Planning for Prevention Across Systems

Regional Forums

June, 2012
Orange County

Day One Agenda

8:00 – 8:30 a.m. **Registration, Networking and Continental Breakfast**

8:30 – 9:00 a.m. **Welcome and Overview**
Laura Colson, California Department of Alcohol and Drug Programs
Kerrilyn Scott-Nakai, Center for Applied Research Solutions (CARS)

9:00 – 10:15 a.m. **Partnering for Success: The Statewide Perspective**
A panel presentation discussing state level prevention planning processes with a focus on opportunities for cross-system partnerships.

Laura Colson, California Department of Alcohol and Drug Programs
Barb Alberson, California Department of Public Health
Tom Herman, California Department of Education

10:15 – 10:30 a.m. **BREAK**

10:30 – 12:00 p.m. **Partnering for Success: Relevant Initiatives**
A panel presentation discussing successes, challenges, and learnings from cross-system prevention initiatives.

Greg Austin, PhD., WestEd
Will Rhett-Mariscal, PhD., California Institute of Mental Health
Andrea Valdez, California Department of Public Health

12:00 – 1:00 p.m. **LUNCH AND NETWORKING**
(Pacific Room, North Tower- 2nd Floor)

1:00 – 2:30 p.m. **Making It Happen: Hands-On Breakout Sessions**
(Participants choose from one of three concurrent activity/planning sessions)

- **Data Use and Action Planning (DUAP)**
  Leslie Poynor, PhD., Health and Development Program, West Ed
  (Breakout room: Salon I, North Tower- 2nd Floor)
- **Engaging the Community and Building Capacity**
  Martha Madrid, Orange County Bar Foundation
  Andrea Valdez, California Department of Public Health
  (Breakout room: Salon II, North Tower- 2nd Floor)
- **All Cooks to the Kitchen! Recipes for Wellness and Success**
  Christina Borbely, PhD., Center for Applied Research Solutions (CARS)
  Jan Ryan, Center for Applied Research Solutions (CARS)
  (Breakout room: Harbor Room, North Tower- 2nd Floor)

2:30 – 2:45 p.m. **BREAK**

2:45 – 4:15 p.m. **On the Road to Success: Local Learnings and Success Stories**
Panel presentation and group discussion regarding best practices, successes, and challenges regarding local cross-system prevention efforts.

Michelle Dusick, County of San Bernardino, Department of Behavioral Health
Mike Lombardo, Placer County Office of Education

4:15 – 4:45 p.m. **Closing and Overview of Day Two**

Day Two Agenda

8:00 – 8:30 a.m. **Registration, Networking, Continental Breakfast and Welcome**

8:30 – 10:15 a.m. **On the Road to Success: Local Learnings and Success Stories**
Panel presentation and group discussion regarding best practices, successes, and challenges regarding local cross-system prevention efforts.

Larissa Heeren, Sonoma County Human Services Department
Gary Najarian, Marin County Department of Health and Human Services
Danelle Campbell, Butte County Department of Behavioral Health

10:15 – 10:30 a.m. **BREAK**

10:30 – 12:00 p.m. **Making It Happen: Hands-On Breakout Sessions**
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  Jan Ryan, Center for Applied Research Solutions (CARS)

12:00 – 1:00 p.m. **LUNCH AND NETWORKING**
(Pacific Room, North Tower- 2nd Floor)

1:00 – 2:30 p.m. **Advancing the Dialogue: World Café Style Discussion**
Participants rotate through small group topical discussions with a dedicated facilitator at each table and a report out session.

2:30 – 2:45 p.m. **BREAK**

2:45 – 3:30 p.m. **Taking It Home and Closing**
Brief action planning activity and facilitated group discussion regarding next steps.

PRESENTER BIOS

Barb Alberson, M.P.H. is a public health educator with more than 35 years of experience in the government sector. For the last 21 years, she has served as the Chief of the State and Local Injury Control Section in the California Department of Public Health. In this role, Ms. Alberson provides direction and support to a multidisciplinary professional staff in designing and implementing a comprehensive statewide injury and violence prevention program. Her program is now one of the largest and most productive of its kind in the nation.

On the national level, Barb has served as a consultant to many federal agencies and national associations, such as the Centers for Disease Control and Prevention; the National Highway Traffic Safety Administration; the National Council on Aging, and Safe Kids Worldwide. She is the California representative to the national Directors of Health Promotion and Education (DHPE), the Safe States Alliance (formerly STIPDA), on the Board of America Walks, and a member of the National Safe Routes to School Task Force. She serves as faculty for numerous national, regional, and state conferences each year. Barb earned her BA from University of California at Los Angeles, and her MPH from California State University at Northridge.

Greg Austin, PhD. is the director of WestEd's Health and Human Development Program, he has responsibility for supervising agency projects and staff relating to building the capacity of schools, families, and communities to promote positive youth development and resilience, achievement, physical and mental health, and well-being. They also work to promote career education opportunities. This multidisciplinary program has helped practitioners and policymakers apply the best research-based knowledge to create safe, drug-free, healthy, and supportive environments that enable youth to thrive and succeed. Projects he directs include survey research, program evaluations, prevention demonstration studies, and technical assistance. He has authored and edited numerous research articles, resource tools, and prevention guides. A major focus of current work is assessing and analyzing the needs of students, schools, and families, providing data to guide programmatic decision-making. He has been the co-director of the biennial California Student Survey since 1989 and developed and directs (since 1997) the Healthy Kids School Climate Surveys of students, school staff, and parents used throughout the nation and internationally. As part of the California School Climate, Health, and Learning Surveys Project, he provides assistance to every school district in California in collecting and using data from students, school staff, and parents to guide school improvement and community programs. He is working with the California Department of Education to foster more positive school climates in sixty low-performing, needy schools in California through a federally-funded Safe and Supportive Schools Grant, as well as to improve school mental health, special education and migrant education programs in all schools and help close the racial/ethnic achievement gap.

Christina Borbely, PhD. is a research consultant at CARS providing technical assistance to California's Safe and Drug Free Schools & Communities grantees. Also a member of the EMT team, Dr. Borbely coordinates program evaluations for El Dorado County Office of Education and San Francisco Big Brother Big Sister. Prior to joining EMT/CARS, Dr. Borbely was a member of the research staff at Columbia University's National Center for Children and Families. Her work in the field of youth development and prevention programs has been presented at national conferences and published in academic journals. Specifically, Dr. Borbely has extensive knowledge and experience in program evaluation and improving service delivery by identifying factors that impact today's young people. She is also involved as a volunteer in providing mentoring and developmental support to youth in underserved populations. Christina received her doctoral degree in developmental psychology, with a focus on children and adolescents, from Columbia University (2004).

Danelle Campbell has over 20 years of experience in the prevention field. She manages the Prevention Unit for Butte County Department of Behavioral Health and provides consultation, facilitation and training at the local, state and national level in areas such as strategic planning, ATOD prevention, youth development, youth evaluation, environmental prevention, community organizing, coalition development and youth grant making/philanthropy. She is responsible for the local development and implementation of several grant initiatives including Safe and Drug-Free Schools and Communities, Office of Traffic Safety, Friday Night Live Mentoring and Drug Free Communities Coalition. Danelle has been a regional trainer for Prevention by Design and a consultant for CARS providing consultation, training and technical assistance to County Prevention Coordinators, staff and community stakeholders – assisting them with the Strategic Prevention Framework (SPF) including needs assessment, capacity building, strategic planning, evaluation and sustainability. She brings innovation, expertise and knowledge of effective prevention programming to statewide efforts including the California Friday Night Live Partnership, where she served as President of the statewide Collaborative. She has developed and implemented four nationally recognized programs including Butte County Friday Night Live/Club Live, Butte County Friday Night Live Mentoring, Butte County Youth Nexus and the Butte Youth Now Coalition - three receiving the Exemplary Substance Abuse Prevention Program award for effective, evidence-based, state-of-the-art substance abuse prevention programs and one for CADCA'S National Coalition of the Year GOT OUTCOMES award.

Laura Colson has worked for the State of California for nearly 30 years. She is currently the Manager for Prevention Services for the California Department of Alcohol and Drug and Programs. Ms Colson has served the Department in a variety of capacities: helping design CalOMS Pv, which is a fully web-based data collection service for primary prevention service/activity data funded with the Substance Abuse Prevention and Treatment (SAPT) block grant dollars via the Department of Alcohol and Drug Programs, provided oversight to the ADP Resource Center, and was a supervisor for the Prevention Services' (SAPT) Block Grant application. She also provides supervision to the the Community Prevention Initiative (CPI) contract, the Governor's Prevention Advisory Council (GPAC) and CalOMS Prevention.

Before joining ADP, she worked with the Department of Corrections and Rehabilitation, overseeing in-prison substance abuse treatment programs, then, worked for one of the in-prison treatment providers as their Director of California Operations. In addition, she worked for the California State Lottery for ten years in Contracts Services and several other State offices in Sacramento and the Bay Area.

Michelle Dusick is a Program Manager for the County of San Bernardino, Department of Behavioral Health's Office of Prevention and Early Intervention. Her primary responsibilities include direct coordination, management and oversight for all substance abuse and mental illness prevention and early intervention programs across the county. She also serves as an adjunct faculty member of the Human Services Department at San Bernardino Valley College, is part of the San Bernardino County First 5 Advisory Committee, and is a member of the County Superintendent of Schools, Student Coordinated Health Advisory Committee. Prior to joining the Department of Behavioral Health in 2005, Michelle worked in the health and human services field for 7 years providing services to transition aged foster youth, TANF recipients, SSI applicants, and still continues to volunteer as a support person for families of special needs children.

Larissa Heeren, MCRP works for the Sonoma County Human Services Department. Ms. Heeren provides staff for the Upstream Investments Policy Initiative. Her primary responsibilities include providing technical assistance to Community Based Organizations wishing to move towards using evidence-practices. Prior to joining the County, she worked on community development projects for the City Administrator's Office in the City of Guadalupe in Santa Barbara County. Her interest in community development and cross-sector collaboration comes from time spent working for Community Action Partnership, providing technical assistance and training around early childhood development to the San Luis Obispo County community. Larissa earned her BA in Sociology from Sonoma State University and her Master's in City and Regional Planning from Cal Poly San Luis Obispo.

Tom Herman has been in education for over twenty years as a high school teacher, coach, mentor teacher, vice principal and principal. Tom currently manages the Coordinated School Health and Safety Office at the California Department of Education. As well as overseeing Coordinated School Health, Tom administers the Safe and Supportive Schools Federal grant for the improvement of school climate, and the prevention of drug, alcohol abuse, and violence in California's schools. Additionally, through the 58 county coordinators, he oversees the technical assistance for Tobacco Use Prevention Education (TUPE) Programs in California. Tom also sits on the Governor's Prevention Advisory Council (GPAC).

Michael Lombardo is the Director of Interagency Facilitation for Placer County Office of Education. In his position he has responsibilities for several Mental Health Services Act programs, prevention services, student attendance, Wraparound and Foster Youth Services. He is the Sacramento Area Coordinator for Positive Behavioral Intervention and Supports (PBIS) programs. Michael has a unique array of administrative experiences including, Director of the Juvenile Detention Facility, Juvenile Probation Management, administrating for the Children's Receiving Home, child welfare programs, and children's mental health programs. He has extensive experience implementing a variety of evidence based practice initiatives in juvenile justice, child welfare, probation and education. Michael received a Bachelor of Arts in Criminal Justice Administration followed by a Masters of Arts in Organizational Management. He has served on several state and local boards and work groups in cross disciplinary practices. He believes strongly in the motto, "serve every child every day no matter what it takes.

Martha Madrid is a qualified leader with proven ability to develop and implement successful evidence based programs for Latino communities. She has consulted with CARS for over 10 years presenting workshops on *Culturally Appropriate Recruitment, Retention Strategies, & Engaging Communities.* She has managed multiple federal grants, tailored and adapted interventions for Latino and incarcerated populations, and delivers services to youth and families in Diversion, Health Education and Mentoring programs. She works closely with evaluation teams to ensure accurate data collection and is active on various Community Boards and advisory committees. Ms. Madrid is an Associate Director employed for over 16 years with the Orange County Bar Foundation in Santa Ana, CA.

Will Rhett-Mariscal, PhD., MS is a Senior Associate with the Center for Multicultural Development (CMD) at the California Institute for Mental Health (CIMH). Dr. Rhett-Mariscal is the primary point person at CIMH on the Prevention and Early Intervention component of the MHSA. In this role he works closely with the California Mental Health Director's Association, the Department of Mental Health, the Oversight and Accountability Commission, counties, and stakeholders to facilitate, develop and provide training and technical assistance statewide and inform policy development.

Jan Ryan has 30 years in the prevention field focused on listening and learning to people first, as a direct service provider, then as a countywide, statewide, and international consultant in Micronesia. Her credibility comes from years in the field learning how to attract individuals to prevention and to inspire providers to customize the service. The result is sustainable prevention processes that are authentic and culturally competent at the person and system levels. Successful grant writing afforded her the rare independence needed to develop innovative program designs and partnerships with law enforcement, mental health, workforce development, and state/county services and, most importantly, the youth and families. She is often asked to "translate" schools and cross-system collaboration into practical strategies that link real people's needs to the services of a comprehensive prevention system.

Current projects include two statewide planning and implementation groups: Governor's Prevention Advisory Council (GPAC) taskforce on underage use and Student Assistance Programs and the Continuum of Services System Re-engineering Task Force, Phase II for the California Alcohol and Drug Programs. She is working with the newly forming Betty Ford Institute to create ways for experienced leaders to work together to improve prevention program design and implementation. She is providing technical assistance to Riverside County Department of Mental Health, Substance Abuse Prevention Services and is a consultant working statewide for the Technical Assistance provided by Community Prevention Institute, Education, Management and Training Inc. and the Center for Applied Research Solutions. Her private consulting group with partner, Jim Rothblatt, is Redleaf Resources Training and Consulting.

Gary Najarian has served for seven years as Resource Development Coordinator in the Department of Health and Human Services (HHS) with the County of Marin. Gary coordinates the new "Prevention Hub", a cross-divisional collaboration effort to enhance primary prevention services within HHS. Gary also serves as the Prevention Coordinator for the Division of Alcohol, Drug and Tobacco Programs. Gary currently coordinates alcohol and drug prevention, media and evaluation efforts under the direction of the new 2010-2015 Continuum of Services Strategic Plan. Included in that plan are three new local community coalitions, and county-wide projects to reduce the appeal and access young people have to alcohol and drugs including Social Host Accountability Ordinance implementation, Responsible Beverage Service, Compliance Checks and Shoulder Tap Operations and the Play Fair initiative.

Previously, Gary served for five years as the Project Director for the Connecticut Coalition to Stop Underage Drinking, an initiative of The Governor's Prevention Partnership in Hartford, CT. As the Project Director of the CCSUD, Gary assisted over 100 communities in Connecticut to implement comprehensive initiatives to stop underage drinking. Included in those initiatives were 40 local ordinances to prevent underage drinking "house parties", the Champions for Youth campaign support to local communities, Minors in Stings, a campus-community initiative and the Governor's Spouse's Initiative.

Gary is a graduate of the UConn School of Social Work where he received his MSW in Community Organizing and Public Policy. He is also a MPH candidate at the UConn Program in Public Health at the UConn Health Center.

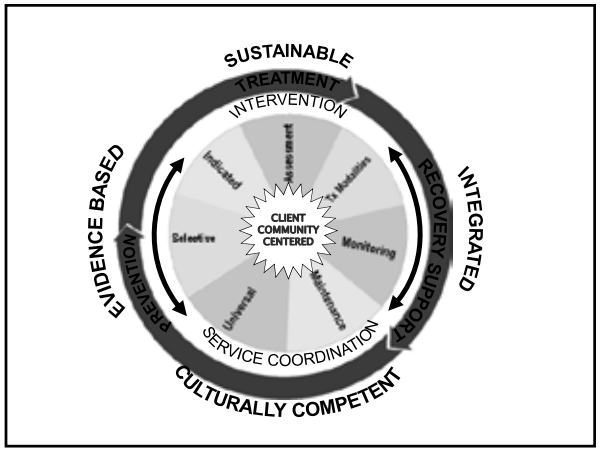
Leslie Poynor, PhD. is the California School Climate, Health and Learning Survey System (Cal-SCHLS) Regional Coordinator for the North Coast/Bay Area Region. She is a Research Associate in the Health and Human Development Program at WestEd in Oakland, California. Her areas of expertise include fostering positive school climates. She is particularly interested in creating an inclusive, trusting community for students from a variety of cultural and linguistic backgrounds. She has conducted a number of original research studies, authored several published education articles, published an edited book, and presented at local, state, national, and international conferences. Her articles have appeared in the Educational Researcher, the Bilingual Research Journal, and the TESOL Journal.

Kerrilyn Scott-Nakai is currently the Project Director for the Community Prevention Initiative and the Culturally and Linguistically Appropriate Strategies (CLAS) project. She has over 12 years of progressive experience conducting research and evaluation projects focusing on ATOD and violence prevention services for youth and their families—with an emphasis on school-based programs. Ms. Scott-Nakai has worked at the local, state, and federal levels. She has overseen several local and statewide evaluation projects (including the California Friday Night Live Mentoring Project, the California Youth Council, and the Orange County On Track Tobacco Free Communities Project) and has substantially contributed to the management and design of large-scale multi-site federally funded prevention studies (including Project Youth Connect and the Mentoring and Family Strengthening initiative). Before joining CARS, Ms. Scott-Nakai conducted school safety research as a consultant for the Florida Safe and Drug Free Schools Program and the Florida Safe Learning Environment Data Project (a three-year longitudinal study). During this time, she provided technical assistance and support to SDFSC Coordinators regarding evaluation and measurement issues. Additionally, Ms. Scott-Nakai taught a Theory of Measurement course at the University of Florida for two years.

Andrea Valdez joined the California Tobacco Control Program (CTCP) in August 2010. She brings six years of tobacco control experience to the position of Program Consultant. Andrea was previously Program Coordinator for the California Youth Advocacy Network (CYAN), a statewide training and technical assistance provider for Prop-99 funded agencies. In this position, she developed expertise in youth and young adult tobacco control issues, especially tobacco use in popular media. Andrea holds a B.A. in Political Science from UC Riverside and a Master of Public Administration from the University of Washington. Andrea is working in CTCP's Local Programs and Priority Populations Unit, focusing primarily on point-of-sale initiatives.

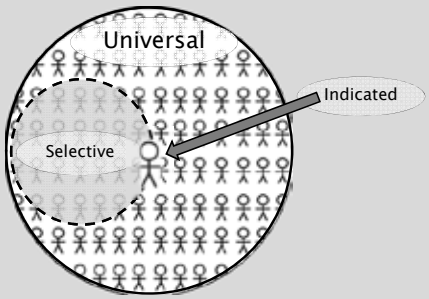
Welcome and Overview


The Prevention Landscape
Opportunities for Cross-System Partnership


SUSTAINABLE
TREATMENT
INTERVENTION
RECOVERY SUPPORT
INTEGRATED
CULTURALLY COMPETENT
SERVICE COORDINATION
PREVENTION
EVIDENCE BASED
CLIENT
COMMUNITY
CENTERED
Assessment
Tx Initiation
Monitoring
Maintenance
Universal
Selective
Indicated


Bridging the Gap
Prevention
Treatment
Recovery

IOM Categories



Environmental

STRATEGIES

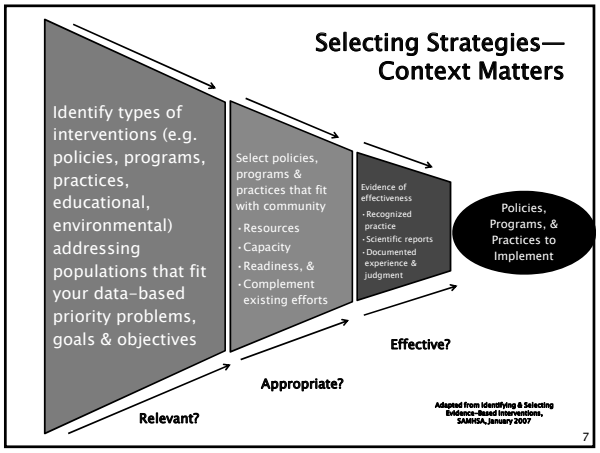
Selective and Indicated

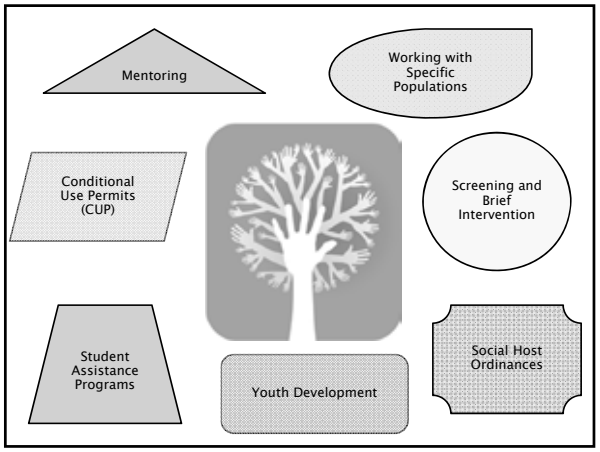
Substance Abuse Prevention's Use of:

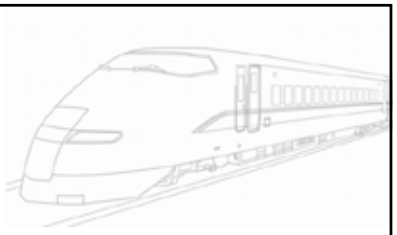
- Evidence Based Practice
- Data Driven decisions


prevention Tactics

A Paradigm Shift in Selecting Evidence-Based Approaches for Substance Abuse Prevention



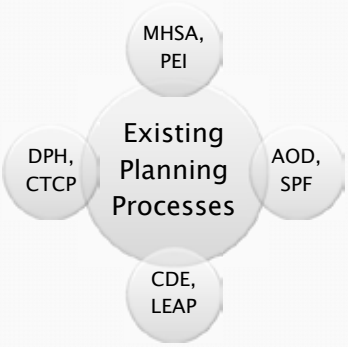




Opportunities for partnership across systems

MOVING FORWARD

SAMHSA'S Strategic Prevention Framework



Cross System

Partnership

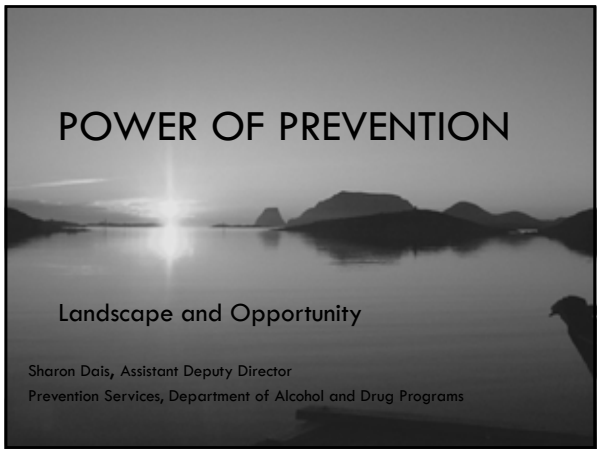

CARS
CENTER FOR APPLIED RESEARCH SOLUTIONS
Community
PREVENTION INITIATIVE

Partnering for Success: The Statewide Perspective

Laura Colson, *California Department of Alcohol and Drug Programs*

Barb Alberson, *California Department of Public Health*

Tom Herman, *California Department of Education*



Substance Use is Widespread . . .

- Americans, only 4% of the world's population, consume 2/3 of the world's illegal drugs.
- 1 in 4 Americans will have an alcohol or drug problem at some point in their lives.
- Adolescent substance use is America's #1 public health problem.

. . . and It's Expensive

- The cost of substance abuse/addiction is $545 a year for each Californian.
- Drug abuse costs the US economy over $600 billion annually in increased health care costs, crime and lost productivity.
- Costs associated with substance abuse exceed the costs for both cancer and diabetes.

The Cost is High for Everyone

Never Waste a Good Crisis

ADP's Vision for Substance Abuse Prevention

- Thinking of whole person wellness and healthy, safe communities
- Thinking across systems and disciplines and investing in partnerships
- Thinking about effective strategies that lead to multiple outcomes

ADP's Vision for Substance Abuse Prevention

- Thinking beyond traditional funding silos
- Relying on:
  - need driven planning
  - evidence-based implementation
  - outcome-based decision making

Planning for Prevention Across Systems June 5-6, 2012

Tom Herman, Administrator
Coordinated School Health and Safety Office

CALIFORNIA DEPARTMENT OF EDUCATION
Tom Torlakson, State Superintendent of Public Instruction

The Problem and the Opportunity

TOM TORLAKSON
State Superintendent of Public Instruction

- Schools/LEAs are suffering
- Loss of Funding Sources
- County Coordinators losing our infrastructure
- Schools and counties are losing their expertise
- Students' needs are not being met

Increased need for Internal Collaboration

TOM TORLAKSON
State Superintendent of Public Instruction

- CDE itself sees the need for internal collaboration
- Divisions are looking at the whole child
- Foster Youth, Mental Health,
- Educational Options for students
- Elements of Coordinated School Health
- After School programs

TOM TORLAKSON
State Superintendent of Public Instruction

Increased Need for External Collaboration

- Department of Public Health
- Department of Alcohol and Drugs Program
- Tobacco Control Program
- County Offices of Education

TOM TORLAKSON
State Superintendent of Public Instruction

CDE's Initiative

- Team California for Healthy Kids (TCHK)
- "Making Healthy Choices the Easy Choices"
- Increase Physical Activity (MVPA)
- Increase access to fresh water
- Increase access to fruits and vegetables

TOM TORLAKSON
State Superintendent of Public Instruction

TCHK Partners

- Department of Public Health
- Food and Agriculture
- Council of Mayors
- Student Health Centers (Prevention services may be housed there)

TOM TORLAKSON
State Superintendent of Public Instruction

Safe and Supportive Schools Grant

- 59 High Schools implementing School-wide improvements
- Data is driving their reform efforts
- Engagement, environment and safety
- Drug and alcohol use still a problem
- Especially among special populations: LBGT students

TOM TORLAKSON
State Superintendent of Public Instruction

Centers for Disease Control Coordinated School Health

- Health Education
- Physical Education
- Health Services
- Counseling and Psych. Services
- Healthy School Environment
- Health Promotion for Staff
- Family and Community Involvement

TOM TORLAKSON
State Superintendent of Public Instruction

Tobacco Prevention

- Emphasis on Youth Development
- Prevention works
- Crosses over into AOD
- Needs of many students are simple:
- Meaningful participation
- High Expectations
- Caring relationships

TOM TORLAKSON
State Superintendent of Public Instruction

How Do We Increase Collaboration?

- Reach out- "Hi I'm Tom, tell me about what you do."
- Build personal relationships
- You can't collaborate with an agency or a non-profit, you collaborate with a person.
- How can you benefit what others do should be the first question.

TOM TORLAKSON
State Superintendent of Public Instruction

Thank you for what you do.

"He who understands the "why", can bear any "how"."
Viktor Frankl

Tom Herman
California Department of Education
(916) 319-0914
therman@cde.ca.gov

Partnering for Success: Relevant Initiatives

Greg Austin, PhD., *WestEd*

Will Rhett-Mariscal, PhD., *California Institute of Mental Health*

Andrea Valdez, *California Department of Public Health*

Adolescent Substance Use Data: The Need, Sources, and Current Trends

Gregory Austin

WestEd Health & Human Development Program (gaustin@wested.org)

California School Climate, Health, and Learning Survey System (Cal-SCHLS)

California Student Survey

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Agenda

- Current AOD use data and trends
- The importance of local data
- Data sources
- Data challenges
- Meeting the challenges

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School-based Prevention's Quadruple Whammy

- (1) NCLB **Title IV** (Safe and Drug Free Schools/Communities) defunded
- Schools have (2) **budget cuts** and (3) **testing** stresses as never before.
- (4) **Generational retirement** of prevention specialists.
- Result:
  - Schools unwilling to do anything that takes away from instruction, is not required, that costs money.
  - Health/prevention programs and staff being reduced.
  - Two decades of capacity building being undermine.
  - School-community collaboration more important than ever.

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14th (2009-10) Biennial California Student Survey

- Little change among 7th graders. Among 9/11th:
- Promising declines in use of tobacco, alcohol, & AOD's on school property.
  - Binge drinking, lifetime drunkenness, drinking & driving.
- Methamphetamine on downward trend
- Marijuana and most other drugs overall stable
  - Including prescription drugs but at troubling level
- Rise in weekly marijuana use and perceived marijuana availability, peer use, and lack of harm
- Marked increase in ecstasy

Sample: 8,390 7th, 9th, 11th graders in 74 randomly-selected schools/classrooms.

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2009 CSS: Heavy Drug Use Indicators

- Most heavy use indicators level
- High Risk Use at 8% (9th) and 17% (11th)
- Estimated AOD **Dependency** down slightly because of declines in alcohol, but no change in **Abusers**
- Total population that might warrant Intervention est. 12% and 22%.

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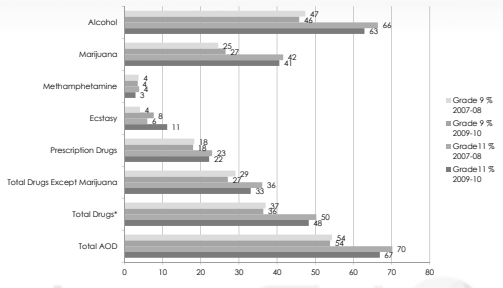
Lifetime AOD Use in 9th & 11th grades, 2007 vs. 2009



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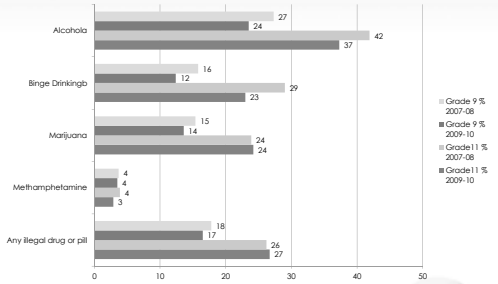
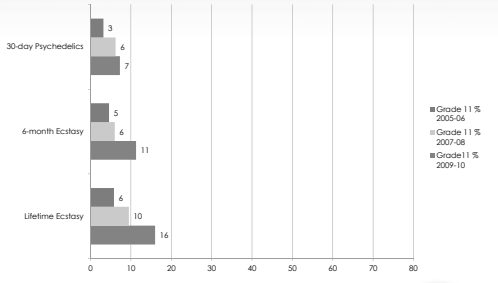
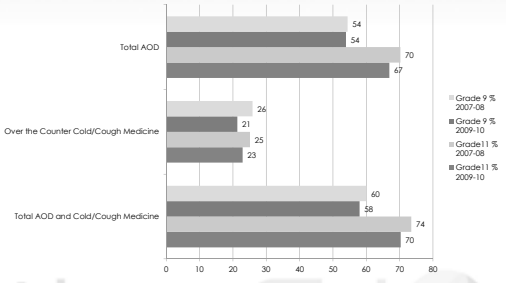
Current (Past 30 Days) Use, 2007 vs. 2009



Lifetime, 6-month, & 30 Day Use of Psychedelics/Ecstasy, 11th grade, since 2005



Total AOD Use and Recreational Cold/Cough Medicine



2009 CSS Implications

- Confirms 2007-09 data that declines in drug use that occurred in the early decade have come to an end.
- Ecstasy a rising problem
- Need to pay greater attention to recreational use of medicinal drugs
- Cutbacks in Title IV funding and school AOD program implementation and staffing do not bode well.

Download *Highlights* and *Compendium of Tables* (6 yrs of data): http://www.wested.org/cs/we/view/pj/572

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The Critical Role of Local Data

- Making the case for AOD prevention and intervention
- Demonstrating need for funding (which shrinking)
- Guiding program planning and implementation
- Demonstrating progress (Accountability)
- Fostering collaboration

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Cal-SCHLS: The Source for Local Data

- California School Climate, Health, and Learning Survey System: Three linked assessment tools (online and print) for local data collection:
  - **CA Healthy Kids Survey** (CHKS)
  - **CA School Climate Survey** (CSCS)
  - **CA School Parent Survey** (CSPS)
- A project of California Dept of Ed, with CHKS support from Dept of Alcohol and Drug Programs
- Developed and operated by WestEd
- Websites: cal-schls/chks/cscs/csps.wested.org Info/help line: 888.841.7536

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What is Cal-SCHLS?

- The oldest and largest effort in the nation to provide schools/communities with local data to :
  - Guide improvement of schools, prevention and intervention programs, and health services.
  - Promote success in school, career, and life.
  - Promote overall well-being among all youth.
- Identified as a model system by the US Dept of Ed (*Successful, Safe, and Healthy Students*)
- The leading source of local, county, and state data on AOD use among California students since 1999

A Data Collection System

- Not just a survey
- Customize to address local data needs
  - Select from survey modules (Required Core + Supplements)
  - Add questions to expand value (other topics, program participation, evaluation etc.).
- Wide variety of guidebooks and resources for understanding and using the data (website)

CHKS Overview

- District level: grades 5, 7, 9, 11, & Continuation
- 2004-11 required every 2 years (Title IV and TUPE)
- Administered by 85% of districts with secondary schools = 98% of enrollment. (90% at school-level)
  - 500,000 students annually (av.) in over 7,000 schools

Local Cost

- $.30 per student basic fee covers data processing and reporting
  - For half of districts, basic fees c.$130 or less.
  - Districts in 6th & 7th deciles, from $150-350.
  - The 10% of largest districts, $1,000.
  - Cost effective means to collect other needed data
- Planning, consent, and instrument photocopying

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CHKS Core Content—AOD Use Major Focus

- Lifetime and 30-day frequency
- Use at school
- Adverse AOD effects (11 indicators)
- AOD Dependency indicators (10 indicators)
  - Based on APA DSM criteria: tolerance, lack of control, interference with life, efforts to stop use
- Perceived availability
- Attitudes. perceived harm & friends disapproval
- Prevention (talk to parents; message exposure)

Supplemental Module with Other Biennial CSS Questions

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CHKS Data Availability

- CDE provides reports at the district, county, and state level
- Publicly posted since 2004 on survey website http://chks.wested.org/reports
  - Response to requests from users
- School reports on request @ $50
  - Currently requested by over 50% of districts
  - Outside requests must be made through districts/schools
- Dataset for analysis under MOU
- Factsheets on key topics (aggregated statewide data)
- Special topic state reports

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Query CHKS

- Key survey results available online (Query CHKS).
  - AOD use: lifetime, 30-day, at school, use level, driving
  - A collaboration with **kidsdata.org**
- Selected cross-tabs (gender, race/ethnicity, school connectedness)
- Data graphing

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Query CHKS—Search Results

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California School Climate Survey of Staff

- Administered at same time/schools as CHKS at no extra cost.
- AOD Content
  - *How much of a problem is use of alcohol, tobacco, other drugs at the school?
  - Policies & practices related to AOD prevention and intervention
- Compare staff perceptions of adverse effect and services provided to student behavior/need
- *Can customize with other AOD questions

***Applies to parent survey**

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Immediate Challenges to Data Availability

- Schools remain the most efficient venue for data collection but resistance growing
  - Title 4 defunding ended CDE requirement and source of covering survey costs
  - Aggravated by budget cuts and testing stresses
- If schools stop survey, lose not only local data but aggregate county and state data.
- Data more important then ever to demonstrate need in the face of prevention cutbacks!

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Agency Responses

- CDE still requires of state TUPE (Tobacco Use Prevention Education) grantees
  - New Tier 1 grants specifically to fund survey
- County agencies collaborating to provide funding to preserve countywide district administration
  - Orange, Sonoma etc.
- DADP alerted County AOD administrators and Prevention Coordinators that SAPT Block Grant Primary Prevention funds can be used to support CHKS

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Agency Response: CSS-CHKS Integration Plan

- State no longer sponsoring separate Biennial CSS (1985-2009) but relying on CHKS.
- Randomly select statewide sample of schools and provide financial incentives if do CHKS with extra AOD module.
  - Cover all district CHKS fees up to 900 students per grade.
- Preserves both district CHKS administration and representative state data.
  - After first 2 yrs, produce annual state reports with rolling averages

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What You Can Do: Preserving Local Data

- Make the case for the survey's value to the school: Speak to their interests
  - See *Cal-SCHLS Guidelines for Survey Administration, 2010-11.* (www.cal-schls.wested.org)
- Foremost: Useful in guiding school reform efforts and improving student attendance, grades, and graduation
  - Assesses school behavior, experiences, attitudes
  - Conditions for learning / school climate factors
  - Learning barriers and supports
    - School reform and prevention are complementary
- Needed to obtain funding in Era of Accountability

Example: Overall Impact of Heavy Use

- For every ten students who report poor school performance, attendance, and violence or weapons possession at school, 3-to-4 students in 9th grade and 4-to-6 in 11th are heavy AOD users (CSS Report).

What You Can Do

- Help cover survey costs
- Help schools analyze and use their AOD data
  - Identify high-risk patterns of use and user groups.
- Collaborate in strategic planning to meet those needs and monitoring progress.
- Provide expertise to help students in need.
- Identify community resources to meet the needs.
- Aid in identifying and implementing research validated programs.

