMHSA Medications, Counseling, and Related Conditions
Peer Distribution	Peers are people with lived experience from the community. In a peer distribution program, peers distribute naloxone to others within the community outside of formal settings (e.g., medical offices, harm reduction agencies).
Peer Support Workers	Peer support workers are people with lived or living experience who help others experiencing similar situations.
Peer Recovery Support Services	Services provided by peer support workers may include emotional (e.g., mentoring), informational (e.g., parenting class), instrumental (e.g., accessing community services), and affiliational (e.g., social events) support. See SAMHSA Peer Support Workers for those in Recovery
People with Lived Experience (PWLE)	People who currently use or formerly used opioids, or their family members.
Recovery	Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. There are four major dimensions that support recovery: • Health: overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being. • Home: having a stable and safe place to live. • Purpose: conducting meaningful daily activities and having the independence, income, and resources to participate in society. • Community: having relationships and social networks that provide support, friendship, love, and hope. See SAMHSA Recovery and Recovery Support
Social Determinants of Health	Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The Social Determinants of Health cover five domains: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context. See Healthy People 2030: Social Determinants of Health
Stigma	Stigma arises from the negative feelings that many individuals harbor against people struggling with mental and/or substance use disorders, and their beliefs that poor personal choices, "moral failing," and defects of character are to blame for the disease. Stigma can reduce willingness of policymakers to allocate resources, reduce willingness of providers in non-specialty settings to screen for and address mental health conditions and substance use disorders, impact a person's standing in their community, limit access to employment or housing, and may limit willingness of individuals with these conditions to seek treatment. Some people object to this term as it may perpetuate a negative connotation. Others favor "prejudice and discrimination" as the societal attitudes and actions that reinforce negative stereotypes and policies.

TERM	DEFINITION
Telehealth	Telehealth is usually used as a broader term. Telehealth typically includes not only telemedicine but also other forms of telecommunication, including asynchronous or "store and forward" systems, which transfer a patient's data or images for a physician or practitioner at another site to access at a later time. With these systems, the patient and provider do not have to be present at the same time. See SAMHSA CCBHCs Using Telehealth or Telemedicine
Telemedicine	"Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment… [Medicaid] does not recognize telemedicine as a distinct service." See SAMHSA CCBHCs Using Telehealth or Telemedicine
Trauma	SAMHSA describes individual trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." See SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach
Trauma-Informed Approach	A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. Referred to variably as "trauma-informed care" or "trauma-informed approach" this framework is regarded as essential to the context of care. See SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Acronyms

ASAP	Agency for Substance Abuse Policy
BIPOC	Black, Indigenous, and people of color
CBPR	Community-Based Participatory Research
CE	Continuing Education
CME	Continuing Medical Education
CTH	Communities That HEAL
DEI	Diversity, Equity, and Inclusion
HCS	HEALing Communities Study
KY-ASAP	Kentucky Agency for Substance Abuse Policy
LC	Learning Collaboratives
LGBTQI+	Lesbian, gay, bisexual, transgender, queer, those who are questioning their sexual orientation or gender identity, and others who are not cisgender or straight/heterosexual
LMDC	Louisville Metro Department of Corrections
MOUD	Medications for Opioid Use Disorder
NIH	National Institutes of Health
OEND	Overdose Education and Naloxone Distribution
ORCCA	Opioid-Overdose Reduction Continuum of Care Approach
OUD	Opioid Use Disorder
PTTC	Prevention Technology Transfer Center Network
PWLE	People with Lived Experience
PWUD	People Who Use Drugs
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SUD	Substance Use Disorders
TTC	Technology Transfer Centers
WIC	Women, Infants, and Children

1. Overview

This publication is a product of the HEALing Communities Study (HCS) informed by the Communities That HEAL (CTH) Intervention Manual and integral contributions from research and community partners across four research sites. This guide was developed in recognition of the need to center community engagement throughout the efforts to address the opioid overdose crisis. This guide exists to help communities decrease opioid overdose deaths; it includes tools and real-world examples that can be used to build and strengthen community coalitions that work to reduce opioid overdose deaths.

Care continuum is the span of care across prevention, diagnosis, engagement, and retention in OUD treatment.

Harm reduction is a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (and their families) with the choice to live healthy, self-directed, and purpose-filled lives. (SAMHSA).

Recovery is a "process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential" (SAMHSA).

WHO IS THIS GUIDE FOR?

The guide was developed for the Substance Abuse and Mental Health Services Administration (SAMHSA) Technology Transfer Centers (TTC) program and other providers of technical assistance as a resource for individuals working to end the opioid crisis. These individuals include community coalition members, professional treatment providers, recovery support specialists, people with lived experience, policymakers, recovery program administrators, and many others working to prevent, treat, and support recovery from substance use disorders. This guide is particularly designed for individuals who can help create new coalitions, or support and encourage opportunities to potentially re-envision existing coalitions, to address the opioid crisis in their communities.

HOW WAS THIS GUIDE DEVELOPED?

This guide leverages insights from the community engagement approach deployed through the Communities That HEAL (CTH) intervention of the HCS. In deploying the CTH, researchers partnered with community coalitions to create data-informed action plans for selecting evidence-based interventions to reduce opioid overdose. As part of the development of this publication, an eight-person technical expert panel reviewed the community engagement elements of the CTH and recommended useful ways to share CTH insights and tools with the TTC network. The panel included experts from recovery and harm reduction agencies, SAMHSA, the National Institute on Drug Abuse, and the HCS. HCS researchers contributed case examples based on their experiences working with community coalitions to respond to the opioid overdose crisis. All experts provided input on the guide and reviewed all content. See **Appendix G** for a full list of contributors. A companion practice guide, *Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) Practice Guide*, features a menu of evidence-based practices for reducing opioid overdose deaths and real-world tips for implementing these practices.

WHAT IS IN THIS GUIDE?

This guide consists of six sections.

1. Guide Overview

Section 1 briefly describes the purpose of this guide, including who it is for and how it was developed.

2. Community Engagement Fundamentals

Section 2 defines community engagement and its principles, describes how coalition building is a key element of community engagement, and provides a brief overview of how coalitions were central to the CTH intervention.

3. Building a Community Coalition

Section 3 provides guidance on defining your community, conducting a community assessment, identifying potential coalition members, and assessing coalition representativeness.

4. Maintaining and Strengthening a Community Coalition

Section 4 reviews the importance of providing bidirectional training opportunities, the importance of developing goals and a shared vision for the coalition, and how to improve coalition efficiency.

5. Assessing Community Engagement and Coalition Functioning

Section 5 provides guidance on how to measure the quality and implementation of community engagement activities and insights on how to improve community engagement within an existing coalition.

6. Appendices

Appendices include tools that can be used to support coalition building and maintenance, biographies of the technical expert panel, and additional information on the HCS study and guide development.

See **Appendix F** and the HCS website for more information: hcs.rti.org

2. Community Engagement Fundamentals

INTRODUCTION

The opioid overdose crisis has had a generational-defining impact on the United States. From mountain towns in remote Appalachia to bustling cities in the Northeast to the West Coast, no community has been spared. The scale of suffering and loss of life is difficult to grasp. For context, in 2020, one person died of an opioid overdose approximately every 8 minutes. In the same year, more Americans died from a drug overdose than from a motor vehicle accident.[1; 2]

From parents who have lost children to small business owners, practitioners, and policy makers, engaged community members have united to make it their collective responsibility to find local solutions to address the opioid overdose crisis. These efforts are bolstered by experts whose lived experiences help inform strategies to protect the lives of people who use drugs and ultimately to strengthen our communities.

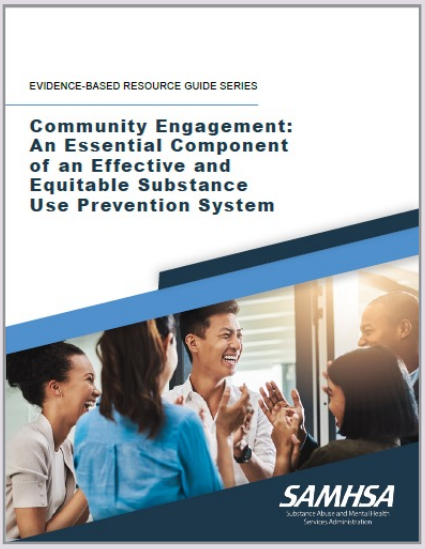
Infused with stories from the field and insights from more than 67 community coalitions across four states participating in the HEALing Communities Study (HCS) and a panel of experts, this guide includes strategies for people and groups committed to ending the opioid overdose crisis. Our focus is on **community coalitions**—groups of people, organizations, community groups, or other bodies who undertake a joint effort to achieve an agreed-upon goal[3]—who are working to end the opioid overdose crisis. Although we share some general fundamentals of community engagement to inform coalition building, our primary focus is on sharing guidance for overcoming some of the unique challenges that may arise when responding to the opioid crisis. These challenges range from addressing stigmatizing beliefs that community members hold about medications for opioid use disorder (MOUD), to ensuring that the coalition is authentically representing the community, to facilitating coalition meetings that bring people who use drugs and law enforcement into the same space. Throughout this guide, we highlight "Stories from the Field," in-depth examples of the challenges coalitions implementing the Communities That HEAL (CTH) intervention faced, their solutions, and their lessons learned. We hope that these insights will inspire you and your coalition to create and sustain effective, community-led change.

WHAT IS COMMUNITY ENGAGEMENT?

Community engagement is defined by the World Health Organization as a "process of developing relationships that enable participants to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes." Community engagement is an ongoing process, not a set of steps to follow and then mark as completed. Genuine engagement seeks to bring together the skills, knowledge, and experiences of the community to create solutions that work for all its members. It aims to ensure that people who are most affected by challenges and inequities have a voice in creating and implementing solutions to accelerate change. For those working to end the opioid overdose crisis, this means working with community members who are most affected by the crisis, including, but not limited to, people with lived experience, service providers, law enforcement, and emergency medical services personnel. We describe exactly who might be at this table and potential ways of engaging them in coalition work within the "Building a Coalition" section.

CORE PRINCIPLES OF COMMUNITY ENGAGEMENT

Community engagement can improve health outcomes, lead to more-tailored programs (i.e., programs that are intended to reach a certain audience), decrease stigma and discrimination, help communities maximize scarce resources, and improve a sense of representation within marginalized communities. The Substance Abuse and Mental Health Services Administration's (SAMHSA's) resource, *Community Engagement: An Essential Component of an Effective and Equitable Substance Use Prevention System*, notes that successful community engagement can take many forms, but shares the following core principles:



Transparency and trust: Community engagement should create an environment where all ideas are respected and considered.

Careful planning and preparation: Community engagement is a rigorous process of organizing around a specific issue.

Inclusion and demographic diversity: Community engagement involves leaders from different sectors of the community, as well as community members themselves. It is important for coalition members to represent the community's diversity.

Collaboration and shared purpose: Community engagement brings together organizations and people around a common purpose or vision.

Openness and learning: Participants should be open to information and ideas from all types of experts.

Impact and action: Community engagement focuses on making a difference and having an effect on the identified topic.

Sustained engagement and participatory culture: Community engagement is ongoing. All participants are valued for their contribution.

COALITION BUILDING AND COMMUNITY ENGAGEMENT

Coalition building is a common approach to community engagement. This guide focuses on engaging communities through building and maintaining coalitions to decrease opioid overdose deaths. The goals of a coalition can be wide ranging, from advocating for specific policy change (e.g., take-home methadone) to sharing resources (e.g., community-based distribution of naloxone).

Coalitions are effective because they can accomplish what would be difficult for an individual to accomplish alone, and they contribute to the community engagement process in several ways. Coalitions can help maximize the influence of people and organizations. Think of a peaceful protest—a group of protestors will most likely be more influential than just one or two. Coalitions can also create new collective resources and connect people to them. Two minds are better than one; in other words, a group working together often creates new ideas and creates them more quickly. And each coalition member brings their own network of connections to the group, therefore creating a larger network for deploying resources and ultimately effecting change.[3]

Evidence-based practices are approaches that have been shown, through research and evaluation, to be effective in decreasing opioid overdose deaths.

COALITION BUILDING AS A PART OF THE CTH INTERVENTION

The CTH intervention engaged communities through coalition building.[4] As part of the intervention, new community coalitions were established, or existing coalitions were enhanced, to support the selection of evidence-based practices for decreasing opioid overdose deaths. These coalitions included members with lived or living experience; representatives from healthcare, behavioral health, and criminal legal systems; policymakers; and other community members. Members worked together using data to prioritize, implement, and monitor evidence-based practices. This guide shares lessons learned and tools from the coalition building work of the CTH to help other communities build and strengthen coalitions committed to addressing the opioid crisis.

COMMUNITY ENGAGEMENT DOS AND DON'TS

Do

☐ **Make time and embrace the process**

Make time to think critically about how you are engaging the community, checking your biases and assumptions, sharing power, and taking the community's lead. Community engagement success lies in the process.

☐ **Be inclusive**

Ask, "Who is in the room and who is not?" Having diverse perspectives is about creating the clearest possible picture of strengths, needs, and solutions.

☐ **Build trust and deeper relationships**

Make sure that roles and responsibilities are clear and decision-making processes are agreed upon.

Engaging community requires bringing ourselves and our identities to the table to build trusting relationships where engagement can thrive. Be vulnerable; share yourself.

☐ **Co-create with shared power and decisions**

Work with communities and share the power of decision-making. The community has expertise that is critical to the success of the program. Listen to what community members want and why before providing input and guidance.

☐ **Be a universally great communicator**

Really, really listen. Be clear and don't use jargon. Use "I" statements. Be present.

☐ **Keep perspective and mess up gracefully**

Remember we are here to save lives together and do less community harm by working with community. You're bound to mess up … try to do so with grace.

☐ **Cultivate the space**

Create spaces where marginalized voices are welcome, disagreement is embraced, and unspoken power dynamics are named.

Don't

☐ **Ignore community engagement and give into stress**

When we are stressed, we are prone to bad decisions and community engagement can take a back seat. But times that can cause stress are often the times to focus most on thoughtful engagement and process.

☐ **Force your agenda**

Don't leverage your expertise over community experience. Check your assumptions, preconceived notions and solutions, and entitlement at the door. Show up to listen and understand before offering guidance.

☐ **Take the path of least resistance**

Confrontation and conflict are key aspects of growth and moving forward. Don't avoid them for the sake of your comfort. Ask tough questions of yourself, your team, and coalitions. Be okay with being asked tough questions.

☐ **Ignore important dynamics**

Keep structural and institutional lenses in mind when working to solve problems and check yourself. Don't try and fix things or people. Don't take up too much space, and don't ignore power dynamics in the room.

Adapted from material developed by

NIH HEAL INITIATIVE

HEALing Communities Study Massachusetts

3. Building a Community Coalition

FRAMEWORK FOR COALITION BUILDING

Understand your community ▶ **Identify potential coalition members** ▶ **Orient members to OUD and EBPs** ▶ **Develop rules of coalition engagment**

1. Understand Your Community

The first step in building a community coalition is gaining a deeper understanding of your community through a community assessment. This assessment should preferably be led by, but at a minimum must involve, those who live in the community and who are intimately familiar with the community's strengths and weaknesses related to the opioid overdose crisis.

Define your community. Before the community assessment, it is important to define the community you are seeking to reach and serve. Specifically, what does community mean to you and potential coalition members? Is it a geographic entity like a town or county, or a sociocultural grouping like a shared faith or cultural background?

Does this community change over time, or is it stable? Could you draw bounds around your community? Who represents the community? Who should speak for the community, even if they are not currently empowered to? Who is most affected by the opioid overdose crisis in your community?

Coalition builders can draft an initial definition of their community to guide community assessment work and coalition member recruitment. However, as members are recruited, the coalition should review and work together to refine their definition of their community.

Engage community experts. You can work with a core group of experts to identify and recruit coalition members and find resources to support coalition efforts. Think beyond academic or technical training—expertise can be deep knowledge of a community or lived experiences relevant to the coalition's work. Ensuring that people most affected by the opioid overdose crisis and those at higher risk of opioid overdose have an active role in building the coalition and goal-setting will maximize the impact of your coalition. Involving these people from the very beginning, before the first coalition meeting is even held, will set the stage for meaningful and thoughtful involvement throughout the coalition's work. Start by reaching out to people you know who are working on addressing the opioid overdose crisis in your community or work in agencies serving people at higher risk of opioid overdose. Share your thoughts about creating a coalition and ask whether they are willing to help by being part of this initial core group.

People to include are:

- **People with lived experience** (i.e., people who currently use or formerly used opioids, or their family members) who can provide key insights on treatment experiences, community-held beliefs that might affect coalition activities, and anticipated challenges and facilitators for implementing evidence-based practices to decrease opioid overdose deaths.

- **Members of local organizations** that deliver services to people at higher risk of opioid overdose (e.g., syringe service programs, addiction treatment organizations) in your community who can share information about how different approaches to decreasing overdose deaths have worked or might work in their settings.

Conduct a community assessment. A community assessment helps answer the question, ***"what is currently being done to address the opioid crisis in my community, and what more can be done?"*** Understanding your community's existing resources to address opioid overdose deaths, gaps in services, and barriers to care is critical for planning an appropriate response to the opioid crisis. This assessment should document the availability of overdose education and naloxone kits and locations treating opioid use disorder (OUD), including medication for opioid use disorder (MOUD). The assessment should also determine whether services are reaching people who are at higher risk for overdose. Speaking with community members, particularly those with lived experience, and with service providers can help identify existing gaps. You can also search online, using Google or another search engine, to identify existing services or organizations in your community.

When seeking community expertise, consider your community's

- **sociodemographic** characteristics (race, ethnicity, age distribution, gender and sexual orientation, etc.);
- **sociocultural** characteristics (political climate, religion, country of origin, languages spoken); and
- **history** of opioid-overdose-related work within the community and key leaders.

The most-successful efforts will establish buy-in and build trust among community members and community leaders and thoughtfully seek out and engage underserved populations.

