TASC Handbook

Taking Action to Address Substance Use in Communities

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Illinois Extension
UNIVERSITY OF ILLINOIS URBANA-CHAMPAIGN

The Ohio State University
COLLEGE OF FOOD, AGRICULTURAL, AND ENVIRONMENTAL SCIENCES

OHIO STATE UNIVERSITY EXTENSION

PURDUE UNIVERSITY

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Acknowledgements

This project would not have been possible without the contributions of many people, including the following:

Pilot Projects

- **Newton County, Indiana**
  Deb Arseneau, Purdue University
- **Jasper County, Indiana**
  Carmen Fortney, Purdue University
- **Wayne County, Indiana**
  Elisa Worland, Purdue University

Peer Reviewers

- Mary Jo Katras, PhD
  Program Leader, Family Resiliency
  University of Minnesota
- Sandra H. Sulzer, PhD
  University of Michigan Law School

North Central Cooperative Extension Association
Funding for *Taking Action to Address Substance Use in Communities* came from the **North Central Cooperative Extension Association** (NCCEA) https://www.nccea.org/.

Foreward

Taking Action to Address Substance Use in Communities (TASC): A Protocol for Communities includes information, tools, and strategies for addressing the impacts of substance use on people and communities. The toolkit includes a handbook, a facilitation guide, and curricular materials. This handbook presents concepts and information about substance use disorder and recovery and guides the reader through the process of developing a Recovery Oriented System of Care (ROSC) to build stronger networks and systems to connect community resources with community members. The objective is to provide the reader with knowledge they may not have so that they can confidently facilitate community action and systems change.

In this toolkit, we use a casual vernacular, along with some technical language. We also use the terms "substance use disorder" and "addiction" interchangeably to make the material more approachable. Further explanation is provided in Chapter 5. Levels of stigma vary across communities, and this curriculum is meant to prepare Extension professionals for encounters with community members of varied beliefs using a variety of terms, including older or lesser preferred terms. For this work, the term "stakeholder" includes anyone who has an interest in the community's work to support recovery, or who may be affected by the project. The term includes those who support the effort and those who are disinterested or disruptive. There is some concern about the term, stakeholder, and its origins in colonialism. We will use the term in these materials because it conveys an expansive definition that includes those who are known and active in recovery efforts and those who are or could be affected by the projects. No other term is adequately inclusive.

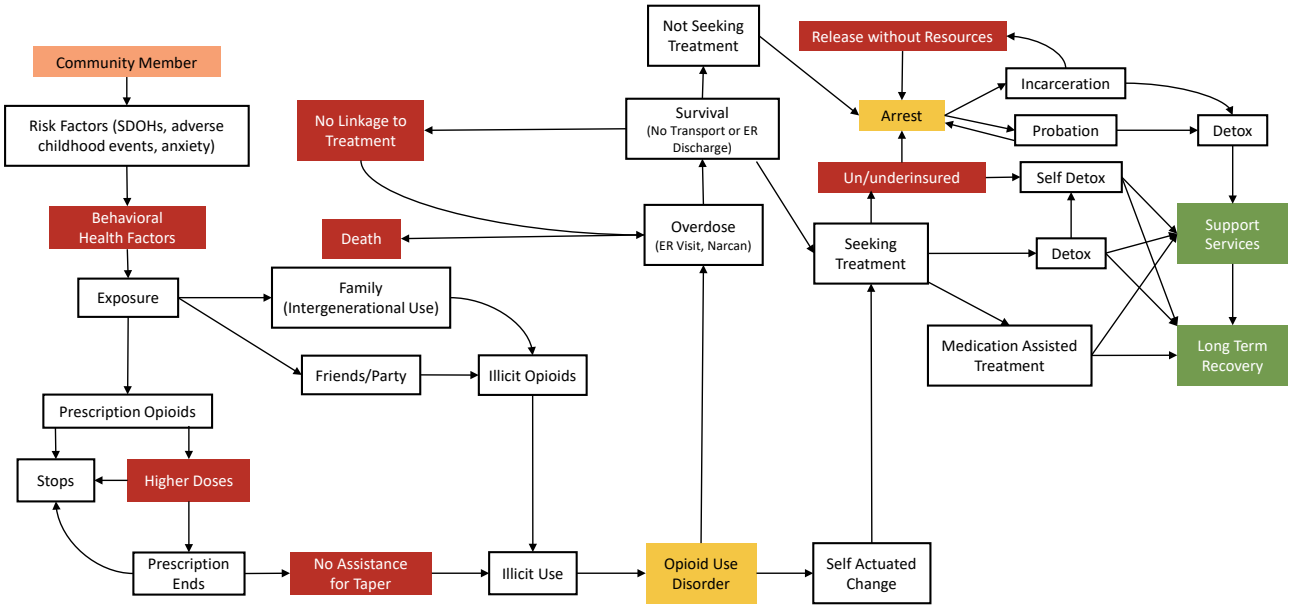
The material for this toolkit has been sourced from research-based best practices, case studies, professional experiences, projects, community stakeholder testimony (including people in recovery), and meeting materials which have been tested in pilot sites. It has been compiled and presented by a team working with ROSC development and systems change.

Extension professionals can use this toolkit to help community members improve planning, networking, and implementation, and provide motivation to what can be a daunting process. The strategies have been successfully used in communities and can be adapted to fit your community. Please review the next few segments of this handbook to learn why the focus will be the creation of a ROSC, and how attitudes about substance use are shifting to support this model.

This project may require approval from your Institutional Review Board (IRB) or a community-based research review board. Contact these organizations to determine if you need to have a protocol reviewed. Example protocol language is included in the facilitation guide.

Each chapter in this handbook presents information that is crucial to your understanding of the process, with implications for implementation. We have structured the material to build knowledge and terminology. Use the table of contents to skip ahead or review chapters as you seek information.

Thank you for deciding to play a critical role in facilitating this process and improving lives in your community.



ABOUT THE TASC TEAM

Dr. Nicole Adams

Dr. Nicole Adams PhD, RN, CEN is a Clinical Associate Professor at the Purdue University School of Nursing. She is a Robert Wood Johnson Nursing and Health Policy Fellow. Her research focuses on community coalitions that address substance use and mental health. Dr. Adams uses a Complex Adaptive System model and community-engaged research to describe and study community coalitions to identify key concepts that lead to successful coalitions and improved community outcomes. She has worked with communities in Indiana, North Dakota, Georgia, and Florida. Her research efforts are focused not only on discovery, but the implementation and rapid translation of science into community action.

