

EVIDENCE-BASED RESOURCE GUIDE SERIES

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



SAMHSA
Substance Abuse and Mental Health
Services Administration

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

Acknowledgments

This guide was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract number HHSS283201700001 / 75S20319F42002 with SAMHSA, U.S. Department of Health and Human Services (HHS). Donelle Johnson served as the contracting officer representative.

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Recommended Citation

Substance Abuse and Mental Health Services Administration (SAMHSA). *Community Engagement: An Essential Component of an Effective and Equitable Substance Use Prevention System*. SAMHSA Publication No. PEP22-06-01-005. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2022.

Originating Office

National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857, Publication No. PEP22-06-01-005. Released 2022.

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Publication No. PEP22-06-01-005

Released 2022

Abstract

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



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

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

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

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

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

Miriam E. Delphin-Rittmon, PhD

Assistant Secretary for Mental Health and Substance Use
U.S. Department of Health and Human Services

Evidence-Based Resource Guide Series Overview

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

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

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

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

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

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

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

Content of the Guide

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

FW Evidence-Based Resource Guide Series Overview

Introduction to the series.

1 Issue Brief

This chapter provides definitions of community engagement; describes how community engagement can support the equitable scale-up of evidence-based practices, programs, and policies; and reviews community engagement principles and proposed benefits.

2 What Research Tells Us

This chapter highlights research on community engagement in substance use prevention, outlining common community engagement activities and outcomes.

3 Guidance for Community Engagement

This chapter presents key considerations and strategies for incorporating community engagement in substance use prevention.

4 Examples of Community Engagement for Substance Use Prevention

This chapter highlights three organizations using community engagement in their substance use prevention interventions.

5 Resources for Evaluation

This chapter provides guidance and resources for evaluating community engagement strategies and activities.

FOCUS OF THE GUIDE

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

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

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



Issue Brief

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

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

Substance use disorders (SUDs) are among the most common disabling conditions in the United States.² They have the potential to impair a person’s ability to work, engage in relationships, maintain mental health,

connect with community, and carry out activities of daily life. [Substance use](#) affects all Americans and all communities—the young and old, all racial and ethnic groups, people of all abilities, and people of all sexual orientations, gender identities, or sex characteristics.³⁻⁷ Substance use affects both [under-resourced](#) and affluent neighborhoods. It impacts all community sectors: business, education, health care, law enforcement, social services, and more.⁸

Prevention systems aim to:

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

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

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

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

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

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

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

- Community voice concerning how substance use affects individuals, families, neighborhoods, and community sectors (e.g., child welfare, health care, law enforcement)
- Assessment of [historical trauma](#) and neighborhood-level [risk](#) and [protective factors](#) for substance use, as well as other social determinants of health
- Capacity building to enable SUD prevention systems, partner organizations, prevention professionals, and others to deliver EBPs successfully
- Collaboration among community partners to identify EBPs that can effectively address problems the community experiences

- Implementation and evaluation of EBPs to measure improvements in community conditions and behavioral health
- Assessment of the community engagement process to ensure it is equitable, meaningful, and continual
- Obtaining feedback from community members to ensure outcomes from EBPs are consistent with community priorities, expectations, and lived experiences

Community Engagement Requires Trust

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

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

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

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

Formally acknowledging a community’s shared traumatic history is a fundamental step in preparing for and planning community engagement efforts that address [health inequities](#).

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

Community engagement can take many forms, and has several core principles.^{15, 16}