Tool 1: Guiding Questions For A Community Assessment

Focus	Guiding Questions	Information Sources
Existing Services	• What are existing services for people at higher risk of opioid overdose in your community? • What substance use treatment services are available? – Recovery support? – Social services?	• Speak with community members about available services, including the following members: – People with lived experience, including people who use drugs (PWUD) – Recovery support service providers – Staff at harm reduction agencies – Treatment providers • Search online for community resources • Search for providers using SAMHSA's Buprenorphine Practitioner Locator
Service	• What are the most pressing gaps between existing services and those needed? • What services have people at higher risk of overdose sought out and haven't been able to locate? • What are the greatest needs expressed by community experts? • What populations are underserved?	• Speak with community members about service needs • Recovery support service providers • Staff at harm reduction agencies • Treatment providers

Another approach to a community assessment is **asset mapping**.

Asset mapping is systematic process of cataloging individual-level and organizational resources in a community. Assets may include people trained to provide peer support services to people in recovery, community-based harm reduction programs, or organizations that provide space and support for community outreach. Assets can be marked on a map of your community. Mapping resources helps you "see" available resources for addressing the opioid crisis, as well as areas where more resources are needed.

This type of assessment leads a community to look within for solutions and resources to solve problems. As a result, asset-based mapping fosters a sense of independence, pride, and possibility as the community discovers and appreciates its own resources. Asset-based mapping can empower residents to realize and use their abilities to build and transform their community and to develop self-reliance.

Examples of individual assets

Skills, talents, and experience of residents, individual businesses, and home-based enterprises; social capital; human capital

Examples of organizational assets

Community members' organizations (service clubs, fraternal organizations, athletic clubs), business associations, financial institutions, cultural organizations, communications organizations, and religious organizations

Example questions

- What is something good that happened to your community recently?
- What personal talents or skills can community members contribute?
- What issues or concerns related to opioid use is your community willing to address?
- Who in your community is working to reduce opioid overdose?

Coalition builders can also engage in a **needs-based assessment**. This type of assessment is based on a community need or a problem that concerns the community. This approach looks at gaps and deficiencies and determines needed improvements. Be aware that this type of assessment can lead to the coalition seeking outside assistance rather than looking for community change agents. Because a needs-based assessment focuses on communities' weakness and inabilities, it can discourage community members, who may begin to believe that only outsiders can "fix" them.

Example questions:

- What is the problem we are trying to solve?
- What needs to be accomplished to reach our goals?
- What are the gaps within existing services in our community for people at high risk of opioid overdose?

Other community assessment approaches to consider: Speak with your community experts to decide on the right approach for your coalition. Additional approaches include the following:

- **Community walks**: A physical walk through a neighborhood of interest to map out and collect information about the neighborhood's resources and dynamics. This method provides a firsthand view of the community, its people, and assets. These assets can be placed on your asset map. Consider having people with lived experience (PWLE), peer champions, or other coalition members representative of the community who are familiar with your community's many people and assets lead this walk.
- **Listening tours**: A talk with community experts. Use descriptive and open-ended questions about the community and its potential assets to allow the interviewee to speak freely.
- **Focus groups**: A focus group is a small-group discussion guided by a trained leader. It is used to learn about opinions on designated topics/ assets.
- **Inventories of individual and organizational capacities**: A technique for collecting information about a community through observation. It works best when conducted at a community meeting or gathering. Consider adding inclusion criteria around this task for larger communities (for example, size, service area, or type of service provided).
- **Visioning**: A collaborative, creative process that results in a blueprint for a shared community vision and values. A shared community vision is an overarching goal for the community now and in the future.

More-formal approaches (asset mapping, focus group) can be useful if sharing information with potential funders or with governmental officials. Less-formal approaches (interviews, visioning) may be particularly useful for generating excitement and buy-in from potential coalition members. Feel free to mix and match approaches to gain deeper understanding of the community content.

Additional resources for conducting a community assessment:

- Community Toolbox: Assessing Community Needs and Resources: Features information on how to assess local needs, including how to conduct public forums and listening sessions, needs assessment surveys, and other approaches to community assessment
- CDC Community Health Improvement Navigator: Features tools such as Vulnerable Populations Footprint, Community Need Index, and CDC Community Health Status Indicators

Should I work with an existing coalition? There may already be a coalition in your community that is working to address opioid overdose deaths or on a related issue, such as other substance use. These existing groups may function as a task force, advisory board, working group, or citizens' committee. Existing groups may have been started by community members or established by government officials.

When deciding whether to work with an existing coalition, consider the following:

- Does the mission/purpose of the existing coalition align with reducing opioid overdose deaths?
- What geographic region does it serve?
- What population(s) does it serve?
- How was it established?
- How long it has been in existence?
- Does it have any organizational or government affiliations?
- How is it funded?
- What is its membership size and composition? Does it represent different types of organizations and diverse community members?

Benefits of working with an existing coalition can include avoiding duplication by coordinating efforts, pooling resources and networks, and starting off with a deeper understanding of previous efforts in the community. An important consideration is whether there is bandwidth and interest in addressing specific goals important to the priorities that the core group of your coalition builders named. Existing coalitions may be established in approach, have a fixed way of operations, and possibly be less open to expansion of mission and change. If there is not perfect alignment, but there remains interest in engaging the coalition, it might help to have a memorandum of understanding that sets out expectations and allows your priorities to be addressed.

2. Identify Potential Coalition Members

Who will be invited to join the coalition, and how will you approach them? Before recruiting coalition members, think through the recruitment process and how to best prepare for sustained engagement over time.

How will you reach out to potential coalition members? Develop a recruitment plan that outlines the steps you will take to recruit potential members. For example:

- Develop a 30-second "elevator pitch" describing the local overdose crisis and potential solutions that the coalition could pursue.
- Share the pitch with your core group of community experts and incorporate their input.
- Ask your community experts to recommend potential coalition members (also referred to as "snowball" recruitment) and use the networking capacity of your core group to the fullest.
- Create a tracking form to document outreach and avoid duplication.
- Decide on the method of outreach. Potential methods include face-to-face meetings, phone calls, email, personal letters, mass mailings, flyers, and posters.
  - Note that not all outreach methods are inclusive. Not everyone has a mailing address or a cell phone; therefore, these should not be exclusively relied upon.
  - Carefully craft messaging included on flyers or posters. Avoid stigmatizing language. We do not recommend publicizing that the coalition is recruiting people who use drugs (PWUD) to serve on the coalition; rather, work through personal networks to reach out. More guidance is shared later within this section.
- Plan for one-on-one meetings, preferably face-to-face, with potential coalition members to gauge views on OUD and interest in participating in the coalition.

See **Appendix A** for a Coalition Checklist

Who should be at the table? Who will be most affected by the coalition's work? Who can help move the coalition's work forward? Informed by your community experts and the community assessment, think about the sectors of community life that will need to be at the table and how best to ensure that those sectors are represented. How will you engage the perspectives of those who are most affected (i.e., those who stand to gain or lose) in coalition decision-making?

Who should be at the table:	
People with lived experience	» People who currently use or formerly used opioids, or their family members, who can speak to the needs, challenges, and preferences related to their firsthand experience
Addiction treatment and recovery facilities	» Opioid treatment programs » Settings providing medically managed withdrawal treatment or socially managed withdrawal
Behavioral health	» Providers who are likely to implement evidence-based practices to decrease opioid overdose deaths
Health systems, agencies, and healthcare providers that are likely to implement evidence-based practices to treat with medications for opioid use disorder and to reduce overdose deaths	» Hospitals (emergency departments and other divisions) » Federally qualified health centers » Primary care practices » Pain management clinics » Maternal health practices (OBGYN, Planned Parenthood, etc.) » Pharmacies
Emergency response units from municipal sub-units or geographical areas	» Emergency management services » Fire departments
Local law enforcement and criminal legal organizations	» Jail/prison administrators » Sheriffs » District attorneys » Narcotics squads » Police (can also be considered first responders) » Drug or treatment courts » Family courts » Community supervision » Probation/parole
Harm reduction services	» Syringe exchange programs » Mobile units » Naloxone programs

Continued

Who should be at the table (continued):	
Organizations that address social determinants of health, including social services and entitlement service providers	» Housing service providers (public and private, hotels, etc.) » Transportation outlets/providers » Food insecurity organizations (food pantries, WIC, etc.) » Employers (large and small) » Education (public school administrators, representatives from local colleges, etc.)
Local service organizations, civic leaders, and other potential influencers	» County administrators and supervisors » Legislators » Prevention resource centers and providers
Other potential partners	» Clergy and faith-based organizations serving affected areas of the community » Media and health messaging resources and outlets » Local advocacy organizations (including previously existing local coalitions) » Victim services » Local businesses, Chamber of Commerce » Veterans and organizations serving veterans » Different municipal subunits or geographic areas of the community
Organizations that support specific demographic groups experiencing OUD-related disparities	» Specific age groups (youth, seniors, etc.) » Black, Indigenous, and people of color (BIPOC) communities » Lesbian, gay, bisexual, transgender, queer (LGBTQI+), and other communities supporting individuals who are not cisgender or straight/heterosexual

How can I ensure that the coalition reflects the community? Coalitions should evaluate membership to determine whether the right people, organizations, and voices are included in its operations and decisions. Diversity of membership should be considered in terms of age, gender identity, sexual orientation, race, ethnicity, class, and ability to reflect the underlying demographic makeup of the community. Geographic diversity is also important, including diversity in municipal subunits or geographic areas of the community.

Communities of color have been and remain disproportionately affected by opioid overdose and premature mortality caused by substance use, exclusion from access to high-quality care, and criminalization. Incorporating a health equity lens into recruitment processes can improve the reach and impact of the coalition's work.

Diversity, Equity, and Inclusion (DEI)

Many community-driven organizations have begun insisting on DEI frameworks when partnering with community coalitions. As discussed within this guide, it's important to include PWUD and PWLE. It's equally important to ensure there are others at the table who may have been traditionally overlooked. For example, there are many Black and Brown communities in addition to organizations that serve Black and Brown communities. When building and growing coalitions, it's important to ensure these people and organizations are involved in your work. To do that, you must be deliberate in inviting them to join you. Consider drafting an equity statement to ground your coalition's DEI efforts and sharing it with community members and organizations during outreach.

Sample Equity Statement

Our coalition is committed to promoting and prioritizing racial equity for Black, Brown, and Indigenous people and other people of color. We will strive to ensure equity, diversity, inclusion, and belonging when setting coalition goals and recruiting peer champions to be involved in or lead our efforts. We will be intentional about including Black, Brown, and Indigenous people and other people of color in developing and executing our plans to ensure all voices in our community are heard and all community members have equitable access to any resources our coalition develops.

Prioritizing health equity

Some best practice tools for integrating equity into coalition recruitment and retention include the following:

- The Opioid Crisis and the Black/African American Population: An Urgent Issue
- Racial Equity and Social Justice Process Guide
- Equitable Hiring Tool
- Fast Track Equity Analysis Tool
- Comprehensive Equity Analysis Tool

Should recruitment involve a screening and interview? Consider meeting with potential coalition members one-on-one to share information on the local OUD crisis, discuss potential solutions, and learn more about the potential member informally to determine fit. Determine their availability to participate in coalition meetings and their interest in potential coalition goals.

How to gauge views on OUD and prevention? Recruitment is also an opportunity to better understand a potential member's views about OUD and evidence-based practices to reduce overdose deaths. Does the member hold beliefs relevant to the coalition's work that may need to be considered? For example, a parent who has lost a child to overdose may not be as receptive to harm reduction approaches such as naloxone distribution and prefer to engage in work more focused on prevention of opioid use. A person in recovery may hold certain beliefs regarding different types of treatment and feel uncomfortable working on efforts to expand the use of MOUD vs. other OUD treatment approaches. Listen to their perspective. Think through how best to leverage their experiences to further the work of the coalition. Note any potentially stigmatizing beliefs, and discuss these beliefs further during coalition training opportunities. Is the potential member open to hearing different perspectives? Be up-front from the outset that although a range of perspectives will be represented within the coalition, stigmatizing language will not be acceptable, and respect for all persons, including those actively using, will be a coalition norm. If the member's views do not seem compatible, be clear and forthright to avoid mismanaged expectations.

How to recruit people with lived experience in a way that protects their well-being? As coalitions tasked with prioritizing our community's needs, we must listen to those in the community most committed to and affected by our work. For initial recruitment, consider complementing existing efforts with a focus on engaging with and recruiting PWLE:

- Leverage existing community workgroups and coalitions not only to increase membership but also to learn how they recruited members with lived experience or members who actively use drugs.
- Relevant groups may be referred to as task forces, community advisory boards, working groups, citizens' committees, or something else.

Prioritizing the Voices of PWLE/ PWUD

Harm reduction, considered a social policy and public health model, was born out of grassroots efforts by PWUD and community activists. PWUD play a critical role in identifying emerging issues, particularly in the evolving drug supply as well as associated health behaviors and outcomes.

PWUD are the only population at risk for overdose and, therefore, the very people our work as a community coalition must prioritize and protect. We need their expertise and lived experience to be successful.

- When deciding what groups to prioritize for potential partnerships, consider what's most important for your members and your work to ensure a good fit. For example, your coalition may prioritize racial equity. It will be important to have candid conversations with potential partners to ensure they, too, are committed to equity for community members who have been systematically underserved and discriminately affected by fatal overdose. (See also the Sample Equity Statement.)
- Work with your local brick-and-mortar harm reduction services, syringe service programs, and opioid treatment programs to learn about their experiences and ask for their help. They most likely know of an individual or a group that is well-connected within the community and can be the voice of those your coalition aims to support (e.g., a community peer or community champion). (See also Coalition Roles: Chairs and Champions.)
- Work with your local leaders to generate a list of existing initiatives, coalitions, or community workgroups who prioritize PWLE membership.

Making these connections and building these relationships takes time. Take small steps. Start with what you know and who you know. Next, supplement that knowledge with information publicly available online. You can be confident in knowing that you are not starting at zero, but rather, building on the successes and lessons learned of those in your community committed to a similar cause. You'll also have the opportunity to pay it forward to the next group looking for *your* advice.

When speaking with potential coalition members with lived experience, consider the following best practices:

> *"The emphasis here is on inclusion. Not representation, not membership. We are not checking a box. We should focus on the process or the processes of inclusion instead of representation or membership. Using a phrase like 'PWLE membership is required/not required' is actually the antithesis of our coalition's efforts to be inclusive."*
>
> —Coalition Inclusion Champion

- Emphasize that participation in the coalition or coalition work will not be connected to any criminal legal purpose, particularly when including law enforcement representation within the coalition.
- Recognize publicly and privately that their knowledge is valuable.
- Allow people to decide on how to introduce themselves and their story. Accept that "PWUD" or "PWLE" may not be what these experts want to be called.

- Do not require people to share their story or disclose their experience. Offer to keep documentation related to personal experiences at a minimum if documentation presents a barrier.
- Avoid tokenism, or only inviting an individual from an underrepresented group to participate to give the appearance that the coalition is diverse and inclusive. Be intentional about inviting PWLE and PWUD to participate in the coalition and creating a coalition culture where they are welcomed, empowered to engage, and valued.
- Don't assume that one individual or a few people can speak for an entire group of people. Seek out multiple perspectives.
- Emphasize that the knowledge and insights of PWLE will be incorporated meaningfully into coalition decision-making.
- Consider reimbursing people for transportation costs or time related to attending coalition meetings, if funding is available, and share this information during recruitment.

Peer Bill of Rights

Consider asking your peer champions to create a bill of rights for your coalition. This not only empowers your peer champions to take ownership but also ensures that all coalition members and community partners maintain respect for all people (i.e., treat one another fairly, with dignity and equity, and support each other to develop your full potential).

Some example rights from the Peer Network of New York's Peer Bill of Rights include the following:

- "Every Peer has the right to be included in the process of making decisions about POLICY and ADVOCACY efforts that impact Peers"
- "Every Peer has the right to be supported in fighting the fear, shame, and stigma that keeps us from participating in our communities and from accessing health services"
- "Every Peer has the right to be supported in developing our skills and knowledge so we can become better harm reduction educators and advocates, and eventually lead and run professional organizations"

Additional resources for engaging people who are actively using drugs

- International Network of People who Use Drugs (INPUD)
- National Harm Reduction Coalition
- National Harm Reduction Technical Assistance Center: offers access to free help in providing or planning to provide harm reduction services
- Hazelden Betty Ford is a national organization offering peer-run training and technical assistance focused on keeping peer integrity first with strength-based delivery

How to achieve buy-in from agencies working to address the opioid overdose crisis? Informed by your community assessment, reach out to organizations that serve people at higher risk of overdose (e.g., harm reduction services, treatment providers, social services, local community groups). Request a brief meeting to share the initial coalition vision (e.g., reducing opioid overdose deaths in your community). Gauge interest in participating by asking whether they would like to send a representative to the initial coalition meeting. Emphasize that participation is voluntary.

If there is a long list of potential members, how will you narrow down the list? Engaging in initial one-on-one meetings with potential members can help determine their fit, availability, and interest in serving on the coalition. Note that there is no one ideal coalition size, and meeting attendance will likely fluctuate over time (see call-out box).

Insights from the implementation of the Communities That HEAL Intervention

Coalition membership, meeting frequency, and attendance

- **No one coalition size fits all communities**: Across the 67 coalitions, coalitions had between 17 and 44 members, reflecting 9 to 23 different organizations per community.
- **Expect meeting attendance to fluctuate over time**: Coalitions held monthly meetings that, on average, were attended by 9 to 19 coalition members. Over a 30-month period, coalition members attended an average of 6.5 meetings. Approximately 30% of coalition members only attended 1 meeting, 50% attended 2 to 11 meetings, and 22% attended 12 or more meetings over the 30 months.

3. Orient Potential Members to the Opioid Crisis in Their Community and Possible Solutions

Local OUD epidemiology. To have the biggest impact, your potential members must first understand the local opioid overdose epidemic. Seek to answer the following questions:

- Who is overdosing (e.g., age, race, ethnicity)?
- Where is overdose occurring (e.g., which neighborhoods)?
- In what settings are people overdosing (e.g., shelters, public restrooms, motels, residential settings)?