Dr. Michael Wilcox

Dr. Michael D. Wilcox, Jr. is Purdue Extension's Assistant Director and Program Leader for Community Development and Associate Director of the North Central Regional Center for Rural Development (NCRCRD). Michael is a Community and Regional Economics Specialist in the Department of Agricultural Economics. As Assistant Director and Specialist, Michael furthers the mission of Purdue Extension by fostering innovative, high-impact Extension programs, and provides motivation, strategy, vision, and coordination for the development and delivery of Community Development Extension programs that address the diverse needs in Indiana communities and beyond. As Associate Director, Michael co-leads the NCRCRD's regional efforts focused on leadership and civic engagement, community resiliency and health and wellness. He is a Senior Associate at the Purdue Center for Regional Development (PCRD), leading and supporting Center projects related to regional development. Michael's Extension and research integrates the economic, environmental and social dimensions of sustainability into addressing community and regional economic issues, with a focus on entrepreneurship, placemaking, and community capacity building. Michael has been involved in research and Extension projects centered on the marketing of tropical tree crops in western Africa and Latin America and conservation agriculture in southern Africa. Michael, an adjunct assistant professor at the University of Kentucky and past president of the National Association of Community Development Extension Professionals, holds a B.S. in Biological Sciences from Cornell, an M.S. in Fisheries and Allied Aquacultures from Auburn, and a Ph.D. in Agricultural Economics from Purdue. He served as a U.S. Peace Corps volunteer in Cameroon.

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Elisa Worland is the Health and Human Sciences and Community Development Educator with Purdue University's Extension program in Wayne County, Indiana. She holds a B.A. in Government and Spanish from Smith College and a Master's in Social Work with a focus on Community-Based Practice from Portland State University. She spent seven years working in social services, primarily with adults experiencing severe and/or persistent mental illness, many of whom were dually diagnosed with substance use disorders. Elisa served in the Peace Corps in Paraguay, conducting health promotion activities in a small town for two years. She extended her service to work with Arovia ("I believe" in Guarani), a government volunteer program for young professionals, to improve their training. She wrote the first draft of Jarovia, Arovia's manual of participatory community tools for development and social innovation, and provided training on these tools to program staff, volunteers, and community health workers throughout Paraguay.

Carl Erich
Carl Erich currently works with the Lafayette (Indiana) Salvation Army as a program lead and caseworker. Previously, he served in an AmeriCorps position as the United Against Opioid Abuse Local Coordinator for two years at the United Way of Greater Lafayette. He possesses a B.A. with a dual major in Political Science and Philosophy from Mansfield University of Pennsylvania, and a Master's in environmental law and Policy from Vermont Law School. Carl is a Certified Recovery Specialist and Community Health Worker and has been trained in the Strategic Prevention Framework. He is passionate about collective action work and social justice issues and has spent his time in Lafayette working on projects and strategic approaches developing a ROSC and enhancing the systems and services in the community while also providing life coaching and advocacy services.

Alicia Espinosa
Alicia Espinosa was recruited to work on this project because of her lived experience with a substance use disorder. She was a CRS (certified recovery specialist) and a recovery coach. Currently, she works at Cummins Behavioral Health Services as a life skills specialist for the SUD population. She earned her B.S. in Sociology at Indiana University Kokomo with an emphasis on criminal justice. She was accepted to the undergraduate research program two semesters in a row and conducted a qualitative research study on how often nonviolent drug offenders are denied employment and housing. Alicia successfully interviewed 16 women and 15 men from seven Indiana counties. This research has been presented at several conferences and is being submitted for publication. Currently, she is attending IUPUI (Indiana University Purdue University Indianapolis) and working on her Master's degree in social work with a concentration in addiction and mental health. Upon completion, she will have her MSW and be eligible for licensure as an LCAC (licensed clinical addictions counselor). She will graduate in the spring of 2022.

Anne H. Silvis
Anne H. Silvis is Assistant Dean and Program Leader, Community and Economic Development, for University of Illinois Extension, and serves on the Community and Economic Development Team for University of Illinois Extension. Her work focuses on community development, leadership development, community assessment and group process skills. Anne directs funded projects in leadership development and community planning and has served as chair of the Board of Directors for Rural Partners, the Illinois Rural Development Council; served on the Board of Directors and as Communications Chair for the International Community Development Society; and serves as the Book Review Editor for the journal, Community Development. Anne is on the advisory board for the Returned Peace Corps Fellows Program at Western Illinois University, and the Illinois Cooperative Development Center. Anne has taught Survey Design and Analysis in the Department of Urban and Regional Planning and Introduction to Leadership Theory. Anne serves on various committees and task forces for the College of Agricultural, Consumer and Environmental Sciences; University of Illinois Extension; and the State of Illinois. Anne is a graduate of the University of Wisconsin at Madison and earned an MBA from the University of Illinois.

Aidan Berg

Aidan Berg, MPH is a research data specialist with the UIUC School of Social Work's Center for Prevention Research and Development (CPRD). He holds a B. S. in Community Health, specializing in Health Planning and Administration, as well as a Master of Public Health in Epidemiology from UIUC. Prior to joining the CPRD, he spent several years working for the University of Illinois Extension in the Community and Economic Development (CED) program, working at the crossroads of rural economic development and health; he assisted the development of strategic health plans for rural communities throughout Illinois alongside his work on the TASC Curriculum.

Dr. Courtney Cuthbertson

Dr. Courtney Cuthbertson is a sociologist of mental health, with a B.S. in psychology and sociology and M.A. and Ph.D. in sociology from the University of Illinois. Their research focuses on how social and community-level trauma result in and are understood as individual-level mental health and substance use issues. Their outreach efforts focus on research-based strategies to enhance community knowledge, skills, and resources to support mental health. Dr. Cuthbertson has conducted research and outreach projects about how communities use data to inform behavioral health intervention strategies; community mental health literacy; mental health and substance use among lesbian, gay, bisexual, transgender, and queer (LGBTQ+) people; stress, mental health and substance use impacts of the water crisis in Flint, Michigan; and stress, suicide risk, depression, and anxiety among agricultural producers. Dr. Cuthbertson has expertise in community approaches to behavioral health prevention and intervention, intersectionality, farm stress and rural resilience, and qualitative research methods. They have worked with communities in Illinois, Michigan, Alabama, Hawaii, Kansas, Kentucky, Maryland, Nebraska, Ohio, Oklahoma, Vermont, Virginia, Washington, Wisconsin, and West Virginia. Dr. Cuthbertson is currently Assistant Professor in Human Development and Family Studies and Extension Specialist at the University of Illinois and co-directs the North Central Farm and Ranch Stress Assistance Center.

Dr. Ken Martin

Ken Martin is a professor in the Community Development program of the Ohio State University Department of Extension. Previously, he served as Chair of the Department of Extension, and Associate Director for Programs for Ohio State University Extension. Dr. Martin's areas of expertise are community resource development, economic development, rural development, public policy analysis, leadership, and rural health development. His research and publications have focused on topics including health care, economic development, policy, local government finance, energy development, and leadership. Prior assignments include appointments as a rural economic development specialist, associate director and director of the Pennsylvania Office of Rural Health, associate director and interim director of the Northeast Regional Center for Rural Development with Penn State University, serving as a member of the Healthy People...Healthy Communities National Initiative Management Team, and director of the Center for Community, Economic, and Workforce Development with West Virginia University Extension Service. His international experience includes teaching English in Algeria, working on environmental remediation and tourism in the Jiu Valley in Romania, and developing and implementing a land grant model of research and Extension at the University of Gaston Berger in St. Louis, Senegal.