See: CHKS Guidebook to Data Use and Dissemination

Partnering for Success: Relevant Initiatives

Mental Health Services Act

Prevention and Early Intervention Component

MHSA PEI Quick Overview

- Mental Health Services Act (2004) provides funding for mental health services through 1% tax on incomes over $1 million
- Sets aside 20% of funding for prevention and early intervention (PEI)
- Counties held local stakeholder processes to identify needs and priorities and develop initial PEI implementation plans
- Over $200 million of PEI set aside for 4-year PEI Statewide projects: Student Mental Health, Stigma and Discrimination Reduction, Suicide Prevention, and Reducing Disparities

PEI Programs Snapshot

- No requirement that a certain amount of funding be spent in prevention versus early intervention
  - but most counties have prevention programs – 97% have at least one
- Community settings- counties committed to provide PEI services at sites where people go for other routine activities, including:
  - schools (93%)
  - primary care (81%)
  - homes (71%)
  - diverse social and community settings (76%)
  - community-based organizations (86%)
  - faith-based organizations (64%)
  - childcare or pre-school (59%)
- 86% of counties included co-occurring mental health and substance-use issues as an element of at least one PEI program

Source: MHSOAC PEI Trends Report 2011

MHSA Update

- **March 2011 - California legislature passed AB100**
  - **made changes to the program approval process (among other things)**
  - **counties no longer seek approval from DMH and MHSOAC, handled locally**
- **Also, 2012-2013 governor's budget proposes reorganization of public mental health**
  - **DMH functions split up by end of FY 2011-12**
  - **Community programs including much of the MHSA moving to Department of Health Care Services**

MHSA Update

- Statewide projects
  - Counties formed a Joint Powers Authority, CalMHSA, to administer three statewide programs: Suicide Prevention, Stigma and Discrimination, Student Mental Health
    - These programs are rolling out now
  - Strategic Plan development for Reducing Disparities project to be completed later this year
- Budget crisis
  - Cuts to treatment services have made early intervention a high-priority over primary prevention

Opportunities for Cross-System Sharing

- Some areas where there may be opportunities to streamline efforts, reduce duplication, and learn from each other include:
  - Integration efforts/ Preparation for health reform
  - Peer services
  - Statewide Projects
  - Strategic Prevention Framework

Integration efforts/ Preparation for health reform

- As county behavioral health test out different ways of partnering with physical health to improve whole health care, good place for other prevention efforts
  - link push for whole health (treatment) to push for "whole wellness"(prevention)
    - Help expand emphasis on integrated health to include integrated prevention – no health without prevention
  - link push for any prevention to whole prevention
    - Support a whole-health perspective to prevention, not just physical health, or just substance use, or just mental health –no health without whole health

Peer Services

- As behavioral health continues to develop and promote peer-run and peer-based services, link to whole health prevention:
  - No health without prevention - Jointly push that peer services include prevention services, not just clinical alternatives (e.g., peer run crisis units) or maintenance (wellness centers for people already in recovery)
  - No health without whole health -Peers can be cross-trained to provide prevention services in multiple disciplines:
    - health educators for multiple health promotion topics
    - screening for early signs of multiple conditions

Statewide Projects

- Stigma and discrimination
  - Media campaigns – could leverage for promotion messages, not just anti-stigma
  - Health literacy- partner for whole health literacy
- Suicide Prevention
  - Build on links between suicide and other public health issues like violence prevention
- Student Mental Health
  - Tie into activities in each of the three higher education systems to leverage resources and promote wellness on campus

Strategic Prevention Framework

- In terms of the SPF, opportunities with MHSA PEI include:

1. Assess Needs –
   - counties have already done their big MHSA PEI needs assessments and benefitted from assessments done by other systems - may want to check out these assessments
2. Build capacity –
   - Workforce development – cross trained
   - Build new partnerships/collaborations with mental health prevention providers

Strategic Prevention Framework (continued)

3. Plan
   - Promote/support development of cross-system prevention planning, coordinated planning
4. Implement
   - Identify opportunities for mutual support, common activities, shared resources

Strategic Prevention Framework (continued)

3. Evaluate

- Mental Health is new to the field of prevention evaluation
- There are no State standards
- Counties develop their own approaches, state organizations are currently looking at building some structure/guidance
  - Offer your expertise and help mental health get up to speed
  - Contribute to discussions about developing evaluation systems – not just to offer your expertise, but to look at opportunities for leveraging activities for joint benefit
  - May be opportunities to leverage resources, share surveys (add questions), develop comprehensive approach

Thank you!

Will Rhett-Mariscal
California Institute for Mental Health
wrhettmariscal@cimh.org

CPI REGIONAL FORUMS

Healthy Retail Environments: An Integrated Approach

Andrea Valdez, California Tobacco Control Program

Sacramento ~ June 5, 2012

Why Tackle The Retail Environment?

- Tobacco Industry's Main Point of Entry
- Historical Experience and Success
- National Interest
- New Opportunities with 2009 FDA Law
- Data

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Why Tackle The Retail Environment

- Tobacco Retail Stores…
  - Are more densely distributed in minority and low SES communities
  - In rural areas tend to have the lowest prices and highest amount of promotions and ads
- Exposure to Retail Store Marketing…
  - Prevents users from quitting

3

Youth Engagement is a Priority

- 25.5% of California's population
- High risk for tobacco use and greatly affected by others tobacco use
- Important part of the CA tobacco control movement
- Community leaders are often more receptive
- Youth are technical wizards on use of social media, video and photo editing, GIS, etc.

Bigger Picture

5

Potential Areas of Integration

6

Integrated Campaign Goals

To improve the health of Californians through changes to the retail environment.

- Working together where it makes sense at the local level
- Creating efficiencies
- Promoting systems change

7

What We've Learned So Far

- Programs often want to work together – just not always sure how
- Many opportunities for integration at the local and state level
- Opportunities for new partners beyond alcohol and healthy foods
- Persistence, commitment, and communication have been key

8

Challenges

- Learning Curves
  - Differing priorities, funding, language, framing
- Emphasis on policy and systems change
  - Levels of capacity and ability to move towards policy differ between programs
- Schedules, staffing changes
  - The bigger the collaboration, the more challenging to maintain

9

Successes

- Retail Environment Campaign Workgroup
  - Partnership of Local Lead Agencies, Statewide Technical Assistance and Training Providers, Network for a Healthy California, and Safe and Active Communities Branch
- National interest
  - A number of states are beginning work on the retail environment
  - California will be a leader in developing an integrated approach to this effort

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Successes

- *Healthy Retailers, Healthy Communities: Integrating Tobacco, Alcohol, and Healthy Foods Strategies Conference*
  - September 13-14, 2012
  - Sheraton Grand Sacramento
  - Save the Date: http://www.cce.csus.edu/conferences/cdph/hrhc12/hrhc12.cfm?pid=13

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Thank You!

California CTCP Tobacco Control Program

Andrea Valdez
Program Consultant
California Tobacco Control Program
916.324.4150
Andrea.Valdez@cdph.ca.gov

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On the Road to Success: Local Learnings and Success Stories

Michelle Dusick, *County of San Bernardino, Department of Behavioral Health*

Michael Lombardo, *Placer County Office of Education*

Following the Leader

Addressing the Needs of Military Families through Collaboration

County of San Bernardino Department of Behavioral Health

It Starts with a Good Idea (and sometimes with no idea at all)

Building on Existing Relationships

- Conversations between Departments
- Input from community agencies and stakeholders
- Participation in community events
- More conversations

and finally…

The idea begins to take shape

The Pilot Project

- Identifying needs and assets
- Designing a program
- Including partners and following their lead
- Clearing the path
- Making it work

Steps and Leaps

Fostering Relationships and Including New Partners

Lessons Learned

- The importance of Cultural Competency
- Close the feedback loop
- Stay focused on items of importance
- Meet regularly
- Honor different perspectives
- Be ready for the next step in the evolution

Be ok with following the lead

http://www.youtube.com/watch?v=fW8amMCVAJQ

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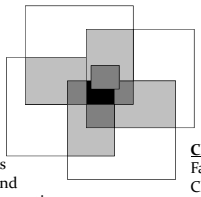
Across System Collaboration

Michael Lombardo
Director Interagency Facilitation
Placer County Office of Education

Placer County Children Systems of Care

Mental Health
Wraparound
Individual
Family
Group

Juv. Probation:
Prevention
Drug Court
Wraparound
Placement
Court Services



Education
Foster Youth Services
Homeless Youth Services
School Based Wraparound
Early Mental Health / Prevention
SARB
Network of Care

Child Welfare/CPS
Family & Children Services
Children Receiving Home
Wraparound
Court Services
Placement

Placer County Children Systems of Care

Mental Health
Wraparound
Individual
Family
Group

Juv. Probation:
Prevention
Drug Court
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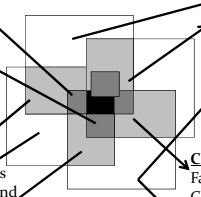
Placement
Court Services
Dual
Jurisdiction



Education
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Child Welfare/CPS
Family & Children Services
Children Receiving Home
Wraparound
Court Services
Placement
Dual
Jurisdiction

Demonstration Example
Student Attendance Review Board

System
- Monthly County Regional Meetings
- Collaboration
  - Community Partners, Parent, Youth, Community Resource Coordinator, Education, Probation, Mental Health, & Social Services, Local Districts
  - Focus on Family Problem Solving
  - Focus on Resources

Funding
- PCOE Management and Technical Support
- Partners Staff Time Case Management
- Increased ADA

Barriers
- Decreased Funding
  - Addressed through partnership and sharing responsibility
  - Mental Health Service Act provided funding for marketing development
- Vision for Intervention
  - Superior Court and District Attorney Collaboration

4

Demonstration Example
Student Attendance Review Board

Outcomes
- WPUSD increased Average Daily Attendance 1.5%
- Sample 57 students/ 47 missed one day or less
- Increased family participation
- Increased usage from local districts and increased confidence
- Increased access to family unique resource development immediately at meeting

5

Demonstration Example
Network of Care

System
- Web Based Resource and Services Directory
- Collaboration
  - Adult System of Care, Placer Collaborative Network, Keiser & Sutter Hospitals, First Five, Placer Co. Office of Education, Valley Vision

Funding
- PCOE: Management and Technical Support
- Adult System of Care: Purchase of Web Service System
- Hospital and Valley Vision: Technical Support and Marketing
- First Five: Funding of AmeriCorps Staff
- PCN Community Collaboration and Engagement
- Mental Health Services Act

Barriers
- Decreased Funding
  - Addressed through partnership and sharing responsibility
- Service to Displaced Individuals
  - Addressed through utilizing the network of school districts, pre-schools, child care providers

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Demonstration Example Network of Care

Outcomes

- Daily usage increased from 145 clicks a day to 685
- Tripled the traffic to service providers directory
- Providers listed increased by 10%
- Massive outreach campaign and site optimization
- Increased AOD service listings
- Developing platform for Tahoe Truckee partnerships

7

Demonstration Example Crisis Resolution Center

System

- 6 bed residential and community prevention center
- Collaboration: Probation, Child Welfare, Mental Health, Education, Community Partner
- No cost to families

Funding

- Placer County Probation
  - Juvenile Crime Prevention Act
- Partner Technical and Staffing Support

Barriers

- Communication
  - Addressed through partnership and sharing responsibility
- Funding
  - Partner staffing support/collaboration
  - CSOC Support of $300,000 in 2006 to keep doors open

8

Demonstration Example Crisis Resolution Center

Outcomes

- 101 youth served in 2010 – 2011 82% or youth returned home successfully
- 11 % returned to alternate care successfully
  - Family member or foster care
- Improved collaborative partnerships
- 356 hours of additional care for families
- Development of Web Based Residential Services System

9

Demonstration Example School Based Wraparound

System
- Student Family Support System
- Use of wraparound principles
- Based entirely through school site and not traditional governmental support
- Designed to shift school culture
- Partnership with student and family

Funding
- PCOE: Management and Technical Support
  - School MediCal Administrative Activities MAA/ Title I and Grant Support
- Local School MediCal Administrative Activities MAA, MHSA and Local Funding
- Increased ADA

Barriers
- Shifting Traditional Paradigm
  - Addressed through examples of student success
- Attrition
  - Increased Coaching and Selection Standards

10

Demonstration Example School Based Wraparound

Outcomes
- First year results are still under evaluation
- 20 school sites involved

Message From Parent:

"My son was on the verge of group home and failing school so I agreed to the Family Support Team as a last resort. After a few months he is attending school and getting Bs and As, getting angry less, has collage goals, getting less referrals and less conflict in our home. Thank you for your support"

11

Thank You!

Center for Applied Research Solutions (CARS)

www.cars-rp.org

Community Prevention Initiative (CPI)

www.ca-cpi.org

Toll-free: 1 (877) 568-4227

On the Road to Success: Local Learnings and Success Stories

Larissa Heeren, *Sonoma County Human Services Department*

Gary Najarian, *Marin County Department of Health and Human Services*

Danelle Campbell, *Butte County Department of Behavioral Health*

APPROACHING CROSS SYSTEM EFFORTS

Prevention Hub

Prevention Hub – What is it?

- A **restructuring effort** intended to link prevention programs, staff and opportunities across the Department;
- A **new way of working cross-divisionally** where content expertise and specific skills are used to maximum advantage
- A **professional development opportunity** for prevention staff to be trained and receive technical assistance
- An **opportunity to leverage prevention resources** in times of diminished budgets, streamline contracts with community partners and collaborate on funding opportunities
- A **communication strategy** to share best practices, engage in media advocacy and advance the value of prevention county-wide

Prevention Hub – What are we doing?

- Realignment of internal structure to support prevention
- Trainings on specific competencies to build skills of partners and staff
- Cross system strategic planning
- Use of collective impact

Collective Impact

SHARING DATA ACROSS AGENCIES AND PREVENTION EFFORTS

Sharing Data – Community Level

- **California Healthy Kids Survey (CHKS)**
  - Healthy Marin Partnership / Marin County Office of Education
  - Addition of Module G
- **Youth Access Survey**
  - Youth Leadership Institute
  - Opportunity to explore how and why youth are accessing alcohol
- **AOD Continuum of Services strategic planning process**
  - Agencies provided data during planning process
  - Three levels of data collection built into the plan – provider, county, independent evaluation
  - Community Coalitions engaged in community level data collection
    - Qualitative and quantitative (police, school, etc)
    - Will begin focusing on cross system

Sharing Data – What's Next?

- **Alignment with Epidemiology**
  - New ways to look at and use data
  - How it is really changing programs?
- **Data in planning processes**
  - Data and assets in the Healthy Eating/Active Living planning process
  - Data opportunities in the MHSA planning process next fiscal year
- **"Healthy Marin 2020" – planning process next year**

WHAT HAS WORKED AND NOT WORKED?

Opportunities & Challenges

Opportunities	Challenges
☐ Prevention staff collaborating on projects much more frequently ☐ Communication from meetings, trainings, events, etc has increased	☐ Hard to give up the old ways of doing things ☐ Concern that certain priorities will disappear ☐ Information overload – what do you DO with the information? ☐ It's not enough to just get it presented back to you – we have to do some thinking with it

Opportunities & Challenges

Opportunities	Challenges
☐ County-wide and local leadership commitment ☐ Looking more closely at outcomes	☐ Communities and partners still very overwhelmed ☐ Still a struggle to move folks away from just "reflection" and process outcomes

Opportunities & Challenges

Opportunities	Challenges
□ Partners eager to collaborate	□ Dwindling resources and changing priorities of funders
□ Opportunity to focus on equity	□ Addressing disparities means challenging power

RESOURCES

Resources

- Module G questions
- Collective Impact Articles
- Youth Access Survey questions?
- Copy of Strategic plan summer
- HealthyMarin.org
- Healthy Community Action Guide

A Final Thought…

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

QUESTIONS?

Partnering for Success

Butte County Behavioral Health Prevention Programs and Services Addressing AOD Prevention, Mental & Emotional Health and Academic Achievement

Presented by:
Danelle Campbell, Butte County Department of Behavioral Health - Prevention Unit
Planning for Prevention Across Systems - Regional Forums
June, 2012
Sacramento-Orange-Monterey

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Agenda

- What is the benefit? What gives us the highest return?
- Butte County Behavioral Health Prevention Unit – Successful partnerships across systems
  - COMMITTED/FNL – Chapters
  - Impact Mentoring
  - Athlete Committed
  - MHSA The Live Spot - Strengthening Families
  - MHSA TAY Youth Employment
- Questions

2

The Relationship of Mental Health, Substance Use and Academic Achievement

•***Mental Health and Learning***

•**Children's mental health is strongly related to their academic achievement. Collaboration among agencies is essential to support the academic achievement and health social-emotional development of children.** Adelman, H. S., and L. Taylor. 2006. The school leader' s guide to student learning supports: New directions for addressing barriers to learning. Thousand Oaks, CA: Corwin Press.

•***Stress and Grades***

•**Students experiencing high levels of psychosocial stress tend to do poorly in school.** Alatorre, A.S. and R. De Los Reyes. 1999. Psychosocial stress, internalized symptoms, and the academic achievement of Hispanic adolescents. *Journal of Adolescent Research* 143:343-358.

•***Depression and Grades***

•**High depression scores are associated with low academic achievement, high scholastic anxiety and poor peer and teacher relationships.** Fosterlin, F., and M.M. Binser. 2002. Depression, school performance and the veridicality of perceived grades and causal attribution. *Personality and Social Psychology Bulletin* 28(10): 1441-1449.

•***Anxiety and Grades***

•**Anxiety disorders are associated with drug use and dependence, suicidal behavior and a reduced likelihood of attending college.** Marmorstein, N.R., and W.G. Iaconon. 2001. An investigation of female adolescent twins with both major depression and conduct disorder. *Journal of the American Academy of Child and Adolescent Psychiatry* 40(3):299-306.

•***Suicide Attempts and School Performance***

•**In a study of adopted teens, investigators found that those who made a suicide attempt in the previous twelve months showed significantly lower levels of school performance and school connected ness than non-attempters.** Slap, G., E. Goodman, and B. Huang. 2001. Adopted as a risk factor for attempted suicide during adolescence. *Pediatrics*. 108(2):E30.

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- ***Alcohol and Drug Use and Test Scores***
- **Moderate substance use and/or violence/delinquency were associated with test scores a full level below scores of groups of students not involved in these behaviors. These finding took into account important factors such as gender, race-ethnicity, and poverty.** Washington Kids Count Human Services Policy Center. May, 2002. The impact of substance use and violence/delinquency on academic achievement for groups of middle and high school students in Washington. University of Washington.

- ***Further Research Linking Mental Health to Academic Achievement***
- **Failure to improve mental health of children and adolescents can lead to school failure and dropout as early as transition to middle school.** Gonzalez, N.A., L.E. Dumka, and J. Deaerdorff. 2004. Preventing poor mental health and school dropout of Mexican American adolescents following the transition to junior high school. *Journal of Adolescent Research*, 19(1),113-131.
- **Less than 25 percent of children with emotional or behavioral disorders graduate from high school.** California Little Hoover Commission. September, 2001.Young hearts and minds: making a commitment to children's mental health.
- Retrieved September 6, 2007 from http://.lhc.ca.gov/lhcdir/report161.html
- **Exposure to violence is associated with higher suspension and expulsion rates and lower school attendance and grades.** Wong, M. 2006. Building partnerships between schools and academic partners to achieve a health-related research agenda. *Ethnicity and Disease,* 16-1:149-153.
- **School-based mental health services programs related to fewer course failures.** Jennings, J., G. Pearson, and M. Harris. 2000. Implementing and maintaining school-based mental health services in large, urban school district. *Journal of School Health*, (70)5: 201-206.
- **Providing early mental health interventions in schools reduces dropout rates and transfers to alternative schools.** Wilson, D. B., D. C. Gottfredson, and S. S. Najaka. 2001. School-based prevention of problem behaviors: A meta-analysis. *Journal of Quantitative Criminology* 17: 247-272.
- **Brief school-based interventions for students exposed to high levels of violence and crime can improve symptoms of Post-Traumatic Stress Disorder (PTSD) and depression, with grade point averages improving as trauma symptoms diminish.** Stein, B.D., L.H. Jaycox, S.H. Kataoka, M. Wong, W. Tu, M.N. Elliott, and A. Fink. 2003. A Mental Health Intervention for School Children Exposed to Violence, *Journal of the American Medical Association 29-6:603–611;* Kataoka, S., 2007. School-based Treatment of Children Exposed to Violence. *Office of Safe and Drug-Free Schools 2007 National Conference.*

4

•Addressing mental health needs of students in family centers in Texas reduced disruptive behaviors and discipline referrals. Hall, S. 2000. Final report youth and family centers program: 1999-2000. Dallas, TX: Dallas Public Schools Division of Evaluation, Accountability, and Information Systems.

•Satisfying the social and emotional needs of students prepares them to learn, increases their capacity to learn, and increases their motivation to learn. It also improves attendance, graduation rates, and reduces suspension, expulsion, and grade retention. Collaborative for Academic, Social, and Emotional Learning. 2003. Safe and Sound: An Educational Leader's Guide to Evidence–Based Social and Emotional Learning Programs. Chicago, IL.

•Students who receive social-emotional and mental health support achieve better academically. School-Based Mental Health Services and School Psychologists. 2006. National Association of School Psychologists.

•Students who had interventions designed to strengthen their social, emotion and decision-making skills had higher standardized test scores and grades. Fleming, C.B., K.P. Haggerty, R.F. Catalano., T. W. Harachi, J. J. Mazza., and D. H. Gruman. 2005. Do social and behavioral characteristics targeted by preventive interventions predict standardized test scores and grades? *Journal of School Health* 75: 342-349.

•School-wide positive behavior interventions and supports show, not only less behavior problems, but also improved academic performance. Nelson, J., R. Martella, and N. Marchand-Martella. 2002. Maximizing student learning: The effects of a comprehensive school-based program for preventing problem behaviors. *Journal of Emotional and Behavior Disorders* 10:136-148.

•School wide prevention programs improve academic performance and attendance as well as lower dropout rates. Wilson, D. B., D. C. Gottfredson and S. S. Najaka. 2001. School-based prevention of problem behaviors: A meta-analysis. *Journal of Quantitative Criminology*, 17:247-272.

•Improving the psychosocial environment of schools can result in higher academic achievement, a safer environment, and truancy reduction. Center for School Mental Health Assistance. 2003. Outcomes of expanded school mental health programs. Retrieved September 5, 2007 from http://csmha.umaryland.edu/resources.html/resource_packets/downlaoad_files/outcomes

5

Committed/FNL-CL Program Model

- Core group of youth
- A trained staff member to support Committed chapter
- Officer meetings
- Chapter meetings
- A weekly session with curriculum guide
- EP Project
- School Climate Project
- Community Service Project
- All project implementation based on data
- Parent, Merchant and Athlete Committed

6

Committed Program Outcomes

- Youth change perception of harm related to ATODV.
- Youth reduce ATODV use.
- Youth experience ATODV free environments rich in youth development standards of practice.
- Change community norms/policy regarding ATOD.
- Youth increase protective factors.
- Youth have a strong commitment to academic achievement.
- Increase skill in leadership and advocacy.
- Decrease youth exposure and access to ATOD.
- Increase mental/emotional health and well being.
- Increase positive school bonding and school climate.

7

Partnerships for Success

- Behavioral Health – Prevention (co-facilitate & support youth in project implementation)
- Behavioral Health – Treatment (referrals)
- School District & Administration (support, buy in, use of facilities, etc.)
- Youth
- Other –campus clubs, organizations, local merchants, etc.
- Service groups (scholarships, parent convenings, etc.)

8

Committed Program Participant Survey

- The Committed Program survey is administered at the end of the program year. This survey measures basic demographic characteristics of the program participants (age, gender, ethnicity/cultural background, socioeconomic status), program participation intensity and frequency, how long youth have participated in the program, how youth experience youth development principals, leadership/advocacy, public speaking, conflict resolution, facilitation, leadership in school, leadership in community, identify self as a leader, strong peer relationships, strong adult relationships, "tolerant" of others' diversity, accepting of own diversity, connectedness to school, connectedness to community, commitment to academic achievement, productive use of afterschool time, contribution to creating change/impact in community, feel safe in program, feel empowered in program, perception of harm related to ATODV, reduce ATODV use, knowledge regarding community ATODV factors/environmental prevention, skills regarding ATODV factors (environmental prevention), access to ATODV, commitment to not use ATODV, and mental/emotional health and well being.

9

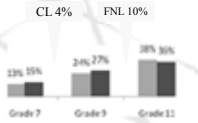
Because I have been in this program…	Participated Multiple Times Per Week	Participated Once Per Week or Less
I care about my school.	86%	55%
I try to improve my grades at school.	84%	63%
I participate in class activities.	84%	56%
I am interested in going to school.	80%	44%
I do well in school.	79%	56%
I try hard in school.	79%	59%
I spend time doing my homework.	71%	46%

10

County and Statewide CHKS Indicators

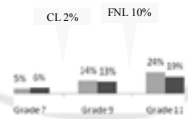
Past 30 Day Alcohol Use

Club Live and Friday Night Live participants were **less likely to report using alcohol during the past 30 days** compared to students across Butte County and California (see below).



Past 30 Day Marijuana Use

Club Live and Friday Night Live participants were **less likely to report using marijuana during the past 30 days** compared to students across Butte County and California (see below).



= Butte County CHKS Findings (2009-2010)
= California CHKS Findings (2007-2009)
= Club Live and Friday Night Live Post Survey Findings (2010-2011)

11

Mental & Emotional Health

- **Mental/Emotional Health:** At the end of the program year, 96% of the Friday Night Live participants said:
  - they feel they have more control over things that happen to them,
  - they can make more of a difference,
  - they learned that they can do things they didn't think they could do before,
  - they feel better about their future

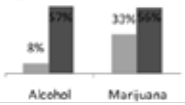
In addition, 95% indicated that they feel they are better at handling whatever comes their way and 91% said they feel better about themselves.

12

Spotlight on Alternative Sites

- Ninety percent (90%) of alternative site participants said that because they have involved with Friday Night Live they care more about their school, try to improv grades more, are able to work with authority figures more to establish new and/o community policies, and spend more time volunteering or helping others in their community.
- At the end of the program, 100% of the participants at alternative sites indicated that they believe they have more control over things that happen to them, can make more of a difference, learned that they can do things they didn't think they could do before, feel better about their future, and are better at handling whatever comes their way.

Friday Night Live participants at alternative sites were less likely to report using alcohol or marijuana during the past 30 days than students at non-traditional school settings Countywide (see figure).



= FNL alternative site participants Post Survey findings (2010-2011)
= Butte County CHKS findings for non-traditional students (2009-2010)

13

impact mentoring

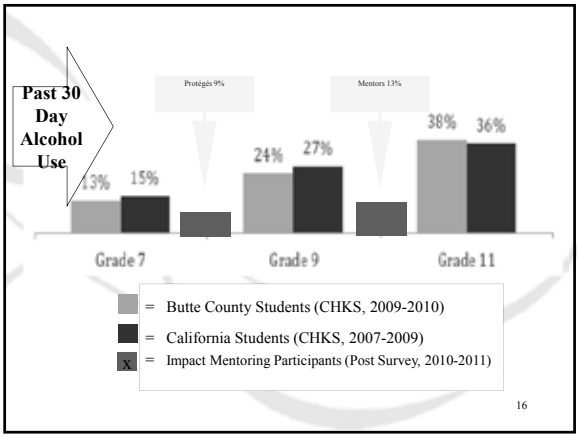
Impact Mentoring matches high school role models with junior high school protégés in a cross-age mentoring experience. Mentors and Protégés meet weekly in a supervised and structured mentoring session.

14

Partnerships for Success

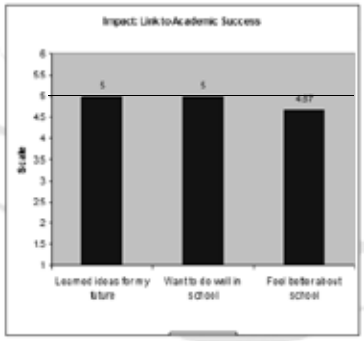
- Behavioral Health – Prevention (facilitate)
- Behavioral Health – Treatment (protégé referrals)
- School District & Administration (referrals, support, buy in, use of facilities, etc.)
- Youth – mentors
- School Counselors (protégé referrals)
- Service groups (scholarships, etc.)
- Parents (family homework)
- Teachers (Solution Focused Goal sign off)

15



16

Protégés: Link to Academic Success



17

Because I have been in this program…

	Protégés	Mentors
I try to improve my grades at school	78%	52%
I try hard in school	76%	52%
I participate in class activities	67%	49%
I am interested in going to school	66%	40%
I do well in school	66%	51%
I spend time doing my homework.	66%	34%

18

Mental & Emotional Health

- At the end of the program year, over 90% of the protégés and mentors said:
  - that they feel they have more control over things that happen to them,
  - can make more of a difference,
  - learned that they can do things they didn't think they could do before,
  - feel better about their future and at handling whatever comes their way, and
  - feel better about themselves.

19

Promising Findings - continued

- Scott D. Miller, Ph.D. – client informed feedback
  - Outcome Rating Scale (personal, family, school, everything)
  - Session Rating Scale (this scale is about the effectiveness of the staff member/mentor - felt heard, respected, worked on what I wanted to work on, good fit)
  - Group Session Rating Scale (relationship, goals, approach, overall)
  - Protégé scores double during the program participation

20

Athlete Committed

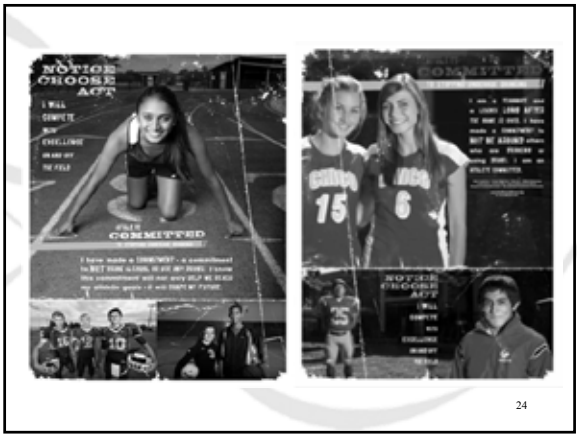
- Schools focused on providing support to coaches, athletes and their parents implement the Athlete Committed campaign. This initiative focuses on creating athlete, parent and coach commitments to creating positive, supporting environments free of bullying, harassment and substance use. It not only focuses on individual accountability, it incorporates principals to address "bystander" behaviors. Athlete Committed urges athletes to renew their commitment to excellence and commit to personal responsibility, team expectations and collective responsibility to never lose their focus or compromise their values.

21

Partnerships for Success

- Behavioral Health – Prevention
- School District & Administration (support, buy in, use of facilities, required training, release time, enforcement of code, etc.)
- School Board (code approval and support)
- Sports Boosters
- Coaches
- Athletes
- Pediatricians
- Local Businesses
- Parents

22



24

Promising Findings

- Athletes reporting that their peers are drinking less as a result of the program
- Athletes report they are attending less parties where youth are drinking alcohol
- Athletes are changing their eating, sleeping and training recovery habits
- All parents and athletes are trained on the same information creating consistency and common expectations
- Principals report less expensions, expulsions and disciplinary actions among athletes

25

The Live Spot - MHSA Prevention & Early Intervention

- Live Spot Oroville & Gridley
  - After School Youth Center
  - Daily/Weekly Classes
  - COMMITTED FNL/CL Chapters
  - Impact Mentoring
  - Strengthening Families
  - Weekly Juvenile Hall Sessions
  - Court Ordered Community Service Hours
  - Strengthening Families

26

Prevention – Treatment – Wellness & Recovery

- Oroville Live Spot
- Over 80 "young people in common" – receiving Live Spot services and showing up in our clinical record system
- 60+ of those are now "closed" to treatment services – Live Spot services are the "Wellness & Recovery" support
- 20+ are still "open" – Live Spot services and counseling services
- Live Spot PEI staff provide support - bill for rehab services

27

Live Spot
Strengthening Families Program

- 16-Week family skills training program found to significantly reduce problem behaviors, delinquency, and alcohol and drug abuse in children and to improve social competencies and school performance

28

Partnerships for Success

- Behavioral Health – Prevention (referrals, facilitate sessions)
- Behavioral Health – Treatment (referrals)
- Probation (co-facilitate and referrals/condition of probation)
- Social Services (referrals)
- Other – churches, organizations, etc. (donations, referrals)

29

Prevention –Treatment Cross System Support

- Treatment referral – build into treatment plan
- Re-visit goals during weekly counseling session
- Support weekly family homework
- De-brief and prepare
- Celebrate success

30

Promising Findings

- Outcomes include increased family strengths and resilience and reduced risk factors for problem behaviors in high risk children, including behavioral problems, emotional, academic and social problems
- Scott D. Miller, Ph.D. – client informed feedback
  - Outcome Rating Scale (personal, family, school, everything)
  - Session Rating Scale (this is about the staff member/therapist - felt heard, respected, worked on what I wanted to work on, good fit)
  - Group Session Rating Scale (relationship, goals, approach, overall)
  - Youth, Parent and Family scores double during the 16 weeks

31

MHSA – TAY Youth Employment

- Hire youth who are current "clients"
- One year supported employment opportunity
- Employed in Prevention Unit – not in the treatment center
- Gain valuable employment skills
- Reduce/eliminate treatment services
- Transition into Prevention Unit services as wellness and recovery support

32

Questions…Comments…

- Questions……Comments…….

33

THANK YOU

"Don't do easy things first or hard things first or urgent things first. Do first things first – the activities that give you the highest return."

John Maxwell, from the book Thinking For A Change

34

Advancing The Dialogue: World Café Style Discussion

Advancing the Dialogue: World Café Discussion

Exercise: For the themes above identify: (1) Successes, (2) Challenges, (3) Strategies/Best Practices, and (4) Recommendations (state and/or local) relevant to your service area or programs

Start by discussing one of the above themes with your peers (Pre-identified for your table) and identify common success, challenges, strategies and recommendations. Use the next page to take personal notes. Use the table-to flip charts to write-up the group's common responses. Take 20 minutes.

Next, move to one other table with a different theme and do the same thing. Take 20 minutes.

After you have discussed two themes, we will reconvene as a large group to report out.

Successes Theme A	Challenges Theme A
Theme B	Theme B
Strategies/Best Practices Theme A	Recommendations (state and local) Theme A

Sustaining Our Efforts
After report out, identify 1-3 things you can accomplish: now, by the end of the year, and long-term.

Now

By end of year

Long-term

Data Use and Action Planning (DUAP)

Leslie Poynor, PhD., *Health and Development Program, WestEd*

Community Prevention Initiative
Data Use and Action Planning (DUAP)

Leslie Poynor, Ph.D.
WestEd
Health and Human Development Program
California School Climate, Health, and Learning Survey System (Cal-SCHLS)
North Coast/Bay Area Regional Coordinator
lpoynor@wested.org
510-302-4241

DUAP Roadmap

- Data Sources
  - What are they?
  - Where can you find them?
  - How valuable are they?
- Reviewing Data
  - How to look at data
  - How to use data for planning priorities
- Action Planning
  - Setting goals and objectives

What are the available data sources?

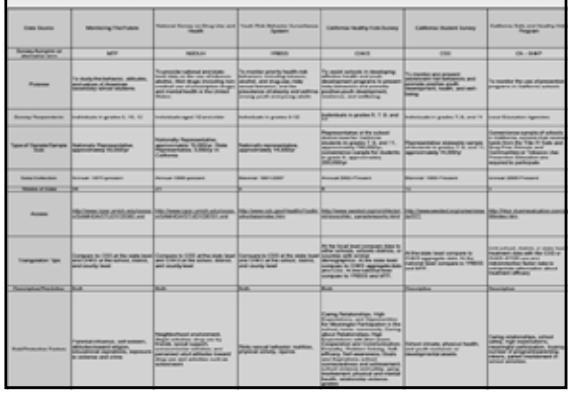
Data Source	Data Aggregated by							
	National	Regional	State	County	Local	Cross-tabs	Ethnicity	Data Formats
Monitoring The Future (MTF)	Yes	No	No	No	No	Yes	Yes, 7 categories	ASCII, SPSS, SAS, STATA, Tab separated
National Survey on Drug Use and Health (NSDUH)	Yes	No	Yes	No	No	Yes	Yes, 7 categories	ASCII, SPSS, SAS, STATA, Tab separated
Youth Risk Behavior Surveillance System (YRBSS)	Yes	No	No	No	No	No	Yes, 5 categories	ASCII, SPSS, SAS
California Healthy Kids Survey (CHKS)	No	No	Yes	Yes	Yes	No	Yes, 7 categories	PDF tables, or SPSS for a fee
California Student Survey (CSS)	No	No	Yes	No	No	No	Yes, 7 categories	Online biennial reports
California Safe and Healthy Kids Program (CA-SHKP)	No	No	Yes	Yes	Yes	No	No	Online summary of data
Each Human Youth Survey (Prevention Needs Assessment Youth Survey)	No	No	Yes	No	Yes	No	Yes, 7 categories	Online summary of data
National Survey of Substance Abuse Treatment Services (N-SSATS)	Yes	No	Yes	Yes	Yes	Yes	No	ASCII, SPSS, SAS, STATA, Tab separated, online reports
Drug Abuse Treatment Outcome Studies (DATOS)	Yes	No	No	No	No	Yes	Yes, 6 categories	ASCII, SPSS, SAS, STATA, Tab separated, online reports
Collaborative Psychiatric Epidemiology Surveys (CPES)	Yes	No	No	No	No	Yes	Yes, 12 categories	SPSS, STATA, SAS, online data analysis
The Partnership Attitude Tracking Study (PATS)	Yes	No	No	No	No	No	Yes, 5 categories	Online reports from Partnership for a Drug Free America
California Health Interview Survey (CHIS)	No	No	Yes	Yes	Yes	Yes	Yes, 7 categories	SAS, SPSS, data files formats, online data analysis through AskCHIS

Time to Talk

Turn to the person next to you and share what you know about these data sources.

- What do they tell you?
- What *don't* they tell you?
- Are they worth the time it takes to review them?
- Have you used them in planning prevention/intervention programs?

Where to find data sources



Which data sources would be most helpful for planning?

Turn to the person next to you and share why you selected the data sources on your list.

- How will this data source help you set priorities?
- How will this data source help you set goals and objectives?

Getting Started: How to Look at Data

1. Look for Trends Over Time
2. Understand How the Survey is Conducted
3. Read News Releases and Survey "Highlights" with Caution
4. Find Local Data

"If you are not getting down into your own local data, you're really missing the mark in prevention."
Tamu Nolfo, PhD
Certified Prevention Specialist
Northern California

Reviewing Local Data

1. Locate local data (i.e., county, district, school level Cal-SCHLS reports).
2. Select the risk and protective factors you want to review (i.e., caring relationships and substance use).
3. Check your assumptions (i.e., your predictions about risk and protective factors).
4. Compare your predictions with the actual data.
5. Dig deeper (i.e., look at the same data disaggregated by ethnicity or gender).
6. Select priorities.

First…

Check Your Assumptions!

Predict how students and staff answered a school climate related question.

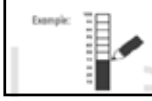
Compare your prediction to the actual CHKS and CSCS data.

STEP 1—PREDICTION STUDENT:
BEFORE you look at your data, think about the students in your school and guess the percentage of their responses to the following questions.

Example: At your school, what percentage of the students in each grade says …

It is very much true/pretty much true that there is a teacher or some other adult who really cares about me?

Color in the purple columns below to represent the percentage you guessed. You are creating a bar graph.

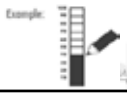


STEP 2— PREDICTION STAFF:
BEFORE you look at your data, think about the staff in your school and guess the percentage of their responses to the following questions.

Example: At your school, what percentage of the staff says …

Nearly all/most teachers really care about all students?

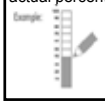
Color in the purple columns below to represent the percentage you guessed. You are creating a bar graph.



STEP 3—ACTUAL STUDENT: Locate your CHKS Reports and look at the actual data for that question.

Example: Refer to Table A3.11 on page 14 in the CHKS Main Report.

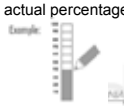
Color in the green columns with your actual percentage.