Use public health surveillance data, mortality data from the medical examiner's office, data from emergency medical services, or conversations with local harm reduction agencies to answer these questions. Examining your community's local overdose data enables you to better understand which people should be prioritized for receiving services and what solutions might work best.

> *When discussing data among coalition or community members, remember that in smaller circles, small numbers may be identifiable as lost or impacted loved ones. Encourage your teams to acknowledge this prior to discussing data.* ***We never want to lose sight that each data point represents a human life.***

Potential solutions. It can be overwhelming to navigate the literature to search for evidence-based practices related to OUD. Equally challenging is orienting potential coalition members to available solutions in an accessible, easy-to-understand manner. However, during initial meetings with potential coalition members, it is useful to discuss the potential activities the coalition could engage in. Remember that your goal is not to make every potential coalition member an expert in all possible strategies the coalition might pursue. Rather, your goal is to introduce the "toolbox" of different approaches that have a strong base of evidence to support their implementation. Refer to our companion practice guide, *Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) Practice Guide*, for a menu of evidence-based strategies proven to decrease opioid overdose deaths, along with tips and case examples from coalitions.

This initial discussion with potential coalition members is to think through the type of work that the coalition could perform, informed by the local OUD crisis and findings from the community assessment. What kind of work could the coalition do? This is also a chance to get excited about the things that a coalition could accomplish and highlight why the coalition is needed. For example, if your community assessment identifies that there are few or no locations for people to pick up a naloxone kit (i.e., overdose education and naloxone distribution [OEND]), you might discuss identifying a local medical provider who could assist in training and hosting a booth at a community event giving out free naloxone kits and information on overdose prevention.

We recommend providing in-depth training on evidence-based practice to decrease opioid overdose deaths for coalition members following the first coalition meeting (see Potential training topic: Scope of opioid overdose crisis).

4. Develop rules of coalition engagement

Plan and hold the first meeting. After working with your core group of community experts to conduct a community assessment and recruit potential coalition members, it is time to plan and hold your first meeting. Ideally, this meeting will be collaborative and have an energy and momentum that will inspire action. While acknowledging that the opioid overdose crisis is a serious topic and many have suffered and lost, cultivating a sense of hope and action will help people come back for future meetings with the enthusiasm and drive to work on the issue.

An agenda for this initial meeting could include the following:

- **Introduce all attendees**: Ask people to give a brief statement of who they are and what issue they are most excited to work on. If appropriate, consider adding a neutral easy-to-answer icebreaker question like "What is your favorite hobby?/What is your favorite local treat?/What is your favorite movie?" to encourage connections and bring energy to the meeting.
- **Orient attendees to the local OUD crisis and community assessment findings**: In a focused, brief presentation, share findings related to the community assessment and the local OUD crisis. Consider showing a short slide presentation displaying maps or main findings to walk through as a group. Ideally, have one of the core community experts share these findings.
- **Agree on coalition goal and purpose**: What is the coalition's overarching goal? It can be as simple as "reduce opioid-related overdose deaths." However, leave enough time and space to engage all members in this discussion. Spending time early on will avoid misunderstanding and conflict later. Note that setting specific goals related to this overarching goal will be a continuous process.
- **Discuss coalition operations**: Using a draft charter (see Draft a Charter) and draft coalition operations, walk through decisions regarding how the coalition will be run and ensure that all attendees feel involved.

Working with a pre-existing coalition?

- The initial meeting can focus on introductions and reviewing a summary of coalition activities to date as well as the community assessment.
- This first meeting provides an opportunity for existing coalitions to get a "fresh start" and become energized by a new way to function.
- Note that not all coalition members will welcome change, and there can be confusion about roles and responsibilities. Therefore, a coalition and community assessment before this first meeting is critical to diffuse some of the skepticism that may arise.

Encourage members to speak up regarding their preferences and aim for consensus. OUD and treatment can be polarizing topics, so it is important that the group establish a process for making decisions when there are disagreements.

- **Decide on initial coalition roles**: Typical coalition roles include a chair and co-chair. Consider holding an election or a nominating process to select a chair. Champions can be coalition members who champion specific issues or coalition activities; the "champion" role is further described below in the section titled Coalition Roles: Chairs and Champions.
- **Establish coalition norms**: To ensure all coalition members feel safe in the meeting environment and to foster a culture of respect, discuss and establish coalition norms. Some suggested norms for consideration are described in Decide on Coalition Norms.
- **Review action items and responsible members**: Decide on actions to be taken before the next coalition meeting and who will accomplish them. This can include things like sharing the charter for final review and approval, sharing meeting notes, following up on questions regarding the local OUD presentation, or reaching out to additional potential coalition members. If known, share the next meeting date so attendees are aware.

Make sure to follow up with attendees promptly with meeting notes and any action items. Request that attendees think about others who might be interested in participating in the coalition and continue recruitment efforts, if needed. Celebrate the success of the first meeting!

Draft a charter (for a new coalition) or memorandum of understanding (for partnering with an existing coalition). It's important to decide how the coalition will function and operate and to document these decisions in writing. For example, how often will the coalition meet? How will decisions be made? These details can be documented in a charter or in operating procedures that should be easily accessible for all coalition members.

See **Appendix B** for a Charter Template

Operating principles and protocols can be documented in a charter, membership agreement, or similar document. **Table 1** lists key elements to cover in a charter and operating procedures. See **Appendix B** for an example coalition charter template. Elements to consider including within coalition operating procedures are presented under Draft Coalition Operating Procedures.

Drafting a document for the coalition to discuss, rather than generating one from scratch during a meeting, will be more efficient and allows the coalition to engage in decision-making regarding coalition activities (rather than logistics) from the start. Before the first coalition meeting, start a draft charter that can be used to guide the coalition through determining how the coalition will function.

The purpose of a charter is to guide coalitions. Charters standardize the procedures of the coalition and create a set of norms that allow the coalition to orient new members to the coalition's culture. The charter development process should involve everyone, be engaging, and generate ideas from all members of the coalition. It is important to spend enough time on the charter so that coalition members fully understand it and agree that the structure and processes are fair, balanced, and legitimate.

Generally, charters will include the following elements:

Table 1. Elements of coalition charter

Element	Brief Description	Key Considerations
Goals and purpose	A high-level summary of what the coalition is aiming to do	Clearly state the impact the coalition hopes to have on the opioid crisis.
Member responsibilities and membership	• Attendance and participation expectations • Term limits • Procedure for new members joining the coalition (Who orients members? What training is provided?) • Procedure for existing members (Is there a debrief? How do you ensure continuity of activities?)	• Incorporate membership targets that relate to the goals of the coalition (e.g., ensure representation of healthcare providers, criminal legal system, people with lived experience). • State membership targets around community representation.
Equity statement	A statement of the coalition's commitment to equity, diversity, and inclusion	See Diversity, Equity, and Inclusion (DEI) for more information.
Coalition structure	• Description of key leadership positions (e.g., coalition chair, co-chair, champions) and responsibilities • Description of any committees and process of creating or disbanding	Suggested champion roles and committees are at Determine Coalition Roles: Chairs and Champions.

Continued

Element	Brief Description	Key Considerations
Decision-making process	• Approach taken to making coalition decisions (democratic process vs. consensus building vs. another approach) with specifics (for example, XX percent of membership must be present for a vote to take place) • Clarification of who can vote for coalition decisions • Build in options for electronic voting • Include a time limit on voting	Carefully consider how to encourage engagement in decision-making for marginalized populations and people with lived experience. Coalition leadership should be sensitive to the fact that coalition members have likely had experiences of not being included within decisions that affected them directly. Ensure power sharing.
Fiscal management and budgeting	• Details of how fiscal decisions will be recorded, monitored, and reported back to the coalition	Ensure that any funding requirements from grants or government partners are considered.
Meeting operations	• Description of meeting frequency (quarterly, monthly, etc.), platform (in person, Zoom), facilitation, communication (notes, slides shared, etc.), and documentation	Consider including relevant protocols for sharing sensitive content (e.g., no personal identifiers when disclosing past or current substance use, incorporating notices before sharing potentially distressing information).
Privacy and confidentiality	• Clarification of whether information shared during coalition meetings is confidential or public • Plans for recording meetings or opening the meetings to the public	Set expectations regarding any recording or photos. For example, coalition members will be notified at least 24 hours ahead of time if the meeting will be recorded.
Compensation	• Description of protocol and expectations related to reimbursing members for meeting attendance	Reimbursement can be used to help offset expenses related to participating in coalition meetings (e.g., transportation, childcare costs), Note that this amount should correspond with the time commitment required to fill the role, and it should not be coercive.

Note that charters are dynamic and can change over time, but changes should follow processes developed by the coalition, which can be outlined in the charter.

Draft coalition operating procedures. Coalition operating procedures should cover the following elements:

Timelines: Most coalitions need rapid progress, so procedures must orient coalitions to necessary timelines. If your coalition has received any sort of external funding (e.g., grants, awards), it is important to have transparent and open communication around the tasks that need to be completed on time to meet your funders' requirements.

Organization of meetings: Meetings should be scheduled in advance at regular times and intervals. When working with existing coalitions, the structure of existing meeting schedules and meeting frequency should be honored. It may be useful to develop a standing agenda that is distributed ahead of and at the meeting. Respecting your members' time is helpful for maintaining engagement.

Meeting locations: Face-to-face meetings are preferable. If desired, meetings may be held in different locations to make the burden of travel more equitable. Coalition members may decide to allow video or audio participation.

Documentation of meetings: Meetings may be recorded to facilitate generation of minutes. Meeting minutes and decisions should be documented using a structured meeting minutes form.

Communication among coalition members: Coalitions may establish ways to maintain contact with one another, local/county leadership, and outside groups. Be sure to consider equity when determining how best to reach all members. Some may have access to email while others don't.

Like charters, operating procedures are dynamic and change over time. Building in a regular review process to update them can help ensure your coalition functioning is thoughtfully considered and updated over time.

Determine coalition roles: chairs and champions. Establish roles needed to manage and run the coalition.

These roles can include the following:

- A **chair and co-chair for the overall coalition**. These people are responsible for overall leadership and decision-making of the coalition. This leader organizes the monthly meeting agendas, ensuring they align with the coalition's goals; meets with the community as needed; and reviews action items, decisions, and minutes.

See **Appendix C** for a sample role description of a potential full-time employee focused on community coalition coordination

See **Appendix D** for a coalition assessment tool

- **Champions**. People who are particularly driven to work on a particular issue may be interested in serving as a champion. Champions can agree to report back to the coalition on their issue of focus or perform actions related to the issue. If enough coalition members are interested, a committee (led by the champion) can be formed. Champion roles could include the following:
  - ***Peer Champion:*** Brings their lived experience from the community. Peer champions can lead recruitment efforts, advise coalition leadership, and provide trainings.
  - ***Community Engagement Champion:*** Leads recruitment efforts and new member orientation; coordinates community engagement training for coalition members.
  - ***Community Data Champion:*** Updates coalition with recent information on the local OUD epidemic.
  - ***Criminal Legal Champion (or Liaison):*** Assesses availability of and accessibility to community resources for people experiencing incarceration (e.g., access to naloxone and MOUD within local prisons and jails).
  - ***Harm Reduction and Outreach Champion***: Assesses availability of and accessibility to harm reduction resources and coordinates outreach with agencies (e.g., syringe service programs, OEND programming).
  - ***Housing and Community Benefits Champion:*** Assesses availability of and accessibility to social services, such as access to safe, temporary housing for PWUD.
  - ***Communication Champion:*** Develops and disseminates communication (e.g., social media posts, newsletters, local news pieces) regarding coalition activities.

Prioritizing the Voices of PWLE/ PWUD

Consider nominating a Peer Champion for your workgroup. This Peer, or Community, Champion will work with their peer networks outside of the coalition while reporting insights to the workgroup to ensure anonymity and safety to peers and current and future coalition members. You may also want to consider forming smaller working groups or subcommittees to foster a safe space and open dialog for your PWUD Peer Champions to share important insights from the community.

Decide on coalition norms. It is critical to establish a set of coalition norms that help create an environment where all members feel comfortable participating and different perspectives are respected. This is particularly important for marginalized groups, such as PWUD, BIPOC, and LGBTQI+. Clear norms can also help foster a safe and welcoming

environment for people who may be triggered by coalition discussions and work, such as people in recovery or people who have lost loved ones to opioid overdose.

These norms can be discussed and decided upon during the first coalition meeting. The following questions can help guide this conversation:

- How can we ensure that everyone has time to voice opinions and concerns?
- How do we want to handle differences in opinion?
- How can we ensure that everyone understands the discussion, without using unfamiliar terms, technical jargon, or acronyms?
- How will we handle discussions that we do not have time to complete during coalition meetings?

Welcome discussion about these norms and, as a group, decide how the coalition will strive to handle these issues.

Be clear about what type of behavior will not be tolerated (for example, use of stigmatizing language or personal insults).

Essential Element: Ensuring PWLE Are Empowered to Engage

What should we do if someone uses stigmatizing language during a coalition meeting?

Coalition norms should empower coalition members to point out any use of stigmatizing language. Understandably, this can be awkward and can make people feel uncomfortable. The following are some tips or suggestions for how to address the use of stigmatizing language:

- Orient coalition members to person-first language and preferred terms related to OUD (e.g., use “patient,” “person with OUD,” or “person in recovery” rather than “addict” or “user”) at initial meetings. These resources can be helpful in guiding this orientation.
- Let people choose how they are described. Terminology may shift.
- Foster an environment of learning together. Even the most well-meaning person can say the wrong thing or state something that can perpetuate stigma. With the goal of educating others, challenge inaccuracies and guide people to the preferred terminology.
- On the other hand, it can be frustrating to feel responsible for educating others and doing so can lead to people feeling burned out. Allow people to share their thoughts, anonymously, with the coalition chair during or after a meeting so the responsibility doesn’t fall only on certain people to advocate for change.

How can we ensure that people with lived experience feel safe and comfortable participating in coalition meetings?

- Foster an environment of listening and open-mindedness.
- Model respectful, person-first language and discuss impact of stigmatizing terms.
- Identify a meeting place that accommodates the needs and requests of people to ensure everyone feels comfortable and safe participating.
- Collectively decide on expectations. For example:
  - If someone uses substances on site, do they want intervention?
  - Any recording, written, audio, or video, will be clearly announced to all.
- Have a plan in place for if and when discussion becomes triggering or distressing. Is there a physical space set aside where coalition members can have a private moment? Is there an easily sharable resource list that might assist in immediate needs (e.g., safe housing, bridge treatment, mental health resources)?
- Understand that it is likely that many coalition members have experienced stigma from healthcare providers, law enforcement, and others represented within the coalition. Interactions may step outside previous relational boundaries. Be willing to take this journey together, knowing it could be vulnerable for all parties. Don't mistake passion for anger.
- Advocate that everyone deserves health and wellness, including those actively using drugs.
- Be willing to have tough conversations with everyone, including people with lived experience.
- Understand that people who are actively using, unhoused, or experiencing

Engaging PWLE Through a Peer Recovery Coach and Peer Champion with Lived Experience

Boston, Massachusetts

Our Community Advisory Board (CAB) encouraged inclusion and engagement with people who were current and former users of drugs. Some people disclosed this information; others did not. **Paul Bowman**, a prominent advocate dedicated to reducing opioid overdose deaths, served as one of our CAB's experts.

He leveraged his lived experience with recovery and substance use disorder to help ensure a safe space for all coalition members to engage and share stories to inform our work. He kept us on our toes by bringing up the most important issues that people who were using drugs were facing, what support they needed, who wanted to elevate their voices, and who preferred to provide insight anonymously. He did not shy away from anything; he made sure we were facing issues head-on and in real-time.

> *He was really a hero for all of us, and we have been able to ensure his influence and legacy is part of our work.*
>
> —Erin Gibson, HCS-MA

significant challenges may have difficulty seeing the coalition's bigger picture because of their immediate present challenges. Be able to bring in the vision and convey, with compassion, that certain actions or statements might not be appropriate if you are seeking to build bridges.

- Ground discussion in an understanding that the coalition is about "us" as a community and not "them" as people with lived experience.
- Emphasize at every meeting: "Nothing about us, without us".

What if the coalition loses a coalition member or peer to overdose?

Many of us have experienced loss or death in our lives. Given the work we do, these experiences may include the death of a loved one to opioid overdose. If a coalition member, peer champion, or any individual you work with loses their life to overdose, it is important to be prepared to come together to support one another while honoring your colleague's life.

You may want to address this possibility in case it occurs. Consider discussing how your coalition would choose to act in this situation. It will be important to sufficiently acknowledge the loss with respect to both the individual who has died and all coalition or community members who knew them.

Consider drafting a plan for meetings following loss. Create time and space for a moment of silence. You may want to ask whether coalition members want to share stories. Offer an opportunity to create a mural or another type of memorial to honor the person who passed away.

It will be helpful to establish open dialog around trauma, mental health, and coping strategies as a norm. Consider having a professional grief counselor attend this meeting, and ensure that coalition members are aware that the counselor is available. Learn to Cope and Support After a Death by Overdose are two existing agencies that can assist and even provide services following a substance-use-related death. Remember that we all react differently to different situations, and coalition members may be re-traumatized by an overdose death. Acknowledge and embrace all emotions and focus your time together as much as possible. Allow for open dialog and consider focusing on the core actions (see below).

Core Actions

The following suggestions are from Coping with Overdose Fatalities: Tools for Public Health Workers and based on work from Hobfoll et al.:

1. Promote **safety**
   - Ensure basic needs are met (food, water, medical care, etc.)
   - Advise on the risks of using substances to cope
   - Respond decisively if coalition members express an intent to harm themselves or others
2. Promote **calm**
   - Only share information you know is accurate
   - Listen calmly and without judgement
   - Normalize the sharing of difficult-to-process and intense emotions
3. Promote **connectedness**
   - Find a way for people who have shared the experience to be together to process emotions
   - Establish a norm that members can avoid being in situations or around people that are not healing
   - Have resources and support at hand
4. Promote **hope**
   - Share simple messages of hope. For example, "As hard as this is, I believe we are doing a good job," or "I just believe in helping the next person if we can."
   - Stay away from cliché phrases such as "This too shall pass."
   - Invite coalition members to discuss the reasons why they do this work.