Introduction and Overview

KEY CONCEPTS IN ROSC DEVELOPMENT

The way communities are addressing substance use disorder is undergoing a transformation. In the past, addiction was considered an individual's moral failing. Communities addressed addiction through mechanisms designed to control people and command their compliance, such as arrests and jail time. These practices produced limited success. Using new information, substance use treatment providers reframed addiction as a medical condition which requires treatment and a continuum of care, as well as support to provide effective management.

The American Society of Addiction Medicine (ASAM) reflects these changes in perspective and practice in their definition for addiction: *Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases* (2019).

There is increased interest in treating addiction as we do other chronic diseases that are affected by social determinants of health. Social determinants of health are the social and economic environments that create different outcomes for people by shaping individual behavior, access to resources, stressful experiences, and community support (Galea & Vlahov, 2002). Modern models of addressing substance use focus on building supports, expanding resources, and facilitating the treatment and recovery process.

Recovery is not always abstinence from substance use; it is a person's well-being, including physical, mental, emotional, and spiritual well-being. It is about a desirable quality of life, including stable housing and employment, a healthy social life with friends, and hope. According to the National Institute on Drug Abuse (NIDA), an individual experiences a change in their life where they

Guiding Principles of Recovery

SAMHSA highlights ten guiding principles of recovery. Recovery should be:

1. based on hope
2. person-driven
3. open to multiple pathways
4. holistic
5. facilitated by peer-support
6. relational
7. culturally appropriate
8. able to address trauma
9. grounded in respect for the person
10. designed to build on strengths and responsibility.

SAMHSA identifies four major dimensions that support successful recovery

1. health
2. home
3. purpose
4. community

(Substance Abuse & Mental Health Services (SAMHSA), 2012).

aspire to achieve a higher level of health, well-being, and autonomy (NIDA, 2020). Recovery empowers people to make intentional decisions to live self-directed lives (Davidson & Schmutte, 2020). Modifying existing community systems to address the Substance Abuse & Mental Health Services Administration's (SAMHSA) guiding principles is a complex process that involves collaborating with a variety of stakeholders.

The Recovery Oriented Systems of Care (ROSC) model is well-suited to address addiction because it focuses not only on recovery, but an entire community's set of resources, organizations, and relationships (in other words, their *system*) rather than a sole provider of services. A ROSC includes services not usually associated with medical treatment, and necessary for people struggling with substance use, such as housing, childcare, and workforce education/training. Focusing on improving a ROSC can help communities build networks and bonds among various sectors to leverage local resources.

SAMHSA definition of ROSC:

...a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems (Whitter et al., 2010).

It can be intimidating to take on a transformational effort of this scale. This handbook is designed to help Extension professionals in the role of facilitator make the process more manageable and effective by offering insights, processes, and tools to implement and adapt in their unique communities with respect to varying resources, to create a highly functioning ROSC model. This handbook will help guide the reader through the process and its many components, including building a network, creating a vision, planning, and implementation.

Answering the Call to Action

Addiction is a complex issue, with medical and neuroscientific components as well as social and environmental factors (Heilig et al., 2016). Community-based factors influence the odds of someone succeeding in their recovery (White & Cloud, 2008). This presents an opportunity for community members to create a system of care and support for people to live full and healthy lives in recovery. Developing a ROSC transforms existing systems and processes, and changes beliefs and perspectives. The ROSC model has been promoted as one of the most effective ways to address the unique challenges that substance use imposes by facilitating the implementation of efficient and effective initiatives, however empirical evaluations have not been conducted on a broad scale and success is defined by case studies in specific communities (Davidson et al., 2021). In their updated *Recovery is Beautiful* blueprint, the Ohio Association of County Behavioral Health Authorities explained why they put their confidence in the ROSC model:

> "[A] transition to a Recovery-Oriented System of Care is largely driven by the body of research and information demonstrating that this framework successfully improves outcomes by ensuring individuals, families, and communities have timely access to prevention and treatment services, as well as, recovery supports that increase their likelihood of achieving and sustaining recovery."
>
> – Ohio Association of County Behavioral Health Authorities (OACBHA), n.d.

A ROSC represents connected resources and community-based continuum of supports and services. Diagraming or mapping a ROSC can provide communities with a visual representation of assets, barriers, and gaps in the system. A highly functional system provides multiple pathways to recovery, with no wrong doors or dead ends.

Ideally, ROSC development will grow a strong sense of community by bringing stakeholders together to solve problems in mutually beneficial ways. As the process unfolds, more stakeholders may see the benefits and become involved.

> ***"Change is difficult, and requires patience, flexibility, empathy, and ingenuity. However, you will not be alone; allies will emerge, and champions will invest in the process."***
>
> **-TASC Pilot participant**

The following pages provide information about ROSCs, their components, and the Complex Adaptive System (CAS) model for describing the ROSC, along with an overview of how the transformational process will look and feel. These introductory sections are designed to coach facilitators as they engage with their coalitions and conduct early meetings. The content includes tools to use for community meetings, how to build coalitions and supportive networks, how communities can facilitate the development of a ROSC, what a complex adaptive system is and how to use it to create community transformation, the history of ROSC and evidence-based practices, and why the CAS is the model chosen for this handbook. Diversity and inclusion, and its significance in a ROSC and peer support services, is addressed. This handbook will define recovery capital and why it is important; and peer supports — who they are, and why they are significant. Please read this document first and refer to the contents as needed during your project.

CHAPTER 1

Introduction to Community Action

Developing a community-based recovery-oriented system of care (ROSC) is a complex process. A ROSC is a framework for understanding how agencies and organizations relate to one another to support recovery in their community. The approach described in this handbook uses the complex adaptive system model to map the relationships among organizations and the path a person might follow to pursue recovery. The map and mapping process include all facets of the community, not just recovery support services, but also stakeholders such as faith-based groups, schools, the justice system, and social service providers.

What is a ROSC?

A ROSC is a group of organizations who are involved in the journey of community members as they move from active addiction to recovery.

This section of the handbook covers successful facilitation, assembling and motivating a coalition, maximizing opportunity for success, and anticipating and addressing challenges. By developing a comprehensive body of knowledge around community impact and capacity building, the process will shift from one of complex uncertainty to one of decisive action-oriented decision making. The process will retain some elements of complexity and chaos, so the ability to adapt will be critical in moving through uncertainty. Detailed information and specific instructions for facilitation can be found in the facilitation guide.

LEADERSHIP AND FACILITATION

While developing a ROSC, important tasks for a facilitator include gathering and sharing information and helping the group organize. The facilitator is not asked to provide expertise in any particular field, including healthcare, program development, or even community action. The function of the facilitator will shift based on need, vacillating between leadership and management. In this case, *management* refers to tasks such as planning, organizing, and problem solving. *Leadership* refers to helping the group establish a direction and then coordinating them in that direction and inspiring change (White, 2011).

Developing a ROSC requires collaborative efforts from individuals and agencies across the community. The facilitator's role is critical when dealing with a project of this scope, working with stakeholders who hold differing opinions and interests. The person or agency serving as the facilitator must be trusted in the community to mitigate concerns of bias or hidden agendas among coalition partners. A neutral facilitator or non-stakeholder leader can be effective in motivating the group to stay focused on the goals of the community and intervene when conflicts arise (Adams, 2020b; Brennan Ramirez et al., 2008). As an Extension professional, you are well suited to serve as the non-stakeholder leader or facilitator.

