# Office of Substance Abuse Prevention

# Behavioral Health Services Division, Human Service Department

# State of New Mexico

# Coalition Capacity

# and

# Community Readiness

# TRAINING

Funding for this training comes from the New Mexico Behavioral Health Services Division – Office of Substance Abuse Prevention (New Mexico Human Services Department). The New Mexico SPF Rx project is funded by a grant from the Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration (CSAP/SAMHSA). For questions, please contact: Karen Cheman, MPH (Prevention Director, NPN & SEOW Director), [karen.cheman@state.nm.us](mailto:karen.cheman@state.nm.us" \t "_blank), Office of Substance Abuse Prevention, BHSD/HSD, 37 Plaza La Prensa, Santa Fe, NM 87507, [505-476-9270](tel:505-476-9270" \t "_blank).

|  |
| --- |
| **Reflect on the Assessment** |

|  |
| --- |
| Think about the Assessment process thus far… |
| 1. What were some of the positive things that came out of your efforts? |
| 1. What did you learn that you did not expect to learn? |
| 1. What were some of the challenges you experienced? |
| 1. What do you need to know more about? |



**Coalition Development**

This course is designed to assist grantees engaged in coalition building. The materials covered in this training will help partners develop effective coalitions for implementing community level change.

**Objectives**

1. Understand the benefits of developing a coalition
2. Identify effective and sustainable coalition structures and membership
3. Understand how to develop and refine a mission and vision statement
4. Develop a successful elevator speech for recruiting coalition members
5. Understand the requirements of completing OSAP deliverables

**Capacity and Readiness**

The goal of this course is to guide communities to use data gathered during the assessment phase to identify where capacity needs to be built. It is important to remember capacity is about building resources around intervening variables and coalitions, not a specific organization. Participants will identify current resources for each intervening variable, resource gaps, and other factors to consider when addressing intervening variables. Participants will also become familiar with community readiness and the importance it plays in effective community mobilization.

**Objectives**

1. Explain what a community prevention system looks like that addresses ATOD
2. Name at least 5 capacity building activities
3. Analyze gaps and resources around goals and intervening variables
4. Assess levels of readiness using the *Readiness Assessment*
5. Describe your community’s capacity and readiness to address your ATOD priorities
6. Complete a Capacity & Readiness report for their community

|  |
| --- |
| **Agenda** |
| Strategic Prevention Framework Timeline |
| Overview of Assessment Process |
| Coalition Building |
| Vision and Mission Statements |
| Coalition Structure |
| Coalition Building Reporting |
| Introduction to Capacity |
| Systems Thinking |
| Substance Abuse Prevention Systems |
| Identifying Resources/Gaps |
| Community Readiness |
| Capacity & Readiness Reporting |
| Next Steps & Adjourn |

|  |
| --- |
| **What is a Coalition?** |

**What Does a Successful Substance Abuse Prevention Coalition Look Like?**

Community coalitions have been used for many years under different names such as collaborative partnerships, networks, community forums, task forces, and interagency coordinating councils. **Community coalitions are comprised of mutually beneficial relationships between individuals, governmental agencies, private sector organizations and/or community-based organizations that seek to achieve common goals.**

Experience has shown that substance abuse prevention works best and is most sustainable when it is done in the context of coalitions committed to preventing substance abuse in specific communities. These coalitions should include representatives from different parts of the community, such as the local governments, media, law enforcement, schools, and parents, to name a few. The coalitions should also strive to represent the ethnic and economic diversity of the local community.

**Key Ingredients to Building Partnerships:**

• Ensure mutual respect, understanding and trust among members

• Include persons representing administration, service provision, and service “customers”

• Establish clear roles for coalition members and staff to prevent confusion/conflict

• Set specific rules about how to handle conflict

• Build skills, knowledge, and positive attitudes among members

• Select partners with links to resources and represent broad sectors

• Include diverse membership in terms of age, ethnicity, and socioeconomic status (SES)

• Promote benefits to involvement that are clear and outweigh the costs to members

• Start with strong leadership

* Use incentives to reward/motivate
* Link tasks directly to goals
* Share leadership, emphasizing exchange of ideas, voices
* Promote collective leadership based on democratic principles

*Source: Champions for Inclusive Communities, Evidence Based Practices for Coalitions*

**Several conditions have to be present for the formation of a coalition.**

**First**, there has to be an issue that requires addressing or interest in an issue that coalition members find they have in common.

**Second**, potential members have to share a belief that they can achieve success through building a coalition.

**Third**, there must be an understanding that the action taken has to be jointly performed. Once these criteria are met, the building of the coalition begins.

**Benefits of Coalitions**

* The benefits of coalition building go beyond increased power in relation to the opposition. Coalition building may also strengthen the members internally, enabling them to be more effective in other arenas.
* A coalition of organizations can win on more fronts than a single organization working alone.
* A coalition can bring more expertise and resources to bear on complex issues, where the technical or personnel resources of any one organization would not be sufficient.
* A coalition can develop new leaders. As experienced group leaders step forward to lead the coalition, openings are created for new leaders in the individual groups. The new, emerging leadership strengthens the groups and the coalition.
* A coalition will increase the impact of each organization's effort. Involvement in a coalition means there are more people who have a better understanding of your issues and more people advocating for your side.
* A coalition will increase available resources. Not only will physical and financial resources be increased, but each group will gain access to the contacts, connections, and relationships established by other groups.
* A coalition may raise its members' public profiles by broadening the range of groups involved in a conflict. The activities of a coalition are likely to receive more media attention than those of any individual organization.
* A coalition can build a lasting base for change. Once groups unite, each group's vision of change broadens and it becomes more difficult for opposition groups to disregard the coalition's efforts as dismissible or as special interests.
* A successful coalition is made up of people who have never worked together before. Coming from diverse backgrounds and different viewpoints, they have to figure out how to respect each other's differences and get something big accomplished. They have to figure out how each group and its representatives can make their different but valuable contributions to the overall strategy for change. This helps avoid duplication of efforts and improve communication among key players.

**Disadvantages of Coalitions**

* Member groups can get distracted from other work. If that happens, non-coalition efforts may become less effective and the organization may be weakened overall.
* A coalition may only be as strong as its weakest link. Each member organization will have different levels of resources and experience as well as different internal problems. Organizations that provide a lot of resources and leadership may get frustrated with other members' shortcomings.
* To keep a coalition together, it is often necessary to cater to one side more than another, especially when negotiating tactics. If a member prefers high-profile confrontational tactics, they might dislike subdued tactics, thinking they are not exciting enough to mobilize support. At the same time, low-profile conciliatory members might be alarmed by advocates of confrontation, fearing that they will escalate the conflict and make eventual victory more difficult to obtain.
* The democratic principle of one group, one vote may not always be acceptable to members with a lot of power and resources. The coalition must carefully define the relationships between powerful and less-powerful groups.
* Individual organizations may not get credit for their contributions to a coalition. Members that contribute a lot may think they did not receive enough credit.

|  |
| --- |
| **Vision & Mission Statements** |

**A shared vision should unify partners**

* What motivates each of the partners to be involved?
* What do they most want to accomplish through their involvement?
* Can key words and phrases be gleaned from the phrases mentioned above and used to develop the vision and objectives of the coalition?
* How does the coalition’s mission relate to your/the home organization’s mission?