STEP 4—ACTUAL STAFF: Locate your CSCS Reports and look at the actual data for that question

Example: Refer to Table 3.1 on page 18 in the CSCS Main Report

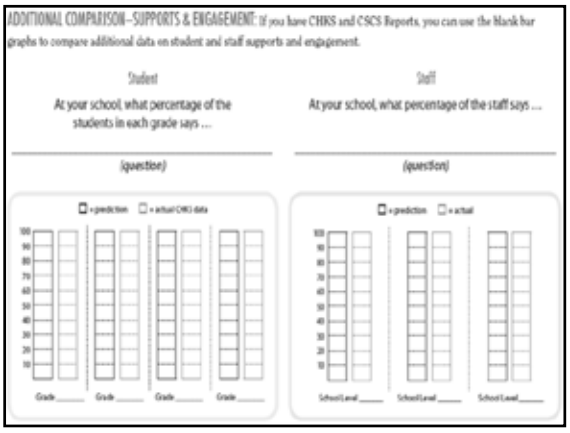
Color in the green columns with your actual percentage.

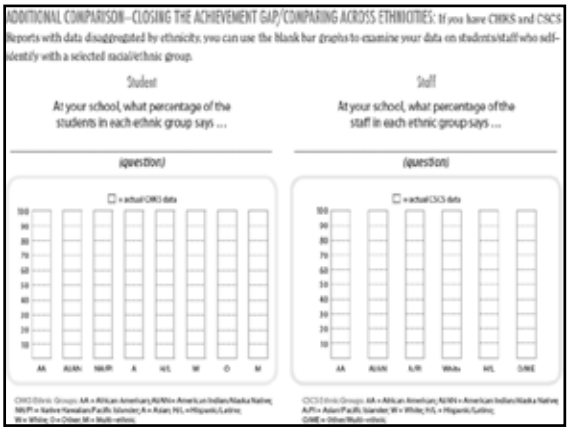


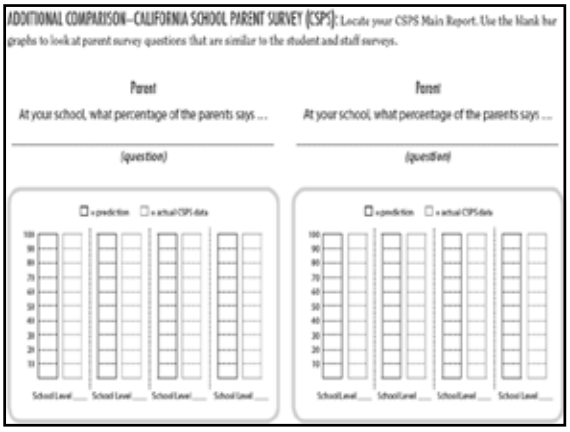
STEP 5–WHAT DID YOU LEARN? Compare your predictions with your data. Compare the student responses with the staff. What did you notice? What did you learn? What are your next steps?

Can you compare these results with results from the parent survey (CSPS)? Would it help to examine your data disaggregated by ethnicity? Do you want to compare the results for Migrant Education students and staff with non-migrant? Should you examine the staff results for Special Education? For additional questions see Appendix 4.

Do you need to create an action plan to strengthen or improve your results? If so, please refer to www.californias3.wested.org for resources on improving your school climate in each of the focus areas.


ADDITIONAL COMPARISON–SUPPORTS & ENGAGEMENT: If you have CHKS and CSCS Reports, you can use the blank bar graphs to compare additional data on student and staff supports and engagement.
Student
At your school, what percentage of the students in each grade says ...
(question)
Staff
At your school, what percentage of the staff says ...
(question)


ADDITIONAL COMPARISON–CLOSING THE ACHIEVEMENT GAP/COMPARING ACROSS ETHNICITIES: If you have CHKS and CSCS Reports with data disaggregated by ethnicity, you can use the blank bar graphs to examine your data on students/staff who self-identify with a selected racial/ethnic group.
Student
At your school, what percentage of the students in each ethnic group says ...
(question)
Staff
At your school, what percentage of the staff in each ethnic group says ...
(question)

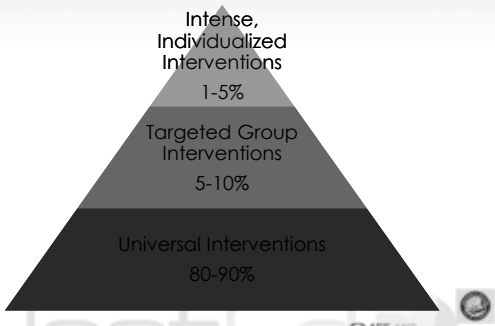

ADDITIONAL COMPARISON–CALIFORNIA SCHOOL PARENT SURVEY (CSPS): Locate your CSPS Main Report. Use the blank bar graphs to look at parent survey questions that are similar to the student and staff surveys.
Parent
At your school, what percentage of the parents says ...
(question)
Parent
At your school, what percentage of the parents says ...
(question)

Making decisions….

- After a thorough review of the available data …
- What kind of Supports and Opportunities does your population need?
- What kind of Prevention and Intervention does your population need?

Making Decisions…

Who needs to be served?



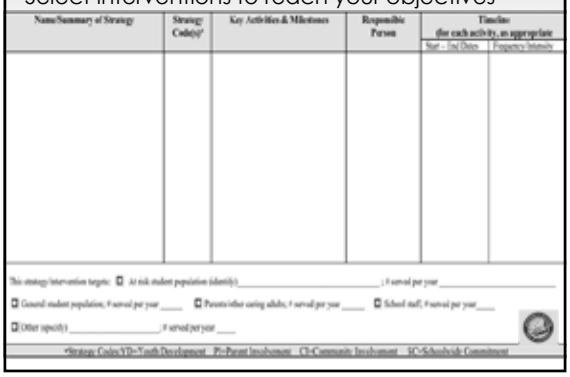
Making decisions….

Setting Goals and Writing Objectives

- What goals are you targeting with your supports or interventions?
- Who is your "general population" in need of supports or interventions?
- What are your objectives for the general population?
- Who are your "at-risk" groups?
- What your objectives for those groups?

Next Steps: Create an Action Plan

Select interventions to reach your objectives



Final Steps…

Implementation and Monitoring

- Stage 1: Development
- Stage 2: Installation
- Stage 3: Initial Implementation
- Stage 4: Full Operation
- Stage 5: Innovation
- Stage 6: Sustainability

CONTACT INFORMATION

Leslie Poynor
lpoynor@wested.org
510-302-4241

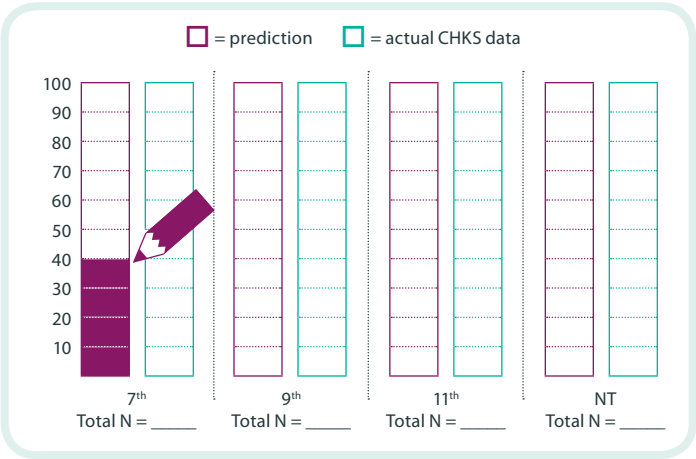
STEPS TO USING THIS WORKBOOK

STEP 1–PREDICTION STUDENT: BEFORE you look at your data, think about the students in your school and guess the percentage of their responses to the following questions. Example:

At your school, what percentage of the students in each grade says …

It is very much true/pretty much true that there is a teacher or some other adult who really cares about me.

Then color in the purple (i.e., dark–colored) columns below to represent the percentage you guessed. You are creating a bar graph. Example:

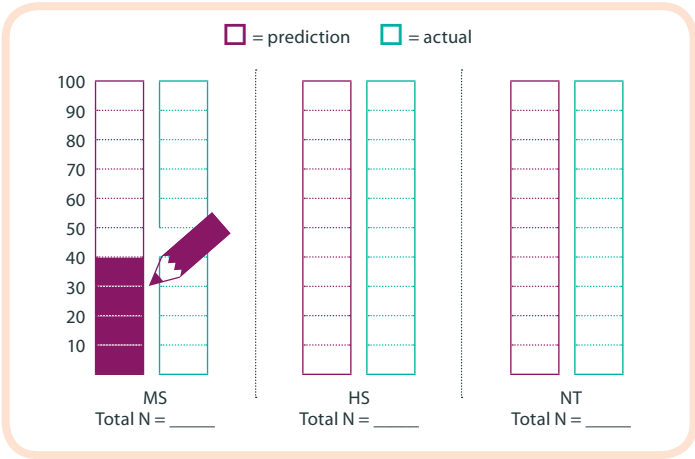


STEP 2–PREDICTION STAFF: BEFORE you look at your data, think about the and staff in your school and guess the percentage of their responses to the following questions. Example:

At your school, what percentage of the staff says …

Nearly all/most teachers really care about all students.

Then color in the purple (i.e., dark–colored) columns below to represent the percentage you guessed. You are creating a bar graph. Example:



HOW TO USE THIS WORKBOOK (CONTINUED)

STEPS TO USING THIS WORKBOOK

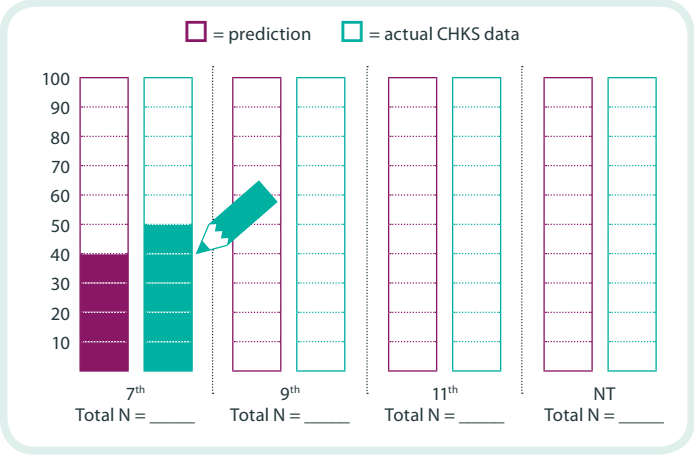
STEP 3–ACTUAL STUDENT: Locate your CHKS Reports and look at the actual data for that question.
Example:

Refer to Table A3.11 in the CHKS Main Report.

Table A3.12
School Protective Factors (Developmental Supports)

At my school, there is a teacher or some other adult...	Grade 7 %	Grade 9 %	Grade 11 %	NT %
who really cares about me (Caring Relationships)				
Not At All True	9	12	8	9
A Little True	25	28	22	29
Pretty Much True	37	38	35	35
Very Much True	29	21	34	27

Then color in the teal (i.e., light–colored) columns with your actual percentage. Example:



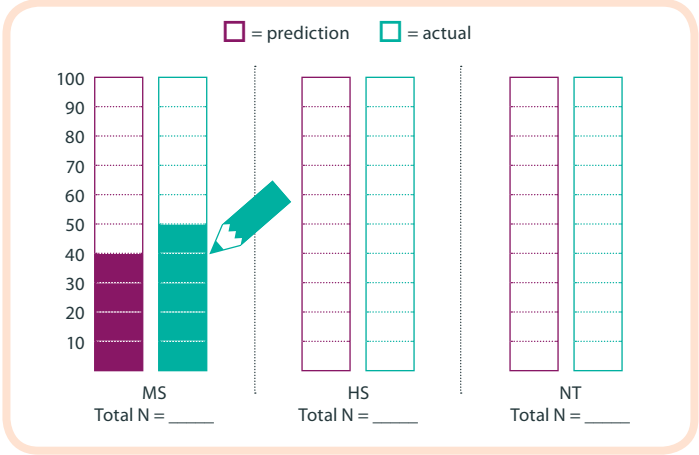
STEP 4–ACTUAL STAFF: Locate your CHKS Reports and look at the actual data for that question.
Example:

Refer to Table 3.1 in the CSCS Main Report.

Table 3.1
Adults Really Care About All Students

	TS %	ES %	MS %	HS %	NT %
Nearly All	63	79	61	41	54
Most	32	19	34	47	46
Some	5	2	5	11	0
Few	0	0	0	1	0
Almost None	0	0	0	0	0

Then color in the teal (i.e., light–colored) columns with your actual percentage. Example:



STEP 5–WHAT DID YOU LEARN? Compare your predictions with your data. Compare the student responses with the staff. What did you notice? What did you learn? What are your next steps?

Can you compare these results with results from the parent survey (CSPS)? Would it help to examine your data disaggregated by ethnicity? Do you want to compare the results for Migrant Education students and staff with non-migrant? Should you examine the staff results for Special Education? For additional questions see Appendix 4.

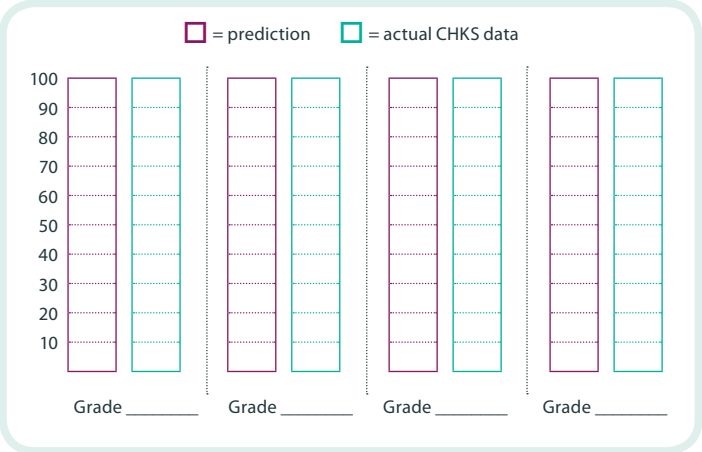
Do you need to create an action plan to strengthen or improve your results? If so, please refer to www.californias3.wested.org for resources on improving your school climate in each of the focus areas.

SCHOOL CLIMATE: SUPPORTS & ENGAGEMENT
CARING RELATIONSHIPS & HIGH EXPECTATIONS

Student
Refer to Table 3.11 in the CHKS Main Report

At your school, what percentage of the students in each grade says …

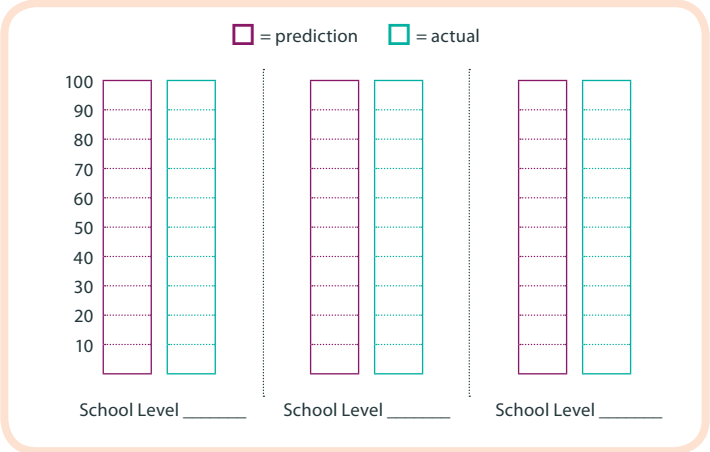
It is very much true/pretty much true that there is a teacher or some other adult who really cares about me?



Staff
Refer to Table 3.1 in the CSCS Main Report

At your school, what percentage of the staff says …

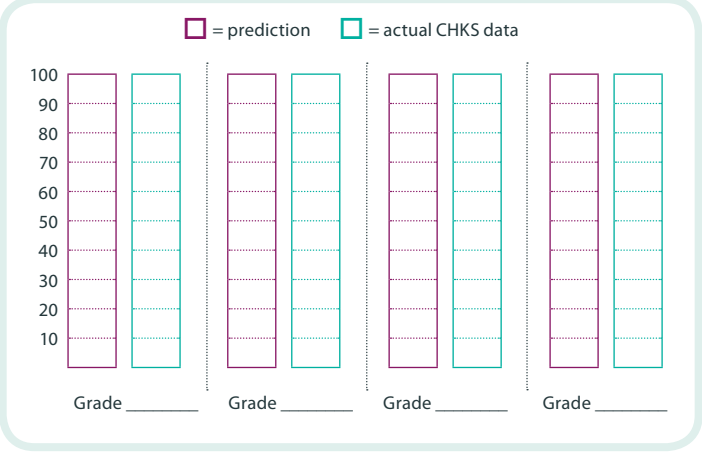
Nearly all/most teachers really care about all students?



Student
Refer to Table A3.11 in the CHKS Main Report

At your school, what percentage of the students in each grade says …

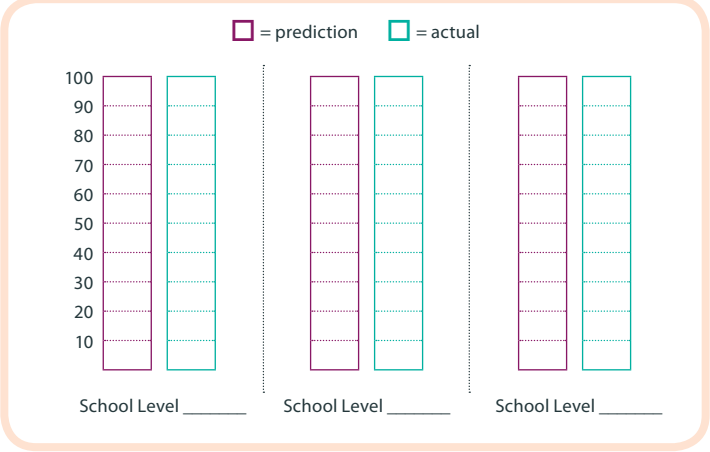
It is very much true/pretty much true that there is a teacher or some other adult who believes that I will be a success?



Staff
Refer to Table 3.5 in the CSCS Main Report

At your school, what percentage of the staff says …

Nearly all/most adults believe every student can be a success?



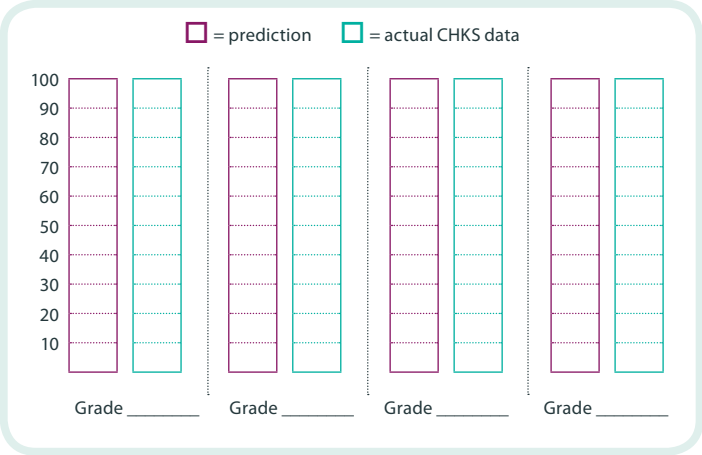
For additional and related questions see Appendix 4 and 5 respectively.

SCHOOL CLIMATE: SCHOOL SAFETY & SUBSTANCE USE
SUBSTANCE USE AT SCHOOL

Student
Refer to Table A4.12 in the CHKS Main Report

At your school, what percentage of the students in each grade says …

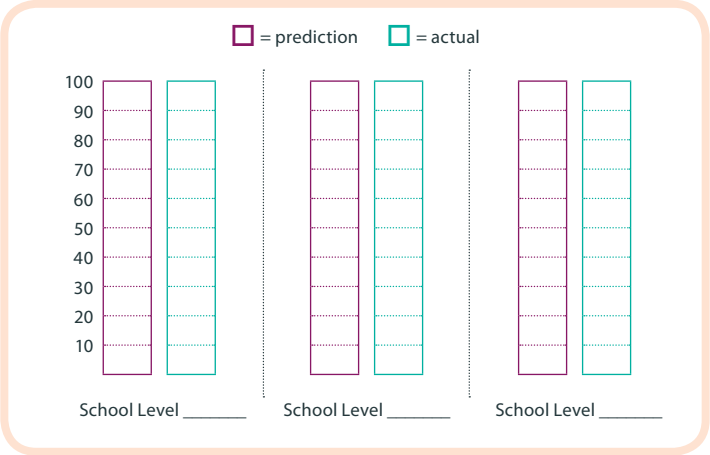
They have engaged in any alcohol, marijuana, or illegal drug use on school property during the past 30 days?



Staff
Refer to Table 6.7 in the CSCS Main Report

At your school, what percentage of the staff says …

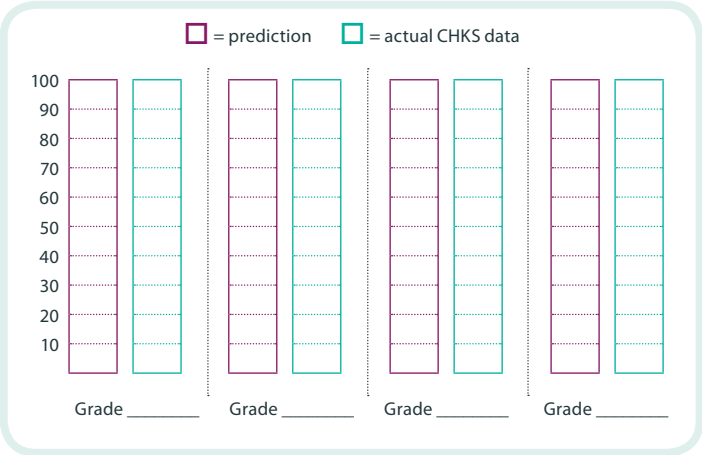
Alcohol and drug use is a moderate to severe problem at this school?



Student
Refer to Table A5.4 in the CHKS Main Report

At your school, what percentage of the students in each grade says …

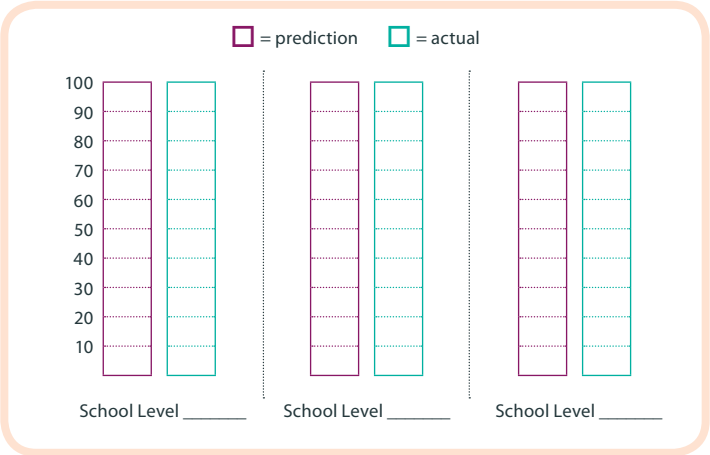
They smoked cigarettes on school property during the past 30 days?



Staff
Refer to Table 6.8 in the CSCS Main Report

At your school, what percentage of the staff says …

Tobacco use is a moderate to severe problem at this school?



For additional and related questions see Appendix 4 and 5, respectively.

APPENDIX 1: COMPARISON GROUP TEMPLATES
SUPPORTS & ENGAGEMENT

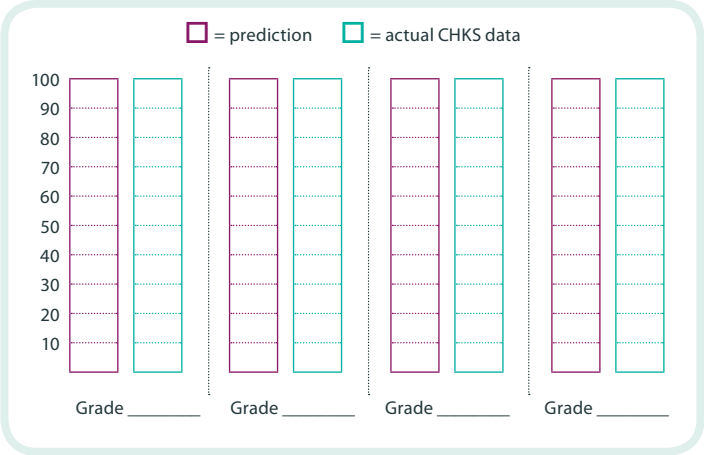
ADDITIONAL COMPARISON–SUPPORTS & ENGAGEMENT: If you have CHKS and CSCS Reports, you can use the blank bar graphs to compare additional data on student and staff supports and engagement.

Student

At your school, what percentage of the students in each grade says …

_____

(question)

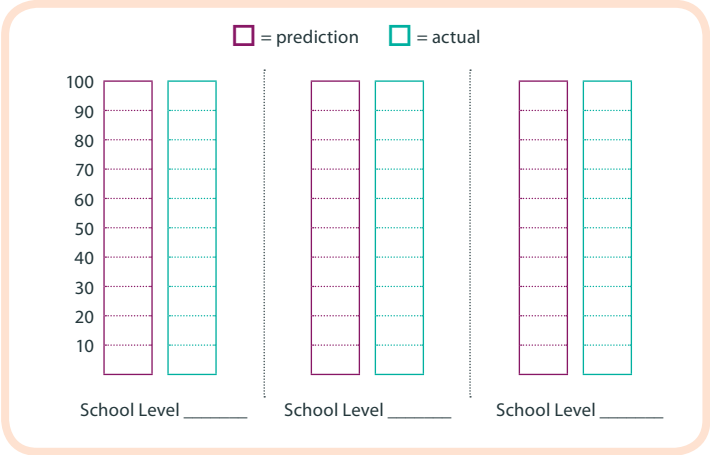


Staff

At your school, what percentage of the staff says …

_____

(question)

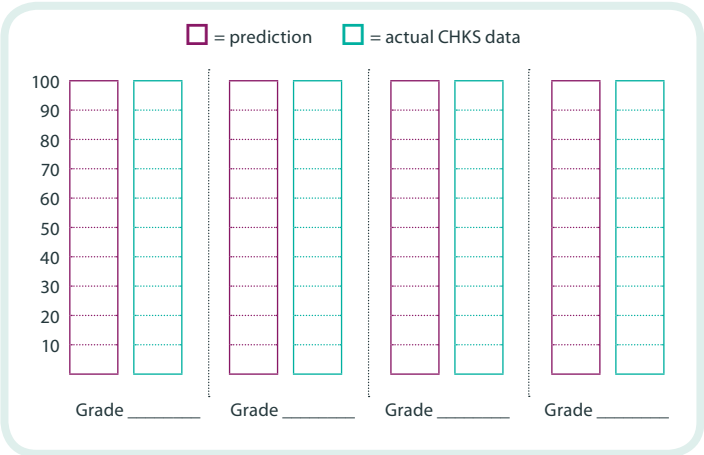


Student

At your school, what percentage of the students in each grade says …

_____

(question)

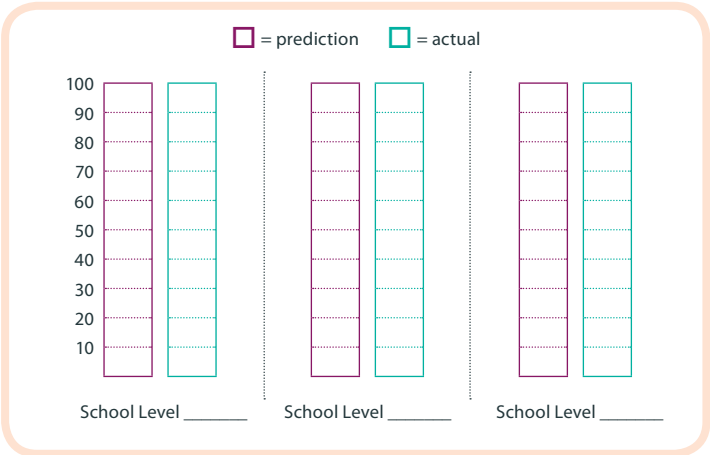


Staff

At your school, what percentage of the staff says …

_____

(question)



COMPARISON GROUP TEMPLATES
WORKSHEET FOR RACIAL/ETHNIC COMPARISONS

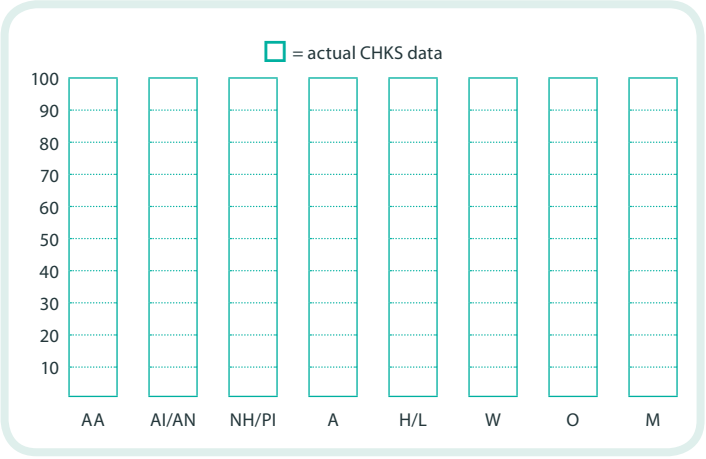
ADDITIONAL COMPARISON–CLOSING THE ACHIEVEMENT GAP/COMPARING ACROSS ETHNICITIES: If you have CHKS and CSCS Reports with data disaggregated by ethnicity, you can use the blank bar graphs to examine your data on students/staff who self–identify with a selected racial/ethnic group.

Student

At your school, what percentage of the students in each ethnic group says …

_____

(question)



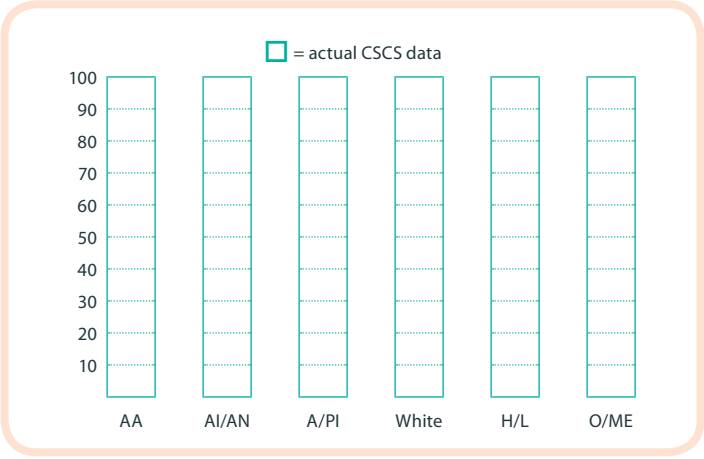
CHKS Ethnic Groups: AA = African American; AI/AN = American Indian/Alaska Native; NH/PI = Native Hawaiian/Pacific Islander; A = Asian; H/L = Hispanic/Latino; W = White; O = Other; M = Multi–ethnic

Staff

At your school, what percentage of the staff in each ethnic group says …

_____

(question)



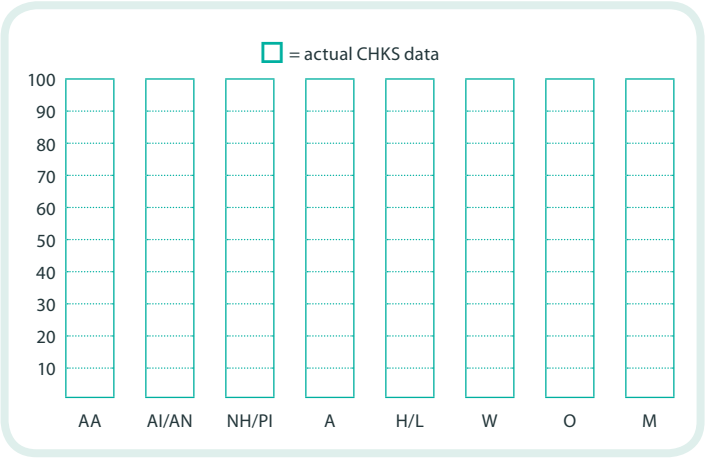
CSCS Ethnic Groups: AA = African American; AI/AN = American Indian/Alaska Native; A/PI = Asian/Pacific Islander; W = White; H/L = Hispanic/Latino; O/ME = Other/Multi–ethnic

Student

At your school, what percentage of the students in each ethnic group says …

_____

(question)



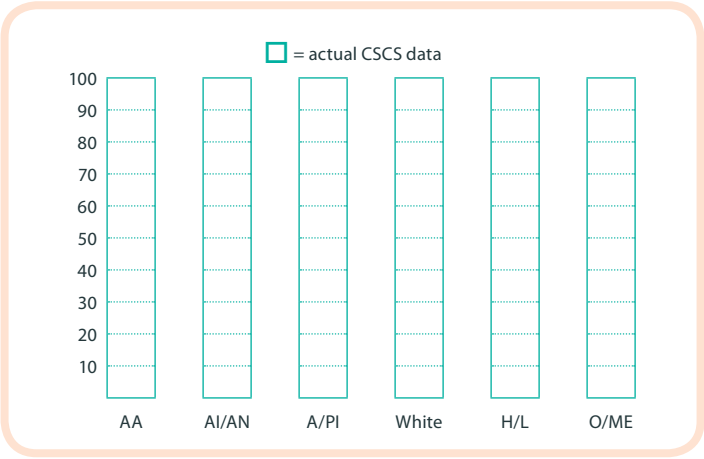
CHKS Ethnic Groups: AA = African American; AI/AN = American Indian/Alaska Native; NH/PI = Native Hawaiian/Pacific Islander; A = Asian; H/L = Hispanic/Latino; W = White; O = Other; M = Multi–ethnic

Staff

At your school, what percentage of the staff in each ethnic group says …

_____

(question)



CSCS Ethnic Groups: AA = African American; AI/AN = American Indian/Alaska Native; A/PI = Asian/Pacific Islander; W = White; H/L = Hispanic/Latino; O/ME = Other/Multi–ethnic

APPENDIX 2: PARENT SURVEY TEMPLATES

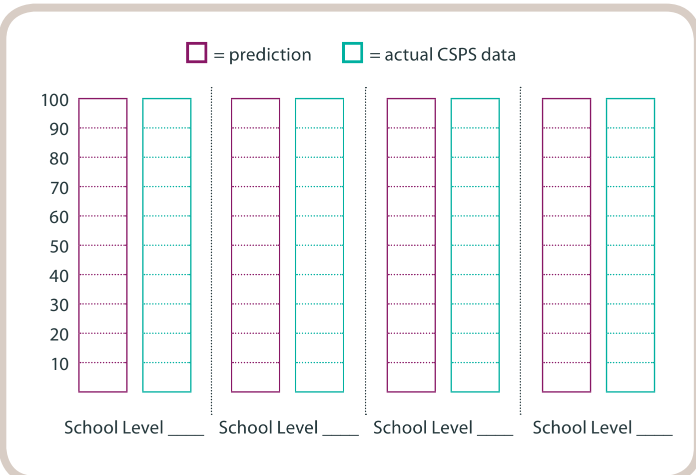
ADDITIONAL COMPARISON—CALIFORNIA SCHOOL PARENT SURVEY (CSPS): Locate your CSPS Main Report. Use the blank bar graphs to look at parent survey questions that are similar to the student and staff surveys.

Parent

At your school, what percentage of the parents says …

____

(question)

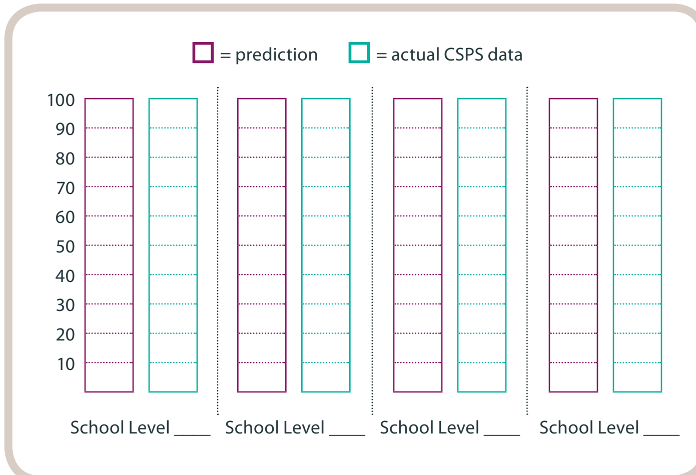


Parent

At your school, what percentage of the parents says …

____

(question)

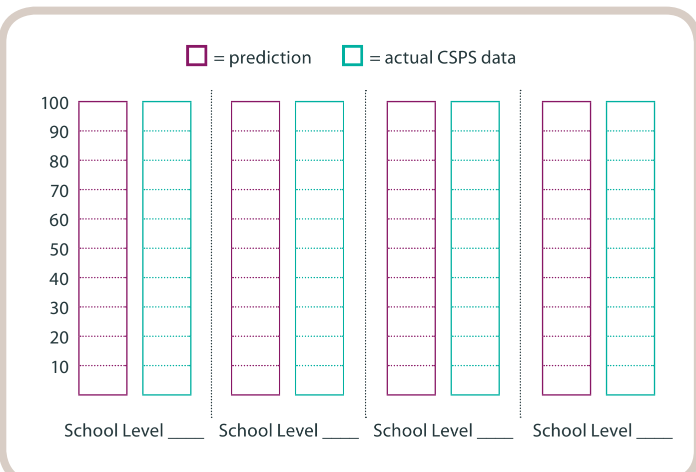


Parent

At your school, what percentage of the parents says …

____

(question)

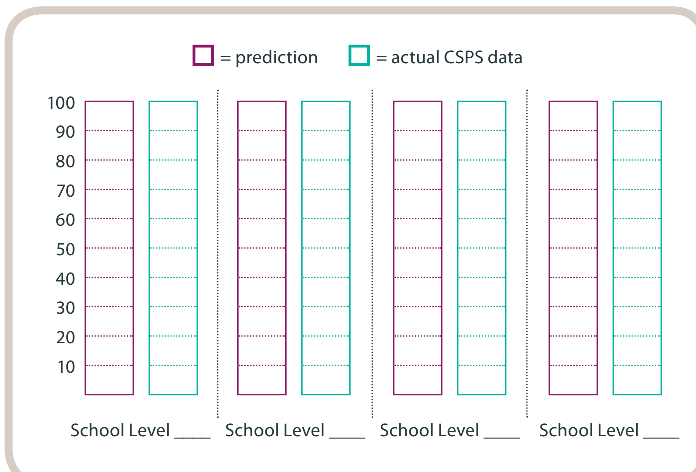


Parent

At your school, what percentage of the parents says …

____

(question)



S3 IMPLEMENTATION BRIEF

The success of your S3 project is dependent on how well you systematically implement throughout the school your Workplan activities for school climate improvement. In this Brief, we outline principles of evidence–based implementation practice that will help ensure the success of your efforts. We review the six typical stages of program implementation, some of the pitfalls you may encounter on the way, and strategies that will help you get going and avoid these pitfalls.[1]

STAGES OF IMPLEMENTATION

Successful implementation of your S3 Workplan begins with a thorough working knowledge of the expected stages for implementation: Development, Installation, Initial Implementation, Full Operation, Innovation, and Sustainability. Understanding how implementation typically progresses will help you predict and avoid potential roadblocks and pitfalls.