Regardless of the facilitator's leadership style and the community's readiness, it is important that the facilitator understand the community. This will help identify where to focus energy, time, and guidance. Early on, a landscape or community assessment can show what functions are already performed by community members and coalitions. This data can help to identify the best use of a facilitator's time and should be updated as the process unfolds.

Community Engagement

In the role of community convener/catalyst, an Extension professional helps community members list and identify stakeholders, and then works with that group to set goals, define roles, clarify their expectations, determine how decisions will be made and how goals will be determined. On a more practical note, the facilitator helps the group decide who takes responsibility for managing the logistics, including ordering and paying for materials, refreshments, and the meeting space. The Extension professional helps the group make decisions and stay on track, without influencing the outcome of decisions or assuming a role in setting goals.

WORKING IN A COALITION

The facilitator begins by gathering information about the community and listening to opinions and insights of community members; this will identify what issues matter most to the community and if there is enough support to develop a ROSC. This assessment of stakeholders should include service providers and recipients, and those in need of service, to understand the landscape of the community (Lamb et al., 2009).

If your community does not have a coalition addressing substance use or an existing coalition that wants to address substance use, please refer to the facilitators guide for building a coalition. More commonly, you will likely find interest for this work in an existing coalition. The facilitation guide also provides detailed instructions for working within and expanding an existing coalition.

Based on the experiences implementing a ROSC in Philadelphia (Lamb et al., 2009; White et al., 2013), there are six distinct goals for a partnership model. We believe each of these six goals are designed to be implemented at ground level and are practical for coalition members to implement, especially with support from team members who are looking at the system from a comprehensive perspective.

1. Enhance partnership between addiction treatment service agencies and individuals and families by including them in decision making and service planning at the agency level.
2. Increase partnership activities between multiple types of services agencies by using forums, multi-agency projects, and weakening competition by celebrating collective achievements. It is important to try and get organizational leadership involved.
3. Strengthen partnerships with coordinating entities and the community by building working relationships with agencies, often at the state level, that disperse resources. This needs to be done as a coordinated community, not individual agencies.
4. Increase direct contact with indigenous recovery support institutions by having service providers connect directly with recovery supports and community groups for treatment and recovery plan implementation. Recovery is an individualistic experience with unique needs for each person, so it is important to be open to many pathways to recovery.

5. Align coalition goals with broader community development goals and activities by linking planning efforts of other community projects with the ROSC development. Through complex adaptive systems, this is more likely to happen organically, but it should still be monitored and updated as community needs evolve.
6. Increase recovery capital through various means such as conferences, trainings, and aligning the community with state initiatives. Basically, build up logistical and knowledge supports so recovery capital capacity expands.

It is important to recognize that this list is not complete or comprehensive. Each community will have opportunities to develop its own ways to achieve these goals as well as other goals that may be unique to their community's overall strategy. However, these six should help move the community closer to ROSC success.

CHAPTER 2

Introduction to Systems Thinking

Systems thinking considers people and/or organizations as related components within a larger network. Each component has its own functions, internal mechanisms, intake of resources, and outputs which interact with other components in the system. Diagramming a system can be useful for evaluating relationships among components and predicting the effects of changes within the system (Peters, 2014). Every community is a system, although most are not diagrammed or thought of in this way.

Implementing systems thinking in addressing substance use is not a new concept. In this chapter we will review the most common models used and the complex adaptive system model that we promote for creating map of the community to use in action planning. This chapter provides the knowledge which supports the materials you will be presenting to your coalition.

TYPES OF ROSC MODELS

The Connecticut Department of Mental Health and Addictions, the first to conceptualize a recovery-oriented system of care, came up with these recovery core values and principles to guide systems change.

Socio-Ecological Model

The Ecology of Human Development, a book published in 1979 by Urie Bronfenbrenner, explains how individuals are impacted by moving through each system and subsystem in society (Wendel & Mcleroy, 2012). The socio-ecological theory explains how policy change at the macro level can affect an individual at the micro level. An example of an socio-ecological system based on this theory begins with an individual (micro) and their development as a child. It recognizes the complexity in the relationships that influence a child that occur at various levels of their environment, which ranges from the family at home, peers, educators at school, and then the norms and values of the culture of which they are part of representing the macrosystem (Guy-Evans, 2020). The theory acknowledges that people are a product of their environment, and this impacts childhood development. Development is contingent upon the reciprocal relationships that happen at the micro-level. The ecological model is visually diagrammed using concentric circles. The framework

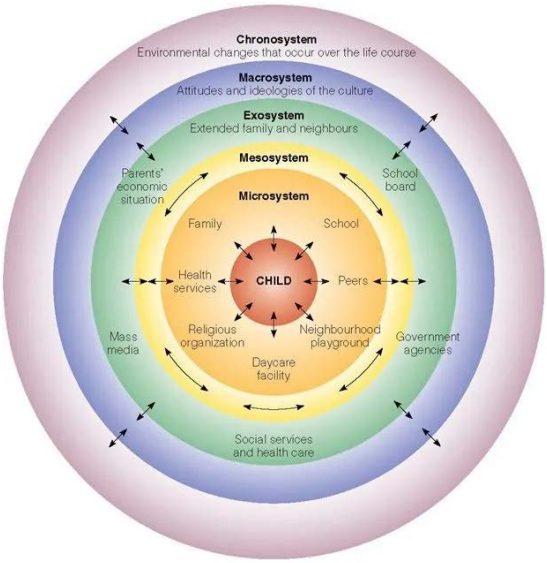


Image from: (Guy-Evans, 2020)

explains the aspects of health problems or issues related to health, allowing for the determination of the auspicious types of intervention and comprehending how issues in society manifest and move through and within various subsystems (Wendel & Mcleroy, 2012).

The people involved in the intervention of community practice must understand how every system and subsystem impacts the individuals the community is trying to help. For example, using the ecological model, community members would identify what impacts a person suffering from a substance use disorder. The various systems consist of family, friends, treatment facilities, recovery housing, the criminal justice system, law enforcement, DCS caseworkers, probation and parole officers, and laws and policies. Their (the person with the SUD) development also influences systems and subsystems that influence one another and the individual as a human being through their experiences (Wendel & Mcleroy, 2012).

Some of the basic principles of the ecological model transcend through other theories and community practice. Empowerment, participatory strategies, research, and scientific interventions to drive the process are all characteristics of the ecological model (Jariego, 2016). Communities can use the ecological systems theory to analyze issues like what is fueling substance misuse locally (Neal & Neal, 2013). This approach recognizes the impact of the environment on an individual, which includes peer, family, and other community influences. Social media has a profound impact on an individual and their development through childhood, adolescence, and early adulthood and would be an example of how a macro-level system can affect the mental health of a single person. Bronfenbrenner conceptualized how social ties and connections impact the development of a person (Neal & Neal, 2013). ROSCs have been represented by applying the socio-ecological model. In developing a community ROSC, organizations, agencies, and other individuals within the system help this potential for wellness become a reality for those impacted by a SUD.