Source: Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., ... Ursano. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry, 70*(4), 283–315

Challenges and Solutions

The previous section outlined the initial steps in building a coalition and some key considerations. This next section addresses some potential challenges that might arise in the process of building a coalition.

Challenge: Avoiding an "us vs. them" mentality

An "us vs. them" mentality can hurt coalitions. The "us" and "them" can range widely, from housed vs. unhoused, experiences with using drugs vs. no drug use, or those who want local treatment vs. those who do not want treatment in their neighborhood.

Solution: Build diverse membership[5]

Why this is important: Involving people who represent the community increases the impact of your coalition's strategy planning and implementation. Including diverse sectors promotes collaboration, builds stronger bridges to the target populations, pools resources, and builds your influence in the community.

> *If you are working in a community where a foreign language is predominantly used and all your materials are in English, this signals 'this information is not for you.'*
>
> —Pedro Alvarez, Assistant Director of Urban Drug User Health & Outreach, MA

Potential solutions: Find people with lived experience, publicly recognize that their knowledge is valuable, and help them feel empowered. The coalition should consider and use their experiences to inform the coalition's actions. Remember that experts who have worked for a long time in the community aren't necessarily enough. Engage people who are actively living in the communities affected by the opioid crisis. Help community members get involved, and consider compensating people for their time and contributions. Be willing to have tough conversations and build bridges. Lastly, understand that language matters, as it can be stigmatizing and harmful.[6] Do think about the language used when recruiting coalition members and understand what language stigmatizes your community. Signal respect and a desire to work together.

Challenge: "The coalition can't agree on anything" or "Members don't feel like they are part of the coalition"

Without cohesion, a lack of engagement can arise, and this can hinder decision-making. Additionally, a lack of cohesion can hurt the efficiency of the coalition.

> *It almost felt like coalition members were just there to be part of the show. They were just there to do what they were told to do. They were getting things done but there was no sense of cohesiveness.*
>
> —Community Engagement Project Manager, OH

Solution: Build coalition cohesion

Why this is important: Feelings of unity, trust, and belonging are a few common features of a cohesive coalition. Cohesion among members appears as strong interpersonal relationships and effective collaboration strategies. Organizational cohesion leads to member satisfaction, commitment, and retention. A cohesive coalition has a positive work environment where members develop trust with each other and are capable of resolving conflicts.

Potential solutions: Cohesion is built through membership. Who are you engaging? Who is represented? Evaluate the signs of cohesion: did a charter result from a collaborative process? Is everyone's voice being heard? Has everyone signed onto one shared goal? Shared goals help ensure cohesion. Cohesion needs to be maintained and addressed in every meeting. Review the decided-upon process of working through disagreements.

Challenge: Coalition members don't feel like they are accomplishing much

For the coalition to run smoothly, members need to be encouraged to take on a variety of roles and responsibilities. These roles can be tied to the members' expertise, abilities, and interests.

Solution: Provide opportunities for member participation

Why this is important: Recruiting members into the coalition can be easy, but if opportunities for participation are not available or provided, they may not feel like they are accomplishing anything, and retention may become an issue. Research has shown that coalition members taking on significant roles creates an empowering environment.[7] Additionally, providing a range of opportunities to members not only supports the coalitions' goal but also helps build members' skills and competencies.

Potential solutions: Empower and educate members to be champions or create and serve on sub committees. These roles empower people to engage and help others engage. Be explicit about the goals of your coalition and ensure members goals align. For example, during meetings, share a list of questions for discussion, form smaller focused groups for specific questions, and have people rotate groups to ensure everyone can share their perspective.

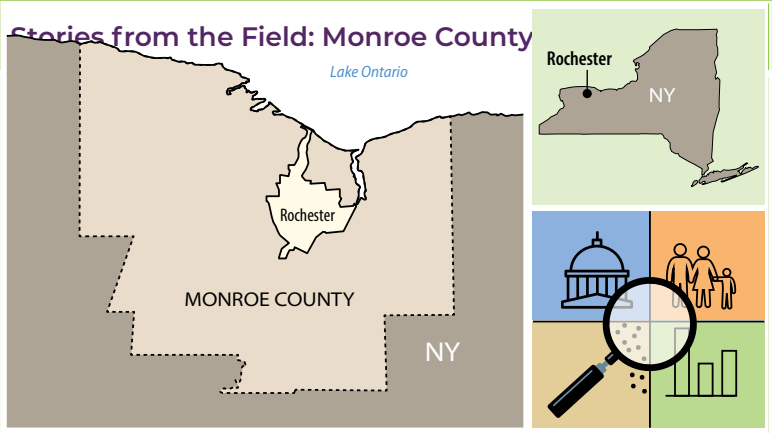
Additional resources for coalition building:

Creating Inclusive Prevention Organizations and Coalitions – Webinar

Building Strong Prevention Coalitions – Webinar

Coalition Building: Recruitment and Retention – Webinar

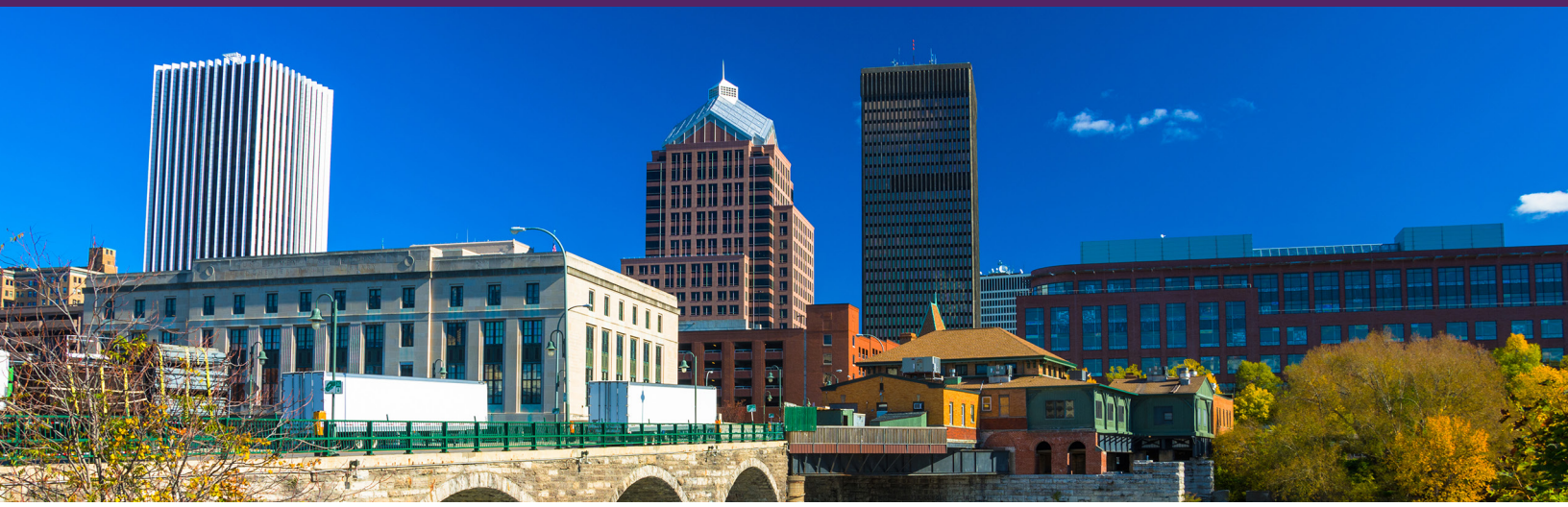
Coalition Building: Coalition Design & Member Engagement – Webinar



STORIES FROM THE FIELD

Utilizing a **readiness assessment** and **coalition membership checklist** to build and engage a coalition that aligns with the community's priorities, experience, and capacity for **opioid overdose prevention in Rochester, New York.**

ROCHESTER · MONROE COUNTY, NEW YORK



Rochester is a large urban community in Western New York covering 35 square miles. With a population of more than 210,000, it is the third most populated city in New York and one of the most racially and ethnically diverse, with nearly 49 percent African American/Black and 19 percent Latino residents.

The median household income is $40,083. Almost a third of the population (about 29 percent) is living in poverty.[8]

Major employers in this community include the University of Rochester, Wegmans, Rochester Regional Health, and Xerox.

Rochester is known for its historical buildings and colleges. It also has a social justice legacy, as the home of historical figures Fredrick Douglass, Harriet Tubman, and Susan B. Anthony.

Authors: Tim Hunt, PhD, Co-Investigator & Intervention & Community Engagement Investigative Lead, New York HEALing Communities Study; Emma Rodgers, MPH, Director of Community Engagement, New York HEALing Communities Study; Frankie Sampson, LMSW, Program Manager, Rochester HEALing Communities Study, Monroe County Department of Public Health.

SUBSTANCE USE AND THE OPIOID CRISIS

- In the early 2000s, Eastman Kodak, Bausch and Lomb, and Xerox downsized
- The community's economic system and the Rochester City School District began experiencing a rise in poverty, crime, and substance use
- In response, local county leaders and partner organizations began enhancing efforts to combat the rise in substance use and opioid overdose deaths
- The Finger Lakes Prevention Resource Center of the National Council on Alcoholism and Drug Dependence-Rochester and the Monroe County Heroin Task Force partnered with local substance use treatment providers, advocacy agencies, and people with lived experiences to provide education and resources with a goal of decreasing unnecessary deaths

RATE OF FATAL OPIOID OVERDOSES IN MONROE COUNTY (31.2 PER 100,000) IN 2020[9]

In 2020, opioid overdose deaths increased 38 percent nationally and 44 percent in New York. Drug overdose death rates increased across all racial and ethnic groups, nearly five-fold for Black New Yorkers, quadrupling for Hispanic or Latino New Yorkers, and tripling for White New Yorkers.[10]

MONROE COUNTY COALITION

The Monroe County Coalition shares workgroup updates during their monthly coalition meeting and engages attendees in ideas sharing and decision-making.

Uplift Irondequoit, Helio Health, Rochester Police Department, Hope Dealers Anonymous, Catholic Ministries, and members of the Monroe County Coalition, work together during Drug Take Back Day in Rochester.

Monthly community naloxone training where community members were invited to become part of the coalition.

Local event hosted by the Monroe County Coalition at a library in Rochester to provide Naloxone education and trainings and information on overdose awareness and the dangers of fentanyl in the community.

Solution: Create a local and racially/ethnically diverse coalition focused on local issues

> *Developing a uniform and culturally competent approach to community engagement is vital in providing an all-encompassing plan of care to African American, Black, Latino individuals, and other minorities in need of substance use treatment, while addressing racial inequalities will prompt positive change.*
>
> — Frankie M. Sampson, LMSW, Program Manager, Rochester HEALing Communities Study, Monroe County Department of Public Health

Challenge: How to successfully engage a community around opioid overdose prevention

- How do we build a multisector and diverse coalition with members who represent our community and have a good understanding of its assets and needs?
- How do we accurately define the problem(s), choose and implement appropriate strategy to effectively address the problem(s), and sustain our efforts?
- Although many county-wide coalitions have focused on reducing opioid overdose deaths, few have targeted the city of Rochester or represented people of color and the organizations that serve them.

STEP 1 We completed a readiness assessment.

The readiness assessment aimed to ensure that our coalition had a deepened understanding of the opioid crisis in Rochester. The tool included questions about

- community demographics;
- overdose rates;
- resources and programs—past and present—for medications for opioid use disorder (MOUD) and overdose education and naloxone distribution (OEND);
- the history and composition of existing coalitions in Rochester and Monroe County focused on the opioid crisis; and
- a list of MOUD, OEND, and Safer Prescribing and Dispensing strategies and communications campaigns currently or formerly implemented in the community.

The tool would help us understand our ability to obtain and share local data and how best to create and sustain relationships with the medical examiner and county coroner.

The readiness assessment is a valuable tool to help coalitions better understand the current climate in their communities and current and previous work to address the opioid crisis. Through the assessment, coalitions may engage with local leadership to solicit feedback on gaps and opportunities to successfully **address the opioid crisis at the local level.**

See **Appendix E** for Coalition Readiness Assessment

Example Questions

- Describe the community. Is it a rural or urban community? What is the population? How many people overdosed in the previous year (fatal and non-fatal)? How many MOUD providers are there? How much naloxone was distributed and by whom?
- What is the history and structure of current coalitions? The perspective and role of county leadership on the opioid crisis?
- What evidenced-based practices are currently being implemented in the community to address the opioids crisis? What was implemented in the past?

STEP 2 We developed a coalition membership checklist.

The coalition membership checklist was used to identify and recruit coalition members who could help with selecting and adopting evidence-based practices within and among Monroe County's healthcare, behavioral health, and criminal justice sectors and settings. The checklist built on information gathered in the readiness assessment and provided detailed information on organizations and people from those organizations who would be active members of the coalition. People with lived experience (PWLE), including people who use drugs (PWUD), and organizations that support specific demographic groups and geographic areas were seen as the priorities for recruiting key coalition partners.

- The coalition membership checklist provided clear guidance on which organizations and individuals the coalition needed to recruit. Recruitment informed by the checklist inspired important discussions about who has been missing from the table historically, how PWLE and PWUD should be not only involved but also in leadership roles, and **the level of influence each coalition member has within their organization to champion and effect change.**

Both the readiness assessment and the **coalition membership checklist** helped us identify the need for building ongoing relationships with community members, partner organizations, and local leaders. With knowledge gained from these tools, we were able to design our community forums to address barriers, including lack of knowledge of local overdose data, that African American/Black and Latino/Latina people were facing.

See **Appendix A** for Coalition Membership Checklist

Sample Questions

- Are there people with living and lived experience who can speak to needs, challenges, and preferences in their community?
- Are there organizations that support specific demographic groups, including specific age groups (youth, seniors, etc.), Black, Indigenous, and people of color (BIPOC) communities, and LGBTQI+?
- How does your implementation and leadership team reflect the communities that this coalition is engaging?
- Are there people who represent health systems, agencies, and health providers that are likely to implement evidence-based practices to treat with MOUD and to reduce overdose deaths?

TIPS FOR YOUR COMMUNITY

> *It is extremely vital to have the presence and buy-in of leadership and community partners to support creative implementation backed by evidence based-practices to increase progress in reducing opioid fatalities and to get buy-in from the community.*
>
> —Monroe County Coalition member

- **The readiness assessment is most useful when the data are current and information is gathered from multiple sources**—for example, beyond a basic Google search. Better data lead to more-accurate and more-detailed information about a community's current and past work and readiness to implement strategies. Data empower coalition members to ask questions to better understand the people who the programs are trying to reach.

- Beyond the initial phases of building a coalition, the **coalition membership checklist can be used to check that all sectors and demographic groups are continuously represented and have leadership roles** as strategies are implemented and evolve. It is an ongoing process and not one point in time.

- **The readiness assessment and coalition membership checklist can help identify gaps and opportunities for community engagement**, such as the need for new coalitions. However, building a diverse, multisector coalition with organizations and people that truly represent their community and can effect real change may not always be easy. Politics and power dynamics, departmental leadership differences, racism, and limited capacity are among the challenges communities face when doing this work. Try to identify and address these challenges early and often.

- **Engaging and providing leadership opportunities for PWLE and PWUD is vital for addressing the opioid crisis locally, but it can be challenging**. Consider partnering with peer organizations, offering stipends to people for coalition contributions and activities, and creating workgroups led by and focused on PWLE who are well versed in client-centered and harm reduction approaches. State partnerships and funding mechanisms are needed to support grassroots organizations with low threshold requirements for sustainability.

4. Maintaining and Strengthening a Community Coalition

Once the coalition is up and running with membership and operations established, it is important to think about how to maintain the momentum. Development of new skills for coalition members through training opportunities, goal-directedness, fostering a culture of hope, and improving efficiency can help maintain and strengthen a coalition.

Training opportunities

Shared Vision

Culture of Hope

Improved Efficiency

PROVIDE TRAINING OPPORTUNITIES FOR COALITION MEMBERS

Collaboration ensures power sharing and the equitable distribution of resources while acknowledging and embracing the many different forms of knowing and knowledge generation. You'll want to try to meet members where they are and try to remember that learning is not always a linear process.

Prioritizing the Voices of People with Lived Experience (PWLE)/ People Who Use Drugs (PWUD)

Coalition members are knowledge holders and experts on their own experiences and environments. Ask questions. Be curious. Listen. Listen again. Together, coalition members can co-produce knowledge and ideas while working across similarities and differences to achieve the shared goal of reducing opioid overdose deaths in your community.

Trainings are an excellent opportunity not only to engage and potentially evaluate coalition members' competencies but also to promote bidirectional learning and knowledge-sharing. There will often be opportunities for your coalition to debrief after trainings for critical reflection and capacity building to encourage continuous development for all members regardless of title, role, or experience and whether they are founding members or new recruits. Conflict may arise. Embrace it. Use conflict management and resolution skills for transparent participatory facilitation. Out of challenges come opportunities.

Dedicate time during a coalition meeting to select training topics. Open discussion with the following prompt:

> *"We want to be sure that (1) we are offering you training related to our coalition's activities, and (2) we are able to learn from your expertise. Please let us know if there are any topics you would like to hear more about or if there are training resources you would like to share with the team."*

Work with coalition members to draft an initial training plan based on shared priorities. This plan should be updated over time, account for changes relevant to the field (for example, the availability of over-the-counter Narcan), and take the formats (e.g., in-person workshops, live webinars, self-study guides) that the coalition members request.

Opportunities for skill building can improve the coalition's impact and promote member retention. Consider tapping into local expertise through community organizations for trainings and developing train-the-trainer models to facilitate sustainability. Trainings may be a mix of in-person, video conference, and recorded formats, which may include asynchronous and synchronous activities, self-paced learning, coaching, learning collaboratives, retreats, facilitated

discussion, training the trainers, and leadership development. Find what works for your coalition. Remember to meet people where they are and be agile. Training formats, funding opportunities, and members preferences for learning and debriefing all may evolve.