STAGE 1: DEVELOPMENT. Your S3 team has already completed much of the Development (Stage 1) work during the early part of the 2011 academic year. However, it is possible that, as you respond to new circumstances and data in the 2012/13 and 2013/14 years, you may need to revisit your Workplan[2]. Following are the types of activities that are involved in Development planning:

a. Identify the need for intervention(s) by considering school climate information made available to you, including your School Climate Report Card and Cal–SCHLS data.

b. Acquire additional information by talking with stakeholder groups. For example, consider the information collected through the Student Listening Circle (a.k.a. "Fishbowl").

c. Consider the fit between strategies outlined in the *What Works Briefs* and your school.

d. Prepare the school community by sharing information about your site's S3 Workplans. Share this information regularly and to as many groups as possible (e.g., parent groups, school site council, school improvement teams, community agency meetings, etc.)

STAGE 2: INSTALLATION. Your S3 team is likely to have begun Workplan Installation (Stage 2) work during the latter part of the 2011–2012 academic year. This work is certain to continue through the life of

1 The success of your S3 efforts will NOT be evaluated based on the quality of your implementation practices. However, the evidence–based programs and practices that you have selected for your grant are less likely to be successful if you do not attend to the implementation process.

2 Work with your Technical Specialist and your California Department of Education S3 Regional Consultant to determine when and if revisions are necessary to your Workplan.

grant, as circumstances inevitably change. Following are the types of activities that are involved in the Installation stage:

a. Explore additional funding streams for your ongoing school climate improvement strategies. This may happen when the S3 team or the student fishbowl identified activities that are important to school climate improvement but cannot be funded directly by S3, such as campus physical improvement or beautification projects. Other grants such as Gear Up and the Tobacco Use Prevention and Education grants may also provide additional funding to supplement prevention activities at school.

b. Ensure that staffing is adequate for successful implementation. This may include hiring new staff, and/or realigning current staff, to ensure that each of the S3 strategies is implemented as designed.

c. Ensure that each of the S3 strategies has been evaluated for space, technology, and other necessary materials.

STAGE 3: INITIAL IMPLEMENTATION. The Initial Implementation stage (Stage 3) is certain to be among the most challenging of the implementation stages, as you will be working against the prevailing school climate, including possible skepticism amongst staff, parents, and/or students.

a. Core components of successful Initial Implementation efforts include: (a) selection of optimal staff to run each of the S3 Workplan strategies; (b) preservice and inservice training for each of your S3 strategies, particularly on selected evidence–based programs; (c) ongoing consultation and coaching for key project staff; and (d) effective staff and program evaluation.

b. Initial Implementation is most likely to be successful when:

   i. Communication between the S3 Implementation Group (see Strategies for Avoiding Pitfalls section) and the rest of the school is ongoing, regularly scheduled, and deliberate.

   ii. The organization promotes a growth–orientation, reinforcing the value of learning new skills and practices and of improving existing ones.

   iii. Dedicated S3 resources are advertised, available, and readily accessible.

   iv. The S3 Workplan activities are viewed by staff, students, and parents as consistent with the school's mission.

   v. You readily draw upon the technical assistance available through your S3 Technical Specialist, as well as through the technical assistance centers affiliated with each of the evidence–based programs selected.

   vi. A system for monitoring implementation progress has been shared with the staff.

IMPORTANT NOTE: Training on the new skills expected of staff and students must be followed by regular coaching (daily is optimal) by a person who is highly regarded in the school, is dedicated to managing the S3 project, and has the authority to remove barriers to S3 implementation.

STAGE 4: FULL OPERATION. Full Operation Implementation (Stage 4) begins when the Workplan strategies have become fully functional, operating as intended. During this stage, school climate improvement strategies will become integrated into the prevailing school culture, affecting the behavior of individuals and groups. When your S3 project is in Full Operation Implementation, students selected for

special programs will be referred appropriately and efficiently following the criteria outlined by those personnel responsible for drafting the referral policies (e.g., Student Assistance Team). S3 strategies and programs will begin to run efficiently, as barriers to implementation have been resolved. It may be the case that you will not reach Full Operation until the final year of your grant (2013 – 2014).

STAGE 5: INNOVATION. Innovation (Stage 5) will involve refining and expanding your S3 activities and programs based on your school's unique experiences over the course of the project. This will only occur after you have achieved success at the Full Operation stage. In many cases, this may mean that this stage will primarily occur after project funding has ended.

STAGE 6: SUSTAINABILITY. Once your S3 strategies and programs have become fully operational and self–sustaining, you will need to begin to consider ways to ensure that they will exist after S3 funding ends. It is expected that, while many schools will begin initial sustainability–related conversations, most S3 schools will not reach this point by the time their S3 funding ends.

SPRING 2012: PREPARING FOR STAGES 2 & 3

In Spring 2012, most S3 schools will be laying the groundwork for the installation and initial implementation of their Workplan activities and programs. Below are activities that will help ensure successful initial implementation:

1. Communicate with your staff and community by developing an understanding of the context for how your high school was selected for the S3 grant.
    a. Explain what school climate efforts have been undergone in the past, including what has and what has not worked.
    b. Explain how the S3 grant is going to be integrated into current school improvement efforts.
    c. Explain how the school climate strategies were selected and why, including costs.
2. Gain spheres of influence.
    a. Identify individuals for your S3 Implementation Group (for more information on the S3 Implementation Group, see Strategies for Avoiding Implementation Pitfalls section).
    b. Plan and implement strategies to mobilize staff members', students', and parents' support for the S3 grant activities. For example, start a social marketing campaign and share your Cal–SCHLS data!
    c. Consider ways to communicate your efforts to school policymakers, such as members of the school board.
3. Clarify feasibility plan.
    a. Explain how you have envisioned the S3 strategies being integrated into the existing infrastructure of the school.
    b. Explain a long–range strategic plan for sustainability of the school climate improvements.

Pitfalls to S3 Implementation

1. Teachers and other school community members are in denial of the school climate problem at your school.
2. Teachers and other school community members aren't aware of the purpose of the S3 strategies selected by the school climate team.
3. Teachers and other school community members don't know what they can do to help support and propel the S3 strategies.
4. Teachers and other school community members are given no resources to help them implement S3 strategies.
5. Teachers and other school community members sense that the principal and/or other key members of the school leadership team do not support the S3 strategies.

STRATEGIES FOR AVOIDING S3 IMPLEMENTATION PITFALLS

1. First among all implementation strategies is to provide *strong management support*. This includes:
   a. Consistent, clear, and positive communication to all stakeholder groups, including parents, staff, and students;
   b. Timely follow–up to questions and action items;
   c. Effective recruitment of school climate advocates to broaden sphere of influence; and
   d. Ongoing reinforcement of student, staff, and parent actions that are consistent with school climate improvement goals
2. Establish an *S3 Implementation Group*.
   a. Establishing a group of individuals who will support your Workplan Implementation efforts over the course of the 3–year grant. This group may include the individuals who have participated in your S3 Intervention Team during the initial stages of the grant (Fall 2011), in addition to other school climate improvement advocates. Of course, the S3 grant *requires* that the S3 Intervention team meet at least monthly to monitor the implementation progress, so it makes sense to fold implementation monitoring responsibilities into this group's agenda.
   b. This group should meet regularly over the duration of the grant, and will be responsible for reviewing grant implementation efforts in order to ensure that lessons learned are incorporated into successive years' implementation plans. This group will ensure that annual implementation routines (e.g., preservice and coaching of new staff in Fall, inservice during winter, and Cal–SCHLS administration and evaluation in spring) are set and remain functional over time. This group is also essential for ensuring that "organizational memory" exists after the grant has ended (Spring 2014).
   c. Some personal characteristics of S3 Implementation Group members will help improve the likelihood of success for the S3 grant implementation. They include:

i. Optimism: Implementation Group members should be hopeful about the possibility for change in the school organization.

ii. Critical insight into the organization: Implementation Group members should have knowledge of the internal workings of the school organization and local community, including formal and informal procedures for coordinating professional development; foreseeable challenges in implementing new programs and activities with particular individuals or departments; known challenges and promising practices for facilitating parent involvement; and knowledge of the special needs and challenges involved in working with various student populations.

iii. Self–reflective: In the interest of organizational improvement, Implementation Group members should be interested in thinking about lessons learned. Each year, the Group members should be considering ways to build upon the school's implementation successes and to avoid running into the same implementation challenges in future years.

iv. Forward thinking and organized: Members will need to have the ability to think ahead to foresee roadblocks, keep high quality notes about their strategies, and maintain an ongoing pace for implementation meetings.

v. Good communicators: Members will need good communication skills in order to work together to solve problems effectively. Additionally, the Implementation Group members will need to be able to communicate their annual goals and lessons learned to the entire school community.

3. Focus on school community members' (staff/parents/students) commitment. You can improve their commitment by being active, vocal champions for your S3 initiative and the importance of school climate improvement, in general.

4. Empower staff members by clearly explaining ways they can become involved. Share the *What Works Briefs* (available at californias3.wested.org) with them. The Quick Wins sections in these Briefs are designed to help individuals consider what they can do immediately to contribute to the S3 effort.

5. Provide teachers with professional development opportunities linked to your S3 activities and programs. Clearly articulate how the in–service or other learning opportunity is linked to your school's Workplan.

6. Make sure that teachers do not feel burdened by S3 activities and programs, but that they are instead perceived as practical and useful.

The implementation guidelines included in this *S3 Implementation Brief* were derived from the following works:

Adelman, H. & Taylor, L. (2003). On sustainability of project innovations as systemic change. *Journal of Educational and Psychological Consultation, 14*, 1–25.

Fixsen, D., Naoom, S., Blase, K., Friedman, R., & Wallace, F. (2005). *Implementation research: A synthesis of the literature.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

SUGGESTED CITATION: WestEd (2012). *S3 Implementation Brief.* WestEd: Los Alamitos. Available for download from: californias3.wested.org

This document was created by WestEd for the California Department of Education, under contract for the Safe and Supportive Schools initiative.

Engaging the Community and Building Capacity

Martha Madrid, *Orange County Bar Foundation*
Andrea Valdez, *California Department of Public Health*

Engaging the Community & Building Capacity

Facilitated by:
Martha Madrid & Andrea Valdez, MPA

Welcome & Overview

- Why Engage the Community?
- Challenges
- Engagement Strategies
- Coalition Example
- Recruitment
- Developing Effective Coalitions
- Exercise: Collaboration Multiplier
- Q&A

Why Engage the Community?

- Engaging the community or target population can provide useful insight and positive direction of the program services and community initiatives.
- In order to benefit the community it must be meaningful to and/or developed by the target population.

Why Engage the Community?

- Engaging the community members give them a sense of ownership and can provide the skills to shape their communities.
- The community will respond better if "gatekeepers or one of their own" is involved in the development, outreach and/or implementation phase.

Top 3 reasons why a community member will choose to participate:

1. A direct benefit to community- something they want or need (park, stop sign, more policing, fewer liquor stores).
2. How, why & by whom they are asked to participate.
3. He/She feels comfortable participating (skill set, people, location).

Top 3 reasons why a community member will choose not to participate:

1) No perceived benefit to community.
2) Unfamiliar with who is asking for their participation; unclear as to why they should and how they are asked.
3) He/she feels uncomfortable participating (language barrier, skill set, location, participants, history of past participation or efforts).

Challenges

What additional challenges have you experienced?

Engagement Strategies

- ***Input: Surveys, questionnaires***
- Explain the importance, what will be done with the information gathered? who is it helping?
- Provide in appropriate language or with bilingual proxy
- Explain terminology, acronyms
- Provide appropriate incentives
- Ensure anonymity

Participation: Focus Group, Meeting, Event, Program attendance

- Date, time & location selected
- Appropriate invitation (flyer, letter, canvas)
- Follow-up (face-face, telephone call, canvas)
- Refreshments, Coffee & Cookies, Family Dinner
- Incentive for participation (marketing items, monetary)

Advocacy / Community Based Initiatives:
Gathering Petitions, Speaking w/Neighbors or City Council, Letter-writing

- Educate the target population
  - Provide easy-to-use materials and resources
- Empower them
  - Engage throughout the process: assessment, strategic planning, community recruitment, implementation, and evaluation
- Provide skills needed
  - Spokesperson training, messaging, community outreach

Example - Community Park

Local agency using promotoras to deliver diabetes & childhood obesity workshops repeatedly heard community members voice concerns that there were no areas for children to exercise or play outdoors.

Community Park

- Began collecting data by conducting door-door surveys- success due to familiar presence
- Agency also conducted focus groups with residents of apartment complex w/ approx. 2000 residents
- Provided weekly educational workshops on leadership, fundraising & advocacy for both teens & adults
- Once residents reached a level of sophistication, agency arranged for participants to observe City Council meetings, facilitated meetings w/elected officials & local businessmen

Community Park

- Over a 4 year period able to secure a state grant, donated land and matching funds from city to build & maintain a park adjacent to apartment complex, they broke ground last year and the park is currently under construction.

Recruitment

Four Basic Methods:

1. Outreach
2. Internal Referral Sources
3. External Resources Sources
4. Mass Marketing

Outreach **– the use of staff or volunteers to seek out and encounter members of targeted population in their own environment and deliver recruitment messages.**

Tips for conducting Outreach:

- Go where & when potential clients gather.
- Identify appropriate outreach workers.
- Conduct outreach in teams.
- Develop Outreach protocols.
- Screen Clients

Tips for developing your Outreach message:

- Make it specific to the service
- Use the language of the target population
- Test it with community members

Internal Referral Sources- the use of staff of volunteers, who provide a service within an agency, to screen clients for other services within the same agency and when appropriate refer clients to these services.

Steps in Giving Internal Referrals:

- Consider all clients, and assess their different needs.
- Develop criteria that will "trigger" your staff as to when to give the referral.
- Use gateway services as incentives to attract clients (free family counseling).
- Develop targeted and appropriate messages to be delivered by individual staff or use social marketing strategies (posters hung in agency).

External Referral Sources- the use of sources external to the agency to deliver recruitment messages for specific intervention services to members of the targeted population.

Steps for using Agency Referral Sources

- ✓ Identify appropriate agencies
- ✓ Establish & nurture linkages
- ✓ Beware of competition that may exist
- ✓ Provide appropriate promotional materials
- ✓ Support bi-directional referrals (MOU)
- ✓ Keep all contact information up-to-date

Steps for using Peer Referral Sources

- ✓ Recruit members of community / targeted population
- ✓ Provide training / orientation about services
- ✓ Document referral follow-up
- ✓ Use of incentives may help

Social Marketing- the use of marketing techniques to deliver specific recruitment messages to specific audiences through use of media.

Examples include:

- An HIV Testing campaign
- Mothers Against Drunk Driving Campaign

Recruitment for Community Based Initiatives

- Conduct activities aimed specifically at recruiting new supporters
  - ✓ start with who you know and who you need
- Train your core group to conduct one-on-one recruiting meetings with key opinion leaders
- Make presentations to organizations
- Have one-on-one meetings with prospective new coalition activists
- Attend community social events

Developing Effective Coalitions

- Handout: The 8 Steps to Effective Coalition Building
- Coalitions are not appropriate for every situation. They are only one of a variety of tools.
- The main factor in unproductive business meetings is having the wrong people present.
- Poll members to see which times & locations present the least conflict, consider traffic & parking issues.
- Provide an Orientation for new members.
- Good food is good for morale!
- Select activities that members will experience as successful – ones they can contribute to. Press release, training.
- Maintain open communication not just with those who attend but those who stopped attending.
- Reciprocity – a coalition works both ways.

An ideal coalition should contain the diverse segments of your community:

- Public Health Professionals
- A Health Expert
- Dedicated Workers
- Youth
- General Community
- Blue collar workers
- Communities of color
- LGBT communities
- Low income communities
- Faith-based communities
- Colleges, universities
- Professional Associations
- Neighborhood Associations
- Political Action Groups
- Environmental Groups

Collaboration Multiplier

(*partial sample*)

Agency / Partner	Expertise	Desired Outcome	Strategies	Strengths & Assets

Building Capacity

- Working together is working smarter!
- Partners can provide opportunities for training, share expertise, access to volunteers, service providers, new community contacts, funding or in-kind services.

EFFECTIVE RECRUITMENT

Part 1: *Four Basic Methods*

AUMENTANDO CAPACIDAD EN PREVENCIÓN
ACCIÓN MUTUA
EXPANDING PREVENTION CAPACITY

Recruitment is...

the way persons at risk for HIV infection or transmission are brought into an HIV prevention intervention program.

Core Elements of Recruitment include:

- Making Evidence-Based Decisions about What May Work
- Using Multiple Sources for Target Population Information
- Recruiting for Specific Services
- Developing Appropriate Messages
- Tracking the Completion of Referrals
- Revising Your Strategies, as appropriate

Four basic methods for recruitment

Deciding your recruitment strategy involves using one or more of the four basic methods for recruitment. You will have to take into consideration the type of intervention you are conducting as well as the resources and abilities of your agency.

1. Outreach
2. Internal Referral Sources
3. External Resources Sources
4. Mass Marketing

---

1. Outreach

The use of staff or volunteers to seek out and encounter members of targeted population in their own environment and deliver recruitment messages.

Tips for conducting outreach	Tips for developing your outreach message
Go where and when potential clients gather	Make it specific to the service
Identify appropriate outreach workers	Use the language of the target population
Conduct outreach in teams	Test it with community members
Develop outreach protocols	
Screen clients	

2. Internal Referral Sources

The use of staff or volunteers, who provide a service within an agency, to screen clients for other services within the same agency and when appropriate refer clients to these services.

Steps in Giving Internal Referrals

- Consider all clients, and assess their different needs.
- Develop criteria that will "trigger" your staff as to when to give the referral.
- Use gateway services as incentives to attract clients (i.e. a needle exchange program to initially bring them in).
- Develop targeted and appropriate messages to be delivered by individual staff or use social marketing strategies (i.e. posters hung throughout your agency).

3. External Referral Sources

The use of sources external to the agency to deliver recruitment messages for specific intervention services to members of the targeted population.

These referrals can be from other agencies working with members of the same targeted population or from peers who are members of social networks within the targeted population.

Steps for Using Agency Referral Sources	Steps for Using Peer Referral Sources
Identify appropriate agencies	Recruit members of high-risk networks
Establish and nurture linkages	Provide training/orientation about services
Beware of competition that may exist	Document referral follow-up
Provide appropriate promotional materials	
Support bi-directional referrals (MOU)	
Keep all contact information up-to-date	Use of incentives may help

4. Social Marketing

The use of marketing techniques to deliver specific recruitment messages to specific audiences through use of media.

Examples include:

- An HIV testing campaign
- A condom use campaign
- A campaign to delay the onset of sexual activity among adolescents

In summary, remember to:

- Develop protocols.
- Train all appropriate staff.
- Develop procedures for quality assurance in recruitment activities, including collection of information.
- Continue assessing your recruitment strategy throughout your program.
- Keep the people doing the work involved in the planning.
- Provide high quality services.

If you want more information about this or other topics visit
www.accionmutua.org *or call* **(213) 201-1345**

Acción Mutua is a program of **AIDS Project Los Angeles** in collaboration with **César E. Chávez Institute** and funded by **the Centers for Disease Control and Prevention**

EFFECTIVE RECRUITMENT

Part 2: *Recruitment Strategies*

Recruitment **is the way persons at risk for HIV infection or transmission are brought into an HIV prevention intervention program.**

Recruitment involves making evidence-based decisions about what may work and then collecting the information to determine whether the strategy is working. Keep what works; replace what does not.

Recruitment Strategies

In order to develop a good strategy you should answer the following six questions about the population you intend to reach.

1. ***Who is being targeted*** **through recruitment?**
2. ***Where*** **is the appropriate place to recruit?**
3. ***When*** **should recruitment be done?**
4. ***What*** **messages should be delivered during recruitment?**
5. ***How*** **should the message be delivered?**
6. ***Who is the most appropriate person*** **to do the recruitment?**

In this bulletin we will cover the first three questions. Although the answer to these questions may seem obvious to you, a good recruitment strategy will grapple with complex information and factors when answering these questions. I will explain this below in more detail.

1. ***Who is being targeted through recruitment?***
   How can you ensure that the people you are reaching are in fact at the highest risk for exposure to or transmission of HIV? If you reach people at low risk for infection or transmission then you are wasting time and resources. Here are two suggestions for targeting the right group of people:

   A. **Use hard data.** Use information that health departments have collected on your target population. If your agency collects data on clients served then use that information as well. Try to develop a highly specific profile of the people you want to serve. Information here should include drug use pattern, homelessness, race/ethnicity, gender. *Danger:* It is easy for CBOs to assume that they know everything about their population because they have been working with them for so long. It would be a mistake to rely entirely on your intuitions about your community. People change, trends change over time, and you must be sure that you are accurately tracking these changes. Use focus groups and key informant interviews to keep your information updated.

   B. **Segment the population.** It is important to break down your population into smaller subgroups. Your intervention targets a small segment of the population, never the entire population.

For example, suppose that I am trying to recruit Latino MSM (men who have sex with men) for testing and counseling. I now ask myself, "Who is being targeted through recruitment?" I realize that I have to segment this population. Am I targeting self-identified gay Latinos or am I including not gay identified Latino MSM (men who have sex with men)? Am I trying to recruit US-born Latinos or recently arrived immigrants? Does my recruitment target bilingual Latinos, monolingual Spanish-speaking or monolingual English-speaking Latinos? Am I targeting Latinos for whom substance use/abuse is an issue? If so, what substance, e.g., alcohol, crystal meth, heroin? My recruitment message will be different depending on who I am trying to reach. A message for self–identified gay Latinos may not work for Latino MSM who do not identify as gay.

The success of my recruitment efforts will depend on how clear I am about who I am trying to reach.

2. ***Where is the appropriate place to recruit?***

What are the venues where potential clients live, socialize, hang out, congregate, do business, receive services, meet partners, or engage in high-risk behavior? In other words, where am I most likely to find the people I am trying to reach? Learn the norms of the environment to determine whether its appropriate for you to be there in the first place.

I must also keep in mind safety, stigma, trust, and drug use patterns at these locations. For example, where I go to look for gay-identified Latinos ages 18-25 will differ from where I will locate Latino MSM ages 30-45 who do not identify as gay.

3. ***When should recruitment be done?***

After you have located potential clients, you need to ask yourself two questions:

A. **What are the best times to reach members of the target population?**
If you are trying to reach people who frequent bathhouses, you may realize that the best time to reach them is during lunch hour on business days, or maybe immediately after 5pm. This will depend on who you are trying to reach.

B. **When are they most receptive to services?**
If you are trying to reach sex workers, offering services while they are trying to work is not the best timing. Instead, you might offer them a card with information of services so they can contact you later.

The important point here is that we need to be sensitive to the best time for reaching a potential client. Just because we know where to find them it does not mean that now we should try to access them at any time. Also, it will be important to schedule staff according to client accessibility.

By now it may be clear that the answers to the recruitment strategy questions require a lot of planning and some research. Also, each question entails asking other questions before you can answer the original recruitment strategy question.

In our next bulletin we'll look at the remaining three steps for developing an effective recruitment strategy.

Adapted from "Developing An Effective Recruitment Strategy for HIV Prevention" by Ted Duncan, Ph.D.

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EFFECTIVE RECRUITMENT

Part 3: *Recruitment Strategies* *Continued*

Recruitment **is the way persons at risk for HIV infection or transmission are brought into an HIV prevention intervention program.**

Recruitment involves making ***evidence-based*** decisions about what may work and then collecting the information to determine whether the strategy is working. Keep what works; replace what does not. The questions below help us gather evidence to support our recruitment strategy.

Recruitment Strategies

In order to develop a good strategy you should answer the following six questions about the population you intend to reach.

1. ***Who is being targeted*** through recruitment?
2. ***Where*** is the appropriate place to recruit?
3. ***When*** should recruitment be done?
4. ***What*** messages should be delivered during recruitment?
5. ***How*** should the message be delivered?
6. ***Who is the most appropriate person*** to do the recruitment?

The previous bulletin focused on the first three questions. In this bulletin we will cover the last three questions. Remember that answering these questions may require you to ask more questions in order to gather data about your target population. A good recruitment strategy will grapple with complex information and factors when answering these questions.

4. What message should be delivered during recruitment?

A good message will take into account the barriers your clients must overcome to receive services, e.g., stigma, transportation. Hence, recruitment messages must effectively address those barriers to accessing and using services. Your message should motivate people to use your services; it should focus on the clients' strengths and avoid fear-based messaging. Stress confidentiality. Remember to make sure that your message is culturally and linguistically appropriate. For example, if your message contains slang words be sure that the words are culturally appropriate because slang used by Latino communities in Los Angeles will be different from those used by communities in New York, and even within communities there are subgroups that use different forms of expression.

Above all, pretest your messages! After you have carefully designed a message conduct a few focus groups to see how your message is being received. This will increase the effectiveness of your recruitment strategy.

5. *How should the message be delivered?*

There are different methods for delivering messages: flyers, email blasts, PSA, newspaper, in safer sex packets, in bleach kits. Be sure to utilize the media sources that your target population uses. If you do a good job answering question four you will also find out what is the culturally appropriate manner to deliver your message. Keep in mind your clients' literacy level. If your message contains too many technical terms or complex vocabulary then your clients will fail to understand the message you are trying to deliver.

By pretesting the method of delivery you will know whether or not your message will be well received. Remember, you can have the most important message in the world, but if it is not delivered in the appropriate manner your message will be lost.

6. *Who is the most appropriate person to do the recruitment?*

Finally, a good recruitment strategy takes into account the actual person who will be conducting the recruitment. Outreach, for example, may not be an appropriate method for everyone on staff because some may be shy or less outgoing. It is important to find the right person to deliver the right message at the right time and in the right way.

Figuring out who is the best person to recruit clients will take some planning on your part. Using members of the target population is often helpful, e.g., IDU's recruiting other IDU's. However, it will be too easy to conclude that only Latinos could recruit Latinos, or that only African-Americans can recruit other African-Americans. For example, in the case of Latinos, a 3rd generation Latino who knows very little Spanish would be inappropriate for recruiting monolingual, Spanish-speaking, recently arrived immigrants, especially if they are from different countries altogether. In this case, a trusted "outsider" who knows Spanish may be more successful in delivering a recruitment message. People from other ethnicities may have a history with the target population and may be accepted within that community. These are the sorts of factors you need to consider when you are determining who is best suited to deliver your recruitment message.

Remember, recruitment is making evidence-based decisions. It should be clear by now that it is unrealistic to develop a recruitment plan in one day. A good recruitment plan carefully considers which method to use (outreach, internal or external referral sources, mass marketing) and develops a strategy by answering the six questions we have examined. Answering these questions takes time, especially because it is of utmost importance to pretest your message and to pretest your delivery method. In addition, there are different ways in which to collect information useful for recruitment: focus groups, one-on-one interviews, group interviews, surveys, field observations, by reviewing your program records, and by reviewing existing research. These different methods of gathering information contribute to your knowledge base and provide evidence to help you develop an effective recruitment plan.

How will you know whether your recruitment strategy is working? One way to track the effectiveness of your strategy is to set up outreach logs, referral forms, and intake forms to capture information on your clients. This information will provide evidence and data for you to know whether you are in fact reaching the population you wish to target, whether they are accessing services, or whether they have received your message. Based on this information you can always revise your recruitment plan.

Gathering information on your target population may require you to assess the community. This process is known as Formative Research. Be on the look out for our technical bulletins on Formative Research. This, too, can help you develop an effective recruitment plan.

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All Cooks to the Kitchen! Recipes for Wellness and Success

Christina Borbely, PhD., *Center for Applied Research Solutions (CARS)*
Jan Ryan, *Center for Applied Research Solutions (CARS)*

CPI REGIONAL FORUMS

ALL COOKS TO THE KITCHEN!
Recipes for Wellness & Success

Christina Borbely, Ph.D., RET Partners
Jan Ryan, Red Leaf Resources

Garden Grove & Monterey, CA~ June 2012

Goal

The goal of this session is to help increase awareness of interventions and strategies that promote learning and wellness for all youth, including those who experience AOD use and/or mental health needs.

2

Objectives

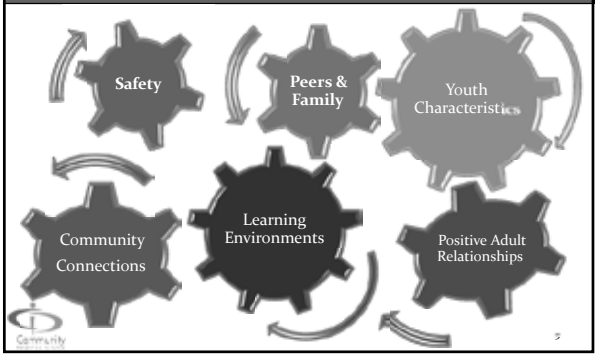
- Understand the relationship between learning and mental wellness
- Recognize the benefit of cohesive systems to support learning and youth wellness
- Learn proven strategies that promote a positive climate and mental health in school and in the community.

3

HEALTHY, EDUCATED KIDS WHO DON'T DO DRUGS

How do I get one???????????

The Context of Wellness

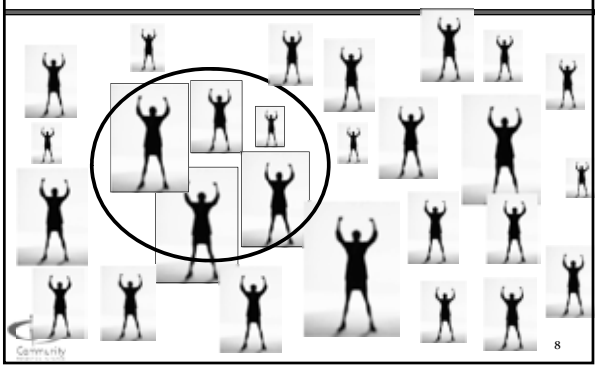


FORMULA FOR YOUTH WELLNESS

MENTAL HEALTH
X
EDUCATION
X
AOD PREVENTION

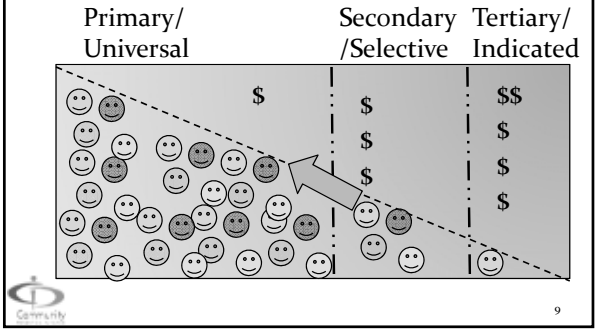
7

Youth Getting Help V. Youth In Need



8

Resources: Youth Impacted



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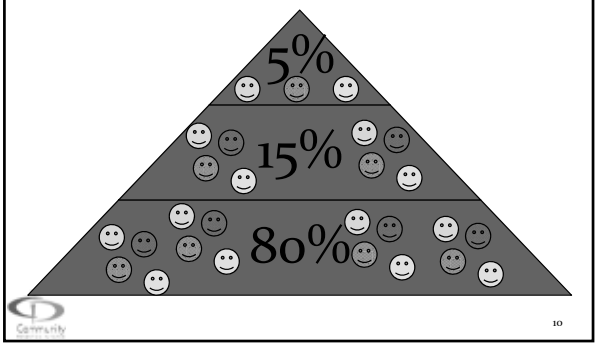
RtI Pyramid



10

CREATING SAFETY

Positive, Consistent, Predictable

- •PBIS
- •Nurtured Heart
- •Response to Intervention
- •BTSA
- •School Safety Plans
- •Bullying Prevention
- •Strengthening Families
- •CMCA
- •Too Good for Drugs
- •All Stars
- •FST
- •SST
- •SART
- •PLC
- •504
- •Healthy Start
- •SAP/Project SUCCESS
- •BBBS
- •ED
- •SDC
- •Residential
- •RSAP
- •Seven Challenges
- •Teaching Kids to Cope

Positive School Climate

- When school members feel safe, valued, cared for, respected, and engaged, learning and wellness increase.

A shared mission, created and sustained by students, parents, and school staff, and supported by the community, for systematic safety, support and inclusion of every child.

12

Positive (School) Climate

- **Definition:** Perceptions about the overall setting where learning and development take place
- **Primary goal:** To support and instruct to a range of individual differences while sustaining a caring atmosphere

EVERY CHILD
EVERY DAY
NO MATTER WHAT IT TAKES

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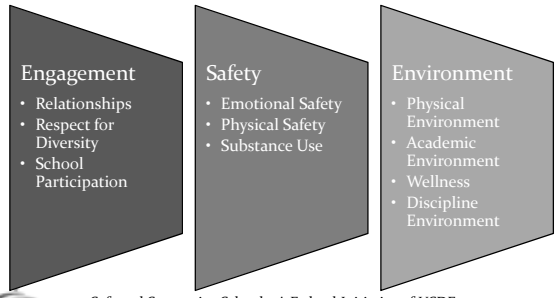
S3 Model for Positive Climate



Safe and Supportive Schools: A Federal Initiative of USDE

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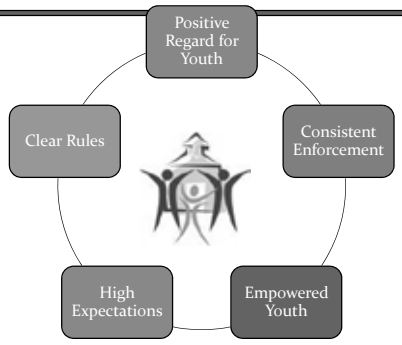
Promoting Wellness



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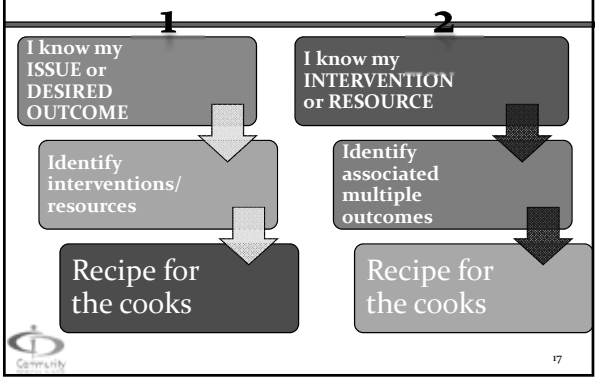
TOWARD BUILDING CAPACITY

Activity

Toward Capacity Building



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Resources

Interventions

- National Registry of Evidence-based Programs & Practices
- CDE's TETRIS: *Eliminating Barriers to Learning Through Early Identification of Student Mental Health Issues*

Data

- Kidsdata.org
- School/district attendance & discipline records

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Thank You!

Christina Borbely, Ph.D.
www.retpartners.com
christina@retpartners.com 415-683-0073

Jan Ryan
www.redleafresources.com
janryanprevention@mac.org

Center for Applied Research Solutions (CARS)
www.cars-rp.org

Community Prevention Initiative (CPI)
www.ca-cpi.org
Toll-free: 1 (877) 568-4227

Toward Capacity Building

Linking NEED to RESOURCES & STRATEGIES

What is the need/issue for: Youth? Families? Staff?	What resource or strategy effectively addresses this need? Individual level? Environmental level?	When & how should an educator access this resource?	When & how should an preventionist access this resource?	When & how should an mental health provider access this resource?

Linking RESOURCES & STRATEGIES to NEED

(Existing) Resource/Strategy	What needs does this resource or strategy meet for students? Families? Staff?	When should an educator access this resource or implement this strategy? A preventionist? A mental health professional?	How should an educator access this resource or implement this strategy? A preventionist? A mental health professional?

Resources

Prevention Program/Strategy Comparison Chart		
Program/Strategy/Intervention	_____	_____
Brief program description/ summary		
Generic Criterion		
NREPP reviewed		
CDE Science-Based Programs List minimum standards		
IOM Population		
Setting		
Target outcomes		
Implementation		
Staffing		
Approach		
Focus Areas		
(sample) Local Criterion		
1. Complementary with {existing intervention(s)}		
2. Ease of implementation		
3. Fills identified gaps		
4. Able to be implemented by available staff (e.g. non-credentialed)		
5. Address standards and primary indicators from the list of School Climate Standards[1]		
6.Level of disruption to school routines		
7. Built-in evaluation components		
8. Cost of program		
9. Target age range or grade level		
10. Addresses substance abuse prevention		
11. IRB required?		

[1] See School Climate Standards for Program Comparison chart for more information

School Climate Standards Matrix for Program Comparison		
Program/Strategy/Intervention	_____	_____
School Climate Standard #1 The school community has a shared vision and plan for promoting, enhancing and sustaining a positive school climate.		
1.1 School policies and practices support school, family, youth and community members working together to establish safe and productive learning community.		
1.1.1 School, family, community and youth members agree to work on strategies to be implemented for ongoing school climate improvement.		
1.1.2 Policies and practices are regularly assessed to ensure continual refinement that enhances the quality of a safe and productive learning community.		
1.1.3 School, family and youth members collaboratively develop, publicize and model codes of conduct that support positive and sustained school climate.		
1.2 Schools gather accurate and reliable data about school climate from students, school personnel and for continuous improvement and share it regularly with the school, community, parents/guardians.		
1.2.1 Educational leaders regularly assess and monitor policies and practices and revise as necessary to determine the effectiveness of school, family and community members working together to support student learning, teaching and positive youth development.		
1.2.2 Schools use multiple evidence-based methods of collecting data, such as surveys, observational methods and behavior reports, that recognize the range of factors that shape school climate (e.g., social norms, school connectedness, sense of safety, discipline, learning/teaching, leadership, absence rates and mobility).		
1.2.3 School, family, community and youth leaders establish procedures for using school climate findings (including disaggregated data) to establish instructional and/or school-wide improvement goals and implementation strategies that will enhance student learning and positive youth development.		
1.2.4 School climate reports are periodically provided that communicate effectively with all school community members and families about goals, benchmarks and progress.		
1.3 Capacity building is developed over time to enable all school community members to meet school climate standards.		