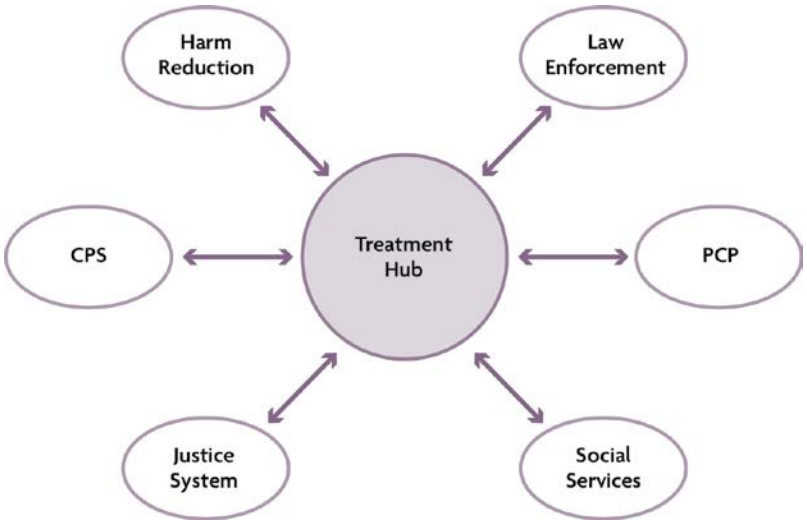
The interconnections among community members can help provide solutions to the problem of SUD. How SUD impacts the whole community, families, and the individual is pertinent to change, and all participatory community strategies use the ecological model at its core. Therefore, mapping out the relationships among community organizations, stakeholders, and individuals is essential in community action work (Scott & Wolfe, 2015).

This model is not without limitations. It is difficult to see the relationships or lack thereof between the agencies and people represented. This model also does not clearly articulate the experiences that people in the community may have as they become involved with substance use, seek treatment, and find recovery. The model does not lend itself to actionable items for a coalition to address. Therefore, we have not chosen the socio-ecological model as the framework for a ROSC in this program.

Hub and Spoke

The definition of the hub-and-spoke model is it is an organizational design which anchors one agency as a centralized component (hub) that is rich in resources and delivers the bulk of high-end services in the middle, and it is surrounded by smaller organizations that delivery other services (spoke) (Elrod & Fortenberry, 2017). In a healthcare system a patient moves among the two parts. For example, if the patient is seen at a spoke facility and needs a higher level of care then they are referred to the main hub (Elrod & Fortenberry, 2017). This model has gained popularity in the healthcare industry due to its emphasis on saving money (Elrod & Fortenberry, 2017). This model is also very easy to visualize and diagram similar to a bicycle wheel with a central node and surrounding spokes.

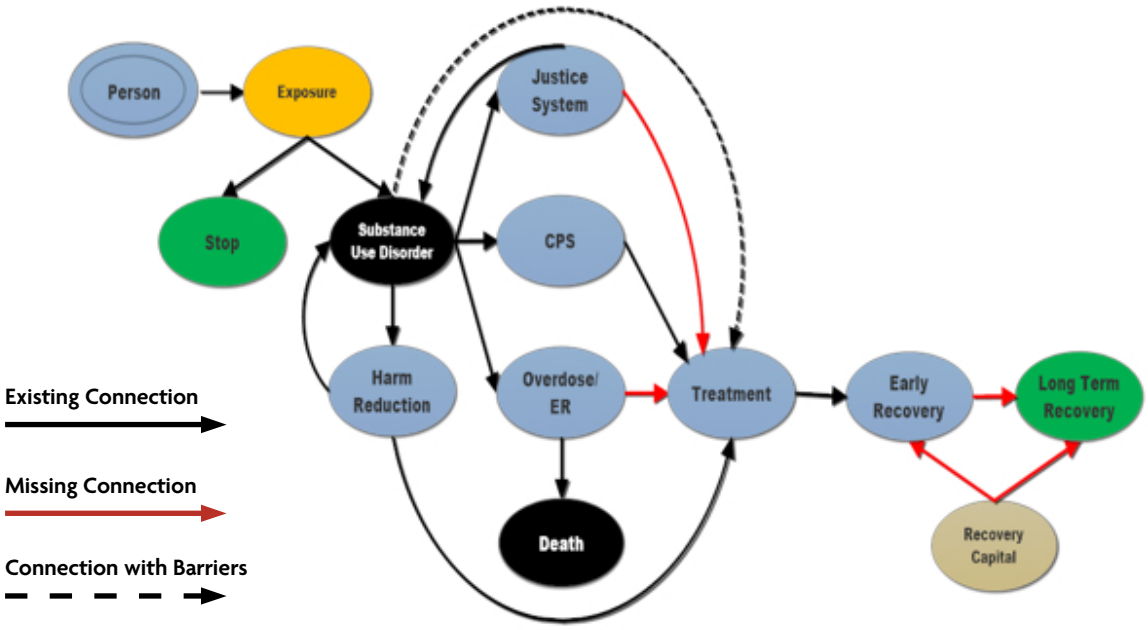
A hub and spoke network is designed around organizations and controlled by the central agency, or hub. This is appealing to many people because it represents a "one-stop-shop", a setup where everyone in the community knows there is one central location to seek help. However, there are several factors that make this model problematic. In many of these network models, the spokes are only connected to the hub and not to each other, so if the client requires multiple services, they must return to the hub for referral to each service. Additionally, this type of system can be exclusive as the controlling central agency can choose the spoke agencies with whom they partner. This network is also reliant on a strong hub organization and if the hub chooses to exit, the entire network dissolves.



Complex Adaptive System

A Complex Adaptive System (CAS) model represents movement of people, resources, or information through a network. Using this framework, diagrams of the community CAS provide a visual reference of the network/community simultaneously including relationships that exist, gaps in the system, and new relationships that need to be created. A CAS diagram of a community-based ROSC depicts the pathway of a community member as they interact with the organizations, agencies, stakeholders, law enforcement,

An example CAS map which maps the pathway of a community memeber through the system
(Note: Map does not reflect any specific community nor every community).



key players in the criminal justice system, elected officials, community members, community leaders, business leaders, other stakeholders, social service providers, SUD treatment providers, religious leaders, peer support specialists, and other people in recovery. Every map is different as it reflects the resources, values, and culture of the community it represents.

In a high-functioning CAS model of a ROSC, there is "no wrong door," which means that agencies and organizations refer clients to each other when their organization is not the right fit for a client seeking services. This is also relevant as a person moves through each component of the system. The focus should be on making personal connections between organizations and providing a "warm hand-off" instead of a cold call referral. A hallmark of the CAS is that there is no central controlling agent, and the system rapidly adapts to change. Therefore, if an agency or organization decides to withdraw from the community, the rest of the system adapts and accommodates the change. This model is also inclusive allowing all entities to participate in the network and develop requisite relationships.