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



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



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



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



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



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



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

Community Stakeholder Examples

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

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

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

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

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

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

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

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

Aligning Current Infrastructure With Needed Supports to Ensure Equitable Care

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

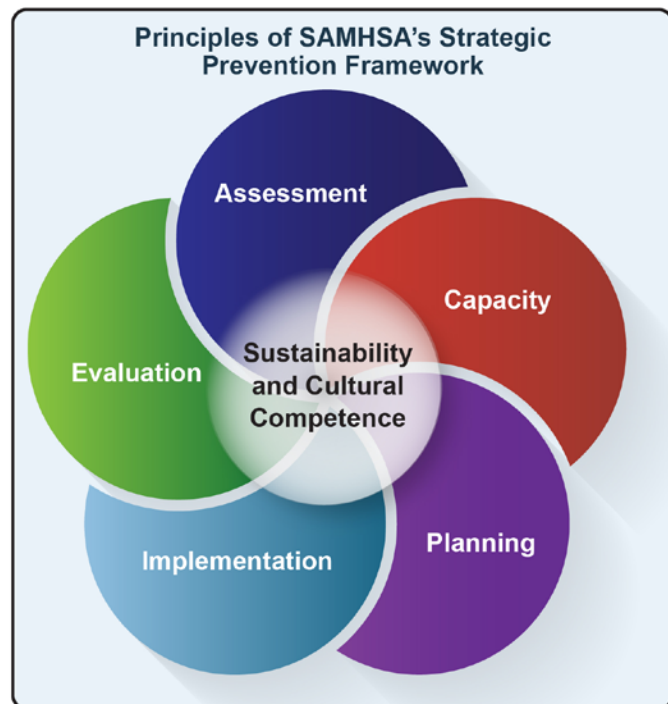
Several models support the scale-up of EBPs and community engagement, including:

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

The above models incorporate the following common elements:

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

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



Strategic Prevention Framework (SPF)

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

The SPF has five steps:

1. Community assessment of epidemiological and other data

2. Capacity building
3. Planning
4. Implementation of effective prevention policies, programs, and practices
5. Evaluation of these efforts

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

How Community Engagement Benefits the Prevention System

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

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

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



What Research Tells Us

Community engagement is “a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes.”¹¹ By building community trust and relationships, community engagement may benefit substance use prevention by promoting implementation of evidence-based practices (EBPs);^{9, 12} selecting EBPs to meet community needs and adapting them, as needed; and increasing EBPs’ sustainability.^{15, 16}

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

- **Community engagement starts with an organizing group, such as a coalition or community advisory board.** The first step reported in reviewed community engagement efforts was gathering local stakeholders from diverse sectors in the community. Coalitions were by far the most common structure for accomplishing this organization. Most coalitions included stakeholders from three or more sectors, often including community members at large who are not paid staff of local organizations.
- **Community engagement typically involves a set of activities.** Most studies engaged community members and stakeholders in multiple

ways. Community engagement activities occurred at every stage of prevention planning and programming—assessment, capacity building, planning, implementation, and evaluation.

- **Many community engagement activities are ongoing, extending over several years or for the duration of the substance use prevention intervention.** Once a community engagement process is in place, it will ideally continue for the duration of a particular prevention intervention, and preferably beyond. Several studies involved coalitions that existed prior to the specific intervention of focus, and many described ongoing engagement of community stakeholders.
- **Community engagement is an important component of many behavioral health programs.** Research on these programs indicates positive outcomes associated with community-driven interventions, although research designs in the existing research literature preclude linking outcomes to community engagement specifically. Many communities have used community engagement to plan, implement, and evaluate evidence-based prevention interventions.
- **Research-based evidence is currently not the best source material for practitioners seeking guidance on how to operationalize or translate community engagement principles into practice.** The available research literature lacks rich, practicable detail. This information is more likely to be found in grey literature

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

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

Evidence Review

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



Gathering the Community

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

Community Engagement Organizing Structures

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





Coalition Engagement

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

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

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

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



Ongoing Engagement During Implementation and Evaluation

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

among community stakeholders for the purpose of advancing outcomes, building capacity, and keeping interventions responsive to current community needs.

Twelve studies discussed maintaining community engagement throughout implementation of the intervention and evaluation.^{25, 31, 33-36, 52, 54, 57, 61-63}

Community structures used engagement techniques, such as regular coalition meetings and focus groups with community members, to inform program delivery improvements.



Implementation Examples from the Literature

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



Community Engagement Activities

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



Community-Driven Needs Assessment

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

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

Implementation Examples from the Literature

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



Community Capacity Building to Deliver the Intervention

Thirteen studies examined initiatives that involved training or technical assistance (T/TA) to build community capacity for planning, delivering, and sustaining an intervention.^{25, 28, 32, 34-36, 43, 44, 47-48, 52, 57, 65}

Public health professionals and lay coalition members delivered T/TA to community members by phone or in person. The trainings varied from a one-time event to multiple sessions of varying lengths. Topics included planning, implementation, and evaluation.