School Climate Standards Matrix for Program Comparison		
Program/Strategy/Intervention	_____	_____
1.3.1 Capacity building includes developing infrastructure, classroom and school-wide prevention and intervention strategies/practices, and developing policy and systemic changes that promote positive school climate.		
School Climate Standard #2 The school community sets policies specifically promoting (a) the development and sustainability of social, emotional, ethical, civic and intellectual skills, knowledge and dispositions and (b) a comprehensive system to address barriers to learning and teaching and reengage students who have become disengaged.		
2.1 Policies and mission and vision statements that promote social, emotional, ethical and civic, as well as intellectual, skills and dispositions are developed and institutionalized.		
2.1.1 Policies promote curriculum content, continued monitoring and standards for social, emotional, ethical and civic learning and are fully integrated into the classroom and school in ways that align with 21st century learning and with students' prevailing cultures, circumstances and languages.		
2.1.2 Policies for instructional and assessment processes and standards are personalized in ways that model and promote mutual respect, caring and a psychological sense of community.		
2.1.3 Accountability measures and data are used and monitored that directly demonstrate the impact of efforts to promote social, emotional, ethical and civic learning.		
2.2 Policies and mission and vision statements are developed and institutionalized that promote a comprehensive system to address barriers to learning and teaching and reengage students who have become disengaged.		
2.2.1 Policies promote engagement and address barriers to learning and teaching while reengaging disconnected students through an intervention framework that generates a comprehensive and cohesive system of learning supports as delineated in Standard 3.		
2.2.2 Policies ensure continuing development and sustainability of a comprehensive and cohesive system of learning supports.		

School Climate Standards Matrix for Program Comparison		
Program/Strategy/Intervention	_____	_____
2.2.3 Accountability measures, data and monitoring are used that directly demonstrate the impact of efforts to address barriers to learning and teaching and reengaging students who have become disengaged.		
2.3 Policies promote use and monitoring of natural and informal opportunities (e.g., recreational and extracurricular aspects of classroom and school life, formulation of codes of conduct and fair enforcement of rules, mentoring, and informal interactions among and with students) to ensure they support the helpful norms of learning and teaching that foster mutual respect and caring; engagement; safety and well being; civil, pro social, responsible behavior; and a psychological sense of community.		
2.4 Policies ensure the operational and capacity building mechanisms (including staff and student development) related to this standard are fully integrated into a school's infrastructure and are effectively implemented and sustained.		
School Climate Standard #3 The school community's practices are identified, prioritized and supported to (a) promote the learning and positive social, emotional, ethical and civic development of students, (b) enhance engagement in teaching, learning and school-wide activities; (c) address barriers to learning and teaching and reengage those who have become disengaged; and (d) develop and sustain an appropriate operational infrastructure and capacity building mechanisms for meeting this standard.		
3.1 Specific practices are designed to enhance engagement of every student through classroom-based social, emotional, ethical and civic learning and in school-wide activities.		
3.1.1 Instructional and engaging practices focus on cognitive and behavioral learning as well as social, emotional, ethical and civic engagement.		
3.1.2 Practices facilitate students' desire and ability to share their perceptions readily (e.g., to enter into dialogues with adults and peers at school), emphasize interests and needs, stress options and choices and a meaningful role in decision making, provide enrichment opportunities, provide a continuum of guidance and support and minimize coercive interactions.		

School Climate Standards Matrix for Program Comparison		
Program/Strategy/Intervention	_____	_____
3.1.3 Based on research about intrinsic motivation, practices are designed to maximize feelings of competence, self-determination and connectedness to others and to minimize threats to such feelings. Practices are designed to minimize psychological reactance by not over-emphasizing social control strategies and not over relying on extrinsic motivation to promote positive social, emotional, ethical and civic behavior and learning.		
3.2 Teachers and school administrators design specific classroom and school-wide practices to address barriers to learning and teaching and reengage those who have become disengaged.		
3.2.1 Practices include a full continuum of integrated systems of intervention designed to: • Promote healthy development and prevent negative problems; • Respond as early after problem onset as is feasible; • Provide for those whose serious, pervasive and chronic negative problems require more intensive assistance and accommodation.		
3.2.2 Classroom and school wide interventions are designed to: • Enhance regular classroom strategies to enable learning (e.g., improving instruction and classroom management practices for maximum engagement and reengagement of all students and to pursue response to intervention practices for those with mild to moderate learning and behavioral problems) • Support transitions (e.g., assisting students and families as they negotiate school and grade changes and many other transitions); • Increase home and school connections; • Respond to and, where feasible, prevent crises; • Increase community involvement and support (e.g., outreach to develop greater community involvement and support, including enhanced use of volunteers and community resources that fill priority gaps in the system of supports); • Facilitate student and family access to effective services and special assistance as needed; • Provide multiple opportunities for students to have leadership roles that enhance their commitment to school and to the development of themselves and others.		
3.2.3 Classroom and school wide practices are designed to address barriers to learning and teaching and reengage those who have become disengaged; these practices are developed into a comprehensive and cohesive system of learning supports that weaves together school and community resources.		

School Climate Standards Matrix for Program Comparison		
Program/Strategy/Intervention	_____	_____
3.3 School leaders develop and sustain a comprehensive system of learning supports by ensuring an appropriate operational infrastructure that incorporates capacity building mechanisms.		
3.3.1 The school has administrative leaders who are responsible for the development, operation and sustainability of high quality practices related to this third standard (Practices are identified, supported and prioritized that (a) enhance engagement in teaching, learning and school-wide activities; (b) address barriers to learning and teaching and reengage those who have become disengaged; and (c) develop and sustain an appropriate systemic infrastructure and capacity building mechanisms for meeting this standard.). These responsibilities are delineated in job descriptions.		
3.3.2 Sufficient staff are assigned to developing and sustaining such high quality practices.		
3.3.3 Leadership and staff are provided continuous professional development in order to develop and sustain practices related to this third standard.		
3.3.4 An effective school family community operational infrastructure is in place for weaving school and community resources together and for ongoing planning, implementing and evaluating the comprehensive system of learning supports.		
3.3.5 The operational and capacity building systems related to this third standard are fully integrated with the school's mechanisms for improving instruction, management and overall governance.		
School Climate Standard #4 The school community creates an environment where all members are welcomed, supported, and feel safe in school: socially, emotionally, intellectually and physically.		
4.1 School leaders promote comprehensive and evidence-based instructional and school-wide improvement efforts designed to support students, school personnel and community members feeling welcomed, supported and safe in school: socially, emotionally, intellectually and physically.		
4.2 Students, their families, school staff and community stakeholders are regularly surveyed and are asked to indicate what the school should do to further enhance a welcoming, supportive and safe environment.		

School Climate Standards Matrix for Program Comparison		
Program/Strategy/Intervention	_____	_____
4.3 School leaders monitor and evaluate the prevention and intervention strategies designed to support people feeling welcomed, supported and safe and use that data to improve relevant policies, practices, facilities, staff competencies and accountability.		
School Climate Standard #5 The school community develops meaningful and engaging practices, activities and norms that promote social and civic responsibilities and a commitment to social justice.		
5.1 Students and staff model culturally responsive and ethical behavior. This reflects continuous learning that builds knowledge, awareness, skills, and the capacity to identify, understand, and respect the unique beliefs, values, customs, languages, and traditions of all members of the school community.		
5.1.1 Curriculum and instructional practices promote curiosity, inquiry into and celebration of diverse beliefs, customs, languages, and traditions of all members of the school community.		
5.1.2 Students have ongoing opportunities to provide service to others in meaningful and engaging ways in their school and in the larger community.		
5.2 Relationships among and between staff and students are mutually respectful, supportive, ethical and civil.		
5.2.1 Every student is connected to a caring and responsible adult in the school.		
5.2.2 Social norms in the school support responsible and positive peer relationships.		
5.2.3 Discipline procedures are aligned with the goals of supporting students in their learning and being respectful of all individuals; the goals are enhanced with authentic student-driven opportunities for reconciliation when appropriate.		
5.3 Students and staff are actively engaged in celebrating milestones and accomplishments as they work to achieve meaningful school and community life.		

All Cooks to the Kitchen! Interventions that achieve multiple outcomes in youth wellness

GLOSSARY OF ACRONYMS

504	Disability plans for students
BBBS	Big Brothers Big Sisters
BTSA	Beginning Teacher Support & Assessment
ED	Emotionally Disturbed (type of SDC)
FST	Family Support Team
NSCS	National School Climate Standards (not federal standard)
PLC	Professional Learning Community
RtI	Response to Intervention
RSAP	Residential Student Assistance Program
S3	Safe Supportive Schools (federal initiative)
SAP	Student Assistance Program
SDC	Special Day Class
SST	Student Study/Success Team
SART	School Attendance Review Board

2011 California Health Kids Survey

2011 California Healthy Kids Survey

Core Module/Module A (attached)

Marin County Customized Module: *(44 questions maximum)*

	CLOSING THE ACHIEVEMENT GAP	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
G1	Teachers and other adults at this school treat all students with respect.	A	B	C	D	E
G2	Teachers and other adults encourage me to work hard in school so I can be successful in college or at the job I choose.	A	B	C	D	E
G3	The teachers and other adults work hard to help me with my schoolwork when I need it.	A	B	C	D	E
G4	Teachers show how classroom lessons are important and helpful to me in real life.	A	B	C	D	E
G5	Teachers give me a chance to take part in classroom discussions or activities.	A	B	C	D	E
G6	The books and lessons in my class include examples of my race or ethnic background.	A	B	C	D	E
G7	All students are treated fairly when they break school rules.	A	B	C	D	E
G8	I have been disrespected or mistreated by an adult at this school because of my race, ethnicity, or nationality.	A	B	C	D	E
G9	There is a lot of tension in this school between different cultures, races or ethnicities.	A	B	C	D	E
G10	The schoolyard and buildings are clean and in good condition.	A	B	C	D	E

	RESILIENCY MODULE	Not At All True	A Little True	Pretty Much True	Very Much True
G11	I know where to go for help with a problem.	A	B	C	D
G12	There are many things that I do well.	A	B	C	D
G13	When I need help, I find someone to talk with.	A	B	C	D
G14	There is a purpose to my life.	A	B	C	D
G15	I have a friend about my own age that really cares for me.	A	B	C	D
G16	In my home there is a parent or some other adult who believes that I will be a success.	A	B	C	D
G17	In my home there is a parent or some other adult who listens to me when I have something to say.	A	B	C	D

	ALCOHOL AND DRUG USE MODULE							
During the past 6 months, about how many times did you use these substances without a doctor's order?								
G18	Have you ever felt that you needed help (such as counseling or treatment) for your alcohol or other drug use?	I don't use alcohol or other drugs	No, but I do use	Yes, I felt like I needed help				
G19	If you drink alcohol how do you most frequently get it? *(Select the main one)* A) At school or school events B) At parties or events outside school C) At your own home D) From friends or another teenager at their home E) From adults who give it or buy it for me F) Buy it themselves from a store G) Take it without paying for it from a store H) At bars, restaurants, clubs or gambling casinos I) Other J) I don't drink alcohol							
G20	In your opinion, how likely is it that a student would find help at your school from a counselor, teacher or other adult to stop or reduce using alcohol or other drugs?	Very likely	Likely	Not Likely	Don't Know			
G21	In your opinion, how likely is it that a student will be suspended, expelled, or transferred if he or she is caught on school property using or possessing alcohol or other drugs?	Very likely	Likely	Not Likely	Don't Know			

	TOBACCO MODULE							
G22	During the past 30 days, on the days you smoked, how many cigarettes did you smoke per day?	Didn't smoke	Less than 1	1	2-5	6-10	11-20	20+

G23	If you smoked cigarettes during the past 30 days, how did you usually get them? *(Select only one response)* A) I did not smoke in the past 30 days B) I bought them in a store such as a convenience store, supermarket or gas station C) I bought them at a vending machine D) I gave someone else money to buy them for me E) I borrowed (or bummed) them from someone else F) I took them from a store or family member G) A friend gave them to me H) A person 18 years or older game them to me I) Other people gave them to me J) I got them some other way							
G24	If you now smoke cigarettes, would you like to quit smoking?	I don't smoke	No	Yes				
G25	How hard would it be for you to refuse or say "no" to a friend who offered you a cigarette to smoke?	Very Hard	Hard	Easy	Very Easy			
G26	During the past 12 months, did you have lessons about tobacco and its effects on the body?	No	Yes	Not Sure				
How true do you feel these statements are about you personally?		Very Much Agree	Agree	Disagree	Very Much Disagree			
G27	Smoking is cool.	A	B	C	D			
G28	Smoking helps you make friends.	A	B	C	D			
G29	Smoking helps control your weight.	A	B	C	D			

	PARENTAL DISAPPROVAL							
How wrong do your parents feel it would be for you to:		Very Wrong	A Little Bit Wrong	Wrong	Not at all Wrong			
G30	Drink beer, wine or hard liquor (for example, vodka, whiskey or gin) regularly?	A	B	C	D			
G31	Smoke cigarettes?	A	B	C	D			
C32	Smoke marijuana?	A	B	C	D			
G33	Use prescription drugs that were not your own or for non-medical reasons?	A	B	C	D			

	PHYSICAL ACTIVITY AND DIET	0	1	2	3	4	5	6	7
On how many of the past 7 days did you . . .									
G34	Exercise or do a physical activity for at least 20 minutes that made you sweat or breathe hard? (For example, basketball, soccer, running, swimming laps, fast bicycling, fast dancing or similar aerobic activities.)	A	B	C	D	E	F	G	H
G35	Participate in a physical activity for at last 30 minutes that did not make you sweat or breathe hard? (For example, fast walking, slow bicycling, shooting baskets, skating, raking leaves, or mopping floors.)	A	B	C	D	E	F	G	H
G36	**After school or on weekends**, which of the following places have you used most frequently in the past 7 days? (a) Parks, basketball/tennis courts, skate parks that I walked to (b) Parks, basketball/tennis courts, skate parks that I was driven to (c) Gymnasiums that I walked to (d) Gymnasiums that I was driven to (e) Fields or open spaces that I walked to (f) Fields or open spaces that I was driven to (g) Swimming pools that I walked to (h) Swimming pools that I was driven to (i) Walking or biking path that I walked to (j) Walking or biking path that I was driven to (k) Doesn't apply - I have not been to any of these places in the past 7 days.								
G37	If you **have been physically active after** school or on weekends in the past seven days, what is the main reason? (a) To be with my friends (b) I'm on a school or after-school sports team (c) I believe it is good for my health (d) It's fun (e) I want to look better (f) I love being outside/close to nature (g) My parents encouraged me to do it (h) Doesn't apply – I have not been physically active outside of school/weekends in the past 7 days								
G38	If you **have not been physically active after** school or on weekends in the past seven days, what is the main reason? (a) Not applicable/I have been physically active in the past 7 days (b) I had no motivation (c) I had to work or study (d) Parents didn't allow me out of the house								

	(e) I had no way to get there (f) I have been injured or ill (g) I didn't have anyone to be active with (h) There are no parks, open spaces or other facilities near my home (i) I chose to spend time on the computer, playing video games or watching television (j) I didn't feel safe in my neighborhood due to violence/crime. (k) The walking/biking conditions made it unsafe								
	During the past 24 hours (yesterday), how many times did you . . .	0	1	2	3	4	5 +		
G39	Eat fruit (Do not count fruit juice.)	A	B	C	D	E	F		
G40	Eat vegetable (Include salads or nonfried potatoes.)	A	B	C	D	E	F		
G41	If you ate junk food (cola, chips, fries, candy, etc.) in the past 7 days, how did you usually obtain it? *(Select one)* (a) Doesn't apply – I have not consumed junk food in the past 7 days (b) I bought it at grocery store (c) I bought it at a convenience store or gas station (d) I got it from home, or it was purchased by my parents (e) I got it at school (a school event, vending machine, food service or cafeteria) (f) I bought it at a fast food restaurant.								
G42	On an average school day, how many hours do you spend on the computer, watching TV or playing video games?	I don't	-1	1	2	3	4	5+	
BMI	How tall are you without your shoes on?								
BMI	How much do you weigh without your shoes on?								

NOTE: Questions highlighted in **GRAY** are necessarily included in the Customized Module and cannot be edited.

Collective Impact

Stanford SOCIAL INNOVATION REVIEW

Collective Impact

By John Kania & Mark Kramer

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Collective Impact

LARGE-SCALE SOCIAL CHANGE REQUIRES BROAD CROSS-SECTOR COORDINATION, YET THE SOCIAL SECTOR REMAINS FOCUSED ON THE ISOLATED INTERVENTION OF INDIVIDUAL ORGANIZATIONS.

By John Kania & Mark Kramer

Illustration by Martin Jarrie

The scale and complexity of the U.S. public education system has thwarted attempted reforms for decades. Major funders, such as the Annenberg Foundation, Ford Foundation, and Pew Charitable Trusts have abandoned many of their efforts in frustration after acknowledging their lack of progress. Once the global leader—after World War II the United States had the highest high school graduation rate in the world—the country now ranks 18th among the top 24 industrialized nations, with more than 1 million secondary school students dropping out every year. The heroic efforts of countless teachers, administrators, and nonprofits, together with billions of dollars in charitable contributions, may have led to important improvements in individual schools and classrooms, yet system-wide progress has seemed virtually unobtainable.

Against these daunting odds, a remarkable exception seems to be emerging in Cincinnati. Strive, a nonprofit subsidiary of KnowledgeWorks, has brought together local leaders to tackle the student achievement crisis and improve education throughout greater Cincinnati and northern Kentucky. In the four years since the group was launched, Strive partners have improved student success in dozens of key areas across three large public school districts. Despite the recession and budget cuts, 34 of the 53 success indicators that Strive tracks have shown positive trends, including high school graduation rates, fourth-grade reading and math scores, and the number of preschool children prepared for kindergarten.

Why has Strive made progress when so many other efforts have failed? It is because a core group of community leaders decided to abandon their individual agendas in favor of a collective approach to improving student achievement. More than 300 leaders of local organizations agreed to participate, including the heads of influential private and corporate foundations, city government officials, school district representatives, the presidents of eight universities and community colleges, and the executive directors of hundreds of education-related nonprofit and advocacy groups.

These leaders realized that fixing one point on the educational continuum—such as better after-school programs—wouldn't make much difference unless all parts of the continuum improved at the same time. No single organization, however innovative or powerful, could accomplish this alone. Instead, their ambitious mission became to coordinate improvements at *every* stage of a young person's life, from "cradle to career."

Strive didn't try to create a new educational program or attempt to convince donors to spend more money. Instead, through a carefully structured process, Strive focused the entire educational community on a single set of goals, measured in the same way. Participating organizations are grouped into 15 different Student Success Networks (SSNs) by type of activity, such as early childhood education or tutoring. Each SSN has been meeting with coaches and facilitators for two hours every two weeks for the past three years, developing shared performance indicators, discussing their progress, and most important, learning from each other and aligning their efforts to support each other.

Strive, both the organization and the process it helps facilitate, is an example of *collective impact*, the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem. Collaboration is nothing new. The social sector is filled with examples of partnerships, networks, and other types of joint efforts. But collective impact initiatives are distinctly different. Unlike most


HOSPITAL
SCHOOL

collaborations, collective impact initiatives involve a centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants. (See "Types of Collaborations" on page 39.)

Although rare, other successful examples of collective impact are addressing social issues that, like education, require many different players to change their behavior in order to solve a complex problem. In 1993, Marjorie Mayfield Jackson helped found the Elizabeth River Project with a mission of cleaning up the Elizabeth River in southeastern Virginia, which for decades had been a dumping ground for industrial waste. They engaged more than 100 stakeholders, including the city governments of Chesapeake, Norfolk, Portsmouth, and Virginia Beach, Va., the Virginia Department of Environmental Quality, the U.S. Environmental Protection Agency (EPA), the U.S. Navy, and dozens of local businesses, schools, community groups, environmental organizations, and universities, in developing an 18-point plan to restore the watershed. Fifteen years later, more than 1,000 acres of watershed land have been conserved or restored, pollution has been reduced by more than 215 million pounds, concentrations of the most severe carcinogen have been cut sixfold, and water quality has significantly improved. Much remains to be done before the river is fully restored, but already 27 species of fish and oysters are thriving in the restored wetlands, and bald eagles have returned to nest on the shores.

Or consider Shape up Somerville, a citywide effort to reduce and prevent childhood obesity in elementary school children in Somerville, Mass. Led by Christina Economos, an associate professor at Tufts University's Gerald J. and Dorothy R. Friedman School of Nutrition Science and Policy, and funded by the Centers for Disease Control and Prevention, the Robert Wood Johnson Foundation, Blue Cross Blue Shield of Massachusetts, and United Way of Massachusetts Bay and Merrimack Valley, the program engaged government officials, educators, businesses, nonprofits, and citizens in collectively defining wellness and weight gain prevention practices. Schools agreed to offer healthier foods, teach nutrition, and promote physical activity. Local restaurants received a certification if they served low-fat, high nutritional food. The city organized a farmers' market and provided healthy lifestyle incentives such as reduced-price gym memberships for city employees. Even sidewalks were modified and crosswalks repainted to encourage more children to walk to school. The result was a statistically significant decrease in body mass index among the community's young children between 2002 and 2005.

Even companies are beginning to explore collective impact to tackle social problems. Mars, a manufacturer of chocolate brands such as M&M's, Snickers, and Dove, is working with NGOs, local governments, and even direct competitors to improve the lives of more than 500,000 impoverished cocoa farmers in Cote d'Ivoire, where Mars sources a large portion of its cocoa. Research suggests that better farming practices and improved plant stocks could triple the yield per hectare, dramatically increasing farmer incomes and improving the sustainability of Mars's supply chain. To accomplish this, Mars must enlist the coordinated efforts of multiple organizations: the Cote d'Ivoire government needs to provide more agricultural extension workers, the World Bank needs to finance new roads, and bilateral donors need to support NGOs in improving health care, nutrition, and education in cocoa growing communities. And Mars must find ways to work with its direct competitors on pre-competitive issues to reach farmers outside its supply chain.

These varied examples all have a common theme: that large-scale social change comes from better cross-sector coordination rather than from the isolated intervention of individual organizations. Evidence of the effectiveness of this approach is still limited, but these examples suggest that substantially greater progress could be made in alleviating many of our most serious and complex social problems if nonprofits, governments, businesses, and the public were brought together around a common agenda to create collective impact. It doesn't happen often, not because it is impossible, but because it is so rarely attempted. Funders and nonprofits alike overlook the potential for collective impact because they are used to focusing on independent action as the primary vehicle for social change.

ISOLATED IMPACT

Most funders, faced with the task of choosing a few grantees from many applicants, try to ascertain which organizations make the greatest contribution toward solving a social problem. Grantees, in turn, compete to be chosen by emphasizing how their individual activities produce the greatest effect. Each organization is judged on its own potential to achieve impact, independent of the numerous other organizations that may also influence the issue. And when a grantee is asked to evaluate the impact of its work, every attempt is made to isolate that grantee's individual influence from all other variables.

In short, the nonprofit sector most frequently operates using an approach that we call *isolated impact*. It is an approach oriented toward finding and funding a solution embodied within a single organization, combined with the hope that the most effective organizations will grow or replicate to extend their impact more widely. Funders search for more effective interventions as if there were a cure for failing schools that only needs to be discovered, in the way that medical cures are discovered in laboratories. As a result of this process, nearly 1.4 million nonprofits try to invent independent solutions to major social problems, often working at odds with each other and exponentially increasing the perceived resources required to make meaningful progress. Recent trends have only reinforced this perspective. The growing interest in venture philanthropy and social entrepreneurship, for example, has greatly benefited the social sector by identifying and accelerating the growth of many high-performing nonprofits, yet it has also accentuated an emphasis on scaling up a few select organizations as the key to social progress.

Despite the dominance of this approach, there is scant evidence that isolated initiatives are the best way to solve many social problems in today's complex and interdependent world. No single organization is responsible for any major social problem, nor can any single

John Kania is a managing director at FSG, where he oversees the firm's consulting practice. Before joining FSG, he was a consultant at Mercer Management Consulting and Corporate Decisions Inc. This is Kania's third article for the *Stanford Social Innovation Review*.

Mark Kramer is the co-founder and a managing director of FSG. He is also the co-founder and the initial board chair of the Center for Effective Philanthropy, and a senior fellow at Harvard University's John F. Kennedy School of Government. This is Kramer's fifth article for the *Stanford Social Innovation Review*.

TYPES OF COLLABORATIONS

Organizations have attempted to solve social problems by collaboration for decades without producing many results. The vast majority of these efforts lack the elements of success that enable collective impact initiatives to achieve a sustained alignment of efforts.

Funder Collaboratives are groups of funders interested in supporting the same issue who pool their resources. Generally, participants do not adopt an overarching evidence-based plan of action or a shared measurement system, nor do they engage in differentiated activities beyond check writing or engage stakeholders from other sectors.

Public-Private Partnerships are partnerships formed between government and private sector organizations to deliver specific services or benefits. They are often targeted narrowly, such as developing a particular drug to fight a single disease, and usually don't engage the full set of stakeholders that affect the issue, such as the potential drug's distribution system.

Multi-Stakeholder Initiatives are voluntary activities by stakeholders from different sectors around a common theme. Typically, these initiatives lack any shared measurement of impact and the supporting infrastructure to forge any true alignment of efforts or accountability for results.

Social Sector Networks are groups of individuals or organizations fluidly connected through purposeful relationships, whether formal or informal. Collaboration is generally ad hoc, and most often the emphasis is placed on information sharing and targeted short-term actions, rather than a sustained and structured initiative.

Collective Impact Initiatives are long-term commitments by a group of important actors from different sectors to a common agenda for solving a specific social problem. Their actions are supported by a shared measurement system, mutually reinforcing activities, and ongoing communication, and are staffed by an independent backbone organization.

organization cure it. In the field of education, even the most highly respected nonprofits—such as the Harlem Children's Zone, Teach for America, and the Knowledge Is Power Program (KIPP)—have taken decades to reach tens of thousands of children, a remarkable achievement that deserves praise, but one that is three orders of magnitude short of the tens of millions of U.S. children that need help.

The problem with relying on the isolated impact of individual organizations is further compounded by the isolation of the nonprofit sector. Social problems arise from the interplay of governmental and commercial activities, not only from the behavior of social sector organizations. As a result, complex problems can be solved only by cross-sector coalitions that engage those outside the nonprofit sector.

We don't want to imply that all social problems require collective impact. In fact, some problems are best solved by individual organizations. In "Leading Boldly," an article we wrote with Ron Heifetz for the winter 2004 issue of the *Stanford Social Innovation Review*, we described the difference between *technical problems* and *adaptive problems*. Some social problems are technical in that the problem is well defined, the answer is known in advance, and one or a few organizations have the ability to implement the solution. Examples include funding college scholarships, building a hospital, or installing inventory controls in a food bank. Adaptive problems, by contrast, are complex, the answer is not known, and even if it were, no single entity has the resources or authority to bring about the necessary change. Reforming public education, restoring wetland environments, and improving community health are all adaptive problems. In these cases, reaching an effective solution requires learning by the stakeholders involved in the problem, who must then change their own behavior in order to create a solution.

Shifting from isolated impact to collective impact is not merely a matter of encouraging more collaboration or public-private partnerships. It requires a systemic approach to social impact that focuses on the relationships between organizations and the progress toward shared objectives. And it requires the creation of a new set of nonprofit management organizations that have the skills and resources to assemble and coordinate the specific elements necessary for collective action to succeed.

THE FIVE CONDITIONS OF COLLECTIVE SUCCESS

Our research shows that successful collective impact initiatives typically have five conditions that together produce true alignment and lead to powerful results: a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and backbone support organizations.

Common Agenda | Collective impact requires all participants to have a shared vision for change, one that includes a common understanding of the problem and a joint approach to solving it through agreed upon actions. Take a close look at any group of funders and nonprofits that believe they are working on the same social issue, and you quickly find that it is often not the same issue at all. Each organization often has a slightly different definition of the problem and the ultimate goal. These differences are easily ignored when organizations work independently on isolated initiatives, yet these differences splinter the efforts and undermine the impact of the field as a whole. Collective impact requires that these differences be discussed and resolved. Every participant need not agree with every other participant on all dimensions of the problem. In fact, disagreements continue to divide participants in all of our examples of collective impact. All participants must agree, however, on the primary goals for the collective impact initiative as a whole. The Elizabeth River Project, for example, had to find common ground among the different objectives of corporations, governments, community groups, and local citizens in order to establish workable cross-sector initiatives.

Funders can play an important role in getting organizations to act in concert. In the case of Strive, rather than fueling hundreds of strategies and nonprofits, many funders have aligned to support Strive's central goals. The Greater Cincinnati Foundation realigned its education goals to be more compatible with Strive, adopting Strive's annual report card as the foundation's own measures for progress in education. Every time an organization applied to Duke Energy for a grant, Duke asked, "Are you part of the [Strive] network?" And when a new funder, the Carol Ann and Ralph V. Haile Jr./U.S. Bank Foundation, expressed interest in education, they were encouraged by virtually every major education leader in Cincinnati to join Strive if they wanted to have an impact in local education.[1]

Shared Measurement Systems | Developing a shared measurement system is essential to collective impact. Agreement on a common agenda is illusory without agreement on the ways success will be measured and reported. Collecting data and measuring results consistently on a short list of indicators at the community level and across all participating organizations not only ensures that all efforts remain aligned, it also enables the participants to hold each other accountable and learn from each other's successes and failures.

It may seem impossible to evaluate hundreds of different organizations on the same set of measures. Yet recent advances in Web-based technologies have enabled common systems for reporting performance and measuring outcomes. These systems increase efficiency and reduce cost. They can also improve the quality and credibility of the data collected, increase effectiveness by enabling grantees to learn from each other's performance, and document the progress of the field as a whole.[2]

All of the preschool programs in Strive, for example, have agreed to measure their results on the same criteria and use only evidence-based decision making. Each type of activity requires a different set of measures, but all organizations engaged in the same type of activity report on the same measures. Looking at results across multiple organizations enables the participants to spot patterns, find solutions, and implement them rapidly. The preschool programs discovered that children regress during the summer break before kindergarten. By launching an innovative "summer bridge" session, a technique more often used in middle school, and implementing it simultaneously in all preschool programs, they increased the average kindergarten readiness scores throughout the region by an average of 10 percent in a single year.[3]

Mutually Reinforcing Activities | Collective impact initiatives depend on a diverse group of stakeholders working together, not by requiring that all participants do the same thing, but by encouraging each participant to undertake the specific set of activities at which it excels in a way that supports and is coordinated with the actions of others.

The power of collective action comes not from the sheer number of participants or the uniformity of their efforts, but from the coordination of their differentiated activities through a mutually reinforcing plan of action. Each stakeholder's efforts must fit into an overarching plan if their combined efforts are to succeed. The multiple causes of social problems, and the components of their solutions, are interdependent. They cannot be addressed by uncoordinated actions among isolated organizations.

All participants in the Elizabeth River Project, for example, agreed on the 18-point watershed restoration plan, but each is playing a different role based on its particular capabilities. One group of organizations works on creating grassroots support and engagement among citizens, a second provides peer review and recruitment for industrial participants who voluntarily reduce pollution, and a third coordinates and reviews scientific research.

The 15 SSNs in Strive each undertake different types of activities at different stages of the educational continuum. Strive does not prescribe what practices each of the 300 participating organizations should pursue. Each organization and network is free to chart its own course consistent with the common agenda, and informed by the shared measurement of results.

Continuous Communication | Developing trust among nonprofits, corporations, and government agencies is a monumental challenge. Participants need several years of regular meetings to build up enough experience with each other to recognize and appreciate the common motivation behind their different efforts. They need time to see that their own interests will be treated fairly, and that decisions will be made on the basis of objective evidence and the best possible solution to the problem, not to favor the priorities of one organization over another.

Even the process of creating a common vocabulary takes time, and it is an essential prerequisite to developing shared measurement systems. All the collective impact initiatives we have studied held monthly or even biweekly in-person meetings among the organizations' CEO-level leaders. Skipping meetings or sending lower-level delegates was not acceptable. Most of the meetings were supported by external facilitators and followed a structured agenda.

The Strive networks, for example, have been meeting regularly for more than three years. Communication happens between meetings too: Strive uses Web-based tools, such as Google Groups, to keep communication flowing among and within the networks. At first, many of the leaders showed up because they hoped that their participation would bring their organizations additional funding, but they soon learned that was not the meetings' purpose. What they discovered instead were the rewards of learning and solving problems together with others who shared their same deep knowledge and passion about the issue.

Backbone Support Organizations | Creating and managing collective impact requires a separate organization and staff with a very specific set of skills to serve as the backbone for the entire initiative. Coordination takes time, and none of the participating organizations has any to spare. The expectation that collaboration can occur without a supporting infrastructure is one of the most frequent reasons why it fails.

The backbone organization requires a dedicated staff separate from the participating organizations who can plan, manage, and support the initiative through ongoing facilitation, technology and communications support, data collection and reporting, and handling the myriad logistical and administrative details needed for the initiative to function smoothly. Strive has simplified the initial staffing requirements for a backbone organization to three roles: project manager, data manager, and facilitator.

Collective impact also requires a highly structured process that leads to effective decision making. In the case of Strive, staff worked with General Electric (GE) to adapt for the social sector the Six Sigma process that GE uses for its own continuous quality improvement. The Strive Six Sigma process includes training, tools, and resources that each SSN uses to define its common agenda, shared measures, and plan of action, supported by Strive facilitators to guide the process.

In the best of circumstances, these backbone organizations embody the principles of adaptive leadership: the ability to focus people's attention and create a sense of urgency, the skill to apply pressure to stakeholders without overwhelming them, the competence to frame issues in a way that presents opportunities as well as difficulties, and the strength to mediate conflict among stakeholders.

FUNDING COLLECTIVE IMPACT

Creating a successful collective impact initiative requires a significant financial investment: the time participating organizations must dedicate to the work, the development and monitoring of shared measurement systems, and the staff of the backbone organization needed to lead and support the initiative's ongoing work.

As successful as Strive has been, it has struggled to raise money, confronting funders' reluctance to pay for infrastructure and preference for short-term solutions. Collective impact requires instead that funders support a long-term process of social change without identifying any particular solution in advance. They must be willing to let grantees steer the work and have the patience to stay with an initiative for years, recognizing that social change can come from the gradual improvement of an entire system over time, not just from a single breakthrough by an individual organization.

This requires a fundamental change in how funders see their role, from funding organizations to leading a long-term process of social change. It is no longer enough to fund an innovative solution created by a single nonprofit or to build that organization's capacity. Instead, funders must help create and sustain the collective processes, measurement reporting systems, and community leadership that enable cross-sector coalitions to arise and thrive.

This is a shift that we foreshadowed in both "Leading Boldly" and our more recent article, "Catalytic Philanthropy," in the fall 2009 issue of the *Stanford Social Innovation Review*. In the former, we suggested that the most powerful role for funders to play in addressing adaptive problems is to focus attention on the issue and help to create a process that mobilizes the organizations involved to find a solution themselves. In "Catalytic Philanthropy," we wrote: "Mobilizing and coordinating stakeholders is far messier and slower work than funding a compelling grant request from a single organization. Systemic change, however, ultimately depends on a sustained campaign to increase the capacity and coordination of an entire field." We recommended that funders who want to create large-scale change follow four practices: take responsibility for assembling the elements of a solution; create a movement for change; include solutions from outside the nonprofit sector; and use actionable knowledge to influence behavior and improve performance.

These same four principles are embodied in collective impact initiatives. The organizers of Strive abandoned the conventional approach of funding specific programs at education nonprofits and took responsibility for advancing education reform themselves. They built a movement, engaging hundreds of organizations in a drive toward shared goals. They used tools outside the nonprofit sector, adapting GE's Six Sigma planning process for the social sector. And through the community report card and the biweekly meetings of the SSNs they created actionable knowledge that motivated the community and improved performance among the participants.

Funding collective impact initiatives costs money, but it can be a highly leveraged investment. A backbone organization with a modest annual budget can support a collective impact initiative of several hundred organizations, magnifying the impact of millions or even billions of dollars in existing funding. Strive, for example, has a $1.5 million annual budget but is coordinating the efforts and increasing the effectiveness of organizations with combined budgets of $7 billion. The social sector, however, has not yet changed its funding practices to enable the shift to collective impact. Until funders are willing to embrace this new approach and invest sufficient resources in the necessary facilitation, coordination, and measurement that enable organizations to work in concert, the requisite infrastructure will not evolve.

FUTURE SHOCK

What might social change look like if funders, nonprofits, government officials, civic leaders, and business executives embraced collective impact? Recent events at Strive provide an exciting indication of what might be possible.

Strive has begun to codify what it has learned so that other communities can achieve collective impact more rapidly. The organization is working with nine other communities to establish similar cradle to career initiatives.[4] Importantly, although Strive is broadening its impact to a national level, the organization is not scaling up its own operations by opening branches in other cities. Instead, Strive is promulgating a flexible process for change, offering each community a set of tools for collective impact, drawn from Strive's experience but adaptable to the community's own needs and resources. As a result, the new communities take true ownership of their own collective impact initiatives, but they don't need to start the process from scratch. Activities such as developing a collective educational reform mission and vision or creating specific community-level educational indicators are expedited through the use of Strive materials and assistance from Strive staff. Processes that took Strive several years to develop are being adapted and modified by other communities in significantly less time.

These nine communities plus Cincinnati have formed a community of practice in which representatives from each effort connect regularly to share what they are learning. Because of the number and diversity of the communities, Strive and its partners can quickly determine what processes are universal and which require adaptation to a local context. As learning accumulates, Strive staff will incorporate new findings into an Internet-based knowledge portal that will be available to any community wishing to create a collective impact initiative based on Strive's model.

This exciting evolution of the Strive collective impact initiative is far removed from the isolated impact approach that now dominates the social sector and that inhibits any major effort at comprehensive, large-scale change. If successful, it presages the spread of a new approach that will enable us to solve today's most serious social problems with the resources we already have at our disposal. It would be a shock to the system. But it's a form of shock therapy that's badly needed. ■

Notes

1 Interview with Kathy Merchant, CEO of the Greater Cincinnati Foundation, April 10, 2010.

2 See Mark Kramer, Marcie Parkhurst, and Lalitha Vaidyanathan, *Breakthroughs in Shared Measurement and Social Impact*, FSG Social Impact Advisors, 2009.

3 "Successful Starts," United Way of Greater Cincinnati, second edition, fall 2009.

4 Indianapolis, Houston, Richmond, Va., and Hayward, Calif., are the first four communities to implement Strive's process for educational reform. Portland, Ore., Fresno, Calif., Mesa, Ariz., Albuquerque, and Memphis are just beginning their efforts.

Channeling Change:
Making Collective Impact Work

Stanford SOCIAL INNOVATION REVIEW

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By Fay Hanleybrown, John Kania, & Mark Kramer

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Channeling Change: Making Collective Impact Work

An in-depth look at how organizations of all types, acting in diverse settings, are implementing a collective impact approach to solve large-scale social problems.