System models are used to represent and simulate the interactions between independent components which are consistent and predictable, such as the computational pathways of a computer. However, there are many systems in which the actions of the components are not stable and their influence on the system becomes unpredictable. As multiple components come together (as they do in a community) it becomes more difficult to diagram the influence of each component and predict the outcomes of an infinite numbers of actions that may take place. Although these systems are complex due to the number of potential outcomes and they evolve rapidly as each component adapts to change, there are patterns and predictions that can be identified and made. This is the core of a complex adaptive system (Holland, 1992).

CAS models are nonlinear, meaning they do not depict a straight line. This is a good fit for diagramming a community of individuals and organizations (components) which are not organized in a linear fashion. Let's imagine this in terms of a shopping mall. If the movement of people through the mall were linear, everyone would go into each store and move from one store to the next down the line. In a CAS model of the mall, people move from one store to another based on needs and not location, and each person can take their own path. Individuals and organizations evolve through time and are impacted by their environment as well as their own internal functions. Change does not happen simultaneously within each component. Rather as a change occurs in one component, it causes ripples throughout the system so that other components and the entire system must rapidly adapt. These adaptations and subsequent changes to the system are not easily predictable. For this reason, the system functions best when there is no central controlling agent trying to manage changes and instead, all components are aligned to a common goal and purpose (Adams, 2020b).

CAS models can also be composed of intricate subsystems with unclear boundaries between them. CAS model diagrams provide a visual representation of the components in the system, however there are also other agents within the system who, although they are may not represented in the diagram, are influenced or can influence the model. These include policy makers, individual practitioners, social service organizations, insurance providers, and people initiating services for their SUD. A CAS model provides a visual depiction of the existing or missing connections among components. New or strengthened connections can lead to shifts and changes in community culture (Ellis et al., 2017).

CHAPTER 3

Diversity, Equity, and Inclusion – An Integrated Approach

As Extension professionals, diversity, equity, and inclusion (DEI) are integral to our work. DEI is vitally important to the success of any intervention and should be considered during all phases of development and implementation, not tacked on as an afterthought. Even communities which are mostly racially homogenous are not monoliths and have cultures that needs to be understood when developing programs. Being aware of DEI when working on a ROSC is vital, as many aspects of trauma (which is linked with substance use disorders) are connected to marginalized identities, and much of U.S. policy surrounding medical treatment, sentencing, drug enforcement, and policing is influenced by characteristics such as race, ethnicity, gender, status, and sexual orientation.

This section offers suggestions for weaving DEI into this work and how to address challenges but cannot make anyone an expert on DEI. Because we cannot understand the lived experience of everyone, we use the term "cultural humility," to acknowledge that no one is in the expert role. As Freire (2012) wrote, "At the point of encounter there are neither utter ignoramuses nor perfect sages; there are only people who are attempting together to learn more than they now know" (p. 90). This section is designed to help Extension professionals better understand how to enter a community and use tools to not only understand the dynamics present, but to work within those when developing a ROSC. This section will not be heavy on academic references, as it is grounded in the practice experience of the authors.

Practice Questions

Liz, a young female Extension educator, moved to her county about 6 months ago. She began her work by reaching out to community members to introduce herself and learn more about the challenges and opportunities in the county surrounding development. Many community members told her that the county is "not that diverse," and that the demographic data showed that only 10% of the population identified as something other than white.

- **How does your community describe itself?**
- **What is the demographic breakdown of the population?**

Diversity

"...[D]iversity is any dimension that can be used to differentiate groups and people from one another... Diversity encompasses the range of similarities and differences each individual brings to the workplace, including but not limited to national origin, language, race, color, disability, ethnicity, gender, age, religion, sexual orientation, gender identity, socioeconomic status, veteran status, and family structures" (HUD, n.d.). Some aspects of diversity are more visible, like age. Other aspects, such as disability, can

be hidden. It is important to not make assumptions about an individual's identity, as many aspects that make us diverse are not readily obvious.

When community members state that the community is not diverse, take another look. Even if a community were 100% White (which is a racial category itself), you would find differences in age, religion, marital status, occupation, veteran status, education level, socioeconomic status, and physical/mental health status. Why does diversity matter? Since no community is monolithic, it is quite likely that when we are tackling complex community problems, we will need a variety of perspectives at the table to create solutions that work.

Identity

Your identity as an educator may affect how you are viewed by your communities, and how they interact with you. Identities may have a strong impact on relationships with community members. A Latinx[1] educator will likely have an easier time connecting with Spanish speaking migrants due to shared cultural ties. How you identify yourself is not always be how you will be perceived by others due to stereotypes and sources of bias. Do an inventory of your different identities. Use the box below as a guide. How do you identify? Which identities do people usually see? Which tend to be overlooked?

Practice Questions

Liz spoke with the previous health and human sciences educator and discovered that she had very little contact with the local Amish community. The male agriculture and natural resources (ANR) educator did have a good working relationship with several Amish farmers who call him regularly. He put Liz in contact with one of them. The contact stated in a kind, though direct manner, that the local Amish community was not interested in health education from Extension at this point and would not be very receptive. They had some bad experiences with the local health authorities and wanted to practice health their own way. The educator was unsure if it was the topic of health was the problem or because she was a woman. After asking around, she found that other people in Extension were working with the Amish, but they were always male and in ANR. She wondered if tagging along with her male colleague in ANR to workshops that involve Amish community members would help build rapport...

- **How would you build rapport with a community you are not currently connected to?**
- **How might they respond to you based on your different identities?**

[1] We use the term Latinx, but realize that how individuals with roots in Latin America may prefer to use other terms to self-identify, such as Chicano/a, Latino/a, Hispanic, Indigena or their country of origin. The "x" at the end is used in some circles to be gender inclusive, instead of "a" to denote feminine or "o" to indicate masculine. In Spanish, "e" is sometimes used instead of "x", as in Latine, as the "x" is seen as an English construction. This is not yet widely used in Latin America, and homophobia and transphobia continue to be common. We use Latinx to be as inclusive as possible, but when working with your community, be sure to inquire as to how individuals prefer to identify instead of assuming, and explore what language/terms with which they are familiar.

Privilege

You may not think much about certain identities. Those are usually areas where we hold privilege. McIntosh describes privilege, "...as an invisible package of unearned assets which I can count on cashing in each day, but about which I was 'meant' to remain oblivious" (McIntosh, 1989). A person who is heterosexual may think very little about his sexual orientation because it is seen as the default in society, whereas someone who is gay may think about it frequently due to concerns around safety, social standing, or workplace discrimination. Where do you hold more privilege?

The identities we think about more are often the ones not privileged in our society and may be ones that result in us experiencing discrimination, microaggressions, and/or oppression. Take, for example, an individual who uses a wheelchair. She will be very aware of her identity as a wheelchair-user because society favors able-bodied people. She may not be hired for a job because the employer assumes she will have more medical issues because she is using a wheelchair or that he will need to make expensive changes to accommodate her. This would be an example of discrimination. "Discrimination occurs when a person is unable to enjoy his or her human rights or other legal rights on an equal basis with others because of an unjustified distinction made in policy, law or treatment" (Amnesty International, 2021). She might be accustomed to, though still annoyed by, people being surprised that she wears makeup and dresses fashionably because people with disabilities are often not seen as sexual. This is an example of a microaggression, "The everyday slights, indignities, put downs and insults that people of color, women, LGBT populations or those who are marginalized experiences in their day-to-day interactions with people" (Wing Sue, 2010). Prior to the passing of the Americans with Disabilities Act, it was legal to discriminate on the basis of disability in hiring and there were no legal requirements that buildings, including government buildings, be accessible. These are forms of institutionalized oppression. As a result, people with disabilities experienced oppression on multiple fronts and often still do today. Someone who is able-bodied may not think about these things because it does not affect the person directly. As an Extension professional, consider in what areas you hold privilege and what areas you might not.