*Source: Health Research and Educational Trust (2003), The Collaboration Primer, Chicago Il.*

Mission statements are similar to vision statements in that they look at the big picture. However, they're more concrete, and they are definitely more "action-oriented" than vision statements. Your vision statement should inspire people to dream; your mission statement should inspire them to action.

|  |  |
| --- | --- |
| **Components of a Vision Statement** | **Components of a Mission Statement** |
| **Your vision is your dream. It's what your organization believes are the ideal conditions for your community; that is, how things would look if the issue important to you were completely, perfectly addressed.**  There are certain characteristics that most vision statements have in common. In general, vision statements should be:  **Understood** and shared by members of the community  **Broad enough** to include a diverse variety of local perspectives  **Inspiring and uplifting** to everyone involved in your effort  **Easy to communicate** - for example, they are generally short enough to fit on a T-shirt | **An organization's mission statement describes what the group is going to do and why it's going to do that.**  Some general guiding principles about mission statements are that they are:  **Concise.** While not as short as vision statements, mission statements generally still get their point across in one sentence.  **Outcome-oriented.** Mission statements explain the fundamental outcomes your organization is working to achieve.  **Inclusive.** While mission statements do make statements about your group's key goals, it's very important that they do so very broadly. Good mission statements are not limiting in the strategies or sectors of the community that may become involved in the project. |
| **VISION EXAMPLES:**  Caring communities  Healthy children  Safe streets, safe neighborhoods  Every house a home  Education for all  Peace on earth | **MISSION EXAMPLES:**  "Promoting child health and development through a comprehensive family and community initiative."  "To create a thriving African American community through development of jobs, education, housing, and cultural pride."  "To develop a safe and healthy neighborhood through collaborative planning, community action, and policy advocacy."  "Promoting community health and development by connecting people, ideas and resources." (This is the mission of the Community Tool Box) |

*Source: The Community Toolbox,* [*www.ctb.ku.edu*](http://www.ctb.ku.edu)

|  |
| --- |
| **Effective Coalition Structures** |

**What needs to be maintained are the key structures, functions, and relationships of the coalition that helped get it started in the first place.**

* The coalition's reason for being—its vision, mission and objectives
* The basic governance and operating rules of the coalition
* The coalition leadership
* The coalition membership
* The division of labor within and among the leaders and members
* The coalition's strategic and action plans, both short-and longer-term
* The coalition's actions and results, so that it is accomplishing something (what it means to) in the world
* The coalition's funding, so that those accomplishments can be continued
* The coalition's visibility in the larger community
* The coalition's public support
* The spirit of the coalition, the good feelings and relationships among all involved, which are a fundamental precondition for the coalition's continued existence.

*"Coalition building is a very lengthy process, and it's one that doesn't always go smoothly or according to anybody's pre-established time line. People in coalitions need to remember that, and to accept that, and not be disappointed that things don't go as quickly as they want to. As each new member comes in, it changes the whole dynamic and the whole focus, and that's part of it. It's constantly evolving. The coalition never has an end in sight, not unless you want to disband it. It just doesn't have an end. It constantly changes. You just have to keep going and plugging away. That 's just the nature of it...."*

|  |
| --- |
| **Structure** |

**Effective coalition structures** are consistently reliable in communication, leadership, member roles, and decision making in order to accomplish activities. Over time when repeatedly utilized, effective coalition structures will strengthen allegiance and deepen the coalition's roots.

**Coalition Structure Considerations:**

* Does your coalition include subcommittees or workgroups to address specific issues?
* Is the structure of the coalition appropriate for the vision and mission of the organization?
* Does your coalition have built in maintenance? A regular means of getting feedback about the way the coalition is run, how it might be improved, etc.?

Coalitions can be organized and administered in a variety of ways. The coalition can be governed by participants, lead organizations, or through the use of a core team. A core team is an entity of the coalition that operates as administrator and manager for the coalition. The core team makes final decisions and holds the conglomerate of programs and service providers operating as the network accountable.

|  |
| --- |
| **Communication** |

**Internal – External – Formal – Informal**

There are three interrelated issues that an organization needs to address in promoting internal communication. The first involves the organizational ***climate and culture*.** The organization has to be a place where open communication is accepted and encouraged. The second concerns ***establishing clear definitions of what needs to be communicated****,* and by whom. If you assumed that everyone always needed to know about absolutely everything, the staff would spend all its time merely receiving and passing on information. There need to be guidelines about what information gets passed along and how information gets passed along. The last issue is that of the ***systems that the organization creates*** to get its work done and to enable internal communication. Are they structured to encourage communication in all directions, or to discourage or channel it in particular ways?

Consider identifying a single point of contact to manage the process and ensure that things get done. Be sure to share responsibilities across coalition members. Plan to periodically bring in new partners for a boost of energy and fresh ideas, and check in regularly with existing partners to see if they have suggestions or concerns. Communication among partners and any staff that are involved is one of the keys to effective implementation.

**Coalition Communication Processes:**

* How do coalition members communicate among themselves?
* How do people find out about the coalition’s activities?
* Is there a balance between formal and informal communication?
* How does the coalition communicate with the community / publicize events?
* Is there an agreed upon communication pathway?
* Does the coalition have a social marketing plan or other communication plan?
* Is there a plan for soliciting feedback from the coalition?
* How well can the coalition inform and engage people, organizations, and communities with diverse cultural and ethnic interest or for whom English is not their dominant language?
* Does the coalition communicate well and regularly with grassroots organizations?

*Source: Health Research & Education Trust (2003), The Collaboration Primer.*

**Coalition Activity – Developing a Communication Plan**

**To develop a plan for communication of any sort, you have to consider some basic questions:**

* Why do you want to communicate with the community? (What’s your purpose?)
* Whom do you want to communicate it to? (Who’s your audience?)
* What do you want to communicate? (What’s your message?)
* How do you want to communicate it? (What communication channels will you use?)
* Whom should you contact and what should you do in order to use those channels? (How will you actually distribute your message?)

**The answers to these questions constitute your communication action plan, what you need to do in order to communicate successfully with your audience. The remainder of your communication plan, involves three steps:**

* Implement your action plan. Design your message and distribute it to your intended audience.
* Evaluate your communication efforts, and adjust your plan accordingly.
* Keep at it!

|  |
| --- |
| **Establishing Roles** |

**Partners should be aware of what’s expected of them.**

* What are the ground rules for participating in the partnership?
* Are roles and responsibilities within the coalition established?
* Have you identified who is best suited to achieve certain objectives (this can be individuals or organizations)?
* If you coalition is not yet formed, how might you make it clear to new members what is expected of them?

**Additional Resources**

* Worksheet: Determining Member Responsibilities
  + <https://captcollaboration.edc.org/collaboration-tools>

|  |
| --- |
| **Decision Making** |

* How are decisions made?
* Is there an agreed upon decision-making process?
* Do all coalition members have the opportunity to participate in decision-making?
* Did all coalition members participate in the creation of the vision and mission?

**Additional Resources**

* Decision-Making Models: Voting Versus Consensus
  + <https://captcollaboration.edc.org/collaboration-tools>

|  |
| --- |
| **Membership** |

* Does your coalition reflect your community?
* Does your coalition include key community decision makers?
* Does your membership have a balance of community residents and organizations?
* Does your coalition include members with different backgrounds, experiences and expertise?
* Does your coalition actively recruit members with different backgrounds, experiences and expertise?

|  |
| --- |
| **Leadership** |

**Leadership – Co-Facilitators / Coordinator**

* Who is your coalition leader?
* Are leadership roles and responsibilities clearly defined?
* Do coalition members have the opportunity to fill leadership roles?
* Are there opportunities to develop leaders?
* Are the ideas of all coalition members heard and respected?
* How adequate is the leadership team in securing resources, managing conflict, balancing needs and interests?
* How is new leadership identified and rotated into key positions?
* What could be done to improve it?

**The most important element in any coalition is the coordinator.** The absence of a coordinator or a coordinator that does not have sufficient time or interest can make or break the work of a coalition. The coordinator is the individual who gets ball rolling, organizes the coalition, provides the essential structure, and leads the organization’s efforts. The importance of a coordinator cannot be stressed enough—too often it is the lack of this essential element that dooms a good idea.

**Here are some universally agreed upon elements of leadership that the coordinator should possess:**

* Respected by others, generate confidence and know how to cooperate
* Able to inspire others and motivate them to take action
* Knowledgeable about their organization/group and the issue(s) the group supports, and is enthusiastic about achieving goals
* Have the capacity to see diversity in all its forms and the skills needed for conflict resolution and consensus building
* Able to build ownership and commitment among others
* Able to take initiative and demonstrate drive when necessary
* Good communicators
* Well-organized

**Additional Resources**

* Do’s and Don’ts of Collaborative Leadership
  + <https://captcollaboration.edc.org/collaboration-tools>

**What Is Collaborative Leadership?**

Facilitating mutual enhancement among those working together for a common purpose

(ArthurTHimmelman@aol.com)

SOME COLLABORATIVE LEADERSHIP CHARACTERISTICS \*

1. A commitment to improve common circumstances based on values, beliefs, and a vision

for change that is communicated both by talking it and walking it.

1. An ability to persuade people to conduct themselves within ground rules that provide

the basis for mutual trust, respect, and accountability.

1. An ability to respectfully educate others about the relationship of processes to

products/outcomes and organizational structure to effective action.

1. An ability to draw out ideas and information in ways that contributes to effective

problem-solving rather than ineffective restatements of problems.