Below, we offer some key modules that you may want to consider as you seek to enhance individual and collective knowledge and skills across all coalition members.

Table 2. Potential modules and learning objectives for coalition member trainings

Module Topics	Brief Description	Learning Objectives
Gauging pre-existing facilitation and community engagement skills	Assess community engagement skill; understand community engagement through personal narratives and experiences	Team-building; the development of a shared understanding of community engagement and assessment
Introduction to community engagement and Community-Based Participatory Presearch (CBPR)	Develop an understanding of the critical importance of community engagement and CBPR to the overall success of your coalition	To clearly articulate CBPR principles and why your coalition is using them
Relationship and coalition building	Develop the community organizing skills to effectively orchestrate and carry out meetings; recruit and retain coalition members; develop community relationships; and learn about community strengths, needs, and context	Build relationships and work across similarities and differences toward a shared goal
Deep listening and communication	Develop communication skills, particularly those related to deep and active listening. Gain an understanding of how best to apply these skills to facilitating meetings and having successful one-on-ones	
Cultural humility	» Understand substance and opioid use disorders in the context of inclusion, equity, diversity, and belonging » Gain a deeper understanding of your own, your coalitions', and your community partners' position compared to others within the community and power » Build an appreciation for others' expertise, knowledge, and leadership » Gain an understanding of public health, healthcare, and substance use through common/mainstream frames and narratives; learn how to incorporate a social justice framework into these narratives » Gain an understanding of your community's specific health equity information and how it relates to success and barriers of your coalition	Exhibit a fundamental knowledge of one's self, identity, and positionality, and how all of these aspects can affect one's relationship with other coalition members and community partners

Continued

Module Topics	Brief Description	Learning Objectives
Facilitating great meetings	» **Participatory Facilitation**: Gain an understanding of the theory behind participatory facilitation and develop skills associated with participatory facilitation, inclusive consensus building, and collaborative decision-making » **Co-creating Great Meetings**: Build knowledge and skills related to co-designing and facilitating great, accessible meetings (i.e., shared power and values-driven agenda making, accessibility, open and iterative feedback practices, community agreements, centering relationship building, navigating power dynamics, power sharing, recognizing success and sharing gratitude, tracking and following up on tasks) » **Embracing Conflict**: Unpack and understand our relationship to conflict; build skills to embrace and harness conflict as opportunities for growth » **Role of the Facilitator**: Deeply understand the role of a facilitator and develop skills to better coordinate collective progress, respectively delegate, and ask for help » **Practice, Practice, Practice**: Develop skills related to co-designing and facilitating meetings through role plays, planning practice activities, etc.	Ask questions and acknowledge community members as knowledge holders or experts of their own experience and environment

CE training resources

- Doing the Work Together: Authentic Partner Engagement in Prevention—Webinar
- Community Toolbox—Collection of resources and trainings

The work we do is difficult. Your coalition may want to consider forming a task force that addresses things like self-care and support for one another. Consider bringing together coalition and community members to (1) create a culture of self-care and personal sustainability and (2) develop strategies that aim to support maintaining coalition membership and community partnerships to address substance and opioid use and stigma long into the future.

Potential training topic: Scope of opioid overdose crisis

Providing specialized training on the opioid overdose crisis for coalition members will ensure they have a foundation of information that will allow them to participate in all types of discussions and decisions. These trainings can take place during regular coalition meetings or online.

Specific topics to consider:

- **Understanding the Opioid Crisis**: Causes and consequences of opioid use disorder (OUD); background on the local epidemiology of OUD; medications for opioid use disorder (MOUD); social determinants of health
  - Addiction 101
  - Overview of Substance Use Disorders—Continuing education (CE)/continuing medical education (CME) credits available
- **Treatment of OUD**: Understanding evidence-based MOUD and nonmedical approaches; state of the delivery system for MOUD—practices and policies
  - Medications for Opioid Use Disorder—CE/CME credits available
  - Screening, Assessment, and Treatment Initiation for Substance Use Disorders (SUD)—community engagement/CME credits available
- **Emergency Management of Opioid Overdoses**: Crisis response and emergency care; distribution of naloxone: rationale and barriers
  - Integrating Opioid Use Disorder Treatment in Clinical Care—CE/CME credits available
  - Naloxone: The Opioid Reversal Drug that Saves Lives
- **Opioid Use and the Criminal Justice System**: The role of law enforcement; opioid use during incarceration and reentry
  - Introduction to the Criminal Justice System and MOUD—CE/CME credits available
- **Preventing SUD**: Evidence-based prevention interventions; prevention in community settings
  - Selecting Prevention Strategies that Work
- **Social Determinants of Health & SUD**
  - Social Determinants of Health & Substance Misuse: Implications for Prevention Planning - Session 1

Potential training topic: Stigma

Think through the beliefs that those within the coalition or community members express regarding OUD. Are there beliefs that have hurt the community? For example, are there community-held beliefs about OUD being a choice rather than a disease? Stigma can stall community engagement, hinder coalition cohesion, and complicate the delivery of evidence-based practices. Therefore, offering coalition members a training on stigma related to substance use or OUD is highly recommended.

The following are some recommended messages to counter some commonly held stigmatizing beliefs:

- OUD is a medical disease
- Anyone can develop an OUD
- MOUD can be an essential part of someone's recovery from OUD
- MOUD improves lives
- Naloxone saves lives

Coalition training materials can share information on these concepts. This will empower coalition members to counter stigmatizing beliefs and can help guide the coalition's activities.

Suggested training materials:

- **The language of addiction**: Why outdated terminology can cause confusion or perpetuate stigma around substance use disorders
  - Changing the Language of Addiction
- **A pledge to use less-stigmatizing language when discussing substance use disorder**
  - Words Matter
- **SUD and stigma reduction**: Practical information to enhance your capacity to engage in effective stigma reduction efforts.
  - Anti-Stigma Toolkit: A Guide to Reducing Behavioral Health Disorder Stigma
- **Cultural understanding of addiction**: Approaches to help reduce stigma and discrimination
  - CCE Dismantling Stigma: Addiction, Treatment, and Policy—CE/CM credits are available
- **Individually held vs. community-held stigma**:
  - Community Perceptions of Opioid Overdose: Brains, Bias, and Best Practices—CE/CME credits are available

After this training, engage in a discussion about where coalition members notice stigma affecting the coalition's work in the community. Are there steps the coalition can take to counter this stigma?

> *The coalition discussed how stigma prevents many in the community from accessing Naloxone. They also mentioned barriers and regulations that dictate which organizations can distribute Naloxone and how that needs to be tracked. The coalition considered these factors when brainstorming interventions, and they were leaning towards expanding Naloxone. A coalition member shared that their agency has been trying to get NaloxBoxes for a while and COVID-19 put a halt on that effort. They added that it is difficult to get places to put out the boxes in public because of stigma, people say that the boxes 'invite those people here.'* (June 2020)[11]

Potential training strategy: Learning Collaboratives or Communities of Practice

Learning collaboratives (LCs) or communities of practice (i.e., "groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly")[12; 13] may be tailored to specific community issues and may target specific community groups (e.g., local hospitals, law enforcement, first responders, housing service providers, harm reduction specialists, and bridge clinic providers).

LCs enable community coalitions, champions, and partner organizations (within or across communities) to learn from each other, share strategies, and problem-solve. They should be developed in response to coalitions' and partner organizations' needs.

LCs may take several forms. They can be designed to provide opportunities for all coalition members to share ideas, discuss barriers, and problem-solve. They may also be designed to share with your community partners and other agencies to increase visibility of your coalition and its goals. LCs can also be made up of subcomponents tailored to smaller, more focused groups (e.g., a group of peer champions, a committee working on a funding application, or coalition members planning a community listening tour).

Ultimately, coalitions' and partner organizations' information sharing needs should drive both the structure of LCs and the topics covered. When planning LCs, ensure your coalition explicitly identifies and commits to its purpose and learning objectives (i.e., how does the content shared support your coalition).

When possible, your coalition should collect some data (e.g., number of participants and their community sector) to inform future planning and sustainability. You may also want to encourage attendees to share their names and contact information, if they are comfortable.

For example, Northeast Ohio Medical University Ohio Opiate Continuing Education TeleECHO is a LC open to buprenorphine prescribers and meets virtually every Friday from 3 to 4 p.m. EST. Providers sign up with an email address. The meetings follow a similar structure each week: half of the teleconference/webinar is dedicated to didactic presentations (e.g., motivational interviewing in an emergency room setting), and the other half is dedicated to case reviews with a panel of experts.

KEEP FOCUS ON A SHARED VISION

A major challenge that many coalitions face is maintaining focus on a shared vision. Coalition members may have "pet" issues that they feel need priority, members may disagree about how to accomplish the coalition's mission, and setbacks or challenges can lead to frustration. Anticipate that these challenges will arise and have a plan in place with the coalition's leadership.

Early wins are particularly important for those who are action-oriented. Are there strategies that can be quickly deployed?

How will the coalition maintain focus on a shared vision? One strategy is reminding coalition members of the agreed-upon vision statement at the start of coalition meetings. Building off this vision can inform and facilitate decision-making. The coalition may choose to capture their vision in terms of SMART goals: Specific, Measurable, Achievable, Relevant, and Time-Bound. To work toward the coalitions' overall goal, short-term goals may need to be met along the way. Another potential approach is guiding the coalition through a Strengths, Weaknesses, Opportunities, and Threats analysis related to the shared mission of the coalition. Elucidating opportunities can re-invigorate members to focus on how the coalition can work toward their goals.

What helps coalitions stay goal-oriented?

- Smaller workgroups
- Shared accountability
- Balance of short- and long-term goals
- Celebrating coalition wins
- Meeting frequently to keep people informed
- Review real-time local OUD data frequently
- Pre-established regular meetings with external contacts (e.g., public health officials, governmental officials) to report on progress
- Being community-driven and community-owned; being accountable to the community

Specific goals that further the overall coalition vision may include selecting and implementing evidence-based practice strategies to reduce opioid overdose deaths. Coalitions could select evidence-based practices within the *Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) Practice Guide*, which include the span of care across prevention, diagnosis, engagement, and retention in treatment.

Goal-directedness is important because it is easy to get sidetracked by smaller issues that surround the coalition's central goals. Thus, task focus is critical in achieving goals.

Example goal from a New York HEALing Communities Coalition:

Vison:
Provide naloxone training and naloxone distribution to people with a SUD upon release from the county jail
Why:
• In the county jail, 75% currently have a SUD. • Within the first 2 weeks of release, people are 40 times more likely to die of an opioid overdose compared to people without a history of incarceration.[14] • To facilitate rapid access to a naloxone kit upon release. • To standardize the process for a jail clinician to train all people with a SUD in jail and provide them with naloxone.
How:
• Jail clinician becomes a trainer and trains willing people in jail. – Upon release, a dose of naloxone is picked up at [Program], or – Upon release, naloxone is received through the mail.
Goal:
• 100% of people with SUD provided with training and a naloxone kit upon release
Technical Assistance, Needed Resources, or Potential Challenges:
• Clinician needed to train people on naloxone administration • Need a process to distribute naloxone upon release • How to afford mailing naloxone

FOSTER A CULTURE OF HOPE

Celebrating successes will strengthen relationships, build trust between coalition members, and foster a culture of hope. Moments of celebration can occur when coalition members

- tell a personal story and further healing from sharing,
- recognize growth in skills and training,
- learn new skills in engagement or collaboration,
- help change a community,
- work within a system to improve it,
- listen and act upon stories shared to change a culture or community-held belief, and
- engage with others in a positive and powerful way.

Adapted from *Engaging Individuals with Lived Experience: A Framework*

Welcome coalition members to share these moments of celebration during meetings and consider reserving set-aside time during coalition meetings to share coalition member wins and achievements.

IMPROVE COALITION EFFICIENCY

Efficiency is critical to a coalition's success. Coalition efficiency refers to the work ethic and task focus of the coalition as well as its ability to effectively use its resources to implement change. People and organizations form coalitions to accomplish together what they cannot alone. However, members and community organizations are very busy and must consider how much time they can give to the cause. How well-organized the coalition is and the clarity of the coalition's goals may factor into their decision to participate. A lack of efficiency can hinder coalition retention, accomplishments, and even efforts to maintain a diverse coalition.

The leaders of the coalition set the tone for coalition efficiency. Having clear agendas with timelines, taking and sharing notes, and being prepared to lead helps others stay committed themselves. Efficiency can prevent duplication of efforts and helps the coalition stand out from other efforts.

It is important for coalition leadership to remain adaptable to how coalition members view efficiency. Some coalition members may prefer a more-authoritative style, while others may prefer more discussion-based decision-making.

As a coalition builds, acquiring and fostering new knowledge and skills can increase the coalition's efficiency and effectiveness. Skills-building opportunities can not only improve the coalition's impact but also promote member retention and self-efficacy.

CHALLENGES AND SOLUTIONS

What If Our Coalition Has Very Limited Resources?

We asked Dr. Tisha Smith from the Monroe County Department of Public Health in Rochester, New York, to tell us about her work on the Opioid Taskforce focused on Monroe County and the Finger Lakes Region and the newly formed Monroe Coalition—the first coalition of its kind in Rochester solely focused on opioids in Black and Brown communities. Specifically, we asked her what advice she would give to other coalitions who may lack resources and how they might work within their means.

> *In thinking about how to gather more people in the room, I think back to an example from years ago. There was a woman who had lost her child here in Rochester to an overdose. She was struggling. She reached out to another mother who had a son that was actively using [drugs]. And the two of them kind of just shared [their experiences] with other people who were going through some things and then other people in the community said, 'hey, yeah, me too.' And from there, they were able to create this kind of bereavement group.*
>
> *It just takes a dynamic person who can pull in other people who are willing to dedicate their time to [address the opioid crisis] and from there, they might know somebody who might know somebody who might know somebody.*
>
> *It's about going out and talking to people about what's going on and them realizing they can help make some change. I don't think it's really an issue of resources. It just takes people that are willing to get involved and getting them together.*
>
> *It's about who you know. Maybe you know somebody who has a radio station that can do free advertising. Maybe there's a free newspaper in your community where you can advertise. It's about involving the people who say they want to be involved and letting them know what you need and what issues you are trying to address.*
>
> *Use social media. Talk with veterans. Make phone calls, lots of phone calls.* ***You can create a movement with just one person—that's all it really takes****. It's that great smile and having the gift for gab to motivate others to assist. When in doubt, talk with your government officials and tell them you need their support and ask them what resources they can provide.*

Coalition Wishlist

Consider creating a coalition wish list and sharing it with organizations in your community. You might need a computer or a printer or maybe some tables and chairs. Add these items to your wish list. Use social media or the local newspaper to share your wish list. Not only might you get some of the things your coalition needs, but you might also create a pathway for partnership. You are increasing your coalition's visibility in your community, letting others know that you are an organization committed to addressing the opioid overdose crisis.

What if power dynamics within the coaliton make it difficult to stay on task or lead to members feeling left out of decision-making?

It is important to consider who feels included and excluded during coalition meetings and in carrying out a coalition activity. This includes when agendas and tasks are being set. There will likely be members who engage in and encourage discussion (planners) and others who are more comfortable with action-directed steps (doers). Empowering both planners and doers is necessary for coalition efficiency. When one group feels discounted or unheard, it can lead to poor power dynamics within the coalition.

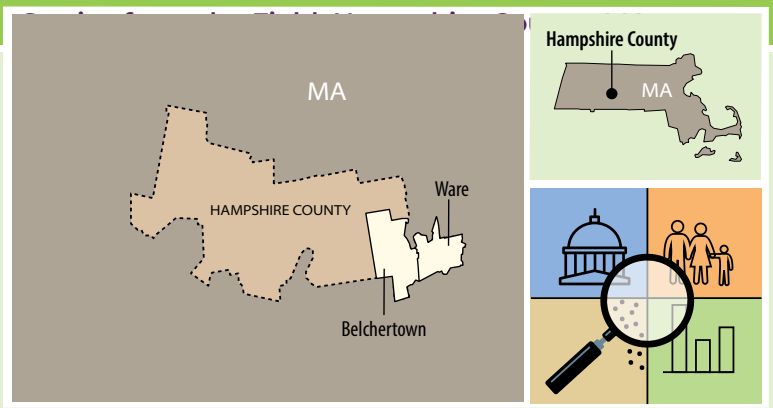
How to address power dynamics

- Consider holding action-focused and planning-focused meetings separately and have a member from each group report out to the larger coalition. This will keep the momentum moving forward.
- Think about the reputation of the coalition as well as who gets credit. It will take deliberate effort to ensure that all coalition members share in coalition victories.

Case study

Efficiency can affect the diversity of a coalition through member retention.

A prominent Black leader within the faith community was engaged early on in coalition efforts. However, inefficient meetings and a lack of progress led him to stop attending coalition meetings. Because he no longer attended meetings or responded to emails, the remaining members of the coalition became increasingly frustrated. As a result, the coalition became divided. This led to negative feelings all around. Inefficient meetings can be detrimental to coalition member retention—particularly for lower-income people who may have care demands or limited time outside of work. It is also a challenge for people representing vulnerable populations who are balancing the needs of the coalition with many other needs of their community. Efficiency signals to coalition members that you respect and value their time.



STORIES FROM THE FIELD

Engaging People with Lived Experience of Opioid Use through **Photovoice** in Belchertown and Ware, Massachusetts

BELCHERTOWN and WARE · MASSACHUSETTS

Belchertown and Ware are two small, rural communities near each other in Western Massachusetts. They are in some of the more remote areas in the state. The median household income is much higher in Belchertown ($77,431) than in Ware ($43,783), and both are lower than the overall state median income ($89,645).[2]

Ware is a historic mill town that experienced severe economic decline when the textile mill closed in 1984 and more recently when the local Mary Lane Hospital closed in 2021. In Belchertown, the economy is driven by the education because there are several colleges in the area. In Ware, the economy is based mostly on healthcare.

Most of the people who live in these communities are non-Hispanic White (89.9 percent), followed by Hispanic (4.4 percent) and Asian (2.4 percent).[1]

Authors: Peter Balvanz, MPH, Associate Director of Informatics, Massachusetts HEALing Communities Study, and Alyssa Curran, Community Coordinator for Belchertown and Ware Coalition.