Recognizing privilege is important in working with diverse populations who may have experienced negative interactions in the past. A White educator seeking to bring members of

Practice Questions

List how you identify for the following – age, nationality, race, marital status, class, mental health/ability, physical health/ability, sex, gender identity, sexual orientation, primary language, religion, body size, and urban or rural.

In which of these areas do you hold privilege? In which areas do you not? In the U.S. those with privilege are generally . . .

- **Age- Mid 20's to early 40's**
- **Nationality- U.S. citizen**
- **Race- White**
- **Marital Status- Married**
- **Class- Upper middle class or higher**
- **Mental Health/Ability- No mental disability or mental illness**
- **Physical Health/Ability- No physical disability or chronic illness**
- **Sex- Male**
- **Gender Identity- Cis-gender**
- **Sexual Orientation- Straight or heterosexual**
- **Primary Language- English**
- **Religion- Christian**
- **Body size- Slim, fit**
- **Urban**

the Black community into a ROSC project may need to do more relationship-building as well as seek to understand how discrimination has played out locally, especially in prior healthcare initiatives or community development, before Black community members are willing to engage with the educator. Building trust will be key.

Being mindful of the messenger is equally important. Perhaps the Extension professional is not the best person to be recruiting certain segments of the population. The Extension professional may seek out individuals who already have a solid connection with those harder-to -access groups, and have that individual make the ask. For example, if the educator is already connected with peer support specialist, they might ask that the peers invite people with lived experience of substance misuse and recovery because there will already be trust and rapport.

One way an educator can build rapport is by learning about the history of different groups within the community. Knowing the history and being sensitive to a variety of lived experiences helps you understand and empathize with the group. This will inform your facilitation of the ROSC as you bring often marginalized people to the coalition. The educator in the development plan example found that when she mentioned her observations about black history being left out of the plans, Black community members were more willing to open up to her. Acknowledging the existence of historical and present discrimination and its effects can go a long way toward rapport building.

Practice Questions

Despite finding articles on how the county was an instrumental component of the underground railroad and was home to one of the Negro League Baseball teams, Liz noticed that no Black historical figures were mentioned in the main city's history section on their new development plan. When she reached out to Black leaders in the community, they were willing to speak with her, yet she got the impression they were feeling her out to see if she is actually committed to working with them.

Ask yourself

- **Based on the areas where I hold privilege, what might be some of the areas where I lack awareness?**
- **How has this group in the community been treated by people who look like me?**
- **How has this group historically been treated by the community at large?**
- **Is there someone who already has rapport with this group or is part of this group that could introduce me?**

Inclusion

Diversity and inclusion are two terms that are often conflated. It is not enough to have a diverse group at the table. Warm bodies in seats does not guarantee a vibrant meeting. There need to be mechanisms in place so that the diverse crowd can collaborate on equal footing. The act of leveling the playing field so that all voices can be heard and valued is inclusion. How will you ensure that the member of your local NA chapter who has a 20-year history of using meth feels her voice and experience is as valid and valued as that of the male doctor who is director of the local hospital? Will the line staff from a local recovery program feel comfortable expressing their views if they contradict the opinion of their supervisor who is

also in the meeting? How will you help a formerly incarcerated individual feel safe at your meeting when individuals from the sheriff and police departments are present? And more fundamentally, do people outside of SUD treatment providers know what a ROSC is? There are power dynamics that will come up in your meetings and anticipating the needs of your audience ahead of time can go a long way towards fostering inclusion. The tone you set at the first meeting will likely transfer to future meetings.

Practice Questions

The ROSC project kicked off in Liz's community, but there were few peers or people in recovery at the first meeting. Liz knew that the leader for the local clubhouse for NA/AA meetings had been in other meetings where she had announced the project. She called the leader to personally invite her and others attending meetings at the clubhouse to attend the next ROSC workshop. The leader was confused about what a ROSC was and what the group was trying to accomplish. Liz put the project in layman's terms, without jargon, so that the leader would understand how this might benefit the community. After she understood, she readily agreed to attend.

There are many ways of making your meetings inclusive. Using processes and group agreements that have been agreed upon by the participants, and reviewing those each meeting, help make the space feel more inclusive.

Logistics	• Will your meeting be after normal work hours so that working people can attend? • Is the building wheelchair and stroller friendly? • Is the building accessible by public transit? Will transit still be running when you have meetings? • Will there be food or childcare available? • Will interpreters be needed so that those who are deaf, hard of hearing or do not speak English well can engage? • If it is a virtual meeting, will people be able to phone in to the meeting or will they need computer access? • How will you recruit people? Radio? Facebook? Flyers? Newspaper? Text message? Instagram? Email? • What will you name the workgroup or meeting so that people understand what you are doing?
Process	• Do you have group agreements that provide guidance for how people are to engage with each other in the space? • Are you using a variety of techniques to engage people in the meetings? (For example, storytelling, having small group work versus the entire group, and drawing or writing activities.) • How will you elicit divergent views? Use prompts such as "What are some other views or perspectives that would broaden our view?" or "Does anyone have a different perspective?" • How will you build rapport? You may want to use icebreakers at the beginning of the meeting or have a meal so that people engage with each other. • How will you manage power dynamics? You might ask that people utilize only their first name instead of title or institution to level the playing field. Assigning people to groups where they are not with people who may hold power over them is one way to manage power dynamics. • Some individuals are accustomed to sharing ideas and thinking quickly. Others might need more time to process information before sharing. You might consider methods, such as saying, "That was a lot of information. I am going to allow folks 5 minutes to jot down their ideas individually and then we will break into groups where you can share your ideas". • How will you avoid the use of jargon or make space to explain it for those who are unfamiliar with the terms?

Avoiding Tokenism

Tokenism is the act of singling out an individual or small group of individuals to participate in a group or activity based solely on some aspect of their identity and not on what the individual can bring to the group. It is more about checking a box than it is about real inclusion. This can also include actions such as asking the "token" individual to speak for all of their community on a topic. It can be difficult to avoid tokenization in small towns or counties where there may not be a large population of a marginalized group. You might notice the same few people of color are asked to be on all of the boards or committees. It is common for committees to only think of skin color when they think of diversity, forgetting that they may also need voices from the LGBTQI+ community, disability community, or from different socioeconomic classes.

Seek out leaders in the communities you want to engage and ask them for suggestions of people to participate in your committee. Follow up with asking why they are recommending that individual, what skills, knowledge, or experience will they be bringing to the table. Many of the leaders in Liz's community were willing to suggest other people to participate because they were well aware that they were getting older and that they needed to engage new people to serve in board and committee roles.