Implementation Examples from the Literature

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





Community-Led Selection of EBPs or Other Prevention Interventions

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

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



Implementation Examples from the Literature

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



Refinement or Adaptation of Interventions in Response to Community Input

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

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

Implementation Examples from the Literature

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





Community-Led Implementation and Data Collection

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

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

Implementation Examples from the Literature

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



Community Interpretation of Data Collected

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

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

Implementation Examples from the Literature

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



Community-Led Dissemination of Intervention Outcomes

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

Implementation Example from the Literature

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



Outcomes Summary

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

Implementation-Level Outcomes

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

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

Service-Level Outcomes

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

Individual-Level Outcomes

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

Research Opportunities

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

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

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

Association is *not* causation.

Limitations and Gaps in Current Literature

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

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

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

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

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

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

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



Future Research

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

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

Guidance for Community Engagement



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



Prioritizing Community Engagement

Consideration:

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

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

Community Engagement Activities in Substance Use Prevention

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

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

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

Strategies:

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

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

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



Addressing Diversity, Equity, Inclusion, and Accessibility

Consideration:

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

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

- Mitigate power dynamics, which might prevent authentic engagement with residents
- Explicitly address structural racism and other forms of oppression as a meaningful and influential part of the context⁷⁴
- Validate the knowledge and experiences of marginalized communities

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

Strategies:

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

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

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



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



Establishing Trust

Consideration:

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

Strategies:

- **Commit to the process of individual growth.** Community members should actively seek information, earnestly visualize what needs to

change, and engage in shared learning. They should have conversations and embrace a spirit of humility, and not make assumptions regarding the experiences of marginalized communities. When people share their experiences, others should affirm and validate them.

- **Focus on relationships and identify trusted messengers.** Building trust and relationships is critical to effective community engagement but it takes time. Identifying trusted messengers, establishing strong relationships, and respecting local cultural and community norms will help support the process of adoption or necessary adaptation, enhancing buy-in and support for the resulting program or strategy. It is important to understand that trusted messengers are not found, rather they emerge from community suggestions. They are not always a community leader, and they may be an individual or a whole organization.
- **Consider measuring community readiness to identify potential mistrust and safety concerns.** Community members can provide insight regarding current levels of trust within the community and underlying drivers of trust issues, as well as information regarding any historical trauma and perceived safety concerns. This information will allow conveners to respond to underlying concerns, enabling trust to develop. Community readiness assessments can also identify differences in perceptions among various community stakeholder groups.



Learning From the Experiences of Other Communities

Consideration:

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

[Evidence-based decision making](#) combines the best available research evidence with the experiential evidence of field-based expertise and context.

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

Strategies:

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

Ensuring Capacity to Carry Out Community Engagement

Consideration:

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

have sufficient capacity, commitment, leadership, and vision to build an effective coalition or partnership.⁸⁰

Strategies:

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

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



Sustaining Community Engagement Efforts

Consideration:

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

Strategies:

- **Establish clear goals and priorities with a plan of action.** Defining goals and setting clear priorities gives the community an opportunity to define a plan of action and estimate the time and resources needed to achieve desired outcomes. Action plans serve as short- and long-term roadmaps that allocate resources and help maintain focus and momentum.
- **Monitor community engagement processes and adjust, as needed.** Community needs may evolve over time. The suitability and effectiveness of some community engagement activities may also change. It is important to monitor community engagement processes to ensure continued community satisfaction with the community engagement approach and effective implementation of community engagement strategies.

- **Give coalition members a reason to stay involved.** Providing community members with opportunities for direct responsibilities, actively sharing useful information, and fostering collaborations among members are strategies to keep members engaged.
- **Develop a marketing strategy.** A marketing approach can increase understanding of the vision, mission, and goals of the community engagement. Marketing approaches should document ways the community can get involved. Engaging the media in recognizing the coalition's work is also an effective way to sustain and increase commitment.
- **Share results and celebrate successes.** Community engagement takes time and can reflect a significant amount of hard work and patience. In this context, even the smallest wins can serve as inspiration and motivate members to keep pushing and moving forward. Celebrating progress and recognizing the contributions of community members can inspire continued and increased participation.





Implementing Community Engagement Remotely

Consideration:

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

Strategies:

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

Resources

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

Community Engagement Strategies and Practices

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

Supporting Frameworks for Implementing Community Engagement

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

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

Adopting/Adapting EBPs

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

Community-Defined Evidence/Practice-Based Evidence

- CDC developed a [resource](#) that discusses various types of evidence.

Equity-Focused Community Engagement

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

Assessing Community Readiness

- The Tri-Ethnic Center for Prevention Research created [Community Readiness: A Handbook for Successful Change](#).