RATE OF FATAL OPIOID OVERDOSES

Fatal opioid overdoses were higher in these communities (51 per 100,000) than the state average (33.1 per 100,000). Also, the total number of fatal opioid overdoses among residents in 2021 was 14, which doubled from 7 in 2020, with most occurring in Ware.[15]

BELCHERTOWN AND WARE COMMUNITY COALITION

Challenge: How to learn about what's driving opioid use in these communities from the perspective of people with lived experience (PWLE) to help prevent overdose

Despite our community coalition being highly engaged in discussions around opioid overdose and gaps in harm reduction services, we have had limited insight from PWLE.

Solution: Engage PWLE in a Photovoice project to better understand their views on the local opioid epidemic and what they think can be done to address it.

WHAT IS PHOTOVOICE?

Photovoice is a type of participatory research that involves researchers and participants collaborating to understand social issues and take actions to bring about social change. Specifically, Photovoice uses photography and focus group discussion.

WHAT ARE THE GOALS OF PHOTOVOICE?

- Record and reflect community strengths and issues
- Promote critical discussion on the causes of the issues and how they may be addressed
- Reach policymakers and decision-makers with the results and encourage them to adopt policies that promote health

> *The opposite of addiction is not recovery—it is connection.*
>
> *—Community Coordinator reflecting on themes from their Photovoice project while speaking at the 2023 Human Service Forum Legislative Reception*

Through four Photovoice sessions with 12 PWLE in Ware, our coalition aimed to generate insights into what's causing the opioid epidemic locally and how to protect against it.

The **Photovoice project** provided unique insight into participants' experiences and what they think is causing the opioid epidemic locally. These ranged from direct links, such as starting at a young age to take opioids to manage pain, to indirect links, including social determinants of health (SDOH). SDOH are the nonmedical factors that influence health outcomes, such as lack of transportation to healthcare services.

Photovoice participants discussed how the declining local economy has eroded recreational opportunities and that the few remaining social outlets center around alcohol. Partly because of the resulting lack of social connection and few positive social outlets in the community, adults are more likely to use substances and young people begin to use substances at an early age. This increases their risk for substance use disorder and limits their opportunities in the future.

Photovoice participants also shared that the lack of transportation severely limits not only recreation but also economic opportunities and options for recovery from opioid use because treatment facilities are far away.

OUTCOMES

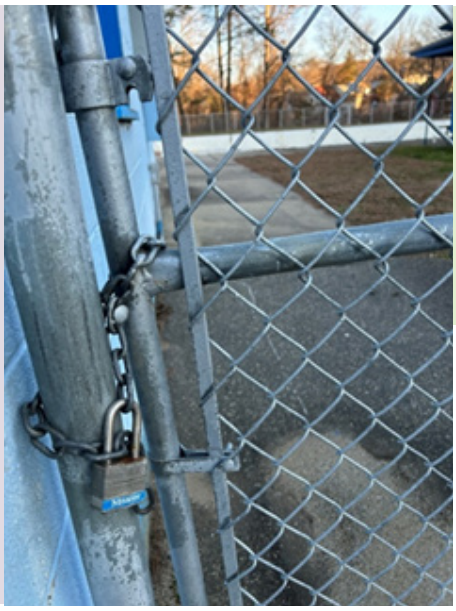


Image of a swimming pool, no longer maintained, that has been closed and locked (photo credit: Ware Photovoice Participant)

> *It's so easy to get distracted and lose touch with other people in recovery when there's nowhere for us to go and do anything. And then once we lose connection with those people, we're more vulnerable to making poor decisions because we don't feel a part of anything.*
>
> —Ware Photovoice Participant

> *I've had this Jeep, but have needed to fix it. But without a way to get to a job, I can't make the money I need to fix it, and it keeps me in this cycle of never being able to get my feet under me.*
>
> —Ware Photovoice Participant

Photovoice participants valued the opportunity to

- reflect on what enables and what protects against opioid use,
- suggest potential solutions, and
- continue to work with their community partners to implement proposed solutions.

For example, the recognized lack of recreational opportunities inspired a plan for Recovery Center of Hope clients to lead a park clean-up day to pick up trash and empty alcohol mini-bottles. Photovoice participants recognized their ability to create change in their community, which brought our community and coalition together.

For another example, concerns about the harmful impact of the lack of transportation influenced our coalition to implement a mobile methadone clinic, a transportation program, and gas cards to help people with opioid use disorder who were leaving incarceration travel to appointments with medications for opioid use disorder service providers.

HUMAN SERVICE FORUM LEGISLATIVE RECEPTION

In January 2023, our coalition shared the Photovoice group's vision to revitalize their community with state representatives at the Human Service Forum Legislative Reception.

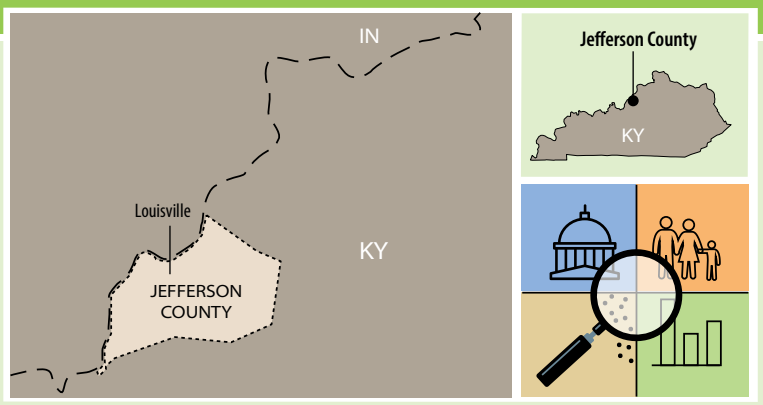
For instance, our Community Coordinator explained that there are few opportunities to connect in person in Ware. The lack of transportation adds to **social isolation**, which has led to a **300 percent increase in overdose death rates** in Ware. The coordinator was able to successfully lobby for state representatives to visit Ware and hear directly from our Photovoice participants, who are the experts.

At the conclusion of the project, our experts expressed a desire to continue Photovoice as a way to further explore what's driving opioid use and mobilize around potential solutions. As a result of the impact of this project, the local District Attorney's office provided funding to continue Photovoice at a new recovery center in the community.

TIPS FOR YOUR COMMUNITY

- Photovoice is a creative tool that helps communities gain insights to address the opioid epidemic from people with lived experience of opioid use.
- The findings from these activities can help shape a community's strategy to address the opioid epidemic. They can also be used to apply for funding to support community engagement around the opioid crisis.
- With permission, photos and quotes from Photovoice projects can be used as communications materials from the local community.
- Photovoice is an effective tool to engage and learn from groups that have been economically and socially marginalized and to mobilize groups to implement change.

Photovoice participants and facilitators meet at the Ware Recovery Center



STORIES FROM THE FIELD

How a **community listening tour** helped build a **diverse and representative coalition** committed to **reducing overdose deaths** in Jefferson County, Kentucky

LOUISVILLE · JEFFERSON COUNTY, KENTUCKY

Jefferson County is next to the Ohio River near Kentucky's border with Indiana. More people live in Jefferson County than in any other county in Kentucky.

The county has more racial and ethnic diversity than the rest of the state. For example, nearly 23 percent of people who live in Jefferson County are Black or African American, and about 9 percent were born outside the United States.

Jefferson County has a slightly smaller percentage of residents who live below the federal poverty level as compared with the whole state. But there are real social and economic disparities within the county. For example, the average income of the top 20 percent of Jefferson County residents is nearly 16 times greater than the average income of the bottom 20 percent of residents.[17] Also, Jefferson County residents are segregated by race, with most of its Black residents living west of Louisville's Ninth Street Divide.[16; 19]

Authors: Kacey Byczek and Amanda Fallin-Bennett

SUBSTANCE USE AND THE OPIOID CRISIS

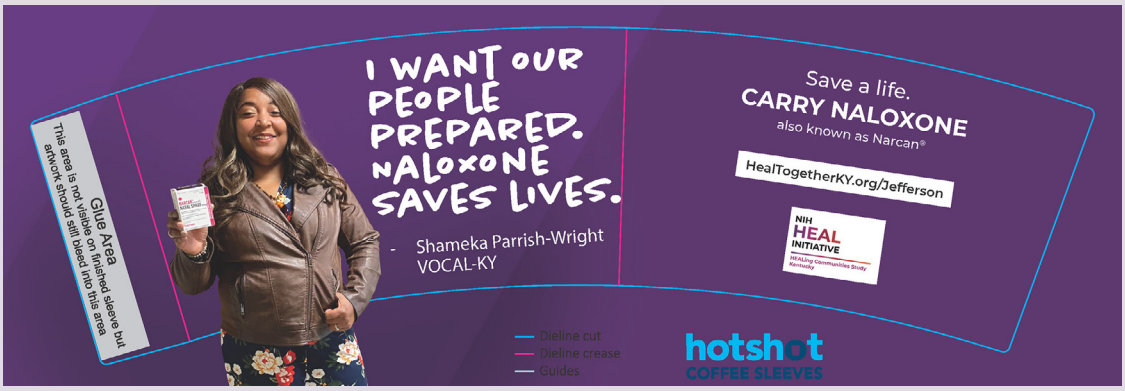
Jefferson County has many strengths that can help address the opioid crisis. For example, it has 11 syringe service program sites, five opioid treatment programs, several buprenorphine prescribers, and a willingness to try new strategies to reduce opioid overdoses.

Jefferson County's jail, Louisville Metro Department of Corrections (LMDC), is among the first jails in the United States to install naloxone in every one of its dorms and offer buprenorphine treatment to people already prescribed the medication and to people who are pregnant (regardless of whether they were previously prescribed the medication).[18] Overall, the county has demonstrated support for harm reduction services and a readiness to implement progressive approaches to providing medications for opioid use disorder (MOUD).

RATE OF FATAL OPIOID OVERDOSES IN JEFFERSON COUNTY

Drug-overdose deaths in Kentucky rose 14.6 percent in 2021. Jefferson County reported 569 overdose deaths, an 11 percent increase from the 512 overdose deaths reported in 2020. The county's overdose death rate was 77 per 100,000, well above the statewide rate of 52.9 per 100,000.[20]

JEFFERSON COUNTY HEALING COMMUNITIES STUDY COALITION



A mock-up of a purple coffee sleeve featuring Shameka Parrish-Wright, a Black woman who resides in Louisville's West End. Ms. Parrish-Wright is a former Louisville mayoral candidate and the Executive Director of VOCAL-KY (Voices of Community Activists and Leaders Kentucky), a statewide grassroots membership organization that builds power among low-income people directly impacted by HIV/AIDS, substance use, incarceration, and homelessness. Beside her photo is a quote from Ms. Parrish-Wright, which reads, "I want our people prepared. Naloxone saves lives" in blue text.

Photo Credit: Kacey Byczek, Jefferson County co-Community Coordinator, and Jennifer Reynolds, HCS Communications Manager

Challenge: How to ensure that a community coalition implementing strategies to reduce opioid overdose deaths reflects the community's unique diversity and includes a broad group of local leaders and partners

In 2000, the Kentucky Agency for Substance Abuse Policy (KY-ASAP) was created to look at substance use and its related harms. Across the state, KY-ASAP works with 79 local ASAP coalitions. Each one has a community-based strategy and plan for prevention, treatment, and law enforcement.

Local ASAP coalitions distribute funding on the local level for initiatives that address substance use. They also recommend policies at the local and state levels. Jefferson County is part of a regional ASAP partnership that includes six counties. These counties vary in how rural they are, their social and economic status, and the level of opioid overdose they have.

Jefferson County needs highly local input to help successful implementation of overdose reduction initiatives. That includes people who represent its racial, economic, and geographic diversity.

Solution: Conduct listening tours to gather insights from the many people and groups in the community committed to a common goal

We conducted a listening tour to meet with local leaders and community members familiar with our community's unique needs.

Among the first to participate in the listening tour were the Jefferson County KY-ASAP and HCS Community Advisory Board representatives. In this and all future meetings, we asked for additional recommendations for other people with whom we should speak, thus helping our team's network of community connections "snowball" over time.

> *It's been an honor and a privilege to be a part of the Jefferson County HCS Coalition. One of the most meaningful things that I've been able to witness from the coalition itself is the level of collaboration that was organically forged [between coalition members and partner agencies], which has been an extreme asset. Traditionally, Louisville has been very siloed, and more of a competitive landscape. Since the coalition was built, I've seen so much consistent, continual collaborations outside of the HCS meetings and beyond the HEAL Initiative. Really being able to look at the data the HCS team was able to provide to see where everyone was working in the city and where the service delivery gaps were, and then watch the coalition go into action because they had information to make informed decisions about overdose reduction strategies for Jefferson County has been amazing. Another amazing aspect of the coalition...are all of the educational resources that the HCS has created and disseminated—now providers and practitioners have an agreed-upon best practice and agreed upon language, which is key because communication between providers, between patients, and between the public is one way we reduce stigma.*
>
> —Jeremy Byard, Jefferson County HCS Coalition Chair

We looked online for local MOUD providers, opioid treatment programs, and leaders in the recovery community. We also reviewed reports from the local health department on health and resource gaps to understand the local context and identify additional partners, such as champions and thought leaders.

Listening tour participants each had their own views about Jefferson County's ability to address the opioid overdose crisis. However, several common ideas came to light:

- Lack of resources in the mostly Black West End of Louisville
- Transportation issues that prevent people from starting and staying on MOUD
- Separate and isolated harm reduction services

We focused on building a coalition of people who are familiar with these issues and with Jefferson County's racial, geographic, and social and economic diversity. The listening tour included 36 champions working in the healthcare, harm reduction, and criminal legal systems and community organizers and people with lived experience. Ultimately, 26 champions joined our coalition.

COALITION SUCCESSES AND OTHER BENEFITS

- As of April 6, 2023, more than **3,500 units of naloxone** have been distributed throughout Jefferson County. This has been done through direct delivery of opioid overdose education and naloxone distribution (OEND) and naloxone distributed through local partner agencies and organizations.
- As recommended by our coalition champions, we prioritized OEND at places in the West End and in programs that serve people with a high risk of opioid use disorder—such as Feed Louisville, which does daily outreach to people experiencing housing instability and manages a hotel for people transitioning to housing.

> *"As a prevention specialist in Jefferson County, it has been refreshing seeing the impact of OEND in our community. When we set up a booth with a sign that says, "Free Narcan available here," we never know what reactions we may get. However, in Jefferson County, we are met with a lot of people thanking us for being there.... One time in front of a local trailer park, a woman drove by and saw me conducting OEND. When she got close enough, she rolled her window down and said, "God bless you for being here!" and proceeded to tell me she was three years into recovery. Many of the connections we have made have been at events where people see what we do, and either want their place of business to participate, or recommend places where they feel OEND is needed. We are consistently recognized by community members as providers of a much-needed service, in areas that otherwise may feel neglected or underserved. I consider myself lucky to be a part of this life-saving initiative.*
>
> —Bennett Becherer, Jefferson County Prevention Specialist

Coalition members from the local health department and LMDC helped us foster a connection with, to our knowledge, the first incarcerated individual in Kentucky to use naloxone to reverse an overdose in a jail. The coalition shared this story in a local communications campaign focused on naloxone and fentanyl awareness, highlighting the importance of making naloxone readily available to people facing incarceration.

TIPS FOR YOUR COMMUNITY

- Get insights from local leaders and community members.
- Build partnerships and communication with different types of allies, such as faith leaders, journalists, people who work in substance use fields, and people with lived experience.
- Include a diverse group of service providers and people with lived experience to help bridge gaps between local organizations and to broaden services.

Overdose Education and Naloxone Distribution Outreach Manual

HCS-KY staff at the State Capitol for Overdose Awareness Day in Franklin County, Kentucky

This manual provides a blueprint for sustaining or launching successful OEND outreach programs based on lessons learned from the HEALing Communities Study in Kentucky.

Among its many features are venue outreach and scheduling ideas, a supply checklist, and a breakdown of program costs.

You can download the manual from this website: https://fw.uky.edu/HEALKYResources

5. Assessing Community Engagement and Coalition Functioning

Is your coalition successfully engaging the community? Could coalition functioning be improved? Are coalition activities reaching those at greatest risk of opioid overdose death? These questions should be asked regularly over time to prevent stagnation, reduce disengagement among coalition members, and retain perspective into the coalition's relationship with the community.

Evaluation can be used to gain insight on participants' needs and wants and improve how things are done in your coalition.

EVALUATE THE RELATIONSHIP BETWEEN THE COALITION AND COMMUNITY ORGANIZATIONS

Evaluating and measuring the relationship between the coalition and community organizations can improve a coalition's impact, function, and longevity. This can be done through formative evaluation, active listening, conversations with community members or partner organizations, and surveys of coalition members.

Refer back to your community assessment and work with your champions to think through different community organizations in your community. Are they represented within your coalition? Do you have coalition members who might facilitate improved communication between the coalition and organization? What have been barriers to a better relationship, and can these barriers be addressed?

For example, one coalition had a representative from an opioid use disorder (OUD) treatment provider attend the first several coalition meetings. Over time, that representative moved on to a new position, and no one else from the treatment center was sent as a replacement. Now the coalition no longer hears updates from the treatment center, and the work the representative engaged in—facilitating a linkage program for people leaving incarceration and entering treatment—has stalled. By going back to the initial community assessment, coalition leadership identified this gap and reached out to the treatment center to ask whether they would like to continue involvement with coalition work.

The PARTNER Tool

This tool can be used to assess the strengths (and gaps) of relationships among coalition members, how members perceive trust and value in partnerships, the creation of member relationships, and how they have evolved, as well as to identify needs and gaps related to outcomes and success at reaching coalition goals.

Resource for more information: Varda, D. M., & Sprong, S. (2020). Evaluating Networks Using PARTNER: A social network data tracking and learning tool. In A. W. Price, K. K. Brown, & S. M. Wolfe (Eds.), *Evaluating Community Coalitions and Collaboratives. New Directions for Evaluation, 165*, 67–89.