1. A willingness to actively encourage partners to share risks, responsibilities, resources,

and rewards and to offer acknowledgments of those making contributions.

1. An ability to balance the need for discussion, information sharing, and story telling

with timely problem-solving and keeping focused on responding to action-oriented

expectations of those engaged in common efforts.

1. An understanding of the role of community organizing as the basis for developing and

expanding collaborative power.

1. A commitment to and active engagement in leadership development activities, both

informal and formal, that can take the collaborative process to higher levels of

inclusiveness and effectiveness.

1. An ability to communicate in ways that invite comments and suggestions that address

problems without attacking people and, when appropriate, draws upon conflict resolution

and win-win negotiating to resolve differences.

1. A very good sense of humor, especially whenever collaborative processes get ugly or

boring or both.

**Coalition Development Report**

**New Mexico Office of Substance Abuse Prevention Grantees**

**Due - May 31, 2017**

Please submit this report to the following people:

[Karen.Cheman@state.nm.us](mailto:Karen.Cheman@state.nm.us), Liz Lilliott [lilliott@pire.org](mailto:lilliott@pire.org), Michael Coop, [coopconsulting@gmail.com](mailto:coopconsulting@gmail.com)

|  |  |
| --- | --- |
| **Coalition Name:** |  |

|  |  |
| --- | --- |
| Project Director: |  |
| Program Coordinator: |  |
| Other Staff: |  |
| Report Completed by: |  |
| Date Completed: |  |

**Briefly describe your coalition**

|  |  |
| --- | --- |
| Key Members: |  |
| Core Team Members: |  |
| Key accomplishments to date (highlights): |  |
| Challenges or barriers experienced: |  |

**Mapping Partnerships**

**STEP 1:** List your Collaborative Community Partners. Partners are principally agencies, institutions and organizations. An engaged individual, such as a youth, parent or person in recovery who may not be affiliated with any one organization could also be a Collaborative Partner representing an important population in the community.

**STEP 2:** Using the table on the following page, determine what sector the Partner belongs to and place the code that best identifies their principal affiliation. You may use up to 2 codes per partner. If you feel that a partner encompasses more than two categories, please use the two that best describe the role that the partner plays in your coalition.

1. **Chart your Collaborative Community Partners**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DATE form was completed:** | | | | |
| **STEP 1** | **STEP 2** | **STEP 3** | **STEP 4** | |
| **Partner Name (agency, organization, institution)** | **Partner Code** | **Partner Collaborative relationship score** | **Active Coalition Member?**  **If so, name member(s)** | **Number of active coalition members** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| *Add more rows as necessary* |  |  |  |  |
| **Step 5: Please add up the total number of partners and active coalition members** | | | | |
| **Total:** |  | | | **Total:** |
|  |  |

**Collaborative Partner Types and Codes**

|  |  |  |
| --- | --- | --- |
| **Partner Sector** | **Partner Code** | **Example** |
| Parents/Community Members | PAR | Parent Teacher Organization, booster club, advocacy groups, general public |
| Youth | YTH | Athletic club, after school program, youth groups |
| Schools/SHAC | SCH | School Health Advisory Council, middle school, high school, higher education institution |
| Pain Management Specialists | PMS | Medical providers whose focus is on evaluating, diagnosing, and treating chronic pain |
| Law Enforcement Agencies | LAW | State police, municipal police, judges, attorneys, drug courts |
| Local Media | LMD | Newspaper, radio, television, social media |
| Physicians | PHS | Doctor, MD, medical practitioner, general practitioner, clinician, family doctor, nurse practitioner |
| Religious or Fraternal Organizations | RLG | Religious officials, bible study groups, the rotary club, kiwanis |
| Treatment Providers | TRT | Medical practitioners, clinics and facilities whose focus is on treating substance abuse |
| Pharmacy | PHA | Pharmacists, pharmacies |
| State, Local or Tribal Agencies | SLT | Veterans and military organizations, tribal representatives, state representatives |
| Other Substance Abuse Organizations | SAO | Recovery organizations |
| Other | OTH |  |

**STEP 3:** Partner Collaborative relationship score: With your coalition members, using the scale below, assess each community partner agency/organization/group in terms of their collaborative relationship with your coalition. Higher numbers reflect greater involvement, participation, and investment in the coalition. Be as accurate as possible. It is not expected that every partner will or should have high collaboration, nor is it necessary that every partner engage in significant participation to be effective in the role for which you need them.

|  |  |
| --- | --- |
| **Score** | **Collaborative Quality** |
| 1 | Operates separately, works individually, little to no interaction with the coalition occurs |
| 2 | Awareness of the coalition, loosely defined roles, little communication, decisions are made independently |
| 3 | Provides information to the coalition, somewhat defined roles, formal communication, and all decisions related to coalition goals are made independently |
| 4 | Shares information and resources, defined roles, frequent communication, some shared decision making related to coalition goals |
| 5 | Shares ideas, shares resources, frequent and prioritized communications, equal participation in decision making regarding coalition goals. |
| 6 | Members belong to one system, frequent communication is characterized by mutual trust, and consensus is reached on all decisions. |

**STEP 4:** List all active coalition members for this Collaborative Partner. An active coalition member is an individual who attends your coalition meetings regularly and contributes to its efforts. You may have a Collaborative Partner who does not have an active coalition member/representative. That may be how your coalition works, and having a representative for that organization may or may not be important. If that is the case, write “no” in this column. If you have more than one representative from one agency/group, then write in all the individuals, and then tally the number in the next column.

**STEP 5**: Enter the date completed (highlighted) and tally the number of active Coalition members in the highlighted cell.

1. **Map your community partners and coalition members:**

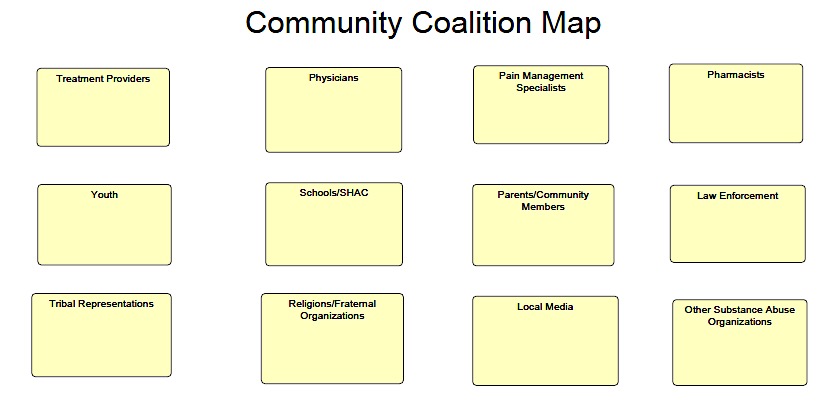
Based upon the table you just completed at the top of this document, and the template provided on the following page, you will map your Collaborative Partners and Substance Abuse Coalition members.

**STEP 1:** In the boxes on the mapping template, write in the names of your active coalition members and their corresponding organization/agency from the table above.

**STEP 2:** In *italics*, write the names of any Collaborative Partners who are not represented by active members in your coalition but who contribute to your coalition in some capacity.

You will complete this mapping exercise each year. When you repeat this exercise in the future, you can drag and drop your partners as they move in and out of the coalition. You can add new partners as well, but keep the old ones even if their participation becomes minimal (you can score those low on the collaboration scale). Keep the original formatting so you can visualize how partners have changed and how your coalition evolves over time. This exercise should help you understand who might not be represented in your coalition but should be, and who are the “go to” members when you need assistance. Coalitions are organisms that are expected to change over time as needs change and develop and as trust and community relationships grow.

After completing these two exercises, you may want to consider creating the “ideal” coalition with all the members you want and even identify how each partner and/or member can contribute substantively to the functioning of the coalition and to prevention activities in the community. This would be your coalition wish list. You can then plan how and when you could bring these partners/individuals on board to strengthen your coalition.