BY FAY HANLEYBROWN, JOHN KANIA, & MARK KRAMER

What does a global effort to reduce malnutrition have in common with a program to reduce teenage substance abuse in a small rural Massachusetts county? Both have achieved significant progress toward their goals: the Global Alliance for Improved Nutrition (GAIN) has helped reduce nutritional deficiencies among 530 million poor people across the globe, while the Communities That Care Coalition of Franklin County and the North Quabbin (Communities That Care) has made equally impressive progress toward its much more local goals, reducing teenage binge drinking by 31 percent. Surprisingly, neither organization owes its impact to a new previously untested intervention, nor to scaling up a high-performing nonprofit organization. Despite their dramatic differences in focus and scope, both succeeded by using a collective impact approach.

In the winter 2011 issue of *Stanford Social Innovation Review* we introduced the concept of "collective impact" by describing several examples of highly structured collaborative efforts that had achieved substantial impact on a large scale social problem, such as The Strive Partnership[1] educational initiative in Cincinnati, the environmental cleanup of the Elizabeth River in Virginia, and the Shape Up Somerville campaign against childhood obesity in Somerville, Mass. All of these initiatives share the five key conditions that distinguish collective impact from other types of collaboration: a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and the presence of a backbone organization. (See "The Five Conditions of Collective Impact" below.)

We hypothesized that these five conditions offered a more powerful and realistic paradigm for social progress than the prevailing model of isolated impact in which countless nonprofit, business, and government organizations each work to address social problems independently. The complex nature of most social problems belies the idea that any single program or organization, however well managed and funded, can singlehandedly create lasting large-scale change. (See "Isolated Impact vs. Collective Impact" on page 2.)

Response to that article was overwhelming. Hundreds of organizations and indi-

FAY HANLEYBROWN *is a managing director of FSG, where she oversees the firm's Seattle office and collective impact approach area. Before joining FSG, she was a consultant at McKinsey & Co., and a vice president at investment bank UBS Warburg in Hong Kong.*

JOHN KANIA *is a managing director at FSG, where he oversees the firm's consulting practice. Before joining FSG, he was a consultant at Mercer Management and Consulting and Corporate Decisions Inc.*

MARK KRAMER *is the co-founder and a managing director of FSG. He is also the co-founder and the initial board chair of the Center for Effective Philanthropy, and a senior fellow at Harvard University's John F. Kennedy School of Government.*

The Five Conditions of Collective Impact

Common Agenda	All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions.
Shared Measurement	Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.
Mutually Reinforcing Activities	Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.
Continuous Communication	Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and create common motivation.
Backbone Support	Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies.

Isolated Impact vs. Collective Impact

Isolated Impact	Collective Impact
◆ Funders select individual grantees that offer the most promising solutions.	◆ Funders and implementers understand that social problems, and their solutions, arise from the interaction of many organizations within a larger system.
◆ Nonprofits work separately and compete to produce the greatest independent impact.	◆ Progress depends on working toward the same goal and measuring the same things.
◆ Evaluation attempts to isolate a particular organization's impact.	◆ Large scale impact depends on increasing cross-sector alignment and learning among many organizations.
◆ Large scale change is assumed to depend on scaling a single organization.	◆ Corporate and government sectors are essential partners.
◆ Corporate and government sectors are often disconnected from the efforts of foundations and nonprofits.	◆ Organizations actively coordinate their action and share lessons learned.

viduals from every continent in the world, even including the White House, have reached out to describe their efforts to use collective impact and to ask for more guidance on how to implement these principles.

Even more surprising than the level of interest is the number of collective impact efforts we have seen that report substantial progress in addressing their chosen issues. In addition to GAIN and Communities That Care, Opportunity Chicago placed 6,000 public housing residents in new jobs, surpassing its goal by 20 percent; Memphis Fast Forward reduced violent crime and created more than 14,000 new jobs in Memphis, Tenn.; the Calgary Homeless Foundation housed more than 3,300 men, women, and children and contributed to stopping what had been the fastest growing rate of homelessness in Canada; and Vibrant Communities significantly reduced poverty levels in several Canadian cities.

The initiatives we cited in our initial article have also gained tremendous traction: Shape Up Somerville's approach has now been adapted in 14 communities through subsequent research projects and influenced a national cross-sector collaborative. The Strive Partnership recently released its fourth annual report card, showing that 81 percent of its 34 measures of student achievement are trending in the right direction versus 74 percent last year and 68 percent two years ago.[2] Its planned expansion to five cities when the article came out has since been vastly expanded as more than 80 communities (including as far away as the Ruhr Valley in Germany) have expressed interest in building on The Strive Partnership's success.

Part of this momentum is no doubt due to the economic recession and the shortage of government funding that has forced the social sector to find new ways to do more with less—pressures that show no signs of abating. The appeal of collective impact may also be due to a broad disillusionment in the ability of governments around the world to solve society's problems, causing people to look more closely at alternative models of change.

More and more people, however, have come to believe that collective impact is not just a fancy name for collaboration, but represents a fundamentally different, more disciplined, and higher performing approach to achieving large-scale social impact. Even the attempt to use these ideas seems to stimulate renewed energy and optimism. FSG has been asked to help launch more than one dozen collective impact initiatives, and other organizations focused on social sector capacity building such as the Bridgespan Group, Monitor Institute, and the Tamarack Institute in Canada, have also developed tools to implement collective impact initiatives in diverse settings.

As examples of collective impact have continued to surface, it has become apparent that this approach can be applied against a wide range of issues at local, national, and even global levels. In fact, we believe that there is no other way society will achieve large-scale progress against the urgent and complex problems of our time, unless a collective impact approach becomes the accepted way of doing business.

At the same time, our continued research has provided a clearer sense of what it takes for collective impact to succeed. The purpose of this article, therefore, is to expand the understanding of collective impact and provide greater guidance for those who seek to initiate and lead collective impact initiatives around the world. In particular, we will focus on answering the questions we hear most often: How do we begin? How do we create alignment? And, How do we sustain the initiative?

AWAKENING THE POWER OF COLLECTIVE IMPACT

Of all the collective impact examples we have studied, few are as different in scale as GAIN and Communities That Care, yet both of these efforts embody the principles of collective impact, and both have demonstrated substantial and consistent progress toward their goals.

GAIN, created in 2002 at a special session of the United Nations General Assembly, is focused on the goal of reducing malnutrition by improving the health and nutrition of nearly 1 billion at risk people in the developing world. The development of GAIN was predicated on two assumptions: first, that there were proven interventions that could be employed at scale to improve nutrition of the poor in developing countries, and second, that the private sector had a much greater role to play in improving the nutrition even for the very poor. GAIN is now coordinated by a Swiss Foundation with offices in eight cities around the world and more planned to open soon. In less than a decade, GAIN has created and coordinated the activity of 36 large-scale collaborations that include governments, NGOs, multilateral organizations, universities, and more than 600 companies in more than 30 countries. GAIN's work has enabled more than 530 million people worldwide to obtain nutritionally enhanced food and significantly reduced the prevalence of micronutrient deficiencies in a number of countries. In China, South Africa, and Kenya, for example, micronutrient deficiencies dropped between 11 and 30 percent among those who consumed GAIN's fortified products. During that time, GAIN has also raised $322 million in new financial commitments and leveraged many times more from its private sector and government partners.

At the other end of the spectrum, the Franklin County / North Quabbin Region

of Western Massachusetts has a population of only 88,000 people dispersed across 30 different municipalities and 844 square miles. When two local social service agencies—the Community Coalition for Teens and the Community Action of the Franklin, Hampshire, and North Quabbin Regions—first called a meeting to discuss teenage drinking and drug use, they were astonished that 60 people showed up. From that first meeting, coincidentally also in 2002, grew Communities That Care, that now includes more than 200 representatives from human service agencies, district attorney's offices, schools, police departments, youth serving agencies, faith-based organizations, local elected officials, local businesses, media, parents, and youth. Overseen by a central coordinating council, the initiative operates through three working groups that meet monthly to address parent education, youth recognition, and community laws and norms. In addition, a school health task force links these work groups to the 10 public school districts in the region. Over an eight-year time frame, the work of Communities That Care has resulted not only in reducing binge drinking, but also in reducing teen cigarette smoking by 32 percent and teen marijuana use by 18 percent. The coalition has also raised more than $5 million of new public money in support of their efforts.

Different as they may be, these two initiatives demonstrate the versatility of a collective impact approach and offer broad insights into how to begin, manage, and structure collective impact initiatives.

THE PRECONDITIONS FOR COLLECTIVE IMPACT

Three conditions must be in place before launching a collective impact initiative: an *influential champion, adequate financial resources,* and a sense of *urgency for change.* Together, these preconditions create the opportunity and motivation necessary to bring people who have never before worked together into a collective impact initiative and hold them in place until the initiative's own momentum takes over.

The most critical factor by far is an *influential champion* (or small group of champions) who commands the respect necessary to bring CEO-level cross-sector leaders together and keep their active engagement over time. We have consistently seen the importance of dynamic leadership in catalyzing and sustaining collective impact efforts. It requires a very special type of leader, however, one who is passionately focused on solving a problem but willing to let the participants figure out the answers for themselves, rather than promoting his or her particular point of view.[3] In the case of GAIN, four individuals with deep experience in the development field—Bill Foege, the former director of the US Centers for Disease Control who is largely credited with eradicating small pox, Kul Gautam, a senior official at UNICEF, Duff Gillespie, head of the Office of Population and Nutrition at US Agency for International Development (USAID), and Sally Stansfield, one of the original directors at The Bill & Melinda Gates Foundation—came together to look at large scale opportunities to address malnutrition in populations at risk in the developing world. Together they galvanized the 2002 UN General Assembly special session that led to the creation of GAIN and to the subsequent engagement of hundreds of government, corporate, and nonprofit participants.

Second, there must be adequate *financial resources* to last for at least two to three years, generally in the form of at least one anchor funder who is engaged from the beginning and can support and mobilize other resources to pay for the needed infrastructure and planning processes. The Gates Foundation, the Canadian International Development Agency, and the USAID played this role in the case of GAIN. For Communities That Care, a federal grant provided the necessary multi-year support.

The final factor is the *urgency for change* around an issue. Has a crisis created a breaking point to convince people that an entirely new approach is needed? Is there the potential for substantial funding that might entice people to work together, as was the case in Franklin County? Is there a fundamentally new approach, such as using the production, distribution, and demand creation capacities of the private sector to reach millions of people efficiently and sustainably, as was the case for GAIN? Conducting research and publicizing a report that captures media attention and highlights the severity of the problem is another way to create the necessary sense of urgency to persuade people to come together.

BRINGING COLLECTIVE IMPACT TO LIFE

Once the preconditions are in place, our research suggests that there are three distinct phases of getting a collective impact effort up and running.

Phase I, *Initiate Action,* requires an understanding of the landscape of key players and the existing work underway, baseline data on the social problem to develop the case for change, and an initial governance structure that includes strong and credible champions.

Phase II, *Organize for Impact,* requires that stakeholders work together to establish common goals and shared measures, create a supporting backbone infrastructure, and begin the process of aligning the many organizations involved against the shared goals and measures.

> The appeal of collective impact may be due to a broad disillusionment in the ability of governments to solve society's problems, causing people to look at alternative models of change.

Phase III, *Sustain Action and Impact,* requires that stakeholders pursue prioritized areas for action in a coordinated way, systematically collect data, and put in place sustainable processes that enable active learning and course correcting as they track progress toward their common goals. (See "Phases of Collective Impact" on page 4.)

It is important to recognize that the initiative must build on any existing collaborative efforts already underway to address the issue. Collective impact efforts are most effective when they build from what already exists; honoring current efforts and engaging established organizations, rather than creating an entirely new

solution from scratch.

Being realistic about the time it will take to get through these initial organizing stages is equally important. It takes time to create an effective infrastructure that allows stakeholders to work together and that truly can ameliorate a broken system. The first two phases alone can take between six months and two years. The scope of the problem to be addressed, the degree of existing collaboration, and the breadth of community engagement all influence the time required. Conducting a readiness assessment based on the preconditions listed above can help to anticipate the likely time required.

Once the initiative is established, Phase III can last a decade or more. Collective impact is a marathon, not a sprint. There is no shortcut in the long-term process of social change. Fortunately, progress happens along the way. In fact, early wins that demonstrate the value of working together are essential to hold the collaborative together. In a collective impact education initiative FSG is supporting in Seattle, for example, collaboration in the first year of the initiative led to a dramatic increase in students signing up for College Bound scholarships; not the ultimate goal, but an encouraging sign. Merely agreeing on a common agenda and shared measurement system during Phase II often feels like an important early win to participants.

SETTING THE COMMON AGENDA

Developing a well-defined but practical common agenda might seem like a straightforward task. Yet we find that regardless of the issue and geography, practitioners struggle to agree on an agenda with sufficient clarity to support a shared measurement system and shape mutually reinforcing activities. Setting a common agenda actually requires two steps: creating the boundaries of the system or issue to be addressed, and developing a strategic action framework to guide the activities of the initiative.

Creating Boundaries. Establishing the boundaries of the issue is a judgment call based on each situation. For example, in another collective impact initiative that focused on teen substance abuse, a cross sector set of stakeholders in Staten Island, N.Y. drew their boundaries to include key factors such as parental and youth social norms as well as prevention and treatment activities. They could as easily have included many other related "root causes" of substance abuse such as youth unemployment or domestic violence. While these issues undoubtedly contribute to substance abuse, the group felt less able to impact these areas, and therefore left these issues outside the boundaries of their efforts. On the other hand, working with retailers to limit the availability of alcohol to minors, although outside the social sector, was determined to be an issue inside the boundary of what the group felt they could take on.

Or consider the boundaries drawn by Opportunity Chicago, a collective impact effort that included foundations, government agencies, nonprofits, and employers working to connect low-skilled public housing residents to employment in connection with the city's sweeping plan to transform public housing. The initiative's leaders realized that new housing would not help if the residents could not meet the work requirement established to qualify for residency. As a result, they included workforce development within the housing initiative's boundaries and established Opportunity Chicago, the collective impact initiative that ultimately placed 6,000 residents in jobs.

Boundaries can and do change over time. After nearly a decade of addressing teen substance abuse prevention, Communities That Care is launching a second initiative to address youth nutrition and physical activity, applying the existing structure and stakeholders to a closely related but new topic area within their mission of improving youth health in their region.

Determining geographic boundaries requires the same type of judgment in balancing the local context and stakeholder aspirations. While Shape Up Somerville chose a city-wide focus to tackle childhood obesity, Livewell Colorado addressed the same issue for the entire state by bringing together a more widely dispersed group of representatives from businesses, government, nonprofits, healthcare, schools, and the transportation sector.

Although it is important to create clarity on what is and what is not part of the collective efforts, most boundaries are loosely defined and flexible. Subsequent analysis and activity may draw in other issues, players, and geographies that were initially excluded. Communities That Care, for example, began by serving only Franklin County, and expanded their geographic boundaries in their seventh year to include North Quabbin.

Developing the Strategic Action Framework. Once the initial system boundaries have been established, the task of creating a common agenda must shift to developing a strategic framework for action. This should not be an elaborate plan or a rigid theory of change. The Strive Partnership's "roadmap" for example, fits on a single page and was originally developed in just a few weeks. The strategic framework must balance the necessity of simplicity with the need to create a comprehensive understanding of the issue that encompasses the activities of all stakeholders, and the flexibility to allow for the organic learning

Phases of Collective Impact

Components for Success	PHASE I Initiate Action	PHASE II Organize for Impact	PHASE III Sustain Action and Impact
Governance and Infrastructure	Identify champions and form cross-sector group	Create infrastructure (backbone and processes)	Facilitate and refine
Strategic Planning	Map the landscape and use data to make case	Create common agenda (goals and strategy)	Support implementation (alignment to goals and strategies)
Community Involvement	Facilitate community outreach	Engage community and build public will	Continue engagement and conduct advocacy
Evaluation and Improvement	Analyze baseline data to identify key issues and gaps	Establish shared metrics (indicators, measurement, and approach)	Collect, track, and report progress (process to learn and improve)

process of collective impact to unfold. This framework for action can serve a critical role in building a shared agenda. As Chad Wick, one of the early champions of The Strive Partnership explains, "Our map got everyone to suspend their own view of the world and got us on a common page from which to work. It allowed others to suspend their preconceived views and be open minded about what was and what could be."

Hundreds of organizations and individuals from every continent in the world, even including the White House, have reached out to describe their efforts to use collective impact.

Successful frameworks include a number of key components: a description of the problem informed by solid research; a clear goal for the desired change; a portfolio of key strategies to drive large scale change; a set of principles that guide the group's behavior; and an approach to evaluation that lays out how the collective impact initiative will obtain and judge the feedback on its efforts.

Since 2002, the Tamarack Institute has been guiding Canada's approach to fighting poverty through the Vibrant Communities initiative in a dozen Canadian cities. The Tamarack Institute refers to their strategic action frameworks as "frameworks-for-change," and cogently describes their value as follows: "A strong framework for change, based on strong research and input from local players, shapes the strategic thinking of the group, helps them make tough choices about where to spend their time and energy, and guides their efforts at monitoring and evaluating their work. Ask anyone involved in the effort about where they are going and their road map for getting there, and they will tell you."[4]

We believe their description applies equally well to any strategic action framework that guides a common agenda. Our experience also suggests that it may not always make sense to start off by implementing every single strategy identified in the common agenda. It is also important to pursue a portfolio of strategies that offer a combination of easy but substantive short-term wins to sustain early momentum for the initiative, as well as more ambitious, long-term systemic strategies that may not show impact for several years.

Importantly, strategic action frameworks are not static. Tamarack goes on to note: "They are working hypotheses of how the group believes it can [achieve its goals], hypotheses that are constantly tested through a process of trial and error and updated to reflect new learnings, endless changes in the local context, and the arrival of new actors with new insights and priorities."

FSG research bears out this need for continuous adaptation. The Strive Partnership has evolved their roadmap three times in the last five years. GAIN has built in a robust feedback loop from its programming, and over the past eight years has incorporated best practices and lessons learned as a fundamental component of its fourth annual strategic action framework. And Communities That Care has revised its community action plan three times in the last eight years.

Implementing a collective impact approach with this type of fluid agenda requires new types of collaborative structures, such as shared measurement systems and backbone organizations.

SHARED MEASUREMENT SYSTEMS

Practitioners consistently report that one of the most challenging aspects to achieving collective impact is shared measurement—the use of a common set of measures to monitor performance, track progress toward goals, and learn what is or is not working. The traditional paradigm of evaluation, which focuses on isolating the impact of a single organization or grant, is not easily transposed to measure the impact of multiple organizations working together in real time to solve a common problem. Competing priorities among stakeholders and fears about being judged as underperforming make it very hard to agree on common measures. Organizations have few resources with which to measure their own performance, let alone develop and maintain a shared measurement system among multiple organizations.

Yet shared measurement is essential, and collaborative efforts will remain superficial without it. Having a small but comprehensive set of indicators establishes a common language that supports the action framework, measures progress along the common agenda, enables greater alignment among the goals of different organizations, encourages more collaborative problem-solving, and becomes the platform for an ongoing learning community that gradually increases the effectiveness of all participants.[5] Mutually reinforcing activities become very clear once the work of many different organizations can be mapped out against the same set of indicators and outcomes.

Consider the collective impact effort to reduce homelessness in Calgary, Canada, supported by the Calgary Homeless Foundation (CHF). When stakeholders first came together to define common measures of homelessness, they were shocked to discover that the many agencies, providers, and funders in Calgary were using thousands of separate measures relating to homelessness. They also found that providers had very different definitions of key terms, such as the "chronic" versus "transitional" homeless, and that their services were not always aligned to the needs of the individuals served. Merely developing a limited set of eight common measures with clear definitions led to improved services and increased coordination. Even privacy issues, a major legal obstacle to sharing data, were resolved in ways that permitted sharing while actually increasing confidentiality. As Alina Turner, vice president of strategy at CHF put it, "Putting shared measures in place is a way to start the deeper systems change in a way that people can get their heads around . . . starting from a common framework to get alignment across a whole system of care."

Developing an effective shared measurement system requires broad engagement by many organizations in the field together with clear expectations about confidentiality and transparency. The Calgary homelessness initiative worked with both

a cross-sector advisory committee and a service provider committee to develop common measures from evidence-based research. The measures were then refined through iterative meetings with dozens of stakeholders before being finalized.

Shared measurement systems also require strong leadership, substantial funding, and ongoing staffing support from the backbone organization to provide training, facilitation, and to review the accuracy of data. In CHF's case, the foundation funded and staffed the development of the homelessness management information system (HMIS) and the process of developing shared measures.

Developments in web-based technology permit huge numbers of stakeholders to use shared measurement inexpensively in ways that would have been impossible even a few years ago. CHF has adopted a sophisticated HMIS system with different levels of secure data access for providers, government agencies, and funders. The Strive Partnership, in collaboration with Cincinnati Public Schools, Procter & Gamble, and Microsoft, has made major advances in shared measurement by introducing the "Learning Partner Dashboard," a web-based system that allows schools and nonprofit providers to access data including the performance of individual students and the specific services they receive. Memphis Fast Forward's Operation, Safe Community, built a tool for tracking and publicizing county-wide crime data and facilitated the memorandum of understanding that resulted in data sharing and participation by all five local municipal police departments and the Sheriff's office.

Having shared measures is just the first step. Participants must gather regularly to share results, learn from each other, and refine their individual and collective work based on their learning. Many initiatives use standardized continuous improvement processes, such as General Electric's Six Sigma process or the Model for Improvement. In the case of GAIN, the initiative has both a performance framework and rigorous monitoring and evaluation criteria which feed into an organization-wide learning agenda. Their Partnership Council, comprised of world experts in the fields of nutrition, agriculture, economics, and business, advises the board of directors on the learning agenda, reviews the data to ensure its integrity, and recommends programmatic and management improvements.

> There is no other way society will achieve large-scale progress against urgent and complex problems, unless a collective impact approach becomes the accepted way of doing business.

Regardless of the continuous improvement approach chosen, the backbone organization plays a critical role in supporting the process of learning and improving throughout the life of the collaborative.

KEEPING COLLECTIVE IMPACT ALIVE

Two key structural elements enable collective impact initiatives to withstand the overwhelming challenges of bringing so many different organizations into alignment and holding them together for so long: the *backbone organization* and *cascading levels of linked collaboration.*

Backbone Organization. In our initial article we wrote that "creating and managing collective impact requires a separate organization and staff with a very specific set of skills to serve as the backbone for the entire initiative." We also cautioned, "Coordinating large groups in a collective impact initiative takes time and resources, and too often, the expectation that collaboration can occur without a supporting infrastructure is one of the most frequent reasons why it fails."

Our subsequent research has confirmed that backbone organizations serve six essential functions: providing overall strategic direction, facilitating dialogue between partners, managing data collection and analysis, handling communications, coordinating community outreach, and mobilizing funding.

Although the core backbone functions are consistent across all of the collective impact initiatives we have studied, they can be accomplished through a variety of different organizational structures. (See "Backbone Organizations" on page 7.) Funders, new or existing nonprofits, intermediaries like community foundations, United Ways, and government agencies, can all fill the backbone role. Backbone functions can also be shared across multiple organizations. The Magnolia Place Community Initiative in Los Angeles, for example, strives to optimize family functioning, health and well-being, school readiness, and economic stability for a population of 100,000. The Initiative has a small, dedicated staff that drives the work. Multiple partner organizations from the 70 organizations in the network fulfill different backbone functions, such as collecting and analyzing data, and maintaining a coherent strategic vision through communications.

Each structure has pros and cons, and the best structure will be situation-specific, depending on the issue and geography, the ability to secure funding, the highly important perceived neutrality of the organization, and the ability to mobilize stakeholders. Backbone organizations also face two distinct challenges in their leadership and funding. No collective impact effort can survive unless the backbone organization is led by an executive possessing strong adaptive leadership skills; the ability to mobilize people without imposing a predetermined agenda or taking credit for success. Backbone organizations must maintain a delicate balance between the strong leadership needed to keep all parties together and the invisible "behind the scenes" role that lets the other stakeholders own the initiative's success.

Backbone organizations must also be sufficiently well resourced. Despite the growing interest in collective impact, few funders are yet stepping up to support backbones associated with the issues they care about. Adopting a collective impact approach requires a fundamental shift in the mindset of many funders who are used to receiving credit for supporting specific short-term interventions. Collective impact offers no silver bullets. It works through many gradual improvements over time as stakeholders learn for themselves how to become more aligned and effec-

tive. Funders must be willing to support an open-ended process over many years, satisfied in knowing that they are contributing to large scale and sustainable social impact, without being able to take credit for any specific result that is directly attributable to their funding.

Worse, backbone organizations are sometimes seen as the kind of overhead that funders so assiduously avoid. Yet effective backbone organizations provide extraordinary leverage. A backbone's funding is typically less than 1 percent of the total budgets of the organizations it coordinates, and it can dramatically increase the effectiveness of the other 99 percent of expenditures. Backbone organizations can also attract new funds. As mentioned above, both GAIN and Communities That Care have raised substantial new funding for their work.

Even the best backbone organization, however, cannot single-handedly manage the work of the hundreds of stakeholders engaged in a collective impact initiative. Instead, different levels of linked collaboration are required.

Cascading Levels of Linked Collaboration. We have observed markedly similar patterns in the way successful collective impact efforts are structured across many different issues and geographies. Each begins with the establishment of an oversight group, often called a steering committee or executive committee, which consists of cross-sector CEO level individuals from key organizations engaged with the issue. Under the best circumstances, the oversight group also includes representatives of the individuals touched by the issue. This steering committee works to create the common agenda that defines the boundaries of the effort and sets a strategic action framework. Thereafter, the committee meets regularly to oversee the progress of the entire initiative.

Once the strategic action framework is agreed upon, different working groups are formed around each of its primary leverage points or strategies. GAIN, for example, is overseen by a board of directors, with a 100-person secretariat that operates through four program initiatives: large-scale fortification, multi-nutrient supplements, nutritious foods during pregnancy and early childhood, and enhancing the nutritional content of agriculture products. These programs are supported by 15 working groups on both technical and programmatic topics like salt iodization, infant and child nutrition, and advocacy, as well as functional working groups on evaluation and research, communications, and donor relations. Livewell Colorado operates with 22 cross-sector coalitions that reinforce the state's common agenda within individual communities. Communities That Care has three working groups focused on parent education, youth recognition, and community norms, and a school health task force. More complicated initiatives may have subgroups that take on specific objectives within the prioritized strategies.

Although each working group meets separately, they communicate and coordinate with each other in cascading levels of linked collaboration. Effective coordination by the backbone can create aligned and coordinated action among hundreds of organizations that simultaneously tackle many different dimensions of a complex issue. The

Backbone Organizations

Types of Backbones	Description	Examples	Pros	Cons
Funder-Based	One funder initiates CI strategy as planner, financier, and convener	Calgary Homeless Foundation	◆ Ability to secure start-up funding and recurring resources ◆ Ability to bring others to the table and leverage other funders	◆ Lack of broad buy-in if CI effort seen as driven by one funder ◆ Lack of perceived neutrality
New Nonprofit	New entity is created, often by private funding, to serve as backbone	Community Center for Education Results	◆ Perceived neutrality as facilitator and convener ◆ Potential lack of baggage ◆ Clarity of focus	◆ Lack of sustainable funding stream and potential questions about funding priorities ◆ Potential competition with local nonprofits
Existing Nonprofit	Established nonprofit takes the lead in coordinating CI strategy	Opportunity Chicago	◆ Credibility, clear ownership, and strong understanding of issue ◆ Existing infrastructure in place if properly resourced	◆ Potential "baggage" and lack of perceived neutrality ◆ Lack of attention if poorly funded
Government	Government entity, either at local or state level, drives CI effort	Shape Up Somerville	◆ Public sector "seal of approval" ◆ Existing infrastructure in place if properly resourced	◆ Bureaucracy may slow progress ◆ Public funding may not be dependable
Shared Across Multiple Organizations	Numerous organizations take ownership of CI wins	Magnolia Place	◆ Lower resource requirements if shared across multiple organizations ◆ Broad buy-in, expertise	◆ Lack of clear accountability with multiple voices at the table ◆ Coordination challenges, leading to potential inefficiencies
Steering Committee Driven	Senior-level committee with ultimate decision-making power	Memphis Fast Forward	◆ Broad buy-in from senior leaders across public, private, and nonprofit sectors	◆ Lack of clear accountability with multiple voices

real work of the collective impact initiative takes place in these targeted groups through a continuous process of "planning and doing," grounded in constant evidence-based feedback about what is or is not working.

The working groups typically develop their own plans for action organized around "moving the needle" on specific shared measures. Once plans are developed, the working groups are then responsible for coming together on a regular basis to share data and stories about progress being made, and for communicating their activities more broadly with other organizations and individuals affected by the issue so that the circle of alignment can grow. This confers an additional benefit of collective impact: as the common agenda's center of gravity becomes more apparent to all those working on the issue, even people and organizations who have not been directly engaged as a formal part of the initiative start doing things in ways more aligned to the effort. Brenda Ranum, a leader within The Northeast Iowa Food & Fitness Initiative that has brought five rural counties together to improve access to healthy, locally grown foods and to create opportunities for physical activity, refers to this benefit in alignment as getting "order for free." In our own consulting work supporting collective impact initiatives for issues as varied as juvenile justice reform, sustainable fishing, education reform, youth development, and agricultural development, we have also observed the benefits of this "order for free" phenomenon.

The backbone organization provides periodic and systematic assessments of progress attained by the various work groups, and then synthesizes the results and presents them back to the oversight committee that carries the sustaining flame of the common agenda.

The number of working groups and the cascading layers of collaboration may also change over time. As working group strategies are modified based on an examination of what is working, some groups may end and new ones begin to pursue newly identified strategies defined by the common agenda. What is critically important is that all strategies pursued clearly link back to the common agenda and shared measures, as well as link to each other.

Memphis Fast Forward illustrates how one community can address multiple complex issues through this multi-level cascading structure. The work of Memphis Fast Forward is overseen by a 20-person cross-sector steering committee with the goal of making Memphis one of the most successful economic centers in the southern United States. They developed a common agenda focused on four key levers: public safety, education, jobs, and government efficiency. Each lever constitutes its own sub-initiative and is overseen by its own cross-sector steering committee and supported by a dedicated backbone organization. Each sub-initiative then cascades into linked working groups focused around the strategic levers unique to each of the four selected areas. Public Safety, for example, has developed its own strategic action framework that has 15 strategies, each with lead partners and cross-sector representation. The combined efforts of these linked work groups has led to a decrease in violent and property crimes of 26 percent and 32 percent respectively over the last five years.

One of the lead individuals associated with Memphis Fast Forward characterizes both the challenges and the value of this approach: "By using a decentralized but linked approach, each effort has its own governance and unique structure but all efforts come together to share learnings. It took us a while to realize the value in formally bringing the backbone organization leaders together for sharing and problem solving. Initially, the different initiatives were only loosely communicating, but then we realized that we had a great opportunity to all learn from each other and should do so more intentionally and proactively." Now leaders from the four initiatives meet monthly.

THE ESSENTIAL INTANGIBLES OF COLLECTIVE IMPACT

Our guidance here on implementing collective impact has said little about the "softer" dimensions of any successful change effort, such as relationship and trust building among diverse stakeholders, leadership identification and development, and creating a culture of learning. These dimensions are essential to successfully achieving collective impact. We, as well as others, have written extensively about the profound impact that getting the soft stuff right has on social change efforts. And indeed, all of the successful collective impact practitioners we've observed can cite numerous instances when skillful implementation of these intangible dimensions was essential to their collective efforts.

One such intangible ingredient is, of all things, food. Ask Marjorie Mayfield Jackson, founder of the Elizabeth River Project, what the secret of her success was in building a common agenda among diverse and antagonistic stakeholders, including aggressive environmental activists and hard-nosed businessmen. She'll answer, "Clam bakes and beer." So too, The Tamarack Institute has a dedicated "Recipes Section" on its website that recognizes "how food has been that special leaven in bringing people together." In attempting collective impact, never underestimate the power and need to return to essential activities that can help clear away the burdens of past wounds and provide connections between people who thought they could never possibly work together.

As much as we have tried to describe clear steps to implement collective impact, it remains a messy and fragile process. Many attempts will no doubt fail, although the many examples we have studied demonstrate that it can also succeed. Yet even the attempt itself brings one important intangible benefit that is in short supply nowadays: hope. Despite the difficulty of getting collective impact efforts off the ground, those involved report a new sense of optimism that dawns early on in the process. Developing the common agenda alone has produced remarkable changes in people's belief that the future can be different and better even before many changes have been made. For many who are searching for a reason to hope in these difficult times, this alone may be purpose enough to embrace collective impact. ◆

1 Originally named Strive when the earlier article appeared.

2 http://www.strivetogether.org/wp-content/uploads/2011/11/2011-Strive-Partnership-Report.pdf.

3 We described the qualities of such a leader as Adaptive Leadership, in Ronald Heifetz, John Kania, and Mark Kramer, "Leading Boldly," *Stanford Social Innovation Review*, winter 2004.

4 *Cities Reducing Poverty: How Vibrant Communities Are Creating Comprehensive Solutions to the Most Complex Problems of Our Times*, The Tamarack Institute, 2011: 137.

5 Mark Kramer, Marcie Parkhurst, and Lalitha Vaidyanathan, *Breakthroughs in Shared Measurement and Social impact*, FSG, 2009.

Continuum of Alcohol, Tobacco and Other Drug Services Strategic Plan

Continuum of Alcohol, Tobacco *and* Other Drug Services Strategic Plan

Highlights 2010-2015

Marin County Department of Health & Human Services • Division of Alcohol, Drug and Tobacco Programs

Acknowledgements

The Marin County Department of Health and Human Services, Division of Alcohol, Drug and Tobacco Programs wishes to acknowledge the leadership and tremendous contributions of countless individuals in developing a Strategic Plan that will guide the delivery of a comprehensive continuum of prevention, intervention, treatment and recovery support services for the next five years. The Division also wishes to extend appreciation to the Board of Supervisors, Advisory Board on Alcohol and Other Drug Problems, Department of Health and Human Services leadership, Division staff and community partners for providing the support and expertise necessary to advance alcohol, tobacco and other drug issues in Marin County.

Strategic Plan Subcommittees

Don Blasky, Bay Area Community Resources

Teresa Bowman, Helen Vine Detox Center

Otis Bruce, Marin County Office of the District Attorney

Don Carney, YMCA

Brandi Comaroto, Youth Leadership Institute

Elizabeth Dandenell, Therapist

Kate Deveney-Chilton, Youth Leadership Institute

Kristen Gardner, HHS: Community Mental Health Services

Jose Gomez, Bay Area Community Resources

Sarah Grossi, HHS: Division of Social Services

Andrea Hedin, Kaiser Permanente

Laura Kantorowski, Bay Area Community Resources

Tracy Keough, O'Rorke, Inc.

Chris Kughn, HHS: Community Mental Health Services

Beth Lillard, Bay Area Community Resources

Patty Lyons, HHS: Division of Aging and Adult Services

Lynn McLeod, Marin Services for Women

Carlos Molina, Family Service Agency

Melinda Moore, MK Associates

Susan Morrow, Redwood High School PTA

Cindy Myers, Marin Services for Women

Sharon O'Hara, SE O'Hara and Associates

Maureen O'Rorke, O'Rorke, Inc.

Angelo Patillo, Helen Vine Detox Center

Adrianna Popescu, Marin Services for Women

Ann Pring, HHS: Community Mental Health Services

Susan Quigley, Huckleberry Youth Programs

Alissa Ralston, Bay Area Community Resources

Jim Ricci, Center Point

Roberta Romeo, Marin County Commission on Aging

Sandra Rosenblum, HHS: Maternal and Child Health

Angelo Sacheli, HHS: Division of Social Services

Gary Scheppke, Marin County Mental Health Board

Angela Schneider, Ohlhoff Recovery Programs

Lisa Schwartz, Marin County Office of Education

Steve Shapiro, Marin County Probation

Meg Sherry, Bay Area Community Resources

Brian Slattery, Marin Treatment Center

Rebecca Smith, HHS: Community Health & Prevention

Sparkie Spaeth, HHS: Community Health & Prevention

Jasmine Stevenson, Huckleberry Youth Programs

Teresa Torrence-Tillman, Marin County Probation

Julie Van Winkle, HHS: Policy and Planning

Jose Varela, Marin County Public Defender

Teri Vyenielo-Rockas, Kaiser Permanente/ Healthy Marin Partnership

Pat Wall, HHS: Division of Aging and Adult Services

Mary Jo Williams, Bay Area Community Resources

Strategic Plan Advisory Committee

Kate Deveney-Chilton, Youth Leadership Institute

Laura Kantorowski, Bay Area Community Resources

Cindy Myers, Marin Services for Women

Michael Scippa, Advisory Board on Alcohol and Other Drugs/Marin Institute

Teresa Torrence-Tillman, Marin County Probation

Teri Vyenielo-Rockas, Kaiser Permanente/ Healthy Marin Partnership

The Division of Alcohol, Drug and Tobacco Programs would also like to thank the individuals who responded to survey requests and participated in Key Informant Interviews and Focus Groups. Participants included young people, individuals in recovery, clients currently engaged in treatment, safety net and healthcare service providers, front line staff in Social Services and community provider settings, law enforcement officials, school personnel, County Department Heads, HHS Division Directors and other key community stakeholders.

We would like to extend a special acknowledgement to *Christina Borbely* and *Kerrilyn Scott-Nakai* from the Center for Applied Research Solutions for providing ongoing technical assistance and support in facilitating and designing the Strategic Planning process.

Letter to the Community

Dear Community Members of Marin,

The Continuum of Alcohol, Tobacco and Other Drug Services Strategic Plan marks the commencement of a comprehensive approach to preventing, treating and providing ongoing recovery support services for the problems associated with the use of alcohol, tobacco and other drugs in our community.

Marin is vibrant and strong with access to unparalleled community resources; however, individuals, families and communities continue to experience the devastating impacts related to the use of alcohol, tobacco and other drugs. We too often see individuals who are homeless or unemployed due to problems with alcohol and other drugs, or individuals filling our jails and emergency rooms who could benefit from intervention and treatment services for their substance use issues. It is easy for young people to access alcohol, tobacco and other drugs and they are using these substances at alarmingly high rates and experiencing significant health and safety consequences. Families are struggling to stay intact and families are spending their life savings to put a loved one through treatment. Finally, communities themselves are dealing with alcohol, tobacco and other drug nuisances, drug related crime and a host of other consequences to businesses, community events and their bottom lines in an era of shrinking public resources.

Acknowledging our limited public resources for alcohol, tobacco and other drug issues, it is our intent and long-term vision that individuals at-risk of or experiencing problems related to their substance use will be identified early and referred to appropriate services. Someone looking for help for a friend or family member will only need to make one phone call. Individuals with complex or co-occurring mental health and substance use disorders will have access to integrated treatment services from highly qualified practitioners. Communities will demand change and will implement policies and practices that affect the way alcohol, tobacco and other drugs are viewed and addressed at the local level.