To examine the relationships within and between the coalition's agencies and organizations, consider the following:

- Use your initial community assessment or coalition checklist (**Appendix A**) to identify the organizations and entities that do work related to opioid overdose in your community.
- Assess the *current* relationship between each organization and your coalition. What is the quality of the relationship? How connected are they to coalition activities? Are there goals that you share that you can leverage to further your relationship?
- Think through the organization's power, influence, and trust within the community. Are they an essential member to have at the table? How can you successfully engage with them?

With this information, the coalition can discuss the strengths, challenges, and possible solutions to strengthen the relationship between organizations and coalitions.

How can we increase engagement with potentially resistant sectors?

When evaluating the coalition's engagement with community organizations and sectors, coalitions may find less engagement with certain sectors. Perhaps these sectors are represented within the coalition through meeting attendance, but engagement is minimal. Perhaps schedules are very busy, and members have limited time or energy to commit. Perhaps other coalition members express stigma or resistance when members from this sector try to engage in conversations or relationship building. Ideally, the coalition can recognize this as an opportunity to build bridges and improve the interaction.

Commit to understanding what barriers your coalition members face. For example, one coalition chair would personally reach out to any coalition members with attendance gaps. They would discuss barriers to meeting attendance and use this information to consider other options: changing the meeting times, offering hybrid attendance options to avoid travel, and allowing members to provide asynchronous input (e.g., via email) if they were unable to attend because of work schedules. This was most needed for coalition members who were employed within the healthcare sector.

After conducting a coalition evaluation, one coalition recognized that law enforcement was not very engaged in coalition work. Although a law enforcement officer attended every coalition meeting, they weren't involved with coalition conversations and activities. The coalition decided to share findings from the evaluation during a coalition meeting. Without making law enforcement feel "called out," the coalition presented suggestions about how to improve engagement. Coalition leadership also engaged the law enforcement representative in a one-to-one conversation about the law officer's perception of coalition functioning and activities. Additional representation from the criminal legal system was requested to provide more than one perspective at coalition meetings, and specific programs (anti-stigma trainings for officers, naloxone leave-behind programs) were introduced that provided a bridge to a more-engaged relationship.

Although the evaluation process presents a chance to address these potential barriers, from the beginning, coalition members should check whether organizations that assign representatives to the coalition are assigning the "right" representatives. Too often, members are "voluntold" to attend and represent but may not have motivation or interest. Being clear about the role and responsibilities of coalition membership can help avoid this challenge.

The following are some additional tips for working with law enforcement:

- Ensure all coalition members recognize these people as coalition partners committed to addressing the opioid crisis and not as law enforcement agents.
- Leverage champions (e.g., Criminal Legal Champion) to further relationships.
- Provide additional training opportunities on naloxone and medications for opioid use disorder (MOUD) to improve engagement and reduce stigma.
- If needed, the interaction may be influenced (or enforced) via funding requirement. For example, a grant specifying the required level of participation from the criminal legal sector.

EVALUATE THE COALITION'S ENGAGEMENT WITH THE COMMUNITY

Consider dedicating a coalition meeting to critically (but constructively!) evaluate how successful the coalition has been in engaging with the community. Potential questions to guide this discussion:

- **Are the right community members at the table?**

  This is a good assessment question, as it can be asked repeatedly over time as coalition members enter and leave the coalition. Think through your local OUD data: are people at greatest risk of opioid overdose represented?

- **Can new members easily join?**

  Has the coalition developed an inclusive culture? Are new members welcomed and oriented? How can you make the coalition more welcoming to the community?

- **Does the process and structure of coalition meetings allow all voices to be heard and equally valued?**

  Where and when do meetings take place, and who leads them? How are decisions made, and how are conflicts handled? Do members feel able to share their insights, and have those insights inform the coalition's actions? Revisit coalition procedures over time and account for changes.

- **Are community members aware of coalition activities?**

  Think through any public-facing activities the coalition has engaged in (naloxone trainings, safe medication disposal events or locations, etc.). Are people aware? How have you shared information about these events (e.g., social media, flyers, word of mouth), and are there other ways that might be better suited for specific populations? Consider asking coalition members to reach out to friends and acquaintances and ask about their level of awareness.

- **In what ways have community members been involved in coalition activities?**

  Beyond awareness, gauge how community members were engaged in the development and involvement with coalition plans and activities. Can you quantify community members' engagement? For example, how many pounds of leftover medication were dropped

off at a safe disposal event? How many people picked up free naloxone kits at a coalition event? Use metrics like this to evaluate how successfully these activities are reaching the community. Report these metrics back to the coalition members so they can understand the reach of coalition activities and brainstorm new approaches to increase reach.

- **Do you have demographic information on community participation in coalition activities? Is your community represented?**

  If possible, evaluate how community participation aligns with the demographics of your community. Is there a way to make events or activities more inclusive? Examples include hosting an event in a location with easily accessible public transportation or offering materials in languages spoken in your community.

- **What lessons has your coalition learned?**

  This assessment is an excellent time to celebrate any successes the coalition has made. Celebrate accomplishments in building connections within the community while learning from any mistakes made. Focus on a growth mindset and admit when things could have been done better. Community engagement is an ongoing process.

Case study

Assessing Community Engagement and Coalition Functioning in Ross and Brown Counties, Ohio

In Ohio, a coalition's efforts occurred alongside pre-existing coalitions and assessing coalition functioning was seen as critical. An assessment was done to identify the critical partners and to assure buy-in and response from the organizations within the coalitions. It was designed to assess various aspects of the network, including aspects of coalition structure and function.

Although these insights are critically important for coalitions to address complex problems faced by their communities, collecting these data and making them available often requires resources not available to community coalitions. In addition, coalitions often do not reflect on their own structure and function even though these play a significant role in coalition effectiveness. Therefore, the coalition leadership chose to gather insights directly from coalition members to inform strategic planning.

Continued

Working with each coalition's leadership, the coalition developed and conducted a survey using the PARTNER tool. They collected data regarding the resource contributions, desired outcomes, and perceived success of our coalition. In addition, the survey compiled data on the relational ties, trust, and value among coalition members. Response rates ranged from 52 percent to 91 percent with 7 out of 9 counties having a response rate of 70 percent or higher. Survey responses informed a report to each coalition for reflection and review. The survey results are being reviewed as part of a larger strategic planning process that includes a focus on sustainability.

Counties recognized various takeaways from the findings. For example, the coalition has discussed both the connections among coalition members (both as a positive and as a challenge) and identifying sector involvement (or lack thereof) have been discussed by the coalition. Lessons learned from this process include the importance of having coalition leadership as champions for the surveys, the need for ongoing processes to support community coalitions in understanding and using data on how the coalition functions, and the importance of focusing on the long-term "life" of the coalition to successfully sustain the coalition's mission and work.

EVALUATE COALITION MEMBERS' EXPERIENCES

How do your coalition members feel about the coalition? Regularly checking in with coalition members can help gauge how people are feeling about the coalition's activities and direction. Welcoming members to provide input, even anonymously, can help get a sense of how people are feeling about their involvement. Consider conducting a more-formal survey at regular intervals (e.g., every 6 months) to assess your members' feelings comprehensively.

Below are potential survey questions:

Thinking about your work in this community coalition, please rate your level of agreement with the following statements.					
I am committed to the work of the coalition	1	2	3	4	5
I can influence decisions that this coalition makes	1	2	3	4	5
This coalition is effective in achieving its goals	1	2	3	4	5
This coalition can influence decisions that affect the community	1	2	3	4	5
I am satisfied by the amount of influence I have over the decisions that this coalition makes	1	2	3	4	5

When the term "leaders" is used in this section, we mean the leadership of this coalition. Thinking about your work in this opioid coalition, please rate your level of agreement with the following statements.					
I am satisfied by the amount of influence I have over decisions that this coalition makes	1	2	3	4	5
The coalition leaders are able to guide the coalition toward the accomplishment of its goals	1	2	3	4	5
The leaders run effective meetings	1	2	3	4	5
The leaders articulate the vision of the coalition	1	2	3	4	5
The leaders encourage commitment to the coalition from coalition members	1	2	3	4	5

1. Strongly disagree **2.** Disagree somewhat **3.** Agree somewhat **4.** Agree strongly **5.** Prefer not to answer

Understanding how coalition members perceive the value of their involvement and the coalition's efforts to date can help the coalition more effectively engage members. For example:

- If members feel like they are not able to influence decisions, consider dedicating a coalition meeting to goal-setting and agenda-setting. Make efforts to acknowledge the voices of all members. Engage coalition members in choosing new board members and deciding on strategies to achieve consensus and voting.
- If members feel like the coalition has not been effective, consider reviewing progress to date with the coalition and inviting critical but constructive input on how these efforts could be more successful. Sharing a report to an external partner or to community partners can be another way to highlight successes made to date.

- If members say that leaders don't run effective meetings, consider reviewing operating procedures with coalition leadership and share with coalition membership to update any needed components.
- If members feel uninformed, consider sending more-frequent updates to coalition members or revisit the method of communication used.

As with most coalition work, improving how coalition members experience their role within the coalition will be an ongoing process that requires consistent and collective review, recognition of achievements, and recommendations for improvement. Coalition leadership should share their intention to reflect and respond to what is shared and highlight a commitment to ensuring meaningful participation for all.

Additional resources on coalition evaluation

- Community Toolbox—free resources, including a section on evaluating community programs and initiatives
- Prevention Technology Transfer Center Network (PTTC) Resources on Evaluation

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Appendices

APPENDIX A. COALITION MEMBERSHIP CHECKLIST

Type of Organization/Individuals
People with lived experience who can speak to needs, challenges, and preferences in their community
☐ People who are in recovery from opioid use disorder and/or other substance use disorders
☐ People who are actively using opioids or other substances with potential for lethal consumption e.g. methamphetamine or cocaine mixed with fentanyl
☐ Family and network members of individuals who overdosed because of opioids
☐ Peer organizations
Addiction treatment and recovery facilities
☐ Opioid treatment programs
☐ Settings providing medically managed withdrawal treatment or socially managed withdrawal
Behavioral health treatment providers that are likely to implement evidence-based practices to reduce overdose deaths
☐ Behavioral health treatment facilities
Health systems, agencies, and health providers that are likely to implement evidence-based practices to treat with MOUD and to reduce overdose deaths
☐ Hospitals (ER and other divisions)
☐ Federally qualified health centers
☐ Primary care practices
☐ Pain management clinics
☐ Maternal health practices (OBGYN, Planned Parenthood, etc.)
☐ Pharmacies
Emergency response units from municipal sub-units or geographic areas
☐ EMS services
☐ Fire departments
Local law enforcement and/or criminal legal organizations
☐ Jail/prison administrators
☐ Sheriffs
☐ District attorneys
☐ Narcotics squads
☐ Police (can be considered first responders)

Continued

Type of Organization/Individuals
☐ Drug or treatment courts
☐ Family courts
☐ Community supervision
☐ Probation/parole
Harm reduction services
☐ Syringe service programs
☐ Mobile units
☐ Naloxone programs
Organizations that address social determinants of health, including social services and entitlement service providers
☐ Housing providers (public and private, hotels, etc.)
☐ Transportation outlets/providers
☐ Food insecurity organizations (food pantries, WIC, etc.)
☐ Employers (large & small)
☐ Education (public school administrators, representatives from local colleges, etc.)
Local service organizations, civic leaders, and other potential influencers
☐ County administrators and supervisors
☐ Legislators
☐ Prevention resources centers and providers
Other key partners
☐ Clergy and/or faith-based organizations serving affected areas of the community (behavioral health sector)
☐ Media and health messaging resources and outlets
☐ Local advocacy organizations (including outside local coalitions)
☐ Victims services
☐ Local businesses, Chamber of Commerce
☐ Veterans and/or organizations serving veterans
☐ Different municipal sub-units or geographic areas of the community
Organizations that support specific demographic groups
☐ Specific age groups (i.e., youth, seniors, etc.)
☐ BIPOC communities
☐ LGBTQI+ communities

APPENDIX B. COALITION CHARTER TEMPLATE

For communities to successfully address the opioid crisis, they need implementation strategies that take their unique local needs and resources into account. Coalitions can help develop a community-driven change process that will enable communities to be more effective in preventing deaths from opioids.

Coalition Goal

The overarching aim of this coalition is to reduce opioid-related overdose deaths.

Coalition Priorities

This coalition will use the following priorities to guide decision-making:

- Elevating local expertise.
- Building on existing community assets.

Membership

List coalition members, committee members (if applicable), and member contact.

Roles & Responsibilities

Describe the roles and responsibilities of people in the coalition.

Committee Structure and Duties

If applicable, describe committees that will support the work of the coalition. List each of the committees, their makeup, and the goals of the committee.

Finances and Budgeting

How will financial decisions be made, recorded, monitored, and reported back to the coalition?

Meeting Operations

- Meeting frequency: The coalition meetings will be held _____.
- Meeting platform: Meetings will be held [*in person, online, both*].
- Agenda: An agenda is distributed at least _____ hours in advance of the meetings by the chair.
- Facilitation: Meetings will be facilitated by _____.

- Documentation: Notes will be taken at all meetings to ensure follow-up and shared via _____ within _____ [*timeframe*].
- Decision-making: The coalition will make decisions and approve actions that are consistent with the coalition's strategic priorities. The coalition will use _____ decision-making strategy.

Communication Procedures

The group will agree upon operational protocols with respect to communication and interactions. *The coalition engages its members through communication protocols, which include the following: …*

Schedule of Meetings

Add a list of monthly coalition and subcommittee meetings. Note whether the meeting is in person, over phone, over Zoom, or other.

Timeline and Milestones

Add a timeline and milestones.

Privacy and Confidentiality

Is information shared within coalition meetings confidential?

APPENDIX C. COMMUNITY COALITION COORDINATOR JOB DESCRIPTION

Summary: The Community Coalition Coordinator will help build the local community coalition's capacity and prepare the coalition to sustain community-led efforts. The coalition's overarching goal is to reduce opioid use disorder and opioid overdose mortality by adopting evidence-based practices. An ideal Community Coalition Coordinator candidate should believe strongly in the value of harm reduction for preventing deaths and the importance of having voices of people with lived experience at the table.

Suggested Duties and Responsibilities

- ☐ Serve as the community organizer of the community coalition.
- ☐ Collaborate with members to enhance coalition building and community engagement.
- ☐ Responsible for agenda development, training needs, planning, and other coalition-related tasks as needed.
- ☐ Help identify a diverse and representative set of key people to serve on the coalition, including content area champions related to naloxone, medications for opioid use disorder, opioid prescription safety, data, and communications.
- ☐ Work constructively with a diverse group of key people, including community leaders, addiction treatment providers, law enforcement, medical and mental health providers, and recovery programs.
- ☐ Facilitate the development of a charter and meet expectations set by the charter.
- ☐ Facilitate coalition meetings.
- ☐ Aid in conducting a needs assessment, selecting evidence-based practices, and monitoring and evaluation.
- ☐ Create plans to promote sustainability of coalition activities.
- ☐ Partner with champions to prepare and disseminate information to coalition, partners, and the public.
- ☐ Promote the inclusion of people who use drugs, people with lived experience, families, people of color, unhoused people, and other key populations.
- ☐ Support diverse perspectives, constructive dialogue, and consensus-building among coalition members with a variety of backgrounds.
- ☐ Other duties as necessary.

Suggested Qualifications

- ☐ Flexibility and willingness to work as part of a team
- ☐ Local expertise, relationships, and knowledge of community history and dynamics; preference for residents
- ☐ Strong meeting planning, scheduling, and facilitation skills
- ☐ Experience building and coordinating coalitions of diverse people
- ☐ Capable of communicating among many partners in organized and clear manner
- ☐ Strong writing and public speaking skills
- ☐ Alignment with cultural humility and the tenets of harm reduction
- ☐ Experience with research and working to address opioid use disorders a plus

Suggested Education or Equivalent Experience

- ☐ Professional training in public health, social work, community health, or similar field in human services OR equivalent years of experience and service
- ☐ Multilingual skills highly recommended

APPENDIX D. COALITION COMPOSITION ASSESSMENT TOOL

The following are recommended for members in a coalition to address opioid overdose deaths.

- ☐ People with lived experience with opioid use disorder (OUD), particularly those that have experience with medications for OUD as a pathway to remission and recovery (e.g., peer support specialists, attendees of recovery meetings supportive of medications for opioid use disorder [MOUD], and those identified as key opinion leaders that support harm reduction efforts).
- ☐ People employed in the criminal legal sector (e.g., local jail employee, community supervision programs, drug court and law enforcement).
- ☐ People employed by agencies providing medication for OUD (e.g., prescribing providers, case workers/care navigators in MOUD providing agencies).
- ☐ People familiar with safe opioid prescribing, dispensing, and disposal (e.g., opioid-prescribing MDs, PA, and APRNs; pharmacists; pharmacy technicians and members of regulatory or prescription drug monitoring boards or programs).
- ☐ People familiar with local challenges and opportunities related to naloxone (e.g., local harm reduction staff, quick response teams, pharmacists, pharmacy technicians, and health department employees).
- ☐ People who are local opinion leaders and influential in local and organizational decision-making (e.g., local coalition chairs, local governmental leaders, and organizers of local community events and trainings).
- ☐ People involved in providing ancillary services relevant to remission and recovery from OUD (e.g., social support services and assistance programs).
- ☐ People involved in local emergency response (e.g., emergency management services, fire departments, police, quick response teams, and social work teams).
- ☐ Family and friends of people with OUD.
- ☐ People involved in monitoring or collecting local data relevant to OUD.
- ☐ Leaders and providers from healthcare settings.
- ☐ Members of faith-based communities.
- ☐ Members of cultural and traditional community groups.

How might the current makeup of this coalition influence decision-making?

Does the coalition reflect county demographics with respect to age, gender, sexuality, race, and ethnicity?

☐ Yes ☐ Somewhat ☐ No

If no or only somewhat, what groups do you feel are missing and how may we reach them with invitations?