**Results from the New Mexico Coalition Capacity Checklist**

Please include/attach a summary report from SurveyMonkey and use the results to answer the questions below.

|  |
| --- |
| **How many completed checklists did you complete?** |

|  |
| --- |
| **RESULTS from the Coalition Capacity Checklist** |
| **What were your 2 highest scoring areas?**  EXAMPLE: C. Coalition leadership (4.58) & D. Outreach and communication (4.17) |
| **What were you 5 highest scoring individual items?**  EXAMPLE:  C.1. Coalition leaders are skillful at building relationships with community partners (4.78),  E.5. Meetings are held in central location (4.78),  C.2. Coalition remains focused on and progressing toward goals (4.67),  E.1. Our coalition has a regular meeting cycle (4.67),  E.7. Minutes are documented and distributed (4.67) |
| **Why might these have risen to the top?**  EXAMPLE: *We continually work to build trust and positive relationships with whoever comes to the table and we act on ideas for bringing in new partners. Our coalition also has a monthly article in the local paper on upcoming events and does a lot of outreach at different community events. I think the high scores also point to the skilled leadership of our coalition coordinator who is able to make people feel comfortable and valued.* |
| **What were your 2 lowest scoring areas?** |
| **What were you 5 lowest scoring individual items?** |
| **Why might these need additional attention?** |
| **What were some of the highlights that coalition members mentioned as your coalition’s BEST attributes?** |

|  |
| --- |
| **Based on these results, what are you most proud of?** |

|  |
| --- |
| **What specifically can you do to build your coalition’s capacity in the next 6 months?**  **EXAMPLES (delete these before submission):**   * *Strengthen (coalition) structure and membership by defining members’ roles and responsibilities.* * *Strengthen (coalition) leadership by having two leading members attend leadership training.* * *Gaining one additional Certified Prevention Specialist (beyond the 1 required by grant) Indicator: number of CPS obtained.* * *Build (coalition) capacity by increasing outreach and communications between members and key stakeholders through sharing of activities and seeking feedback from community residents.)* |

|  |
| --- |
| **What would you like to do but you currently lack the necessary resources to do (skills, people, funds, etc.)?** |

|  |
| --- |
| **How do your assessment findings inform your coalition building effort?** (EXAMPLE - Maybe your assessment showed a lack of consistent enforcement – how might your coalition build capacity in that area? Or maybe you need more law enforcement representatives on your coalition. Maybe you need to work on Rx issues but do not have contacts in the medical field, etc.). |

|  |
| --- |
| **Community Capacity** |

**Capacity building** aims to increase the ability of professionals, organizations, leadership, departments, and the community to effectively address the goals of a project and/or needs identified in the assessment.

***Community is* a group of people who share a commonplace, experience, or interest**.

This term often to refer to people who live in the same area: the same neighborhood, the same city or town, and even the same state or country.People may also consider themselves part of a community with others who have had similar experiences (part of a racial/ethnic community, religious community, etc.).

***Community health*refers to the well being of everyone in a community.**

It asks the question, "How healthy are all of the members of our community? Our children and adolescents? Older adults? The poor?"

<http://ctb.ku.edu/en/table-of-contents/overview/model-for-community-change-and-improvement/building-capacity/main>

***Community capacity*refers to the ability of community members to make a difference over time and across different issues.**

Capacity isn't a one-time thing; like learning to ride a bike, it's not something that disappears once you've experienced it. And like riding a bike, we get better the more we practice.

For example, if a high school student overdoses on prescription painkillers, people might be really angry. For a few weeks -- or even a few months -- people might work together to prevent youth from misusing opioids. But if those efforts fade away, and people go back to what they see as their "normal lives" -- that's not building community capacity. It must be seen as a process, where people see working on community issues as a part of their "normal lives."

Or, if a community that develops a successful collaboration for substance abuse might decide later that rates of childhood immunization aren't high enough in their community, and also work effectively to improve those rates. By translating what they learned while developing the substance abuse coalition (for example, ways to recruit members or to work with the media) they should be able to do a good job and effectively improve the immunization rates.

A community has demonstrated strong community capacity when it can bring about community changes over time and across concerns.

<http://ctb.ku.edu/en/table-of-contents/overview/model-for-community-change-and-improvement/building-capacity/main>

|  |
| --- |
| **Capacity Building Activities** |

* Training
* Developing/Fostering committed staff
* Convening key stakeholders, coalitions, and service providers to plan and implement sustainable prevention efforts
* Mobilizing resources within a geographic area
* Securing financial and organizational resources
* Discussing descriptive local incidents related to the issue
* Pointing out media articles that describe local issues critical to the coalition
* Preparing and submitting articles for church bulletins, local newsletters, club newsletters, etc.
* Public forums
* Utilizing key leaders and influential people to speak to groups
* Maintaining a comprehensive database
* Developing and fostering supportive leadership
* Forming partnerships
* Holding face to face meetings
* Coordinating Town Hall meetings
* Hosting parent workshops
* Conducting one on one visits
* Holding one on one phone calls and conference calls
* Presenting information
* Expanding key stakeholders / partners
* Attending events
* Hosting events
* Gathering data / information
* Gaining media exposure
* Recognizing local supporters and volunteers
* Leveraging resources to address community issues

CAPACITY

Aptitude – Ability - Resources - Competence - Volume - Sustainability

|  |
| --- |
| **COMMUNITY AND SYSTEM CHANGE** |

***Community change*** happens by developing or modifying a *program,* bringing about a change in *policy*, or adjusting a *practice*related to the group's mission.

**A System is:**

* An organized assembly of resources and procedures united and regulated by interaction or interdependence to accomplish a set of specific functions.
* A collection of personnel, equipment, and methods organized to accomplish a set of specific functions.
* A group of interacting, interrelated, and interdependent components that form a complex and unified whole.

***System changes***are similar to community changes, but take place on a broader level. A change in school policy to offer in-school suspension for students' ATOD violations as alternative to out of school suspension and expulsion.

**Systems Perspective: Events, Patterns, or System?**

Thinking through a systems perspective helps us see the events and patterns in our lives in a new light—and respond to them in higher leverage ways. For example, suppose a fire breaks out in your town. **This is an event.** If you respond to it simply by putting the fire out, you're reacting. (That is, you have done nothing to prevent new fires.) If you respond by putting out the fire and studying where fires tend to break out in your town, you'd be paying attention to **patterns**. For example, you might notice that certain neighborhoods seem to suffer more fires than others. If you locate more fire stations in those areas, you're adapting. (You still haven't done anything to prevent new fires.) **Now suppose you look for the systems**—such as smoke-detector distribution and building materials used—that influence the patterns of neighborhood-fire outbreaks. If you build new fire-alarm systems and establish fire and safety codes, you're creating change. Finally, you're doing something to prevent new fires! SOURCE: [www.pegasuscom.com/systems-thinking](http://www.pegasuscom.com/systems-thinking)

**Systems have several defining characteristics:**

* Every system has a purpose within a larger system.
* All of a system's parts must be present for the system to carry out its purpose optimally.
* A system's parts must be arranged in a specific way to carry out its purpose.
* Systems change in response to feedback.
* Systems maintain their stability by making adjustments based on feedback.

**Comprehensive Substance Abuse Prevention System will include:**

* **Ecological Model - Multiple Domains**
* **Public Health Triad**
* **Institute of Medicine – Continuum of Care**

**Ecological Model - Risk & Protective Factor Theory**

In theory when community and system changes occur together, they should change the environment in which a person behaves. This is sometimes referred to as increasing *protective factors*and/or decreasing the *risk factors*that community members face.

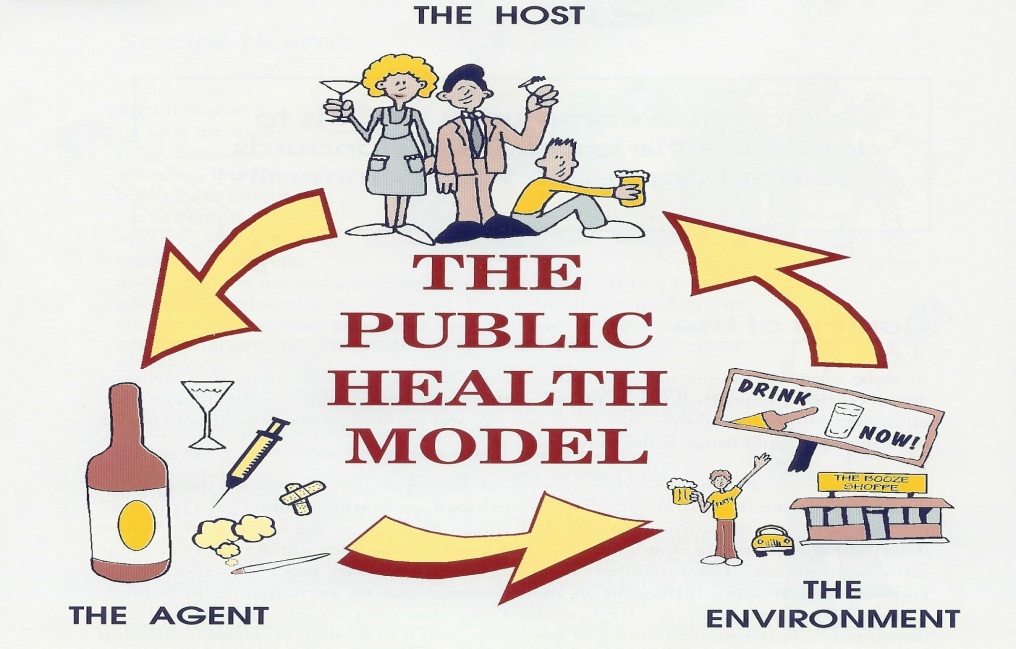
*Risk and protective factors*are aspects of a person's environment or personal features that make it more likely (risk factors) or less likely (protective factors) that they will develop a given problem. For example, if drugs are readily available in your community, then easy accessibility is a risk factor. If they are very difficult to find, then that lack of drugs is a protective factor.