Implementing Community Engagement Remotely

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

Training and TA Organizations

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

Examples of Community Engagement for Substance Use Prevention

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

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



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

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

As these examples demonstrate, community engagement involves a set of activities and can look different across communities, aligned to the goals of the particular

community and prevention intervention. The examples affirm the benefits of community engagement in addressing substance use. Several common themes emerged:

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

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

South Portland, Maine

Program

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

Challenge

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

Intervention

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

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

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

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

Outcomes and Other Benefits

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

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

South Portland, Maine

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

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

—*School social worker*

Lessons Learned

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

Related Resources

- SoPo Unite [home page](#)
- Maine Department of Education Newsroom [article](#)



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

Cherokee Nation of Oklahoma

Program

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

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

Challenge

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

Intervention

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

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

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

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

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

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

Cherokee Nation of Oklahoma

Outcomes and Other Benefits

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

Lessons Learned

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

Related Resources

- [Study protocol](#) for the Cherokee Nation HEAL Initiative
- [Summary of current intervention](#)
- [Summary of previous intervention](#)



Papa Ola Lokahi—Substance Use Needs Assessment

Hawai'i

Organization

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

Challenge

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

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

Intervention

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

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

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

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

Outcomes and Other Benefits

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

Lessons Learned

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

Papa Ola Lokahi—Substance Use Needs Assessment Hawai'i

Related Resources

- Papa Ola Lokahi [homepage](#)
- [Native Hawaiian and Pacific Islander Hawai'i COVID-19 Response, Recovery, & Resilience Team](#)





Resources for Evaluation

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

Importance of Minimum Practice Standards and Measurement of Community Engagement

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

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

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

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

Creating And Measuring Community Engagement Practice Standards: An Illustrative Example

Standard and Description	Quality Criteria	Actions	Indicators
Participation: Communities assess their own needs and participate in the analysis, planning, design, implementation, monitoring, and evaluation of interventions. Community views and needs are given due weight in all aspects of policy, planning, research, and practice.	Meaningful participation is recognized as a right and is essential for informed decision-making and collective self-determination.	<ol style="list-style-type: none"> 1. Have clear objectives for levels of participation based on necessary minimums for achieving outcomes and impacts. 2. Create transparency around the proposed levels of participation. 	<ol style="list-style-type: none"> 1. A mechanism for ensuring participation has been developed. 2. Operational policies and procedures for participation of community members are in place.

Note: Adapted from UNICEF's [Minimum Quality Standards and Indicators for Community Engagement](#)

Types of Evaluations

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

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

- **Impact evaluation:** Documents short- and long-term impacts of community engagement or the contribution of community engagement to the larger intervention it is supporting. Impact evaluations attempt to identify the direct, causal impact of community engagement on specific goals or whether outcomes from the intervention can be attributed to the implemented community engagement. These evaluations can be challenging to implement.

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

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

Using Process Evaluation to Measure the Quality of Community Engagement

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

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



Sample Questions	Sample Indicators	Possible Measures/ Data Sources
<ul style="list-style-type: none"> • Have attitudinal, environmental, and institutional barriers to participation for disadvantaged and marginalized groups been adequately addressed? • Have systemic two-way communication mechanisms between conveners and community members been developed? • Have community priorities, resources, and needs been integrated into project plans effectively? 	<ul style="list-style-type: none"> • Engagement level of participants • Perceived equity of processes • Fidelity to strategy and underlying principles 	<ul style="list-style-type: none"> • Surveys • Focus groups • Key informant interviews • Participation rates

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

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

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

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

Culturally Responsive and Equitable Evaluation (CREE)