The priorities and goals outlined in this Plan strive to establish a comprehensive, integrated and recovery-oriented continuum of evidence-based services that are responsive to community needs, engage multiple systems and stakeholders, encourage community participation, promote system integration, and embrace a comprehensive approach to service delivery.

The priority areas and goals position Marin County as a leader in designing and delivering services in a manner that recognizes that a substance use disorder is a chronic health condition requiring a long term recovery management approach similar to the treatment of diabetes and other chronic conditions. It is our collective responsibility to impact the social norms and perceptions around how alcohol, tobacco and other drugs are viewed and how individuals with substance use disorders are recognized and treated, as well as to update the policies and practices that continue to perpetuate substance use disorders being viewed as a social problem, rather than as a health condition.

The need and demand for services, coupled with the economic challenges before us, require that we have a clear direction and that we allocate resources and deliver services in the most efficient, effective and high-quality manner possible. The landscape of the alcohol, tobacco and other drug field continues to change, but the priority areas and goals outlined in the Plan position Marin County for new opportunities, including accessing benefits from the recent parity legislation and healthcare reform, as well as laying the foundation for achieving this great task before us.

To realize this vision, we are developing implementation and evaluation plans, and activities will commence beginning in the Fall of 2010. We invite you to visit our website at **www.co.marin.ca.us/adtp** where we will post regular updates and annual evaluation reports.

Join us in this groundbreaking work as we embark on implementing a comprehensive and integrated continuum of alcohol, tobacco and other drug services.

Sincerely,

DJ Pierce, OTR, MPA
Division Chief
Marin County Division of Alcohol, Drug and Tobacco Programs

Background

The Marin County Department of Health and Human Services, Division of Alcohol, Drug and Tobacco Programs is responsible for planning, coordinating and managing a continuum of publicly funded alcohol, tobacco and other drug prevention, intervention, treatment and recovery services that are responsive to the needs of the community and Marin County. To accomplish this task, the Marin County Division of Alcohol, Drug and Tobacco Programs allocates funding to community-based agencies to provide an array of prevention, early intervention and treatment services for substance use disorders.

The Department of Health and Human Services is working to restructure, redesign and reprioritize declining resources in an effort to move to a more sustainable future. The County Board of Supervisors and the County Administrator's office have asked that all departments seek to realign resources in response to expected long-term downward pressure on public revenues as a result of the current economic downturn and expected structural deficits. Consequently, it is important to acknowledge that the Division's efforts to recalibrate its own system into a more public health and long-term recovery management model are part of a larger Department of Health and Human Services redesign effort.

The existing service gaps, coupled with the direction of local, state and federal initiatives and economic realities, prompted the Division to initiate a community-based Strategic Planning process in order to more effectively organize diminishing resources into a systemically integrated, co-occurring capable, recovery-oriented continuum of alcohol, tobacco and other drug services.

The purpose of the Strategic Planning process was to:

- **Move from an acute to a public health-oriented chronic care service delivery model that embraces an upstream prevention approach;**
- **Maximize current resources while leveraging additional resources where possible;**
- **Streamline service delivery to improve efficiencies and enhance client outcomes;**
- **Recognize the preponderance of co-occurring conditions and thereby ensure a collaborative systems approach that eliminates "silos" and maintains a client-focus;**
- **Move toward a strategic, sustainable and evidence-based approach; and**
- **Align with local, statewide and federal initiatives that deliver a comprehensive and integrated continuum of services.**

Source: Substance Abuse and Mental Health Services Administration

Strategic Planning Process Framework

To develop the Strategic Plan, the Division of Alcohol, Drug and Tobacco Programs engaged service providers and other key community partners, and utilized the Substance Abuse and Mental Health Services Administration's Strategic Planning Framework to guide the planning process. The Division also engaged the expertise of the Center for Applied Research Solutions, a contracted technical assistance provider for the California Department of Alcohol and Drug Programs, to assist with designing the process, providing capacity building trainings and providing ongoing technical assistance.

The steps in the Strategic Planning Framework are as follows:

Assessment: Profile population needs, resources and readiness to address issues;

Capacity: Mobilize and/or build capacity to address needs;

Planning: Develop a comprehensive Strategic Plan;

Implementation: Implement evidence-based strategies and activities; and

Evaluation: Monitor, evaluate, sustain and improve or replace strategies that are not successful.

In the first phase of the planning process, which occurred from March 2009 to January 2010, the Strategic Planning Committees participated in various trainings, conducted a needs assessment, developed data-driven problem statements, identified evidence-based strategies to address the issues, and recommended standards and practices to guide the delivery of high-quality services. In the second phase of the process, which commenced in summer 2010, Division staff developed implementation plans and contracted with an independent evaluation contractor to develop the overall evaluation plan.

Strategic Plan Structure and Participation

The Division of Alcohol, Drug and Tobacco Programs outreached to a variety of stakeholders including representatives from prevention, treatment and recovery service providers, HHS Divisions of Community Mental Health, Public Health, Social Services and Aging and Adult Services, criminal justice partners, County Advisory Board members, school personnel, law enforcement, County and community policymakers and other interested community members and stakeholders. Stakeholders were invited to participate in subcommittees, which were the driving force in determining the Goals, Priorities and Strategies outlined in the Plan. Interested stakeholders that wanted to contribute, but were unable to make the time commitment, were invited to share data and participate in a key informant interview and/or focus group.

The Continuum of Alcohol, Tobacco and Other Drug Services Strategic Plan marks the commencement of a comprehensive approach to preventing, treating and providing ongoing recovery support services for the problems associated with the use of alcohol, tobacco and other drugs in our community.

Current and Future Service Delivery Landscape

Currently, the publicly funded system is focused on: engaging in environmental level changes to prevent alcohol, tobacco and other drug use; working with at-risk populations to reduce and eliminate illegal drug use; implementing population-level approaches to impact the social norms and behaviors around alcohol, tobacco and other drugs; and providing treatment services which are dedicated to serving high-risk and indigent populations, such as individuals that are homeless, pregnant and parenting, HIV positive, Intravenous Drug User (IVDU), justice involved, and other vulnerable populations.

Within our publicly funded system of care, significant gaps exist:

- **Prevention** services are largely focused on universal populations, leaving the higher-risk selective and indicated populations with limited resources;
- **Early intervention** services exist, but are not strategically co-located in settings that reach individuals at-risk of or with substance use disorders;
- **Treatment** is not reaching those who need it. According to the 2008 National Household Survey on Drug Use and Health, nearly 10% of individuals age 12 and older were in need of treatment for an illicit drug or alcohol use problem. Of these, only less than 10% actually received treatment services. Based on these estimates, in Marin, approximately 94% of individuals in need of treatment services are not engaged with the publicly-funded treatment service delivery system;
- The lack of sufficient **Recovery Support Services** reduces the success of long-term recovery. While offered as part of the program design in some of our contracted treatment provider agencies, the Division does not directly coordinate or allocate resources for these types of services creating a gap for those seeking assistance and support to sustain their recovery; and
- Client care is often not coordinated among various service providers and clients are not always actively linked with essential **primary and ancillary services,** including specialty care for clients with trauma or co-occurring mental health and substance use disorders, stable and supportive housing, primary health care, vocational training and other social services.

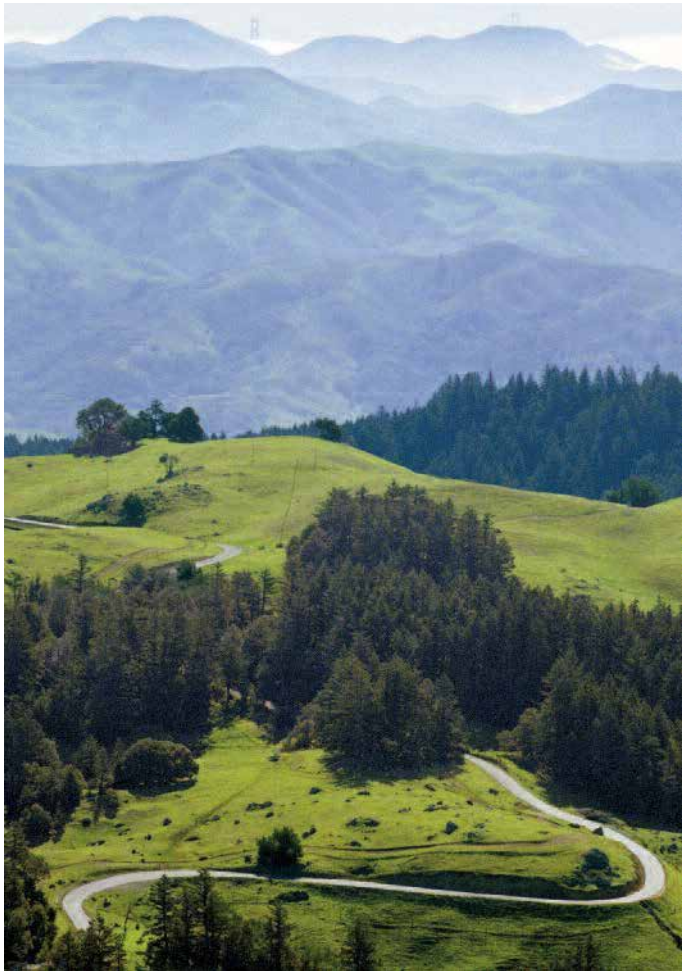
Below is a summary of the current landscape of the alcohol, tobacco and other drug system of care, as well as a snapshot of the vision of what the system of care will reflect as a result of Strategic Plan implementation.

CURRENT SYSTEM OF CARE: *Prior to Strategic Plan Implementation*	IMPLEMENT EVIDENCE-BASED STRATEGIES	**FUTURE SYSTEM OF CARE:** *After Strategic Plan Implementation*
Substance use disorders are commonly viewed as social problems and are often addressed through the justice system or addressed through an acute model of care		**Substance use disorders are viewed as health conditions and are addressed using a public health approach and recovery-oriented chronic relapsing disease model of care**
Primary prevention efforts primarily focus on youth alcohol and tobacco use and utilize environmental prevention approaches		**Primary prevention strategies will continue to place a focus on alcohol, tobacco and environmental approaches, but efforts will also address emerging issues, including prescription drug use and poly-substance use among youth and older adults, and will also include strategies appropriate for selective and indicated populations**
Individuals at-risk of or with substance use disorders or co-occurring conditions are not systematically identified early and referred for services		**Agencies and settings that commonly interact with individuals at-risk of or with substance use disorders, such as primary health clinics, safety net providers, the County Jail and Probation Department, and other school and community settings will be systematically implementing screening, brief intervention and referral services for co-occurring conditions**
Treatment services provided to clients with substance use disorders are often not coordinated with other related services and clients are not consistently linked with appropriate ancillary services		**Centralized assessment and care coordination will attempt, within the constraints of limited funding, to provide client access to comprehensive and integrated co-occurring capable services tailored to their individual needs, as well as coordinated transitioning between modalities of service throughout the continuum**
Evidence-based approaches to preventing and managing substance use disorders are not consistently utilized by agencies, organizations, schools, communities and other partners involved in alcohol, tobacco and other drug efforts		**Relevant agencies, organizations, schools, communities and other partners will utilize evidence-based approaches to preventing, intervening or reducing problems associated with alcohol, tobacco and other drugs**
Insufficient resources, restrictions on categorical funding and artificial barriers that restrict access to ancillary services limits the availability to provide a comprehensive and integrated continuum of services		**While these intractable issues will continue to have an impact, existing resources will be realigned and used as effectively and strategically as possible**

CONTINUING CURRENT EFFORTS

Current efforts that will continue through Strategic Plan implementation are as follows:

- Publicly-funded services for the treatment of substance use disorders will continue to focus on high-risk and indigent populations, such as individuals that are homeless, pregnant and parenting, HIV positive, IVDU, justice involved, and other vulnerable populations;
- The Division of Alcohol, Drug and Tobacco Programs will continue to allocate resources and provide training and technical assistance to the service provider network to enhance their capacity to provide evidence-based services tailored to individual client needs; and
- The Division of Alcohol, Drug and Tobacco Programs will continue to look at trends and emerging issues, as well as at short and long-term client and community outcomes to plan services and evaluate efficacy and efficiency.



Current and Future Fiscal Landscape

The vast majority of financial resources for Division-funded prevention, intervention, treatment and recovery services are from a combination of categorical (68%) and discretionary (32%) federal, state and local dollars. While nearly 85% of the Division's $5,000,000 annual budget is dedicated to direct service delivery, the current gaps necessitate a reallocation of resources to maximize service delivery and ensure a comprehensive and integrated continuum of services.

Detailed on page 6 is the FY 2009/10 breakdown of resources by service modality for alcohol and other drug services. Within the treatment service delivery system, services for clients involved in the Adult Drug Court and PC 1210 (formerly Substance Abuse and Crime Prevention Act /Proposition 36) programs represent 12.3% of the budget. Among tobacco services, 59% ($172,143) and 41% ($122,000) of contracted activities are dedicated to prevention and cessation services, respectively.

Given the finite public resources available for alcohol, tobacco and other drug services, it is imperative to design a service delivery system that is efficient, outcome-oriented and committed to facilitating long-term recovery. To effectively ensure a comprehensive and integrated continuum of services that reflects a public health model, the limited resources must be reallocated to include additional modalities of service, such as recovery support services, as well as must be realigned to more efficiently and effectively match clients with services needed through the continuum.

In addition to reallocating resources in order to provide a continuum of services, the recent and proposed local, state and federal funding cuts merit creative and strategic resource allocation. In addition to ongoing County General Fund reductions for tobacco prevention and cessation services and for treatment services for Adult Drug Court clients, the State's elimination of the Substance Abuse and Crime Prevention Act (SACPA) Program in FY 2008/09 left the treatment system with a $700,000 treatment gap, therefore limiting Marin's ability to serve eligible justice-involved clients.

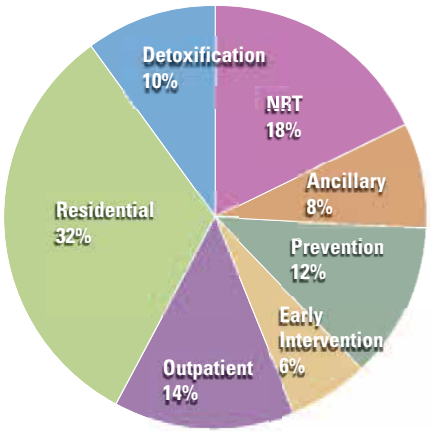
Additionally, the Governor's proposed May revision to the FY 2010/11 budget calls for elimination of Drug/Medi-Cal and CalWORKS, which would reduce an additional $600,000 from existing treatment resources. Services currently being provided with those dollars include Narcotic Replacement Therapy, outpatient treatment for women, outpatient services for individuals with co-occurring disorders, and residential treatment for CalWORKS eligible women.

Primary prevention services are also being reduced with the elimination of the Governor's portion of the Safe and Drug Free Schools and Communities grants, which translates to a $125,000 annual reduction in prevention and early intervention services for students in the Tamalpais Union High School District.

Given the complex and continually changing financial picture, the priority areas and goals outlined in the Plan serves a critical role in determining the prioritization and reallocation of our limited resources. In order to maximize service delivery and ensure a comprehensive and integrated continuum of services, following Strategic Plan implementation, resources are projected to be realigned as detailed below.

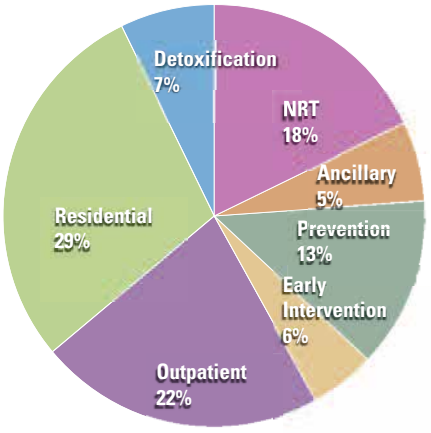
ALCOHOL AND OTHER DRUG RESOURCE DISTRIBUTION

FY 2009/10



Service Modality	Allocation	Percent
Prevention	$505,858	12%
Early Intervention	$277,057	6%
Outpatient/IOP	$591,621	14%
Residential	$1,395,208	32%
Detoxification	$425,900	10%
NRT	$793,450	18%
Ancillary	$328,106	8%
Total	$4,317,200	100%

Year 1: Strategic Plan Implementation



Service Modality	Projected Allocation	Percent
Prevention	$569,178	13%
Early Intervention	$260,366	6%
Outpatient/IOP	$978,461	22%
Residential	$1,301,483	29%
Detoxification	$326,772	7%
NRT	$792,686	18%
Ancillary	$241,909	5%
Total	$4,470,857	100%

Administrative costs and tobacco prevention and cessation resources are not included in the charts.

In view of the finite public resources available for alcohol, tobacco and other drug services, it is imperative to design a service delivery system that is efficient, outcome-oriented and committed to facilitating long-term recovery.

The following allocation and capacity changes expected as a result of Strategic Plan implementation are based on a reallocation of existing resources, with the exception of leveraging new Minor Consent Drug/Medi-Cal funding:

Modality	Projected Reallocation of Resources	Projected System Capacity (Changes)
Prevention	Increase in funding for prevention services to engage in system-wide social norm change Reallocation of existing prevention funding to align with the strategies included in the Plan	Increase in prevention strategies with communities and selective and indicated populations
Early Intervention	Reallocation of existing early intervention resources to align with the strategies included in the Plan, including SBIRT and Centralized Assessment/Care Management	Screen: 15,000 clients (+1,264%) Brief Intervention: 3,405 clients (+389%) Central Assessment: 750 clients (new)
Outpatient/ Intensive Outpatient [IOP]	Increase in resources for outpatient services for priority populations, including adolescents (Minor Consent), high-risk and indigent individuals, such as homeless, pregnant and parenting, HIV positive, IVDU, justice involved, and other vulnerable populations	346 clients (+ 193%)
Residential	Increase in PC 1210 funding for long-term residential treatment services Decrease in funding for long-term residential treatment services	30 beds (0%); 77-123 clients (+ 30%) *Note: A shorter length of stay is anticipated, resulting in increased residential capacity*
Detoxification	Decrease in funding for short-term residential detoxification services	6 – 9 beds; 548 – 821 clients (- 32%)
Narcotic Replacement Therapy [NRT]	Maintain funding for subsidized Narcotic Replacement Therapy services	160 clients (no change)
Recovery Support Services	Increase in funding for Care Management coordination that includes recovery support services Redesign service delivery standards to ensure that recovery management services are integrated into treatment	583-629 clients (new)
Ancillary Services	Increase in access to ancillary services through establishment of formal partnerships with relevant providers across and between systems Decrease in funding for justice funded ancillary services	Varies depending on client needs

Priority Areas

During the Strategic Planning process, the following three themes were identified as the key priority areas necessary to successfully implement a comprehensive and effective continuum of alcohol, tobacco and other drug services. Within each of the priority areas are problem statements that the Strategic Planning committees formulated based on the needs assessment, which included a review of objective data, and input from key informant interviews and focus groups with community stakeholders.

PRIORITY AREA ONE

Impact Norms and Perceptions: Impact how alcohol, tobacco and other drug use, abuse and addiction are viewed and addressed in Marin County.

Corresponding Problem Statements:

- Substance use disorders continue to be viewed primarily as a social problem, rather than as a health condition.
- High-rate, frequent and poly-substance use of alcohol, inhalants, prescription drugs and marijuana are emerging as the predominate pattern of use among youth and older adults in Marin leading to significant academic, health and safety consequences.
- Alcohol, tobacco and other drugs are available in significant quantities in social environments where youth are present leading to regular and heavy consumption, resulting in threats to individual health and community safety.
- Local, state and federal laws and regulations are not being adhered to in retail settings leading to sales and service to minors under the age of 18 for tobacco products, under the age of 21 years for alcohol, and adult sales to intoxicated persons which results in threats to individual health and community safety.

PRIORITY AREA TWO

Improve System Capacity and Infrastructure: Improve the capacity of individuals, agencies and communities to address alcohol, tobacco and other drug issues, as well as develop the infrastructure necessary to provide a seamless and comprehensive integrated continuum of services in Marin County.

Corresponding Problem Statements:

- A significant number of individuals with, or at risk of, alcohol, tobacco and other drug issues are not receiving prevention messages or being identified early and referred for treatment, as screening is not universally implemented in many settings such as school, community, medical or criminal justice.
- Screening for tobacco use is not currently being integrated into the intake and service delivery processes at all substance abuse and mental health treatment agencies in a consistent manner.
- Treatment for client with co-occurring disorders is being met through different systems (Mental Health and Alcohol and Other Drugs) and there is no unifying coordination of this treatment across systems.
- Many Divisions within HHS and Departments within the County work with the same clients and there is no system in place to ensure that there is cross communication regarding client services accessed, history and needs.
- Case management, ancillary and aftercare services, which are integral to achieving long-term recovery, are not systematically provided throughout the assessment, treatment and recovery processes.
- There is limited local alcohol, tobacco and other drug data to demonstrate community-specific needs and the prevalence and impact of culturally relevant, evidence-based programs and strategies.
- The current state-required data collection systems do not accurately reflect a continuum of care model.
- The cost to address alcohol, tobacco and other drug use and its related community consequences is a significant burden on the public health and safety resources in Marin and is out of balance to the resources available for local communities to address the issue.

PRIORITY AREA THREE

Implement Effective Alcohol, Tobacco and Other Drug Services: Implement evidence-based alcohol, tobacco and other drug prevention, intervention, treatment and recovery support services that are aligned with the needs and issues of Marin County and its communities.

Corresponding Problem Statements:

- As a large proportion of available public funding is categorical and restrictive, it is insufficient to adequately address community priorities.
- There is a significant lack of substance abuse treatment services for adolescents and their families.
- All tobacco using clients are not being advised to quit using tobacco and are not being routinely provided with cessation services on site or by referral.
- School curricula, programs and strategies utilized in many settings do not incorporate the latest in science and research, are not implemented with fidelity, decline in frequency as youth age and use increases, and record little to no documented effectiveness or measurement of impact.
- Communities are not engaged in effective alcohol, tobacco and other drug prevention due to a lack of: local data, capacity to address the issues, implementation of evidence-based strategies, and coordinated action.
- Current substance abuse and mental health treatment services in Marin have limited co-occurring capabilities. Economic instability can undermine long-term recovery for many of the clients within the treatment system.

The priorities and goals strive to establish a comprehensive, integrated and recovery-oriented continuum of evidence-based services that are responsive to community needs, engage multiple systems and stakeholders,encourage community participation, promote system integration, and embrace a comprehensive approach to service delivery.

It is our collective responsibility to impact the social norms and perceptions around how alcohol, tobacco and other drugs are viewed and how individuals with substance use disorders are recognized and treated, as well as to update the policies and practices that continue to perpetuate substance use disorders being viewed as a social problem, rather than as a health condition.

Strategic Goals

The Strategic Goals for FY 2010/11 – FY 2014/15, which were shaped by the problem statements established by the Strategic Planning committees, are as follows:

GOALS

1. **Ensure that substance use disorders are viewed as a health condition, rather than as a social problem;**
2. **Ensure that individuals with or at-risk of alcohol, tobacco or other drug problems are identified early, screened and referred for services as appropriate;**
3. **Coordinate, communicate and collaborate across departments, HHS Divisions and community partners to ensure the provision of comprehensive and integrated evidence-based services and strategies for clients and communities;**
4. **Leverage alternative resources to maximize the availability and diversity of available services;**
5. **Deliver services in a manner that is consistent with a continuum of care and chronic relapsing disease model and are tailored to specific client needs and considerations, such as economic status, gender, age, language, sexual orientation, geographic, racial, cultural, legal and other situational issues;**
6. **Support implementation of and consistent adherence to laws, policies, standards and practices that prevent and reduce alcohol, tobacco and other drug problems; and**
7. **Collect and report data on the alcohol, tobacco and other drug system of care.**

Implementing Services: Initiatives, Activities and Outcomes

In order to successfully implement the identified goals in the Strategic Plan, the Division of Alcohol, Drug and Tobacco Programs developed a series of work plans for each of the Strategic Plan Goals, which includes measureable objectives, activities, outcomes, timeframes and responsible entity, and will guide the multiple phases of implementation over the next five years. As part of Strategic Plan implementation, the Division issued Policies, Procedures, Standards and Practices that shall enhance service delivery for contracted provider services. The following are **highlights of the initiatives** that will be implemented to achieve each of the Strategic Goals.

GOAL 1

Ensure that substance use disorders are viewed as a health condition, rather than a social problem.

INITIATIVE

- Shift the view of substance use disorders among the public, service providers, healthcare professionals, policymakers, justice partners, and other community leaders through media, peer-based education campaigns, and policy and practice development.

KEY ACTIVITIES

- Allocate resources to a Media and Public Relations contractor to develop a media advocacy strategy and related media campaigns targeted to shifting the public's perception of alcohol, tobacco and other drug issues;
- Develop and disseminate information on the science and nature of substance use disorders via trainings, fact sheets and presentations to service providers, healthcare professionals, policymakers, justice partners and other community leaders; and
- Engage service providers, healthcare professionals, policymakers, justice partners and other community leaders to serve as "change agents" to educate their peers and implement policies and practices that align with substance use disorders being viewed as a health condition.

STRATEGIC OUTCOMES

- **The system of care reflects a continuum that is consistent with the public health-oriented chronic disease model.**
- **Change in the public's and providers' perception of alcohol, tobacco and other drug use and substance use disorders.**
- **Increase in resources to address alcohol, tobacco and other drug issues.**
- **Increase in the number of service partners and communities addressing alcohol, tobacco and other drug issues.**
- **Extent of service integration among public health, mental health, and alcohol, tobacco and other drug services.**
- **Increase in the perceived harm of high-risk behaviors, including high-rate, frequent and poly-substance use.**

GOAL 2

Ensure that individuals with or at-risk of alcohol, tobacco or other drug problems are identified early, screened and referred for services as appropriate.

INITIATIVE

- Implement Screening, Brief Intervention and Referral to Treatment (SBIRT) in at least 15 primary health, safety net, justice, youth and community settings.

KEY ACTIVITIES

- Identify and disseminate information on evidence-based SBIRT models and tools;
- Seek and leverage resources to provide SBIRT services;
- Engage policymakers and key staff at potential SBIRT sites to implement universal SBIRT practices;
- Provide training and technical assistance to SBIRT sites to integrate SBIRT procedures into routine service delivery and ensure staff ability to provide SBIRT services with fidelity; and
- Ensure the availability of assessment and referral resources for individuals requiring specialty services.

STRATEGIC OUTCOMES

- **Increase in the number of settings incorporating Screening, Brief Intervention and Referral to Treatment (SBIRT) into their service delivery practices.**
- **Increase in the early identification of and intervention with individuals experiencing problems related to the use of alcohol, tobacco or other drugs.**
- **Increase in self-referrals to the alcohol, tobacco and other drug service delivery system.**
- **Long-term decrease in the need and demand for treatment services for substance use disorders.**

GOAL 3

Coordinate, communicate and collaborate across departments, HHS Divisions and community partners to ensure the provision of comprehensive and integrated evidence-based services and strategies for clients and communities.

INITIATIVES

- Increase the capacity of Division-funded contractors, HHS Divisions, County Departments and community partners to deliver comprehensive and integrated evidence-based services for individuals, families and communities.
- Engage communities to identify and implement comprehensive evidence-based strategies that address alcohol, tobacco and other drug issues among universal, selective and indicated populations.

KEY ACTIVITIES

- Engage HHS Divisions, County Departments and community partners that interface with clients at-risk of or with alcohol, tobacco or other drug issues;
- Assess system and staff capacity to implement evidence-based practices for serving clients with a full spectrum co-occurring conditions;
- Identify high-need, high-cost and shared clients and strategic opportunities to collaborate and integrate services;
- Implement policies and practices that enhance access to integrated services;
- Provide training and technical assistance to implement evidence-based strategies, standards and practices and enhance staff capacity to deliver individualized services for clients with complex and multiple co-occurring conditions;
- Allocate funding to three community coalitions and one county-wide coalition to address relevant and emerging alcohol, tobacco and other drug issues;
- Engage stakeholders to form coalitions/groups with diverse sectors of the community; and
- Train coalitions/groups to identify relevant alcohol, tobacco and other drug issues and implement evidence-based strategies to address the issues.

STRATEGIC OUTCOMES

- **Increase in strategic collaboration between HHS Divisions, County Departments and community partners.**
- **Increase in the capacity of system partners to implement evidence-based practices to effectively serve clients.**
- **Increased in integrated treatment planning and information sharing between HHS Divisions.**
- **Increase in clients receiving comprehensive services aligned with their individual needs.**
- **Improved outcomes for clients engaged in the alcohol, tobacco and other drug service delivery system.**
- **Increase in knowledge among partner providers regarding availability and eligibility of services.**
- **Increase in communities using evidence-based strategies to address specific local alcohol, tobacco and other drug issues.**

GOAL 4

Leverage alternative resources to maximize the availability and diversity of available services.

INITIATIVE

- Seek new and leverage existing resources and partnerships in order to provide a comprehensive and integrated continuum of alcohol, tobacco and other drug services.

KEY ACTIVITIES

- Analyze available funding streams and allocate resources via Requests for Proposals, interdepartmental agreements, and annual provider allocations to maximize coordinated and evidence-based service delivery;
- Develop formal agreements and procedures with County Departments, HHS Divisions and community partners to provide reciprocal access to ancillary and specialty treatment services;
- Train County Departments, HHS Divisions and community partners to increase their capacity to internally serve clients with alcohol, tobacco and other drug issues;
- Train service providers to leverage new and existing funding streams, such as submitting grants, billing insurance, accessing Drug/Medi-Cal, collecting client fees and engaging in fundraising;
- Review and analyze policies and legislation that affect resources for alcohol, tobacco and other drug services; and
- Provide technical assistance to communities to implement policies that leverage resources for alcohol, tobacco and other drug services, such as policies that mitigate the costs of harm caused by alcohol.

STRATEGIC OUTCOMES

- **Increase in identifying, preparing and applying for grants.**
- **Increase in resources dedicated to preventing and addressing alcohol, tobacco and other drug issues.**
- **Increase in the amount and quality of evidence-based prevention, intervention, treatment and recovery services.**
- **Decrease costs to local communities and system partners to address problems related to the use of alcohol, tobacco and other drugs.**
- **Long-term decrease in the need and demand for treatment services for substance use disorders.**

GOAL 5

Deliver services in a manner that is consistent with a continuum of care and chronic relapsing disease model and are tailored to specific client needs and considerations, such as economic status, gender, age, language, sexual orientation, geographic, racial, cultural, legal and other situational issues.

INITIATIVE

- Re-allocate and leverage resources to implement a comprehensive, individualized and integrated evidence-based continuum of care ranging from prevention and early intervention to treatment and recovery support services.

KEY ACTIVITIES

- Develop formal agreements and procedures with County Departments, HHS Divisions and community partners to provide integrated services and reciprocal access to ancillary and specialty treatment services;
- Train County Departments, HHS Divisions and community partners to increase their capacity to internally serve clients with alcohol, tobacco and other drug issues;
- Ensure that providers are trained to deliver evidence-based services with fidelity;
- Provide technical assistance to contracted providers to ensure successful implementation of and adherence to the Division's standards and practices for service delivery;
- Re-allocate funding to new initiatives that are in alignment with the Strategic Plan, including: 1) Establishing Community Coalitions to address community-specific alcohol, tobacco and other drug issues; 2) Media and Public Relations services; 3) Centralized Assessment/Care Management services; 4) Outpatient Services for the Safety Net, Justice and General populations; and 5) SBIRT for youth settings;
- Maintain services including Residential treatment, Narcotic Replacement Therapy and Detoxification services; and
- Leverage partnerships and technical assistance resources to ensure access to ancillary services and build a peer-driven recovery-oriented system of care.

STRATEGIC OUTCOMES

- **Increase in implementation of evidence-based practices with fidelity.**
- **Increase in providers' ability to provide individualized services that match client needs, such as being culturally and co-occurring competent, gender-specific, and trauma-informed.**
- **Increase in clients receiving integrated, comprehensive high-quality services aligned with their individual needs.**
- **Increase in clients moving seamlessly through the continuum of services.**
- **Increase in client engagement and retention in services.**
- **Increase in successful outcomes for clients engaged in the alcohol, tobacco and other drug service delivery system, such as abstaining from substance use, securing stable housing and employment, accessing primary health care and engaging in recovery support services.**

GOAL 6

Support implementation of and consistent adherence to laws, policies, standards and practices that prevent and reduce alcohol, tobacco and other drug problems.

INITIATIVE:

- Engage three Community Coalitions, a County-Wide Coalition and the Smoke-Free Marin Coalition to support implementation and enforcement of at least 12 policies that reduce alcohol, tobacco and other drug problems.
- Adopt and implement standards and practices for contracted services to ensure the design delivery of evidence-based prevention, intervention, treatment and recovery support strategies and services.

KEY ACTIVITIES

- Allocate funding to form three community coalitions and a county-wide coalition that address community-specific and emerging alcohol, tobacco and other drug issues;
- Provide training and technical assistance to the coalitions on using data to identify relevant community problems, and evidence-based strategies, including policy, media and enforcement, to address the issues;
- Develop and implement institutional and/or municipal alcohol, tobacco and other drug policies;
- Enforce existing and new alcohol, tobacco and other drug laws and policies;
- Develop and distribute to Division-funded service providers programmatic and administrative standards and practices for contracted services;
- Provide technical assistance and trainings to providers to ensure successful implementation and adherence to the standards and practices; and
- Monitor adherence to the standards and practices and assess fidelity with evidence-based program designs annually.

STRATEGIC OUTCOMES

- **Prevent the illegal use of alcohol, tobacco and other drugs and related community problems.**
- **Increase in enforcement of existing laws and policies.**
- **Increase in implementation of effective policies to prevent and address problems associated with the use of alcohol, tobacco and other drugs.**
- **Decrease in alcohol, tobacco and other drug-related problems, such as crime, injury and violation of other laws, including youth access to alcohol and tobacco, and driving after drinking.**

GOAL 7

Collect and report data on the alcohol, tobacco and other drug system of care.

INITIATIVE

- Establish and utilize a data collection system that demonstrates client and community-specific needs and accurately reflects a continuum of care and public health model.

KEY ACTIVITIES

- Evaluate the current system and needs and identify key indicators for data collection;
- Establish measures and methods of data collection for key indicators;
- Implement data quality standards and procedures for contracted services;
- Provide training and technical assistance to contracted providers and communities to enhance quality data collection; and
- Analyze data and develop and disseminate fact sheets and annual reports to demonstrate community needs, articulate client outcomes, inform program design and service delivery, and determine resource allocation.

STRATEGIC OUTCOMES

- **Increase in the number of measures being collected that reflect a chronic disease model.**
- **Increase in the availability of quality community-specific alcohol, tobacco and other drug-related data.**
- **Increase in programs developing logic models and implementing and evaluating programs in accordance with the models.**
- **Increase in the collection and reporting on program-specific outcome measures.**
- **Increase in the ability to evaluate the effectiveness of interventions and make successful adaptations to deliver the highest quality of services available.**
- **Increase in the use of data to inform policy and funding decisions.**

Shifting How We Do Business:

Policies, Procedures, Standards and Practices

As part of Strategic Plan implementation, the Division of Alcohol, Drug, and Tobacco Programs issued *Policies, Procedures, Standards and Practices* that shall guide service delivery for contracted provider services for the next five years. The policies, procedures, standards and practices are a compilation of: **1)** New policies and practices recommended during the Division's Strategic Planning Process; **2)** Existing policies and procedures implemented by the Division of Alcohol, Drug and Tobacco Programs over the past decade; **3)** Existing state and national regulations, standards and practices, such as the California Department of Alcohol and Drug Programs' Certification Standards and the *National Quality Forum's National Voluntary Consensus Standards for the Treatment of Substance Use Conditions;* and **4)** Recommendations from the Alcohol, Tobacco and Other Drug Contracted Provider network.

In addition to requiring agencies that provide Division-funded prevention, intervention, treatment and recovery services for alcohol, tobacco and other drug issues to comply with all applicable standards, laws and requirements, key themes for service delivery include:

- **Services and Strategies are Evidence-Based:** Agencies providing prevention, early intervention, treatment and recovery services shall utilize evidence-based, culturally relevant strategies and assess fidelity with the program design at least annually.
- **Co-Occurring Competency and Integrated Treatment are the Expectation:** Agencies providing substance use treatment services shall be competent to provide services for clients with co-occurring disorders, as evidenced by the Dual Diagnosis Capability in Addiction Treatment (DDCAT) or COMPASS-EZ Assessment score. Clients with co-occurring substance use and mental health disorders shall be treated by individuals, teams or programs with expertise in co-occurring disorders. Further, each disorder shall be considered as primary and integrated treatment shall be provided.
- **Clients with Multiple Co-occurring Conditions—Including Substance Use, Mental Health and Primary Health Care Issues — Are the Expectation, so Clients Shall Receive Individualized and Comprehensive Services:** Agencies shall actively link clients with appropriate recovery support services, as well as with ancillary resources such as housing assistance, vocational training, and primary healthcare.
- **Addressing Substance Use Disorders Requires a Long Term Recovery Management Approach:** All clients receiving treatment for substance use disorders shall receive post treatment monitoring and support. Support and monitoring can occur through periodic telephone contacts, participation in recovery support groups, or other appropriate activities. Agencies shall be responsible for following-up with the client thirty (30) days after discharge. Care Management shall also follow-up with clients at 3 months, 6 months and 1 year post discharge from a level of service to assess client progress and provide linkages to recovery support services as needed.
- **Resources are Leveraged to Maximize Comprehensive Service Delivery:** Agencies shall be certified or in the application for certification process to provide Drug/Medi-Cal services, as applicable, including Minor Consent services for agencies serving adolescents. Agencies are encouraged to access and leverage alternate funding streams to maximize the availability of services, such as private insurance, grants and donations.
- **Service Systems Shall Engage in Continuous Quality Improvement Efforts:** Agencies providing treatment services for substance use disorders shall conduct at least one NIATx Change Project per contract year. Agencies/individuals shall engage in regular evaluation activities, including coordinating with the Independent Evaluator and relevant contract management staff, to assess progress in achieving the desired outcomes and identify the need for course corrections if necessary.

Evaluation

The Division of Alcohol, Drug and Tobacco Programs is contracting with an independent evaluator to assist with developing the overall system to track and report on strategic outcomes, conduct an annual independent evaluation and provide technical assistance and training to project partners. The Strategic Plan Evaluation Plan and annual evaluation reports will be available on the County website.