The intended effect of environmental change is widespread behavior change by large numbers of people in the community engaging in behavior related to the group's objectives.

|  |
| --- |
| **ECOLOGICAL MODEL** |
| **Individual / Peer** |
| **Family** |
| **School** |
| **Community** |

**Public Health Epidemiological Triad**

Demand for ATOD



Norms, policies, practices that influence / control the social/physical contexts of use

The supply / availability of ATOD

|  |  |
| --- | --- |
| **Public Health** | The focus of public health is on the safety and well-being of entire populations. A unique aspect of the field is that it strives to provide services that benefit the largest number of people. It promotes physical and mental health, and aims to prevent disease, injury, and disability.  <http://www.cdc.gov/violenceprevention/overview/publichealthapproach.html> |
| **Epidemiological Triad** | The traditional model of infectious disease causation, which has three components: an external agent, a susceptible host agent, and an environment that brings the host and agent together so that disease occurs. |
| **Host** | A person or other living organism that is susceptible to an infectious agent under natural conditions. I.e. youth |
| **Agent** | A factor that is essential for a disease. Examples of agents include microorganisms, chemical substances, and forms of radiation. Agents can cause a health problem by either by being introduced, being present in excess, or being present at deficient levels. I.e. Prescription Opioids. |
| **Environment** | An extensive factor, such as geology, climate, insects, sanitation, or health services, which affects an agent and the opportunity for exposure. I.e. Prescription opioids are overprescribed to prevent the patient from experiencing pain and contacting the medical provider again. |
| **SOURCE:** <http://www.umncphp.umn.edu/Surveillance/epief.htm> | |

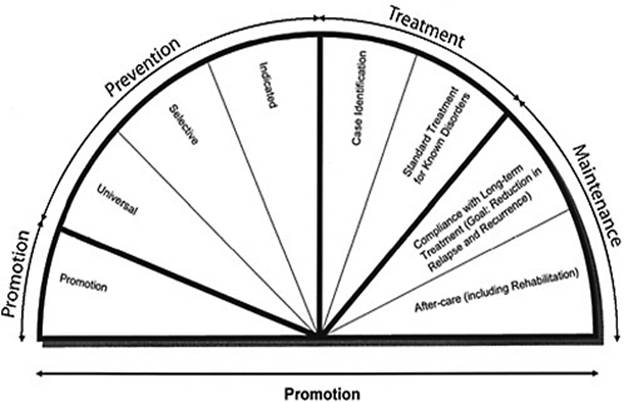
|  |  |
| --- | --- |
| **Public Health Model** | **Medical Model** |
| Primary focus on population | Primary focus on the individual |
| Public service ethic, tempered by concerns for the individual | Personal service ethic, conditioned by awareness of social responsibilities |
| Emphasis on prevention and health promotion for the whole community | Emphasis on diagnosis, treatment, and care for the whole patient |
| Paradigm employs a spectrum of interventions aimed at the environment, human behavior and lifestyle, and medical care | Paradigm places predominant emphasis on medical care |
| <http://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/ten-essential-public-health-services/main> | |

**Institute of Medicine – Continuum of Care**

**Universal**

**Universal preventive interventions are designed to reach the entire population, without regard to individual risk factors, and they generally are designed to reach a very large audience.**

Participants are not recruited to participate in the program and the degree of individual substance abuse risk of the program participants is not assessed. The program is provided to everyone in the population (national, local community, school, and neighborhood) regardless of whether they are at risk for substance abuse. General examples of universal preventive interventions include the use of seat belts, immunizations, prenatal care, and smoking prevention (IOM 1994). Examples of universal preventive interventions for substance abuse include substance abuse education for all children within a school district, media and public awareness campaigns within inner-city neighborhoods, and social policy changes, for example reducing availability by reducing the number of liquor outlets in a municipality.



**Selective**

**Selective preventive interventions target subgroups of the general population that are determined to be at risk for substance abuse.** Recipients of selective prevention interventions are known to have specific risks for substance abuse and are recruited to participate in the prevention effort because of that group’s profile, but the degree of individual vulnerability or personal risk of members of the targeted subgroup generally is not assessed. Vulnerability is presumed on the basis of their membership in the at-risk group. Knowledge of specific risk factors within the target group allows program designers to address specific risk reduction objectives. Selective programs generally run for a longer period of time and require more time and effort from participants than universal programs. General examples of selective preventive interventions include home visitation and infant day care for low birth-weight children and annual mammograms for women with a family history of breast cancer (IOM 1994). Examples of selective preventive intervention for substance abuse include rites of passage programs for at-risk males, and skill training programs that target young children of substance-abusing parents.

**Indicated**

**Indicated preventive interventions identify individuals who are experiencing early signs of substance abuse and other related problem behaviors associated with substance abuse and target them with special programs.** The individuals identified at this stage, though showing signs of early substance use, have not reached the point where a clinical diagnosis of substance abuse can be made. Indicated prevention approaches are used for individuals who may or may not be abusing substances, but exhibit risk factors such as school failure, interpersonal social problems, delinquency, and other antisocial behaviors, and psychological problems such as depression and suicidal behavior that increase their chances of developing a drug abuse problem. Indicated prevention approaches require a precise assessment of an individual’s personal risk and level of related problem behaviors, rather than relying on the person’s membership in an at risk group as in the selected approach. Programs are frequently extensive and highly intensive; they typically operate for longer periods of time, at greater frequency of contact and require greater effort on the part of the participants than do selective or universal programs. Programs require highly skilled staff who have clinical training and counseling skills or other clinical intervention skills. General examples of indicated prevention in the health field include training programs for children experiencing early behavioral problems, medical control of hypertension, and regular examinations of persons with a history of basal cell skin cancer (IOM 1994). In the field of substance abuse, an indicated preventive intervention would be a substance abuse program for high school students who are experiencing a number of problem behaviors, including truancy, failing academic grades, juvenile depression, suicidal ideation, and early signs of substance abuse.

Sources: “Reducing Risks for Mental Health Disorders: Frontiers for Preventive Intervention Research.” National Institute of Medicine. & Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults, National Academy of Sciences, 2009

**Resources and Gaps for Preventing Prescription Painkiller Misuse**

**INSTRUCTIONS:**

Using the table below, list all of the **resources** that currently exist in your organization, coalition, or community for addressing the Intervening Variable. Think about the contributing factors and indicators that emerged throughout your assessment phase (or look at your report). Lastly identify gaps and needs that are currently present in addressing the Intervening Variable.