After reviewing the list above, do you feel that the coalition in _____ (location) has/had adequate representation from every sector on the *priority list? ☐ Yes ☐ No

If not, who is missing, and who might we consider inviting?

Name	Organization/role	Contact information
Name	Organization/role	Contact information
Name	Organization/role	Contact information

After reviewing the lists above, do you feel that the coalition in _____ location has/had adequate coverage for the areas listed that were not marked with *s? ☐ Yes ☐ No

If not, who is missing, and who might we consider inviting?

Name	Organization/role	Contact information
Name	Organization/role	Contact information
Name	Organization/role	Contact information
Name	Organization/role	Contact information

Continued

Do the people that currently make up the coalition have the necessary time to commit to meaningfully serving on the coalition?

☐ Yes, all do ☐ Some do, but others may not ☐ No

If no or only some do, who does or may not?

Name	Organization/role	Contact information
Name	Organization/role	Contact information
Name	Organization/role	Contact information

Who might we consider/have considered inviting in their place? You may want to consider one of their staff or colleagues, or a person from a different but similar organization.

Name	Organization/role	Contact information
Name	Organization/role	Contact information
Name	Organization/role	Contact information

Source: Kentucky HEALing Communities Study

APPENDIX E. COALITION READINESS ASSESSMENT

Instructions: You must download and save the file to your computer before filling it out. Completing the form within your web browser will not save your work.

OVERVIEW OF COMMUNITY	
County	
Geography (Rural/Urban)	
Population	
Total Population	
AA/Black Pop (%)	
Latino/Hispanic Pop (%)	
Overdoses (#/Rates per 100,000 population)	
Fatal Opioid Overdoses	
Non-Fatal Opioid Overdoses	
Fentanyl-Related	
MOUD	
MOUD Providers	
MOUD Prescriptions	
OEND	
EMS	
Law Enforcement	
Overdose Prevention Specialists	
Local Prevention, Treatment, and Recovery Resources	
PWUD Peer Champions and Community Experts	

Source: New York HEALing Communities Study

Continued

APPENDIX E. COALITION READINESS ASSESSMENT

COALITION HISTORY & STRUCTURE	
Coalition	
Name of Coalition Lead	
Name of Coalition	
Year Established	
Fiscal Agent	
Anchor/Lead Agency/Organization	
Coalition Staff	
Program Manager	
Data Coordinator	
Workgroups & Champions	
Coalition Charter or Mission	
Meeting Frequency	
Funders (Current & Past)	

Source: New York HEALing Communities Study

Continued

APPENDIX E. COALITION READINESS ASSESSMENT

COMPOSITION OF CURRENT COALITION	
County	
Criminal Justice	
Jail/Prison	
Courts	
Police	
Probation/Parole	
Healthcare	
Behavioral Health	
SUD Treatment Providers	
MOUD Providers	
Hospitals	
Primary Care	
Maternal Health	
Pharmacies	
Emergency Response (EMS, Fire Dept, etc.)	
Peer Organization	

Source: New York HEALing Communities Study

Continued

APPENDIX E. COALITION READINESS ASSESSMENT

COMPOSITION OF CURRENT COALITION	
People with Lived Experience & Loved Ones	
PWLE	
PWUD	
Family & Friends of People with OUD	
BIPOC Communities	
BIPOC Individuals	
BIPOC Organizations	
Gov't Agencies	
Local Prevention, Treatment, and Recovery Resources	
Elected Officials	
Faith-Based Organizations	
Housing	
Communications	
Local Media	
Staff with Communications Experience (social media, PR, campaigns, etc.)	
Local Businesses	
Veterans	

Source: New York HEALing Communities Study

Continued

APPENDIX E. COALITION READINESS ASSESSMENT

CURRENT & PAST EVIDENCED-BASED PRACTICES IMPLEMENTED IN THE COMMUNITY TO ADDRESS THE OPIOIDS CRISIS	
County	
Overdose Education and Naloxone Distribution	
Medications for Opioid Use Disorder	
Safer Prescribing, Dispensing & Disposal	

COMMUNICATIONS CHANNELS, CAMPAIGNS & PRESS COVERAGE (EARNED MEDIA)	
County	
Website (URL)	
Social Media Channels	
Facebook	
Instagram	
Twitter	
Current & Past Media Campaigns	
Earned Media Received (examples)	

Source: New York HEALing Communities Study

Continued

APPENDIX E. COALITION READINESS ASSESSMENT

COALITION'S ACCESS TO DATA & ABILITY TO SHARE WITH THE PUBLIC	
County	
Relationship with Medical Examiner? (Yes/No)	
Relationship with County Coroner? (Yes/No)	
Utilize ODMAP? (yes/no)	
Existing Dashboard (on website, internal site, etc.)	

Source: New York HEALing Communities Study

Additional Questions:

Does the coalition reflect county demographics with respect to age, gender identification, sexual orientation, race, and ethnicity, and class? □ Yes □ Somewhat □No

If no or only somewhat, what groups do you feel are missing and how may we reach them with invitations?

Does the coalition reflect different municipal sub-units or geographic areas of the community?

If not, who is missing and who might we consider inviting?

APPENDIX F. HEALing COMMUNITIES STUDY

The National Institutes of Health and the Substance Abuse and Mental Health Services Administration launched the HEALing Communities Study (HCS) to test the immediate impact of an integrated set of evidence-based interventions across healthcare, behavioral health, criminal legal, and other community-based settings to prevent and treat opioid misuse and opioid use disorder within highly affected communities. The HCS tests the impact of the Communities That HEAL (CTH) intervention, which seeks to integrate prevention efforts, overdose treatment, and medication-based treatment in select communities hard hit by the opioid crisis. The CTH intervention contains three components: (1) a community-engaged coalition and data-driven process to facilitate the implementation of evidence-based practices; (2) the Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) menu of strategies; and (3) communication campaigns to address stigma and increase knowledge of, and demand for, evidence-based practices. This comprehensive treatment model was tested in a coordinated array of settings, including primary care, emergency departments, and other community settings.

The goal of the HCS is to reduce opioid-related overdose deaths by 40 percent over the course of 3 years. Research sites partnered with 67 communities highly affected by the opioid crisis in four states to measure the impact of these efforts. The study looks at the effectiveness of coordinated systems of care designed to increase the number of people receiving medication to treat opioid use disorder (OUD), increase the distribution of naloxone, and reduce high-risk opioid prescribing. The study also supports harm reduction research to investigate the effectiveness of rapid-acting fentanyl test strips in modifying drug use behaviors and exploring drug checking needs in clinical settings.

Because implementation of evidence-based practices to reduce opioid overdose deaths within communities remains suboptimal, community engagement strategies were employed to improve the uptake and sustainability of those practices. Community coalitions were required to select at least five ORCCA menu strategies with a minimum of (1) one strategy involving active OEND; (2) three strategies involving medications for opioid use

disorder (MOUD) expansion, linkage, and retention; and (3) one strategy on safer opioid-prescribing/dispensing practices. In addition, the study protocol required coalitions to implement at least one evidence-based practice strategy in three key sectors (behavioral health, criminal legal, and healthcare). Coalitions were encouraged to consider evidence-based practice strategies focused on those most vulnerable to opioid overdose (e.g., people with a prior opioid overdose, people who inject drugs, etc.) and priority settings (e.g., correctional settings, syringe service programs, etc.). Additional detail on the development of community coalitions can be found in the article Community engagement to implement evidence-based practices in the HEALing communities study.

Research grant awards were issued to the University of Kentucky in Lexington; Boston Medical Center in Boston; Columbia University in New York City; and Ohio State University in Columbus. The HEALing Communities Study is a multiyear study under a cooperative agreement supported by the National Institute on Drug Abuse, part of the NIH. The study launched in 2019, and results will be shared in the summer of 2023. Technical details and specifics about study design and how intervention success was evaluated can be found in the article The HEALing (Helping to End Addiction Long-term SM) Communities Study: Protocol for a cluster randomized trial at the community level to reduce opioid overdose deaths through implementation of an integrated set of evidence-based practices.

APPENDIX G. ACKNOWLEDGMENTS

Technical Expert Panel Members

- **Pedro Alvarez**, Assistant Director of Urban Drug User Health & Outreach, Tapestry
- **Lawrence Bryant**, PhD, MPH, Assistant Professor, Kennesaw State University
- **Judy Harness,** RN, MS, Community Engagement Project Manager, HEALing Communities Study Ohio
- **Tim Hunt**, PhD, MSW, Associate Director, Columbia University School of Social Work
- **Ben Riker**, Director of Government Alliances, Velocity BioGroup
- **Clayton Ruley,** MLSP, MSS; Director of Diversity, Equity, Inclusion and Harm Reduction; Community Liver Alliance
- **Reyna Saures**, Administrative Services Manager, Commonwealth Healthcare Corporation: Community Guidance Center
- **Hilary Surratt**, PhD, Associate Professor, University of Kentucky

HEALing Communities Study

- Continuum of Care Work Group
- Community Engagement Work Group

Substance Abuse and Mental Health Services Administration

- **Yngvild K. Olsen**, MD, MPH, Director of the Center for Substance Abuse Treatment
- **Karran Phillips**, MD, MSc, Deputy Director of the Center for Substance Abuse Treatment
- **Carter Roeber**, PhD, MA, Social Science Analyst, National Mental Health and Substance Use Policy Laboratory
- **Humberto Carvalho**, MPH, Project Officer, Center for Substance Abuse Treatment

National Institute on Drug Abuse

- **Redonna K. Chandler**, PhD, Director of the HEALing Communities Study
- **Jennifer Villani**, PhD, MPH, Associate Director of the HEALing Communities Study
- **Andrea Czajkowski**, MBA, PMP, Program Analyst, HEALing Communities Study

RTI Data Coordinating Center

- **Joëlla W. Adams**, PhD, MPH, Research Epidemiologist
- **Megan Hall**, MPH, Research Clinical Study Specialist
- **Beth Linas**, PhD, MHS, Research Epidemiologist
- **LaShawn Glasgow**, DrPH, MPH, Senior Director, Center for Program and Policy Evaluation to Advance Community Health
- **Craig LeFebvre**, PhD, MS, Communications Scientist
- **Emmanuel Oga**, MD, MPH, Senior Research Epidemiologist
- **Lauren Farmer**, BA, Project Management Specialist

RTI Editing and Design

- **Vivien Arnold**, MA, Senior Graphic Designer
- **Ally Elspas**, BA, Senior Graphic Designer
- **Rebecca Hipp**, BS, Senior Project Management Specialist
- **Claire Korzen**, BA, Editor
- **Shari Lambert**, BFA, Senior Graphic Designer
- **Michelle Myers**, BS, Senior Editor

APPENDIX H. TECHNICAL EXPERT BIOGRAPHIES

Pedro Alvarez is the Assistant Director of Urban Drug User Health & Outreach at Tapestry. Mr. Alvarez started his career at Tapestry in January 2016 as a Harm Reduction Counselor providing direct service to active injection drug users and their immediate social networks. Within his new role, he oversees HIV prevention programs that service drug users, with a specific focus on harm reduction services centered in heavily concentrated urban areas. Mr. Alvarez is fortunate enough to work in his hometown community for a community-based organization that truly cares about its residents. He is passionate about community education and awareness surrounding topics of harm reduction and the intersection of healthcare and innovation. He serves on the Board of Directors as Vice President of The Consortium, which works to create conditions in which people with lived experience can fully participate in decision-making processes related to their and their community's needs. He is also a member of the Department of Public Health's Latinx advisory group and numerous community-based efforts related to social justice and the Latinx population.

Lawrence Bryant, PhD, MPH, brings a plethora of experiences and knowledge dealing with substance use disorders (SUD), HIV/AIDS prevention, cultural responsiveness, and issues related to race and sexual orientation. He has successfully developed and implemented a statewide strategic plan for Georgia in response to the opioid and prescription drug overdose epidemic. As a result of this formative work, Dr. Bryant received a grant to do a multicultural needs assessment among vulnerable populations in support of the Statewide Strategic Plan from the Georgia Department of Public Health. Dr. Bryant has also published more than 20 peer-reviewed articles in the areas of HIV/AIDS, homophobia, racism, and tobacco use prevention. He has been a registered respiratory therapist for more than 45 years, most recently fighting on the front lines of the COVID-19 pandemic. As a part-time Assistant Professor at Kennesaw State University and Capella University, Dr. Bryant teaches SUD, health, and wellness courses and does research and training in SUD prevention, treatment, and recovery. Dr. Bryant is a sought-after speaker and presenter at the national and international levels, and on August 16th, 2022, celebrated 30 years in recovery.

Judy Harness, RN, MS, has proudly served the HEALing Communities Study for Ohio as Project Director of Community Engagement since 2020. For her, responding to the call to get involved in the work of the opioid crisis is an opportunity to serve those most in need. Having family members impacted by the devastation of addiction was the doorway to working on the HEAL study. She has worked in the field of community health as a Clinical Nurse Specialist for the past 20 years. Primarily working in the field of tobacco cessation research, she has managed various projects in the Appalachian communities of Ohio. She has been a nurse since 1985 and has a passion for people! Although she loves caring for those in the hospital, she is happy to devote herself to promoting positive health initiatives in communities across Ohio and

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beyond. She is active in her local community, married to her best friend for 35 years, mother of four, and Grandma to eight beautiful children, not including two lovely pups who think they are children. A two-time graduate of The Ohio State University, she is a proud Buckeye! O-H.....I-O!

Timothy Hunt, PhD, MSW, is an Associate Research Scientist and Associate Director with the Social Intervention Group, the Global Health Research Center of Central Asia, and Columbia's Center for Healing of Opioid and Other Substance Use Disorders-Enhancing Intervention, Development and Implementation (CHOSEN) at the Columbia University, School of Social Work. Dr. Hunt has provided trauma-informed family therapy, substance abuse treatment, and HIV prevention and care for more than 33 years. His global and domestic research includes (1) designing, testing, and disseminating HIV/sexually transmitted infection prevention and health promoting interventions; (2) studying the effectiveness of capacity-building strategies and methods to support evidence-based interventions and core competencies of the healthcare workforce in Europe, Central Asia, and the Middle East; and (3) the adaptation and translation of evidence-based interventions aimed at reducing harm caused by addictions, reducing harm caused by intimate partner violence, and promoting wellness. He is co-investigator for the HEALing Communities Study, co-designing and leading the community-engaged intervention, and for the New York State engagement of the criminal legal sector aimed at reducing overdose deaths in 16 New York State counties, in collaboration with 67 counties from Ohio, Massachusetts, and Kentucky. Dr. Hunt is an international trainer in Motivational Interviewing and a CDC Master Dissemination Trainer.

Ben Riker is a father of two, a person in recovery, and a passionate advocate for data-driven, evidence-based policy surrounding education, treatment, and recovery from SUDs. His professional background includes all aspects of organizational peer-professional integration and programming, including training, coaching, and supervision as well as community and professional education and outreach. Ben has experience as a Friends of Recovery-New York Best Practice Trainer; is a member of the Agency for Substance Abuse Policy—New York City Board Trainer Registry; and serves on the Partnership to End Addiction's FIRST Research Network National Advisory Board, Faces and Voices of Recovery's National Public Policy Committee, and the NY Association of Substance Abuse Provider's Harm Reduction Committee.

Clayton Ade-Andrew Ruley, MLSP, MSS, is a social worker by trade and currently the Director of Diversity, Equity, Inclusion, and Harm Reduction at the Community Liver Alliance (CLA). Before his work with CLA, Clayton worked for 12 years at Prevention Point Philadelphia serving in a host of official (and unofficial) leadership roles, from coordinating free medical clinics in the Street-side Health

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Project, the Stabilization Treatment and Engagement Program (STEP), directing the Harm Reduction Service Center, to leading the Community Engagement and Volunteer Services Department. Clayton graduated from Bryn Mawr Graduate School of Social Work and Social Research (GSSWSR) in 2010 with a dual MSS and MLSP. While at GSSWSR, Clayton was a 2009 Ruth Mayden Scholar, first Annual Kevin J. Robinson awardee, and a 2010 Fellow with the Black AIDS Institute's African American HIV University program. He earned his undergraduate degree from Bloomsburg University, where he majored in political science and mass communications. A social worker coming from a family of social workers (mom, dad, brother, sister-in-law, godfather), Clayton is a harm reductionist, social justice advocate, and avid user of media who loves to inform and be informed. Clayton is a lifelong Philadelphia resident.

Reyna Malone Saures, a resident of the Commonwealth of the Northern Mariana Islands (CNMI), has been engaged in behavioral health in different facets. From May 2013 to May 2015 and again from March 2019 to January 2022, she served as the Director of Behavioral Health (Community Guidance Center) under the Commonwealth Healthcare Corporation (CHCC)—the Single State Authority for Behavioral Health services in the CNMI. Currently, she serves in the Director's office as the Administrative Services Manager working with CHCC behavioral health programs across the continuum of care and across service and age populations, as well as in areas that promote strategic planning, data-driven systems, evaluation, and quality assurance. Most notably, she is mother to a son on the spectrum for autism and family member and friend to individuals with lived experience. Both her personal and professional experiences in the field fuel her passion to advocate for and engage in policies, best practices, and activities that promote hope, healing, and health among those she loves, is surrounded by, and serves in her community.

Hilary L. Surratt, PhD, is Associate Professor in the Department of Behavioral Science at the University of Kentucky and Director of Evaluation at the Center for Clinical and Translational Science. Her research interests include SUD and infectious disease, with a focus on optimizing behavioral and structural interventions to improve care for people who use drugs. As a Kentucky native with a passion for working in underserved communities, she has forged successful bidirectional partnerships with rural Appalachian County health departments to undertake critical harm reduction research in areas of the state that have been devastated by the opioid epidemic. She has embraced the opportunity to contribute to rural community-engaged substance use research with the goal of informing effective practice and promoting equitable access to evidence-based treatment and care for underserved rural populations. Dr. Surratt has published more than 150 peer-reviewed articles and book chapters; her recent work has appeared in *Drug and Alcohol Dependence, Frontiers in Psychiatry, Therapeutic Advances in Infectious Disease*, and *Journal of Clinical and Translational Science*.