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For additional information or copies of Strategic Plan documents, please contact the Marin County Department of Health and Human Services, Division of Alcohol, Drug and Tobacco Programs at **www.co.marin.ca.us/adtp** or 415.473.3030

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Continuum of Alcohol, Tobacco *and* Other Drug Services Strategic Plan

Highlights 2010-2015

Marin County Department of Health & Human Services • Division of Alcohol, Drug and Tobacco Programs

The Eight Steps to Effective Coalition Building

Prevention Institute
Putting prevention at the center of community well-being

THE EIGHT STEPS TO EFFECTIVE COALITION BUILDING

Increasingly, the problems that communities need to resolve are complex, requiring comprehensive solutions. Addressing issues such as health promotion and chronic disease prevention requires the inclusion of people from diverse backgrounds and disciplines. Work in partnerships, collaborations and coalitions can be challenging but a powerful tool for mobilizing individuals to action, bringing community issues to prominence and developing policies. These associations are also an effective means of integrating health services with other human services so that resources are not wasted and efforts are not needlessly duplicated. Coalitions are often best equipped to utilize the resources and findings of participants and apply them more effectively than any single group or organization.

The Eight Steps to Effective Coalition Building is a framework developed by Larry Cohen, et. al., for engaging individuals, organizations and governmental partners invested in addressing community concerns. The complete document (available at www.preventioninstitute.org) offers concrete steps towards building effective partnerships and provides tips for making collaborations and partnerships work. Rather than creating new projects or programs, effective coalitions can harness existing resources to develop a unique community approach and achieve results beyond the scope of one single institution or organization.

1. Discuss and analyze the group's objectives and determine coalition need(s)

A coalition is a prevention *tool*, so groups must be specific about what needs to be accomplished. After the needs have been determined, the group must consider if a coalition is the best approach to meet the identified needs. Groups must ask the following questions: What are we trying to accomplish? What are our community's strengths and needs? What are the pros and cons associated with the proposed collaboration? What are our objectives and what types of activities seem logical? Cohen suggests using the *Spectrum of Prevention* to help define a group's possible actions.

2. Recruit the right people

The group's objectives will prescribe the type of coalition developed. Some groups may choose to start small to accomplish specific tasks and then strategically expand. Depending on the needs of the coalition, either program directors or front-line staff should be encouraged to attend. In addition, invite community members, youth leaders, and politicians. The size of the group matters. It takes large groups longer to define and agree on common objectives and activities. Yet large groups may have access to greater resources that may be required for accomplishing certain tasks.

265 29th Street
Oakland, CA 94611
510.444.7738
fax 510.663.1280

www.preventioninstitute.org

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3. Adopt more detailed activities and objectives suiting the needs, interests, strengths, and diversity of the membership

A key to a successful coalition is the early identification of common goals and benefits of working together. The coalition must avoid competing with its members for funding. An important consideration for adopting specific coalition activities is to identify some short-term outcomes. For example, if a coalition's objective is to increase public knowledge about chronic disease as a preventable community problem, a short-term outcome could be the publication of two editorials in the local newspaper.

4. Convene coalition members

A coalition can be convened at a meeting, workshop, or conference. The lead agency should plan the first meeting using a time-specific prepared agenda, a comfortable and well-located meeting area, and adequate refreshments. It is appropriate to prepare a draft mission statement and proposal for coalition structure and membership. Anticipate that not all invited members will become coalition members.

5. Develop budgets and map agency resources and needs

Lead agencies usually provide staff time to keep the coalition up and running and to handle detail work. Though coalitions can usually run on a minimal budget, each member's time is a valuable contribution.

6. Devise the coalition's structure

Structural issues of the coalition include: how long the coalition will exist, meeting locations, meeting frequency and length, decision making processes, meeting agendas, membership rules, and participation between meetings by subcommittees or planning groups. Templates of different coalition structures should be collected prior to the meeting and presented for discussion to reduce the time needed to make management decisions.

7. Plan for ensuring the coalition's vitality

Methods for noting and addressing problems, sharing leadership, recruiting new members, providing training on identified needs, and celebrating success can help ensure a coalition's viability and success. It is very important to recognize both the individual and organizational contributions to a coalition each step of the way.

8. Evaluate programs and improve as necessary

Each coalition activity and event should include evaluations. This can be as simple as a satisfaction survey or it could be the more formal use of pre- and post-tests of specific subject knowledge.

265 29th Street
Oakland, CA 94611
510.444.7738
fax 510.663.1280
www.preventioninstitute.org

The full document, *Developing Effective Coalitions: An Eight-Step Guide*, written by Larry Cohen, Nancy Baer and Pam Satterwhite is available at: www.preventioninstitute.org

Community Advisory Board (CAB)

SHARED ACTION

SHARED ACTION HD

Community Advisory Board (CAB) for an HIV Prevention Program

What is a Community Advisory Board?

A Community Advisory Board (CAB) is a select group of community members who provide recommendations regarding HIV prevention programs. A CAB can help by advising organizations on the needs of the communities they serve as well as assist in identifying appropriate programs to help meet those needs. This group of individuals can also provide input at various levels of a program's process (e.g., designing and implementing services, recruitment and retention of clients). The main role of a CAB is to provide their expertise and guidance based on the group's knowledge and experience. However, a CAB cannot tell an agency how to run their programs.

What are the purposes of a CAB?

The main purpose of a CAB is to serve as a bridge between a program's goals and the community. This group can also serve several purposes including but not limited to:

Purposes of a Cab

Raising awareness on community issues and/or current hot topics in HIV prevention to program staff.

Identify necessary cultural adaptations in relation to the specific target community.

Assist in selecting appropriate HIV prevention programs for the target population.

Provide feedback on projects.

Make suggestions for modifications to programs during the pre-implementation phase

Who should be included in a CAB?

Typically, a CAB consists of 10-15 people; however, this may vary depending on the scope of the program and an agency's needs. Members of a CAB must possess appropriate knowledge and insight about communities infected and affected by HIV/AIDS. The CAB should be diverse and include representatives from different regions of the target area as well as have experience in the CAB process.

The goal of the CAB will determine who should be included on the board. Potential members could be persons living with and affected by HIV/AIDS, representatives from the private sector, local and state health departments, community-based organizations (CBOs), AIDS service organizations, educational institutions, advocates or others working or volunteering in the HIV/AIDS field.

Questions that may help guide in identifying and selecting CAB memebers include:

(1) How to identify the community, and

(2) Who speaks for the community?

How to identify CAB members

Recruitment is fluid and ongoing, allowing new members join as attrition occurs. Several ways to identify appropriate CAB members can include conducting key informant interviews to identify leaders or gatekeepers in the community, attending key community meetings to identify appropriate members, consulting with colleagues or co-workers regarding individuals who might be good candidates for CAB members, or approaching individuals that have served on previous CABs.

Should there be a CAB orientation?

It is highly encouraged that CAB members receive an orientation and background materials prior to the first meeting. A CAB orientation may help to bring all members up-to-date on HIV 101, clarify their responsibilities, and explain meeting commitments. These factors are important in making sure the group is as consistent as possible during the working year.

Is it necessary to provide compensation and or incentives?

Compensation and incentives are not mandatory. If incentives are given, these will be constrained by what the budget and the program funder will allow.

What are the benefits of participating in a CAB?

Some benefits for the CAB members may include:

- Learning more about the impact of HIV/AIDS on their community
- Sharing personal experiences
- Learning about other agencies and their practices
- Increasing knowledge about HIV/AIDS
- Influencing policies
- Validating the legitimacy of a new program
- Adding meaningful contribution to their community
- Receiving incentives

Although CAB members will more likely participate if they are compensated, it should be noted that they may be less likely to provide critical feedback because of the pressure that you are paying them. If an agency cannot provide traditional incentives, to its CAB then providing certificates for their participation, "official" CAB badges, acknowledgments in newsletters, or conducting activities to honor and show appreciation for their effort and expertise.

How many times should a CAB meet?

The frequency of CAB meetings can depend on several factors:

1. The availability and locations of the CAB members can affect how frequent meetings are to occur. If the CAB consists of experts from around the country, it will take a lot of coordination to get them all in the same place at the same time.
2. The timeline of the project may also dictate when the CAB meets. Funding sources may state that a "CAB must convene at least 4 times a year." Alternatively, a CAB meeting may be necessary before certain milestones are completed.
3. Funds available to run a CAB may also affect how often a CAB can meet since staff effort is required to coordinate the meetings and funds are needed to cover compensations and incentives.

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Collaboration Multiplier

COLLABORATION MULTIPLIER

Enhancing the Effectiveness of Multi-Field Collaboration

Collaboration Multiplier is an interactive tool for strengthening collaborative efforts across diverse fields. A multi-field approach has proven vital for tackling today's complex social challenges. Whether the goal is promoting health equity, strengthening local economies, reducing greenhouse gas emissions, or enhancing community safety, improving our well-being requires community-wide changes that include strengthening government policies and the practices of key organizations. Multi-field collaboration expands available resources, strategies, and capabilities to achieve outcomes that could not be accomplished by one field alone.

Collaboration Multiplier provides a systematic approach to laying the groundwork for multi-field collaboration. The tool guides organizations through a collaborative discussion to identify activities that accomplish a common goal, delineate each partner's perspective and potential contributions, and leverage expertise and resources. *Collaboration Multiplier* is based on the understanding that different groups and sectors have different views of an issue and different reasons for engaging in a joint effort. For example, a collaborative formed to increase access to healthy food in underserved neighborhoods can more effectively engage partners by recognizing that each has their own goals. A grocery store operator might expand fresh food offerings to enhance sales and profits, a health department would support the effort to improve health, and the Mayor might see enhanced food retail as fundamental for a flourishing community. *Collaboration Multiplier* helps surface these perspectives and forge strategies that advance their objectives simultaneously.

Collaboration Multiplier can be used in different stages of collaboration. It can be used by a newly formed or established partnership that wants to strengthen its collective effort, or it can be used by an individual or small set of organizations that recognize the value of a diverse partnership and want to think strategically about whom to invite to the table.

The Collaboration Multiplier Process

Collaboration Multiplier occurs in two phases: 1) Information Gathering and 2) Collaboration Multiplier Analysis

In the first phase, the key sectors and fields that can contribute to a solution are identified. Then key information from the *perspective of each field* (or prospective field) is collected according to a common set of categories. Specific categories vary based on the particular collaboration, but typical examples include:

- **Importance:** Why is this issue important?
- **Organizational Goals:** What are the goals related to this issue?
- **Audience:** Who is the primary audience/ constituency?
- **Expertise:** What unique expertise does this field bring to the collaborative?

Partner	Importance	Organizational Goals	Expertise	Assets & Strengths	Key Strategies	Desired Outcomes	Partnership	Organizational Benefit

- **Assets/Strengths:** What resources (skills, staff, training capacity, funding) can be brought to the table?
- **Key Strategies:** What key strategies/ activities are currently implemented relevant to this issue?
- **Desired Outcomes:** What specific results/outcomes are desired as a result of this collaboration? What does success look like?
- **Data:** What data is collected, and how?
- **Partnership:** Which partners/participants can be brought to the table to enhance outcomes?
- **Organizational Benefit:** What is the benefit of participating in this collaborative?

Compiling this information can provide a "big picture" snapshot for partners and lays the groundwork for a collaborative discussion.

In the next phase, the collaborative engages in a "collaboration multiplier analysis" to discuss the implications based on the information collected. Some key areas of discussion can include:

- What partner strengths can the collaborative utilize? How do you leverage each partner's expertise?
- What results and outcomes can be achieved together?
- What strategies/activities can two or three partners work together on?

Collaboration Multiplier serves as a starting point for appreciating what different fields can bring to the table and for building effective interdisciplinary efforts through partnership. After completing the two-phase process, partners can begin developing a comprehensive strategy to achieve their shared vision. To support strategic efforts, *Collaboration Multiplier* is designed to complement and inform Prevention Institute's *Spectrum of Prevention,* a tool for developing multifaceted activities for effective prevention, and *The Eight Steps to Effective Coalition Building,* a step-by-step guide for coalition development and sustainability. Effective collaboration can be a powerful force for mobilizing individuals to action, bringing health and safety issues to prominence, forging joint solutions, and developing effective policies. By working through *Collaboration Multiplier*, partners will see the fruits of their efforts grow exponentially.

For more information, visit Prevention Institute's website at www.preventioninstitute.org or e-mail virginia@preventioninstitute.org.

Collaboration Multiplier Example: Traffic Safety Coalition

Goal: Decrease traffic-related crashes and fatalities
Phase I: Information Gathering

(This is a sample; expected levels of detail would be greater)

	Expertise	Desired Outcomes	Strategies
Public Health	Population-based prevention approaches and data collection of injury rates	Reduce unintentional injuries among all travelers, including drivers, pedestrians, bicyclists, disabled, elderly	Facilitate environmental and policy changes (i.e., pedestrian/ bicycle-friendly street design, car seats, seat belts, driving under the influence, bicycle helmets)
Law Enforcement	Expertise in legal requirements and crash investigations and has the authority to enforce traffic laws	Increase compliance to traffic safety laws	Enforce traffic laws, patrol neighborhoods, implement check points, cite reckless drives, and participate in educational campaigns
Transportation Engineering	Road and sidewalk design that provides safe travel for multiple modes of transportation	Prevent traffic crashes and reduce severity of injuries if a crash occurs	Promote safety regulations for occupants and vehicles n Implement street designs that promote safety
Optometry	Understanding of how people visualize traffic signs and signals	• Improve vehicle displays, traffic signals, and road signage • Better driver assessment for licensing purposes	Utilize color and design features to increase driver attention to traffic signals and signs

Phase II: Collaboration Multiplier Analysis

Public Health

Expertise:
Population-based prevention approaches and data collection of injury rates

Desired Outcomes:
Reduce unintentional injuries among all travelers, including drivers, pedestrians, bicyclists, people with disabilities, elderly

Key Strategies:
Facilitate environmental and policy changes (i.e., pedestrian/bicycle-friendly street design, car seats, seat belts, DUI, bicycle helmets)

Law Enforcement

Expertise:
Expertise in legal requirements and crash investigations and has the authority to enforce traffic laws

Desired Outcomes:
Increased compliance to traffic safety laws

Key Strategies:
Enforce traffic laws, patrol neighborhoods, implement check points, cite reckless drivers, and participate in educational campaigns

Shared Outcomes

- Improved transportation infrastructure and systems
- Ability for motorists, bicyclists, pedestrians, people with disabilities, and elderly to travel easily and safely
- Decrease in traffic-related injuries and deaths

Partner Strengths

- Subject matter expertise
- Authority and ability to implement policies and environmental changes
- Understanding of motor vehicle patterns and individual transportation behaviors
- Knowledge of street and vehicle design

Joint Strategies/Activities

- Incorporate health and safety elements into transportation planning
- Promote complete streets policies
- Connect roadways to complementary systems of trails and bike paths
- Implement smart growth strategies, including transit-oriented developments

Transportation Engineering

Expertise:
Road and sidewalk design that provides safe travel for multiple modes of transportation

Desired Outcomes:
Prevent traffic crashes and reduce severity of injuries if a crash does occur

Key Strategies:

- Promote safety regulations for occupants and vehicles
- Implement street designs that promote safety (e.g., traffic calming)

Optometry

Expertise:
Understanding of how people visualize traffic signs and signals

Desired Outcomes:

- Improved vehicle displays, traffic signals, and road signage
- Better driver assessment for licensing purposes

Key Strategies:
Utilize color and design features to increase driver attention to traffic signals and signs

Collaboration Math

COLLABORATION MATH:
Enhancing the Effectiveness of Multidisciplinary Collaboration

221 Oak Street
Oakland, CA 94607
510.444.7738
fax 510.663.1280
www.preventioninstitute.org

Prevention Institute
Prevention and equity at the center of community well-being

COLLABORATION MATH:
Enhancing the Effectiveness of Multidisciplinary Collaboration

Applying Collaboration Math to the U.C. Berkeley Traffic Safety Center—A Case Study

This document was prepared by Prevention Institute with funding from the U.C. Berkeley Traffic Safety Center through the California Office of Traffic Safety. Principle authors are:

Larry Cohen, MSW

Manal J. Aboelata, MPH

Toni Gantz

Jennifer Van Wert

This paper applies *Collaboration Math* to the U.C. Berkeley Traffic Safety Center (TSC) (www.tsc.berkely.edu). Their mission is to reduce traffic fatalities and injuries through multi-disciplinary collaboration in education; research; and outreach. A main goal of the Center is to strengthen the capability of government, academic institutions and local community organizations to enhance traffic safety.

Prevention Institute is a non-profit, national center dedicated to improving community health and well-being by building momentum for effective primary prevention. Primary prevention means taking action to build resilience and to prevent problems before they occur. The Institute's work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Since its founding in 1997, the organization has focused on traffic safety, injury and violence prevention, health disparities, nutrition and physical activity, and youth development. This, and other Prevention Institute documents, are available at no cost on our website.

221 Oak Street
Oakland, CA 94607
510.444.7738
fax 510.663.1280
www.preventioninstitute.org

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Setting New Directions in Traffic Safety

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INTRODUCTION

Reducing the toll of traffic-related injuries requires a concerted effort, calling on the resources, commitment and expertise of diverse agencies, professionals and community members.[1,2] Traffic safety is affected by numerous aspects of community life such as how neighborhoods are designed, how fast cars travel and how safe people feel walking or driving to key destinations. Preventing traffic-related injury is a responsibility shared by many. As evidenced by many federal, state and local efforts, partnerships, coalitions and networks have become common ways to address the incidence of traffic crashes, fatalities and other injuries.

The purpose of this paper is to describe *Collaboration Math,* a tool developed to help individuals and groups representing different disciplines, organizations or constituencies work together effectively. This practical tool was designed to make key differences and similarities within groups explicit, so that they are more likely to succeed in the challenging work of building and sustaining collaborations. In 2002, the Traffic Safety Center (TSC) at the University of California, Berkeley worked with *Collaboration Math* and this paper highlights the process for using the tool by providing specific examples from the TSC.

The mission of the TSC is "to reduce traffic fatalities and injuries through multidisciplinary collaboration in education, research and outreach." Participants of the TSC represent disciplines of public health, engineering, transportation studies and optometry and include the Institute of Transportation Studies, UC Berkeley's Schools of Public Health and Optometry, Partners for Advanced Transit and Highways (PATH), the Technology Transfer Program, Prevention Institute, and the Prevention Research Center. The California Office of Traffic Safety, through the Business, Transportation and Housing Agency is the primary funder of the TSC. Prevention Institute worked with members of the TSC to apply *Collaboration Math* with the goal of supporting and enhancing the group's multidisciplinary approach.

> *"...The determinants of health are beyond the capacity of any one practitioner or discipline to manage....We must collaborate to survive, as disciplines and as professionals attempting to help our communities and each other."*
>
> INSTITUTE OF MEDICINE[3]

WHY COLLABORATE?

Injuries remain the leading cause of death for Americans ages 1-34,[4] and disproportionately affect rural, low-income and youth of color.[5,6] Traffic-related injuries represent the largest proportion of injuries and involve a complex set of issues. No one organization possesses all of the resources, knowledge, or political will to identify and implement the range of effective countermeasures or prevention strategies needed to prevent traffic-related injuries. Addressing issues such as neighborhood design (do pedestrians have to cross high speed thoroughfares?); availability of products (are child passenger safety seats affordable?); access to services (are quality emergency services accessible?); and safety (do people feel safe? How much do injuries affect the community?) requires multiple partners and multi-faceted solutions.

Addressing issues such as neighborhood design; availability of products; access to services; and safety requires multiple partners and multi-faceted solutions.

Collaborations provide the opportunity to generate broad-based support to improve traffic safety and prevent injuries. Collaborations can create a forum for research institutions, grassroots organizations, community members, government agencies and other participants to cooperate, share information and resources and minimize reinventing the wheel.[7] The Institute of Medicine's landmark publication, *Reducing the Burden of Injury: Advancing Prevention and Treatment* underscores the value of collaboration in injury prevention: "To increase the impact and reach of injury prevention programs and to maximize the expertise and resources available, injury prevention and safety professionals have to expand collaborative activities and work together."[8]

Budgetary constraints may also provide the impetus for effective, purposeful collaborations. When fiscal challenges arise, the need to conserve resources, reduce unnecessary duplication of services, and achieve greater reach in a given community becomes even more pressing than in times of surplus. When state dollars for transportation, health, education and safety are all shrinking, shared approaches that are presented as a common cause have greater credibility to funders. When issues are presented by multiple interests, they can reach broader constituencies and as a result, may have greater success in communities and bureaucracies.[9]

Effective collaboratives that represent diverse agencies may also be more appealing to funders. Increasingly, federal and state funders are looking to support groups that represent multiple sectors (e.g., schools, health departments and community members) or multiple disciplines (e.g., law enforcement, health services, and city planners). Collaborations that are up and

EXAMPLE: OLDER ADULT MOBILITY

Developing safe intersections for senior pedestrians is a traffic safety issue best addressed with input from diverse disciplines. An effective and lasting solution to traffic safety for elders does not lie with any single organization.

Public health, optometry and human bio-dynamics research can inform planners and engineers about danger zones for older pedestrians, older adults' behaviors and their needs related to mobility. Transportation engineers can then develop longer crossing signals and city planners can ensure that traffic islands, larger and more visible signs, and attractive, safe resting stops are placed near intersections and along sidewalks. By tapping each other's expertise, professionals can improve traffic safety utilizing a more integrated approach. The likelihood that changes to the streets will be accepted by local constituents is enhanced greatly if proposed approaches are advanced and promoted by a community collaborative. Needless to say, it is not simple to figure out all of the key players interested in and capable of reducing pedestrian injuries to the elderly. At the same time, unless all potential stakeholders are engaged, it is likely that the full range of approaches and possible solutions will not emerge. On Queens Boulevard in New York City such an effort was developed. There were numerous deaths and injuries on this street and investigation revealed they were largely occurring among seniors. Further study showed those who had impaired mobility didn't have enough time to get across the streets. The signal timing was changed and the center islands were expanded. Deaths and serious injuries plummeted.[10]

running are best situated to respond to requests for proposals quickly. Existing collaborations are also more likely to present a cohesive structure and demonstrate to funders a history of effectively working together.

Innovations in data sharing, public-private sector partnerships and new legislation often result from diverse groups and agencies working together. Strategic collaborations can bring together individuals and organization with distinct, but complementary skills that allow the collaboration as a whole to use resources effectively, to advance research and practice and to use systems thinking to understand common problems and develop shared solutions.

COLLABORATION MATH: A TOOL FOR MULTIDISCIPLINARY COLLABORATIONS

Successful collaborations require developing a working knowledge of how other agencies (or disciplines) think, function and define success. Mandates, problem definitions, data sources, and stakeholders are likely to be different, especially when working across disciplines. *Collaboration Math* was designed to aid multidisciplinary groups and it can also be used to facilitate collaboration between similar organizations, such as multiple school districts, or agencies within a public health department. Specifically, *Collaboration Math* helps multidisciplinary groups:

- Identify common and divergent approaches and goals
- Better understand each other's perspectives
- Take stock of individual and collective resources
- Identify what (or who) is missing
- Forge comprehensive approaches and joint solutions
- Clarify how people from each discipline view and approach the issue
- Avoid the assumption that people from different disciplines think the same (or even similarly) about the issue
- Avoid incorrect assumptions about shared language or perceptions
- Orient new collaborative members to the breadth and depth of the organization
- Distinguish the added value and role of additional disciplines that join the group

Collaboration Math provides a structure for deepening a group's understanding of its own anatomy—starting with the basics, such as, "Who is 'at the table'?", "What resources do they bring?" and "How do they envision their role in developing solutions?"

Collaboration Math illustrates the range of strategies, solutions, and outcomes that each participating group uses and can help diverse groups combine their various definitions, goals, and strategies through such processes as *averaging* definitions, *adding* data sources, *multiplying* training efforts, and *averaging* solutions. The remainder of this document describes the tool and its application at the TSC.

Collaboration Math is designed to eliminate misconceptions, clarify the benefits of collaboration and suggest what needs to be better understood or studied.

HOW COLLABORATION MATH WORKS

Collaboration Math uses a matrix in which each collaborative member provides key information according to a common set of categories (See below).

SAMPLE COLLABORATION MATH MATRIX (PARTIAL)

	Problem Definition	Key Issues	Data	Funding	Training	Partners	Approaches/ Outcomes
Group A							
Group B							
Group C							
Implications							

A representative from each group or discipline should provide the information in each category as it pertains to his/her agency or discipline. The representative will fill in the row moving from left to right, starting with the name of his/her discipline in the far left column of the table (listed as Group A, B, C above). All of the information from each discipline should be filled in or transcribed onto one table. Once the information is compiled, a facilitator can work with the group to compute the "math." Because the process can be rather complex and the tool is still new, a facilitator who is familiar with the tool and skilled in its application can provide guidance and encourage groups to give candid answers. The facilitator can address any unanswered questions related to the tool and can help provide guidelines that may be useful to the group.

Specific matrix categories can vary based on the particular collaboration; however, suggested, useful categories are:

Problem Definition

How does each participant define the issues? What language do participants use to define the issues?

Key Issues

What are each participant's priority areas related to the issues?

Data/Evidence

What information does each participant collect, and how? What is the information to which each reacts with concern? What evidence affirms that efforts are succeeding?

Funding

What funding sources or other resources does each participant bring?

Training

What expertise can each participant share with other participants? Who does each participant typically train? From whom does each participant receive training?

Partners

To what other types of groups is each participant connected? In what other networks do partners participate?

Approaches/Outcomes

What specific results is each participant seeking?

The information entered in the matrix provides the raw material for a discussion of implications. Use of the matrix allows collaborators to see the 'big picture' and lays the groundwork for an organized discussion of the implications of the table's contents. The following paragraphs discuss types of *Collaboration Math* that can be applied to the different columns as viewed by the TSC.

The Collaboration Math matrix allows people to see the 'big picture' and lays the groundwork for an organizational discussion.

Entries in the **PROBLEM DEFINITION** column can be *averaged* to arrive at a common way of defining and speaking about the problem at hand. The shared definition usually represents an agreed upon description that the entire group can utilize. Technical terms should be discussed thoroughly, as sometimes the same word may hold different meanings for different disciplines. For example, traffic engineers and police officers both use the term "warrants" differently. The police officer issues warrants to make arrests, but to a traffic engineer a warrant is the guideline needed to put a traffic safety device in place.

KEY ISSUES help characterize the main elements of work for each discipline and describe how different members of a collaborative think about the topic at hand. For example, some of the key concerns of optometry representatives of the TSC might be issues like signage and headlight illumination whereas law enforcement or health representatives might focus on a topic like driving under the influence (DUI). To identify the group's key issues, the facilitator may *average* the information in the Key Issues column to arrive at a common set of concerns.

Information in the **DATA** column should represent data regularly used by the members rather than data each discipline is responsible for collecting. This may reveal some levels of collaboration that are already taking place. For example, public health professionals working in traffic safety regularly use Fatality Accident Reporting System (FARS) data. Although FARS data is collected by the National Highway Traffic Safety Administration—not public health departments—a public health professional may include FARS among the list of data sources used by public health. Once filled in, the Data column provides a foundation for better understanding the existing data sources used by each group, those that are potentially available to the group as a whole, and also sheds light on the key indicators that each discipline relies on to measure impact and/or effectiveness of intervention

strategies. By scanning down the Data column, the breadth of data that is available to the group becomes apparent. Data can be *added*, revealing a list of all available data sources that may be shared across disciplines.

The **FUNDING** column may be 'added' once each participant identifies funders and sources of funding. The group may not want to start out revealing funding sources during initial conversations. The decision to discuss funding should be considered in light of the possibility that collaborators may unknowingly be competing for the same pots of money. In some cases funding would best be addressed once group members are comfortable with each other, due to the sensitive and potentially politically-charged nature of the topic. A facilitated and structured discussion might yield the best results. For example, several members of the group may be interested in seeking funding for reducing impaired driving and identify ways to add value to funding proposals, rather than working in competition.

The **TRAINING** column is an opportunity for participants to delineate who they train, who trains them, and the subject(s) and format of trainings. The information in the Training column can be *multiplied* to reflect the capacity of the group and individual members to reach others as participants share expertise and methodologies. The matrix also outlines the potential for cross-training as individuals learn and apply each other's methods. Training is also *multiplied* as the group begins to identify a much broader group of potential trainers and trainees beyond collaborative members. All members might benefit from a better understanding of the kinds of road enhancements and signage that improve walkability and level of service through a training from traffic engineers and optometrists.

The **PARTNERS** column can be *added* to reflect the network that the group collectively represents. There may be overlap between partnering agencies. The group should decide ahead of time whether or not to include both formal and informal partnerships. In any case, once the partners are added, it becomes clear that the reach of the group is larger than that of any individual or organization.

APPROACHES/OUTCOMES are the types of efforts a group uses to achieve results and the outcomes that they are seeking. This column may include typical strategies and/or an overall statement about what the group envisions as a solution to the problem. The Approaches/Outcomes column can be *added* to reflect the desired outcomes of all participants in the group or *averaged* to arrive at a common desired solution or outcome. Thus the TSC describes its overall objective as a multidisciplinary collaboration in research, education and outreach.

IMPLICATIONS: When the columns in the matrix are filled in by all members, the facilitator works with the group to analyze and calculate the results of the table. The analysis is summarized in the Implications section of the matrix, which can be an ongoing resource and reference to the group.

The analysis is summarized in the implications section of the matrix, which can be an ongoing resource and reference to the group.

THE TRAFFIC SAFETY CENTER AND COLLABORATION MATH

THE FIVE GOALS OF THE TRAFFIC SAFETY CENTER

The Traffic Safety Center uses a collaborative approach to advance interdisciplinary methods for understanding and preventing injuries as illustrated by its five strategic goals.

1. ORGANIZATION: To maintain a multidisciplinary focus through a broad-based and active staff, Steering Committee and Advisory Board.

The **ORGANIZATION** of the TSC supports its multidisciplinary mission by ensuring that staff, steering committees, and advisory boards have a broad understanding of the overall approach and its value. Meeting agendas and collaborative materials reflect a mix of items relevant to each discipline to emphasize the added value of a multidisciplinary approach. By holding meetings at different organizations, the TSC encourages its members to become familiar with, and better understand the work of, other members.

2. EDUCATION AND TRAINING: To introduce current and future researchers and practitioners in public health, engineering, planning and other disciplines to issues in traffic safety and injury control, and to provide them with appropriate skills, tools and knowledge.

EDUCATION AND TRAINING present opportunities to broaden the knowledge-base of students and professionals as they educate and train across disciplines. Such an approach has the potential to result in a new cadre of practitioners and researchers that is skilled at working across disciplinary boundaries. However, promoting a meaningful, multidisciplinary training agenda requires the development of new materials and approaches.

3. RESEARCH: To capitalize on the wide variety of nationally recognized transportation, vehicle, public health, and safety research and to leverage these multiple disciplines and investigators to a distinctly identifiable set of research products aimed at traffic safety issues facing communities in California.

RESEARCH at the Center focuses on advancing a multidisciplinary research agenda. By engaging multiple disciplines, new areas for study can be defined and explored jointly. In addition, new analytic tools, data linkage and research methods can be applied across disciplines, bringing about new innovation and increasing the knowledge-base for future researchers.

4.TECHNICAL ASSISTANCE: To provide public and private organizations with technical assistance in the areas of data collection and analysis; program development, implementation, and evaluation; grant development; and other project activities.

TECHNICAL ASSISTANCE is an important mechanism for providing other organizations with the tools and skills to be effective in traffic safety. As the TSC builds its base of research products and tools, it will need to continually train those who can use these approaches successfully in professional and community settings.

5. PUBLIC INFORMATION: To be a source of information on traffic safety issues for government, professional, academic, and community programs and departments, as well as for the general public.

PUBLIC INFORMATION provides the opportunity to disseminate information to a diverse audience. Public information in traffic safety is critical because constituents need to be made aware of the magnitude of the problem and effective solutions and political resources. Public information is also an important vehicle for communicating to legislators and decision-makers that there are proven and effective strategies for reducing traffic-related injuries that can save lives and money. Public information is most effective when it is tailored to specific audiences so that they can clearly see how traffic safety is an issue they should be concerned about.

COLLABORATION MATH IN ACTION: TSC APPLIES THE TOOL

The TSC is committed to fostering a collaborative approach by bringing together the participants necessary to enhance the likelihood of decreasing traffic crashes and fatalities. For example, one meeting was held at a location where new auto technologies are tested. The meeting enriched member knowledge of technical aspects of traffic safety previously unfamiliar to many participants. This approach distributes the responsibility of hosting meetings among participants, but more importantly creates an opportunity for participants to better understand each other.

Prevention Institute worked with other members of the TSC to use the *Collaboration Math* tool. The goal of the process was to support and advance the TSC's multidisciplinary efforts by clarifying and documenting the diverse elements and perspectives of participating disciplines.

The *Collaboration Math* matrix (on the next page) reflects information provided by participants of the Traffic Safety Center. Prevention Institute staff collected the information from lead participants in the Center. The table shows a partial *Collaboration Math* chart (the **FUNDERS** and **KEY ISSUES** columns have been omitted for simplicity).

THE TRAFFIC SAFETY CENTER'S COLLABORATION MATH MATRIX (PARTIAL)

Participant	Problem Definition	Data	Training	Approaches/ Outcomes
Public Health	Traffic safety is a community health problem	Morbidity and mortality rates Hospital admissions Emergency Rm data Fatality Accident Reporting System (FARS)	Identifying at-risk communities and individuals Effects of transportation on health	Education campaigns Community participation Environmental and policy change
Law Enforcement	Traffic violations are a community safety issue	Moving violations Crash reports	Promoting use of occupant restraint systems Enforcement techniques Crash investigations	Check points Patrolling and citations Education campaigns
Transportation Engineering	Transportation infrastructure should promote safe and efficient travel	Police reports Crash reports Speed volume and congestion studies FARS	Identifying dangerous roads Safer road and sidewalk design	Improved vehicle safety devices Safer roads and sidewalks Traffic calming
Optometry	Optimal visibility of signals and hazards improves traffic safety	Human factors studies of acuity and driver performance Reaction time to various signals and signs	Identifying how people visualize traffic signs and signals	Better vehicle display, signal and road designs Better driver assessment for licensing purposes
Planning	Traffic safety can be affected by transportation system design and travel behavior	Surveys of travel behavior Census data Zoning maps Traffic congestion and speed counts	Transportation demand Transportation behavior Effect of infrastructure on length and types of trips	Create "safe havens" for vulnerable users Create transportation systems that minimize conflict between users (i.e., pedestrians, bicyclists, and motorists).
Math	**Average**	**Sum**	**Product**	**Sum/Average**
Implications				

Arriving at a **PROBLEM DEFINITION** helped each discipline (public health, law enforcement, transportation engineers, optometry, and planning) learn how the others defined traffic safety. This way the group became better equipped to arrive at a definition for the center that would be inclusive and fully reflective of the group's diversity.

By filling in the **DATA** column, transportation engineers and public health professionals at the TSC saw that both groups identified FARS data as a resource. Interestingly, this data is generated by neither group but by NHTSA and comes from information collected by law enforcement. But it reaffirms to the group the value of sharing information. Awareness of this common data use can help TSC members to identify a common language for discussing traffic safety issues and to help focus prevention/intervention efforts. Having multiple data sources at the ready broadly illustrates the traffic safety problem and can strengthen grant proposals, which often require a clear and concise definition of the problem and its impact on communities. The TSC can now use the matrix to quickly see what data is available (or conversely what may be missing) to define and address key traffic safety issues.

The **TRAINING** column provides TSC participants with a menu of training opportunities. TSC members can provide training for each other, enhancing each member's capacity. The Training column also shows the collective capacity of the group to train others. Training is *multiplied* because members can cross-train each other or can offer trainings external to the group. Once groups effectively train each other, the work of delivering external trainings can then be divided among group members, lessening the work for any one group member.

The *Collaboration Math* tool allowed the Traffic Safety Center to define commonalities among various **APPROACHES/OUTCOMES**. Each group has its own mandates, but scanning down the Approaches/Outcomes column quickly reveals joint approaches and synergy of TSC members. The Approaches/Outcomes column demonstrates considerable overlap and distinct approaches between disciplines. *Averaging* this column revealed that multiple disciplines view environmental change as a plausible solution while others employ different solutions such as educational campaigns to raise awareness. *Adding* together these educational campaigns (i.e., choosing a common theme and time) can maximize effectiveness.

INITIAL IMPLICATIONS OF TSC'S COLLABORATION MATH MATRIX AND NEXT STEPS

Once the matrix was filled out, it became available to the group as a catalyst for discussion and analysis. As noted earlier, each of the five strategic goals of the TSC—Organization, Education and Training, Research, Technical Assistance, and Public Information—demonstrate an intentional

emphasis on and commitment to multidisciplinary collaboration. Carrying out each goal with an emphasis on multidisciplinary work is challenging; therefore, the tool can be a useful resource for further discussion and reflection as the Center evolves. The tool can be a "reflection piece" to ensure that each of its five strategic goals continue to reflect the multidisciplinary foundation upon which the center was created.

The TSC has shared their *Collaboration Math* matrix with the TSC's Advisory Board to give them a sense of the broad capacities of the TSC and to help members more clearly envision ways to build upon the Center's multidisciplinary strength. The *Collaboration Math* tool also proved useful to the TSC as a means of orienting Advisory Board members to the breadth and depth of the group's goals, definitions and strategies.

In the future, the *Collaboration Math* matrix can provide TSC members with a record so that they can identify next steps, additional partners or shared approaches. As representatives to TSC change over time, the *Collaboration Math* tool is a physical record to help them understand others' perspectives and languages. If new disciplines join the Traffic Safety Center, the group may choose to update the *Collaboration Math* chart. This process is critical because it demonstrates that each discipline's understanding of and contribution to the problem is valued by the group and relevant to the work.

CONCLUSION

One of the reasons groups join together is to achieve successes that none is likely to achieve in a stand-alone effort. Multidisciplinary collaborations take a special level of skill and commitment. Harnessing the skills, momentum and commitment of individuals with distinct skill sets, funding streams, analytical tools, and goals can be challenging. While tools and processes do not make the challenges of collaboration disappear, they do provide strategies for acknowledging and addressing difficult issues.[14]

This paper described *Collaboration Math* and its utility at the University of California Berkeley's Traffic Safety Center, a multidisciplinary collaboration focused on preventing traffic-related injuries and fatalities. The tool can also be applied to different disciplines and during a "visioning" process. Like all tools, it must be used in the right situation, with skill and creativity. Certainly, no tool is a substitute for effective, committed people. Ultimately, it is the people in the collaborative and their efforts, vision, and relationships that will determine the collaborative's effectiveness. *Collaboration Math* was developed to assist groups and individuals working in collaboration to be more effective. When a collaborative works well, the result can be a powerful force for mobilizing individuals to action, bringing health and safety issues to prominence, forging joint solutions and developing effective policies.

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Jill Cooper, MSW
Assistant Director,
Traffic Safety Center
University of California at Berkeley
Berkeley, CA

Diane Winn, RN, MPH
Associate Director,
Child Injury and Transportation
Safety Research Group
University of California at Irvine
Irvine, CA

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