|  |  |  |  |
| --- | --- | --- | --- |
| **Goal: Prevent Rx Opioid Misuse** | | | |
| Intervening Variable | Contributing Factors | Resources | Gaps/Needs |
| Social Access | Friends and Relatives share prescription opioids |  |  |
|  |  |
| Youth steal from their parents or grandparents' medicine cabinet. |  |  |
|  |  |
| Retail Access | Patient received a 90 day supply of opioids to avoid having to travel long distances on a monthly basis. |  |  |
|  |  |
| Dr. shopping for prescription opioids. |  |  |
| Public Awareness/Concern | People are unaware of the risk of harming themselves using prescription painkillers for nonmedical reason. |  |  |
|  |  |
| Community is unaware of media campaigns to increase awareness of prescription opioids. |  |  |
| Youth are not aware of the dangers of misusing prescription opioids; compare to less harmful prescription drugs as Adderall. |  |  |
|  |  |

|  |
| --- |
| **Readiness** |

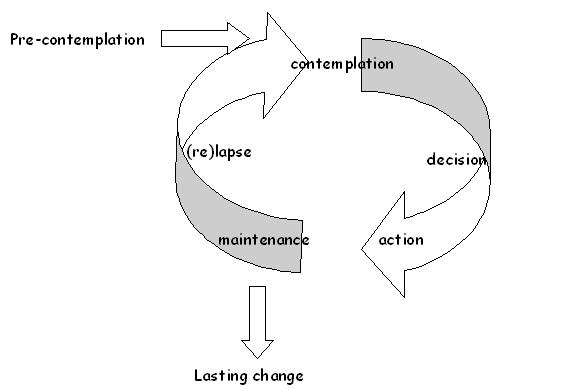
|  |
| --- |
| **Community Readiness is:**   * The degree to which a community is prepared to take action on an issue. * The capacity of a community to implement programs, policies, and other changes that are designed to reduce the likelihood of substance use. |

Think about an issue you are or have faced personally that required you to make changes that may have been difficult (changing your diet, exercising regularly, changing spending habits, asserting yourself, addressing conflict, searching for a new job, etc).

1. What is challenging about the changes you need to make?
2. What do you need in order to make those changes happen?
3. What could other people do to help you in making the changes?

**Change Cycle**

**Pre-contemplation:** The person does not acknowledge a problem exists. They are ‘uninformed’ in the sense that no personally convincing reason for change has been presented as yet.

**Contemplation:** The person is ambivalent - they are in two minds about what they want to do. Sometimes they feel the need to change but not always. 

**Action:** The person is preparing and planning for change. When they are ready the decision to change is made and it becomes all consuming.

**Maintenance:** The change has been integrated into the person's life. Some support may still be needed through this stage. In maintenance lasting change is learned, practiced and becomes possible. When we are able to maintain what we have achieved we exit the cycle entirely.

**Lapse**is a temporary return to ‘old’ unhelpful thoughts, feelings or behaviors.

**Relapse** is a full return to the old behavior.

**Lapse and Relapse** are viewed as intrinsic to the Cycle Of Change and do not infer failure. It does not mean that lapse or relapse is desirable or even invariably expected. It simply means that change is difficult, and it is unreasonable to expect anyone to be able to modify a habit perfectly without any slips. When relapse occurs, several trips through the stages may be necessary to make lasting changes. Each time the person is encouraged to review, reflect and learn from their slips.

Downloaded from <http://www.surreycounsellingservice.co.uk/html/cycle_of_change.html> 4/15/14

**Benefits of knowing your community’s level of readiness to address substance abuse:**

* It builds cooperation and collaboration among systems and individuals
* It increases capacity
* Encourages and enhances community investment on an issue
* Guides that community through the complex process of community change.

|  |
| --- |
| **Stages of Readiness** |

|  |  |
| --- | --- |
| **Stage of Readiness** | **Description** |
| **1. Community Tolerance/No Knowledge** | Substance abuse is generally not recognized by the community or leaders as a problem. “It’s just the way things are” is a common attitude. Community norms may encourage or tolerate the behavior in social context. Substance abuse may be attributed to certain age, sex, racial, or class groups. |
| **2. Denial** | There is some recognition by at least some members of the community that the behavior is a problem, but little or no recognition that it is a local problem. Attitudes may include “It’s not my problem” or “We can’t do anything about it.” |
| **3. Vague Awareness** | There is a general feeling among some in the community that there is a local problem and that something ought to be done, but there is little motivation to do anything. Knowledge about the problem is limited. No identifiable leadership exists, or leadership is not encouraged. |
| **4. Preplanning** | There is clear recognition by many that there is a local problem and something needs to be done. There is general information about local problems and some discussion. There may be leaders and a committee to address the problem, but no real planning or clear idea of how to progress. |
| **5. Preparation** | The community has begun planning and is focused on practical details. There is general information about local problems and about the pros and cons of prevention programs, but this information may not be based on formally collected data. Leadership is active and energetic. Decisions are being made and resources (time, money, people, etc.) are being sought and allocated. |
| **6. Initiation** | Data are collected that justify a prevention program. Decisions may be based on stereotypes rather than data. Action has just begun. Staff is being trained. Leaders are enthusiastic, as few problems or limitations have occurred. |
| **7. Institutionalization/ Stabilization** | Several planned efforts are underway and supported by community decision makers. Programs and activities are seen as stable, and staff is trained and experienced. Few see the need for change or expansion. Evaluation may be limited, although some data are routinely gathered. |
| **8. Confirmation/ Expansion** | Efforts and activities are in place and community members are participating. Programs have been evaluated and modified. Leaders support expanding funding and program scope. Data are regularly collected and used to drive planning. |
| **9. Professionalization** | The community has detailed, sophisticated knowledge of prevalence and risk and protective factors. Universal, selective, and indicated efforts are in place for a variety of focus populations. Staff is well trained and experienced. Effective evaluation is routine and used to modify activities. Community involvement is high. |
| SOURCE: Plested, et. a. (2004) Community Readiness: A Handbook for Successful Change. Tri-Ethnic Center for Prevention Research | |

|  |
| --- |
| **Capacity and Readiness Report Instructions** |

**Readiness Survey Assessments**

This will help gauge your community readiness to address prescription opioid misuse.

1. Distribute the survey to your coalition and concerned community members either via SurveyMonkey and/or paper collection. Think about who may have special knowledge of prescription opioid misuse. Key community members should include someone from a local hospital or pharmacy board, law enforcement, school personnel, City or Tribal council members, etc. You are required to collect a minimum of 20 surveys.
2. The survey is already built in SurveyMonkey for you. If you decide to collect them on paper, we will ask you to enter each assessment into SurveyMonkey yourself. The survey links are: https://www.surveymonkey.com/r/ReadinessAssessmnt\_BernCo\_SPFrx
3. Upon request, Tina Ruiz (ruiztinam@gmail.com) or Kenzie Wannigman (coopconsulting.nm@gmail.com) will provide you with the results of your Readiness Assessments. Usually in the same day but please allow 24 hours.
4. Compile the results and discuss them with your coalition. Bring attention to the sections that rated particularly low or high.  **You must have the readiness survey assessment completed before you have your coalition meeting with the Guiding Questions.**

**Guiding Questions to Determine Levels of Readiness**

1. Go through the Guiding Questions with your core team/program staff to identify examples to discuss with the larger coalition - this will help you keep the discussion more focused and allow you to solicit more information from the coalition.
2. Go through the Guiding Questions with your coalition and come to a consensus on the levels of readiness for each of your priorities (this will take 1 - 1 ½ hours).

**Capacity & Readiness Report**

Use data from the readiness survey and the readiness levels determined by your coalition during the guiding questions exercise to complete the report.

**Capacity and Readiness Report**

**New Mexico Office of Substance Abuse Prevention Grantees**

**Due - May 31, 2017**

Please submit this report to the following people:

[Karen.Cheman@state.nm.us](mailto:Karen.Cheman@state.nm.us), Liz Lilliott [lilliott@pire.org](mailto:lilliott@pire.org), Michael Coop, [coopconsulting@gmail.com](mailto:coopconsulting@gmail.com)

|  |  |
| --- | --- |
| **Coalition Name:** |  |

|  |  |
| --- | --- |
| Project Director: |  |
| Program Coordinator: |  |
| Other Staff: |  |
| Report Completed by: |  |
| Date Completed: |  |

**Briefly describe your coalition**

|  |  |
| --- | --- |
| Key Members: |  |
| Core Team Members: |  |
| Key accomplishments to date (highlights): |  |
| Challenges or barriers experienced: |  |

|  |
| --- |
| **Capacity** |

Based on your brainstorming at the Capacity & Readiness Training and your subsequent conversations with your coalition, please complete the following tables for each priority, and the intervening variables that have emerged as important in their influence of the substance abuse problems in your community. Please list several of the resources around each intervening variable, gaps, and potential strategies to fill in the gaps. These may be the strategies that you include in your strategic plan to help increase your coalition’s capacity or your community readiness.