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

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

Assessment Domain	Indicators	Possible Measures/ Data Sources
Strengthened partnerships and alliances	<ul style="list-style-type: none"> • Diversity and inclusivity: multicultural, multiethnic, and multigenerational, including those not traditionally involved in healthcare policies • Partnerships and opportunities: ensure participants are fully benefiting • Acknowledgment, visibility, recognition: recognition of community participants as equals and public acknowledgments of their contributions • Sustained relationships: to maintain continuous communications • Mutual value: ensures communities are equitably benefiting from the partnership • Trust: to build a long-lasting and robust relationship; • Shared power: community participants are actively engaged in leadership roles • Structural supports: infrastructure needed for continued community engagement 	<ul style="list-style-type: none"> • Surveys • Focus groups • Key informant interviews • Document reviews
Expanded knowledge	<ul style="list-style-type: none"> • New curricula, strategies, and tools: formal community engagement products that permit dissemination of new knowledge • Bi-directional learning: community and partners collaboratively generate new knowledge • Community-ready information: creates actionable findings and recommendations for community use 	<ul style="list-style-type: none"> • Document reviews • Surveys • Focus groups
Improved health and healthcare programs and policies	<ul style="list-style-type: none"> • Community aligned solutions: ensures that models and solutions fit the community needs • Actionable, implemented, and recognized indicators of success, with solutions endorsed by community members • Sustainable solutions: new interventions and resources that remain in the community after application, to support future programs, if needed 	<ul style="list-style-type: none"> • Surveys • Focus groups • Key informant interviews • Document reviews • Incidence rates of targeted behaviors
Thriving communities	<ul style="list-style-type: none"> • Physical and mental health: “whole-person” health, including shared healthcare decision-making • Community capacity and connectivity: growth in community skills and capacity • Community power: ensures the community initiates, guides, and owns new efforts • Community resiliency: reflects the community’s strength and capacity to self-manage • Life quality and well-being: improvements in the drivers of health, including health equity 	<ul style="list-style-type: none"> • Surveys • Focus groups • Community-level secondary data (e.g., crime data; ER visits related to substance use; education data related to absences, suspensions, and graduation rates)

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

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

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

Strategies to Practice Equitable Evaluation

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

Evaluation Process Step	Guiding Questions
Putting together an evaluation team	<ul style="list-style-type: none"> • Are proposed team members culturally and racially diverse? • Do they represent different backgrounds and beliefs and have lived experience with the issue at hand? • What types of training or capacity building are necessary to enable all members of the evaluation team to participate in the evaluation?
Evaluation purpose(s) and audience(s)	<ul style="list-style-type: none"> • Does the overall evaluation purpose explicitly reference progress toward equity at multiple levels (e.g., individual, structural, or systemic)? • Do evaluation audiences include the under-resourced and other populations served?
Evaluation questions	<ul style="list-style-type: none"> • Has the organization involved community members in the identification and prioritization of evaluation questions? • Do the evaluation questions consider the extent to which different groups experience community engagement and prevention services differently?
Outcomes and indicators	<ul style="list-style-type: none"> • Have community members participated in the identification of outcomes and indicators? • Are outcomes and indicators meaningful and relevant to community members? • Do selected outcomes and indicators reflect community engagement principles and community-identified community engagement priorities and practice standards? • Do selected outcomes and indicators provide the community with evidence of progress?
Data collection, analysis, and dissemination	<ul style="list-style-type: none"> • Is the organization or community transparent about how and why it collects and uses data? • Are community members involved in data collection, and how? • Are data collection tools culturally relevant to and appropriate for the community? • Is disaggregated data prioritized to account for contextual and cultural differences? • Is the organization actively engaging the community in interpreting the data and formulating recommendations? • Is the community involved in presenting evaluation results to different audiences?

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

Evaluation Resources

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

The CDC summarizes [essential elements of program evaluation Framework for Program Evaluation](#) in public health.

The Rural Health Information Hub's module on [Evaluating Rural Programs](#) offers information on evaluating rural community health programs.

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

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

SAMHSA's [Substance Abuse and Mental Health Data Archive](#) provides access to useful datasets and analysis tools.

SAMHSA's annual [Behavioral Health Equity Report](#) is a helpful data resource to support evaluation.

CREE Resources

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

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

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

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

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

Cultural Competence Resources

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

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

The CDC provides practical strategies for [Culturally Competent Evaluation](#).

The Great Plains Tribal Epidemiology Center created an [Indigenous Evaluation Toolkit](#).

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

SAMHSA developed a Treatment Improvement Protocol, [Improving Cultural Competence](#), which includes guidance for conducting culturally responsive evaluation.

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Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX 1: Acknowledgments

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

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APPENDIX 2. Literature Review Process

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

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

AND

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

AND

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

AND

(prevention)

AND

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

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

- The publication was a journal article, or research or technical report (relevant dissertations/theses,

systematic reviews, meta-analyses, and scoping reviews were also retained, and their references reviewed using the same criteria).

- The work focused on community engagement, or included community engagement, for behavioral health or public health prevention, treatment, or recovery support services.
- The article was published after 2002 and was written in English.
- The study was conducted in the United States.

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

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

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

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

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

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

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

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

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

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

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Any person depicted in a photo is a model.

Publication No. PEP22-06-01-005

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