|  |  |
| --- | --- |
| **Goal:** | **Prevent Prescription Opioid Misuse** |
| **Intervening Variable** | **Retail Access** |
| **Existing Resources to address this IV** |  |
| **Gaps** |  |
| **Strategies to Overcome the Gaps** |  |
| **Intervening Variable** | **Social Access** |
| **Existing Resources to address this IV** |  |
| **Gaps** |  |
| **Strategies to Overcome the Gaps** |  |
| **Intervening Variable** | **Public Awareness of/Concern of Prescription Opioids** |
| **Existing Resources to address this IV** |  |
| **Gaps** |  |
| **Strategies to Overcome the Gaps** |  |

|  |
| --- |
| **Please name any specific resources you currently do not have but that would help you with the issues mentioned above.** |
|  |

|  |
| --- |
| **Readiness** |

Through all of your assessment, capacity, and readiness data, **what did you determine to be your** **community’s overall level of readiness for each priority (this will be one of the stages of readiness, from tolerance to professionalization)?**

|  |  |  |
| --- | --- | --- |
| **Priority Area** | **Level of Readiness** | **Brief explanation of how this level was determined** |
| Prescription Opioid Misuse |  |  |

|  |
| --- |
| **Priority: Rx Opioid Misuse Readiness Survey Results** |

Please provide results of the Readiness Checklist (below) that were collected via SurveyMonkey.

|  |
| --- |
| **How many completed surveys did you collect?** |

|  |  |
| --- | --- |
| **Prescription Opioid Misuse** | |
| How did you rate the willingness and ability of organizations in your community that have an interest in reducing and preventing prescription opioid misuse to carry out the following activities?  **1=None 2=Low 3=Medium 4=High** | |
|  | **Average Score?** |
| a. Collect data on the nature of local Rx opioid misuse problems |  |
| b. Identify available resources for Rx opioid misuse prevention (personnel, financial, organizational) |  |
| c. Secure support for Rx opioid misuse prevention from local policy makers |  |
| d. Utilize needs assessment data to plan prevention programs and policies |  |
| e. Develop culturally appropriate prevention programs and strategies |  |
| f. Raise community awareness of Rx opioid misuse problems |  |
| g. Identify and implement evidence based or new (but promising) Rx opioid misuse prevention strategies |  |
| h. Convene community meetings to address Rx opioid misuse issues |  |
| i. Collaborate with organizations concerned with preventing other types of problems (HIV, violence) |  |
| j. Allocate local funds to Rx opioid misuse prevention in the community |  |
| k. Develop policies related to or specifically for Rx opioid misuse prevention in the community |  |
| l. Identify the barriers to Rx opioid misuse prevention in the community |  |
| m. Develop a strategic plan to address Rx opioid misuse in the community |  |
| n. Identify and recruit local political leaders or content experts to address Rx opioid misuse |  |

|  |
| --- |
| **What do you think this says about the awareness, willingness, and current action on prescription opioid misuse?** |
|  |

|  |
| --- |
| **Rx Abuse/Misuse Readiness Scores** |

**Please provide a summary of the discussion and the readiness scores your coalition decided upon. This information should be gathered during a coalition meeting using the Readiness Assessment Coalition Question Guide.**

|  |  |
| --- | --- |
| **Community Awareness of Rx Prevention Efforts** | Score: |
| **Please discuss the key findings that helped you arrive at the score above** | |

|  |  |
| --- | --- |
| **Leadership Around Rx** | Score: |
| **Please discuss the key findings that helped you arrive at the score above** | |

|  |  |
| --- | --- |
| **Community Climate around Rx Prevention** | Score: |
| **Please discuss the key findings that helped you arrive at the score above** | |

|  |  |
| --- | --- |
| **Knowledge About Rx Misuse/Abuse** | Score: |
| **Please discuss the key findings that helped you arrive at the score above** | |

|  |  |
| --- | --- |
| **Resources for Prevention Efforts** | Score: |
| **Please discuss the key findings that helped you arrive at the score above** | |

|  |
| --- |
| **Summary** |

|  |
| --- |
| **How does this information on capacity and readiness enhance what you’ve already learned through your assessment and coalition checklists?** (Maybe there are big challenges with engaging law enforcement or particular parts of your community that require more readiness building, maybe certain sectors of the community are less willing to participate in prevention initiatives) |

|  |
| --- |
| **What is one thing your coalition can do right now to support community readiness?** |

|  |
| --- |
| **Looking at the list of readiness building strategies, list three strategies your community might need to do over the next two years and how do the data tell you that? You can refer to your report, the readiness surveys, focus group information, or feedback from your coalition as data sources.** |

**Guiding Questions to Determine Readiness**

**Facilitator instructions:**

* **Ask coalition members to reflect upon the Readiness Assessment results gathered from your partners on Survey Monkey, as well as your Community Assessment data.** Using the questions below to guide the discussion, help the coalition decide as a group the answer to the last question in each section (in bold font) and about each substance priority. Note it may be helpful to assign each group a different section of the readiness doc (leadership, resources, knowledge, climate…) and have them go through the questions as a group and discuss it for their priorities.
* **Make sure that you have someone who is solely able to listen to the discussion AND use a scribe whose job is only to take detailed notes.**  Between the two, you should have good notes and a good context from which to base your answers in a way that can be understood by others who may be unfamiliar with your coalition.
* **This information will be summarized and transferred into your Capacity and Readiness Report. Keep this document with your program documents for future reference.**

**Remind participants to:**

* Consider the diverse communities in your area- you may even want to differentiate among different communities while you take notes (some may be more/less ready than others).
* Consider contingent resources to your community. There may be an important resource that has not been considered.

**Guiding Questions Activity Instructions**

There are many ways to gain consensus among a group around a certain issue. This is one method that might work to help your coalition determine levels of community readiness. *Note: This tool was developed for use with New Mexico Coalitions but is an adaptation of the Tri-Ethnic Center for Prevention Research’s Community Readiness Handbook (2004), Brief Readiness Assessment.*

1. Use five giant post-it notes or a white board to put a large chart for each of the Guiding Question sections (community awareness, leadership, community climate, knowledge, resources). On each chart list the nine stages of readiness using a nine-point scale, leaving enough for people to put dots/stickers/votes. You might also want to make sheets of paper with these charts on them and hand them out to everybody at the meeting. These could become their tally sheets or they could just use them as references.
2. After reviewing the readiness scores, read through the **guiding questions** in the community awareness section and leave some time for discussion. Please set a time limit (suggest limiting it to 10 minutes per section). This means you will not get to discuss each question in detail, but should be used as a framework for helping your group think about your community’s readiness. **Use a facilitator and a note taker/scribe to document the process for easier completion of the report.**
3. After this discussion, have everybody answer the question about rating the readiness level (1-9). Have them bring their dots/stickers/votes to the giant post-it/whiteboard and place their vote according to where they think their community stands. Have them place a different vote for each priority (there will likely be differences in readiness between you selected priorities - - different levels of awareness or leadership, for example.
4. **Repeat this discussion and scoring process for each section in the guiding questions.**
5. Once everything is scored, **average** the scores for each priority to come up with an overall score.
6. Use these averages to guide your group in determining your stage of readiness for each priority. The idea is to have the group AGREE UPON an overall group score for each priority. The group can decide to move the overall score up or down (down is usually safer than up). Use the descriptions of the 9 stages of readiness to help you decide. **The group needs to come to a consensus about the stage of readiness**.

|  |  |
| --- | --- |
| **COMMUNITY AWARENESS OF PREVENTION EFFORTS** | |
| Readiness Stage (1-9) | Votes on community stage of readiness |
| Community Tolerance/ No Knowledge |  |
| Denial |  |
| Vague Awareness |  |
| Preplanning |  |
| Preparation |  |
| Initiation |  |
| Institutionalization/ Stabilization |  |
| Confirmation/ Expansion |  |
| Professionalization |  |

|  |
| --- |
| **COMMUNITY AWARENESS OF PREVENTION EFFORTS** |
| 1. (Besides the OSAP funding) what existing prevention efforts are available in your community for prescription opioid misuse? |
|  |
| 1. Who do these programs serve? (For example, individuals of a certain age group, ethnicity, etc |
|  |
| 1. What segments of the community are inaccessible to these efforts/services? (For example, individuals of a certain age group, ethnicity, income level, geographic region, etc.) |
|  |
| 1. How long have these prevention efforts been going on in your community? |
|  |
| 1. How aware are people in your community of these prevention efforts? |
|  |
| 1. What are the strengths and weakness of these prevention efforts? |
|  |
| 1. What formal or informal policies, practices and laws related to these issues are in place in your community, and how long have they been in place?   EXAMPLE: A “formal” policy would be established policies within schools, police departments, or courts. An example of “informal” would be similar to the police not responding to calls from a particular part of town, etc.) Are there segments of the community for which these policies, practices and laws may not apply? (e.g., due to socioeconomic status, ethnicity, age, etc.) |
|  |
| 1. How do community residents view these policies, practices and laws? |
|  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Overall, how ready is your community of these problems and efforts to solve them?**  Using the nine stages of readiness (9 point scale), assign a score for your community. | | | | | | | | | |
| Community Tolerance/  No Knowledge | Denial | Vague Awareness | Preplanning | Preparation | Initiation | Institutionalization/ Stabilization | | Confirmation/ Expansion | Professionalization |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | | **8** | **9** |
| **Community Awareness** | | | | | | | Score: | | |

|  |
| --- |
| **LEADERSHIP** |
| 1. What leaders (if any) are critical to the success of this project? |
|  |
| 1. How much of a concern is prescription opioid misuse to the leadership in your community? |
|  |
| 1. How are these leaders involved in efforts to prevent prescription opioid misuse? Would the leadership support additional efforts? |
|  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Overall, how ready and willing is your community leadership to address these problems?**  Using the nine stages of readiness (9 point scale), assign a score for your community. | | | | | | | | | |
| Community Tolerance/  No Knowledge | Denial | Vague Awareness | Preplanning | Preparation | Initiation | Institutionalization/ Stabilization | | Confirmation/ Expansion | Professionalization |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | | **8** | **9** |
| **Community Leadership** | | | | | | | Score: | | |

|  |
| --- |
| **COMMUNITY CLIMATE** |
| 1. Under what circumstances do any members of your community think that substance abuse issues should be tolerated? |
|  |
| 1. How supportive are community residents of efforts to address these substance abuse issues, if at all? |
|  |
| 1. What are the primary obstacles to prevention efforts addressing prescription opioid misuse in your community? |
|  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Overall, what do you think the feeling is among community residents regarding prescription opioid misuse?** Using the nine stages of readiness (9 point scale), assign a score for your community. | | | | | | | | | |
| Community Tolerance/  No Knowledge | Denial | Vague Awareness | Preplanning | Preparation | Initiation | Institutionalization/ Stabilization | | Confirmation/ Expansion | Professionalization |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | | **8** | **9** |
| **Community Climate** | | | | | | | Score: | | |

|  |
| --- |
| **KNOWLEDGE ABOUT THE ISSUE** |
| 1. In general, how knowledgeable are community residents about these issues? (For example, dynamics, signs, symptoms, statistics, effects on family and friends, etc.) |
|  |
| 1. What type of information is available to residents in your community regarding prescription opioid misuse? |
|  |
| 1. What local data are available about prescription opioid misuse in your community?   If they wanted to, how would someone in your community obtain this information? |
|  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Overall, how knowledgeable is the community about prescription opioid misuse?**  Using the nine stages of readiness (9 point scale), assign a score for your community. | | | | | | | | | |
| Community Tolerance/  No Knowledge | Denial | Vague Awareness | Preplanning | Preparation | Initiation | Institutionalization/ Stabilization | | Confirmation/ Expansion | Professionalization |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | | **8** | **9** |
| **Community Knowledge** | | | | | | | Score: | | |

|  |
| --- |
| **RESOURCES FOR PREVENTION EFFORTS** |
| 1. To whom would a resident affected by these substance abuse issues turn to first for help in your community? Why? |
|  |
| 1. What is the community’s and/or local business’ attitude about supporting efforts to address prescription opioid misuse? (including offering volunteer/staff time, making financial donations, and/or providing space, etc.) |
|  |
| 1. How are current prevention efforts for prescription opioid misuse funded?   Are you aware of any proposals or action plans that have been submitted for funding that address these issues in your community? (Other than OSAP) |
|  |
| 1. Do you know if there is any evaluation of efforts that are in place to address prescription opioid misuse? Are the evaluation results being used to make changes in programs, activities, or policies, or to start new ones? |
|  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Overall, how good (i.e., prolific, secure, reliable) are the resources in the community supporting prevention of prescription opioid misuse?** Using the nine stages of readiness (9 point scale), assign a score for your community. | | | | | | | | | |
| Community Tolerance/  No Knowledge | Denial | Vague Awareness | Preplanning | Preparation | Initiation | Institutionalization/ Stabilization | | Confirmation/ Expansion | Professionalization |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | | **8** | **9** |
| **Resources to Support Prevention** | | | | | | | Score: | | |

|  |  |  |
| --- | --- | --- |
| **OUR OVERALL READINESS LEVELS**  **Average your scores to the final question in each section above to determine your communities' overall readiness to address prescription opioid misuse.** Using the nine stages of readiness (9 point scale), assign a score for your community | | |
| **Priority** | **Level of Readiness** | **Brief Explanation of why this Level was Chosen** |
| **Prescription Opioid Misuse** |  |  |

|  |
| --- |
| **Action Plan for Completing Capacity and Readiness Tasks** |

**Use the matrix on the next page to plan out when you will complete each task for the Capacity & Readiness Phase.**

**Steps:**

1. **Distribute the Readiness Assessment Surveys to your coalition AND to other community members (via SurveyMonkey or Paper/Pencil).**

You want “general” opinions on readiness from your community. If your coalition members are the only ones to complete the readiness assessments, your readiness scores will likely appear higher than they actually are because your coalition is more knowledgeable and passionate about these issues.

1. **Compile the results / scores from the Readiness Assessments and present them to your coalition.**
2. **Reflect on the Readiness Assessment and use the Guiding Questions to gain insight from your coalition on the level of readiness for preventing Rx Opioid Misuse.**
3. **Average the final scores and come to a group consensus on your community’s level of readiness for each goal area.**

**Complete your Capacity & Readiness Report (DUE May 31, 2017).**

**New Mexico – Partnerships For Success 2015 – Capacity & Readiness Data Collection Guide**

|  |  |  |  |
| --- | --- | --- | --- |
| **Data Source** | **Explanation** | **Date** | **Status? Who? How?** |
| **Readiness Survey** | Distribute the survey link to your community members and coalition stakeholders (or make paper copies and enter the data into Survey Monkey yourself). |  |  |
| Request the survey results from Coop Consulting. |  |  |
| Compile/prepare results of the readiness survey to present to your coalition. |  |  |
| **Determining Readiness / Guiding Questions** | Discuss the results of the Readiness Assessments |  |  |
| Go through the Guiding Questions with your coalition and come to a consensus on the levels of readiness for each of your priorities (this will take 1 ½ - 2 hours). |  |  |
| **Capacity & Readiness Report** | Use data from the Readiness Assessments and the readiness levels determined by your coalition during the guiding questions exercise to complete the report. | DUE May 31, 2017 |  |

**Acknowledgements**

This training manual and the tools associated with it were developed by contractors of the New Mexico Office of Substance Abuse Prevention, under its direction and guidance. It has evolved over an extended period of time beginning in 2004 with New Mexico’s original SPF SIG grant project, when New Mexico’s project team collaborated with staff from PIRE Calverton Center, then under contract to CSAP to design the SPF model for SAMHSA. Coop Consulting, Inc. adapted and prepared this manual and developed some of its content; Elizabeth Lilliott and Martha Waller of PIRE, and Paula Feathers of Kamama Consulting, also made significant contributions to materials included in this manual over its period of development. Material pertaining to the development of logic models, data collection, and data management were provided to New Mexico through a technical assistance initiative of JBS as a SAMHSA/CSAP contractor, and its contracted experts Rebecca Carina and Harold Holder, Ph.D. The materials have been altered and adapted from trainings originally developed with SAMHSA Strategic Prevention Framework State Incentive Grant funds, and Partnerships for Success II funds.

For questions regarding the information in this training, please contact:

* Karen Cheman (Office of Substance Abuse Prevention) [Karen.cheman@state.nm.us](mailto:Karen.cheman@state.nm.us" \t "_blank)
* Michael Coop (Coop Consulting) [michaelcoop@newmexico.com](mailto:michaelcoop@newmexico.com)
* Elizabeth Lilliott (PIRE): [lilliott@pire.orglilliott@pire.org](mailto:lilliott@pire.orglilliott@pire.org)