Practice Questions

Liz notices early on that the same handful of Black and Latino folks serve on all of the boards and committees in town. She wants to invite people of color to participate in the ROSC workgroup. However, she does not want them to feel like she invited them just because of their skin color. She would also like to include individuals who are not involved in every committee in town already.

- **How might you avoid tokenism?**
- **How do you recruit new individuals to your initiative who may not already be involved in boards or committees?**

When engaging people in groups, never ask them to speak for all of one group ("Can you tell us the Black perspective on this?"). No group is a monolith, and we do not want our participants to feel like they are on display in a zoo. When you mix intersectionality in, experiences vary.[2] Instead, ask if anyone has views, experiences, or perspectives that might be from a different angle.

You might ask multiple people from a marginalized group to serve on your committee or coalition. For someone who feels like others have significant power over them, they are more likely to feel comfortable participating and questioning established thoughts if they have peers to support them. Especially make sure that persons in recovery are heard and taken seriously.

Social Determinants of Health

DEI work is not just about how you interact with the community as you go about developing a ROSC. Identity comes into play when you discuss health and how you address disparate outcomes. You refer to those as the social determinants of health. The World Health Organization (WHO, 2011. p.2) states that:

[2] For more on this concept, see Chimamanda Ngozi Adichie's TED talk on "The Danger of a Single Story," https://www.ted.com/talks/chimamanda_ngozi_adichie_the_danger_of_a_single_story/transcript?language=en

> "The bulk of the global burden of disease and the major causes of health inequities, which are found in all countries, arise from the conditions in which people are born, grow, live, work, and age. These conditions are referred to as *social determinants of health*, a term used as shorthand to encompass the social, economic, political, cultural, and environmental determinants of health. The most important determinants are those that produce stratification within a society — structural determinants…"

These social determinants of health are often tied to various elements of our identities. For example, Santoro & Santoro (2018) point out that non-White people often are not treated adequately for pain and that, "News stories involving the Whites and/or middle-class persons with substance use or abuse disorders more frequently include a narrative with clear reasoning to their abuse of opioids that is often attributed to the external factors rather than an inherent moral failing or neurobiological disorder." Often times rural populations have less access to mental health and substance use disorder clinics than urban populations, and may be more hesitant to seek treatment in a small community to avoid gossip or stigma (Madras et al., 2020). "Social factors such as class, education, religious affiliation, ethnicity occupation, and social network all influence the perception and use of health resources in the same locality and thereby influence the construction of distinctive clinical realities within the same health care system." (Kleinman, 1980, p. 39) When filling the gaps in the ROSC, you need to have a clear understanding of what is causing disparities and who is most impacted. You need to approach it from a systems perspective to achieve equity, which is excellently defined by Baltimore Racial Justice Action:

> "The condition and the process together that would be achieved if the identities assigned to historically oppressed groups no longer acted as the most powerful predictor of how one fares. The root causes of inequities, not just their manifestations, would be eliminated. This includes elimination of policies, practices, attitudes and cultural messages that reinforce or fail to eliminate disproportional outcomes (economic, educational, health, criminal justice, etc.) by group identity." (2021)

As you go about our work addressing disparities in outcomes and access, the social determinants of health should be a lens that you use when developing solutions. Purdue University uses the Policy, Systems, and Environment (PSE) approach when considering interventions, recognizing that you need to work on multiple levels to reach equity and that many times there are structural pieces that hold problems in place that must be addressed to move the needle forward. "The choices we make are driven by the choices we have." (Vrazel, 2020)

HISTORICAL AND CURRENT CONDITIONS THAT IMPACT HEALTH AND RECOVERY OUTCOMES

Considering diversity, equity, and inclusion in the context of substance use means being attentive to how bias, discrimination, and privilege impact substance use and related issues for people and communities. This includes how people access and use substances, as well as referrals into treatment or the criminal justice system. For instance, research has demonstrated that people of color are less likely than White people to be prescribed opioids for pain even when clinically indicated. Children and adults who are White and non-Hispanic are more likely to be administered opioids compared to similarly-aged peers of color, and pain in people of color is relatively undertreated compared to White people (Groenewald et al. 2018; Heins et al. 2006; Pletcher et al. 2008). Another example of treatment disparity based on race is that Black patients prescribed opioids were more likely to be subjected to urine tests and referred

for substance misuse screening, and less likely to be referred to a pain specialist (Hausman et al. 2013). These research findings are not pointing to differences in pain or use of prescription opioids; when those are held constant, the findings remain. Rather, what these research findings are highlighting are bias, including implicit bias, among healthcare providers which results in differential access to prescription opioids, monitoring tools, and further referrals. In other words, negative perceptions that are created and reinforced by society shape how healthcare providers interact with and provide care to patients based on race often subconsciously. For more detailed information on racial disparities in substance use and treatment access, you can review the SAMHSA National Survey on Drug Use and Health report found here: https://www.samhsa.gov/data/report/racialethnic-differences-substance-use.

Racial disparities also exist in the justice system. People of color are more likely than White people to be arrested, charged, and sentenced to jail time related to substances and substance use, none of which can be explained by differences in substance possession, use, or legal issues with related behavior (Mitchell and Caudy 2015). Among adolescents, one study showed that even though Blacks were less likely to use or sell drugs than White peers, they were more likely to have been arrested (Kakade et al. 2012).

It is important to understand the historical context related to substance use. How U.S. society has handled substance use and people who use substances has changed over time and continues to change. The War on Drugs was declared by Nixon in 1971 with the goal of reducing drug use, sales, and distribution by investing in legal and criminal justice system solutions. These efforts included the creation of the Drug Enforcement Agency in 1973 to target illegal drug use and smuggling. Several new policies were developed and enacted in this time:

- Stop and frisk policies that allow police to temporarily detain someone to assess whether they have committed a crime, when they believe the individual poses a risk to safety.
- Zero tolerance policies refer to laws and policies that prohibit people who have been convicted of drug-related felonies from using government assistance such as public housing and federal financial aid.
- Mandatory sentencing minimums, established with the 1986 Anti-Drug Abuse Act, which automatically trigger specific amounts of prison time for certain crimes, including drug-related ones.

These policies contributed to what is referred to as "broken windows policing," or the idea that police became more active in communities with higher neighborhood disorder – those neighborhoods with high unemployment, abandoned houses, gang activity, burglaries and thefts, where social norms include seeing intoxicated people or drug deals happening in the open (Hill and Angel 2005). Although the thought was that policing such communities would improve them, research has demonstrated the opposite. Research has also shown that the policies that were developed through the War on Drugs have been used disproportionately against people of color (Nunn, 2002). For instance, geographic analyses have demonstrated stop and frisk events to happen at higher rates in Black and Latino communities which create psychological trauma for people who are targeted and make people in communities feel less safe (Bandes et al., 2019). For example, in one 8-block area in New York City police conducted 52,000 stop-and-frisks over a four-year period: 94% of those stopped had not committed any crime and there was no reduction in overall crime rate (Cooper, 2015; Fabricant, 2011). Another example of disparity was created by the 1986 Anti-Drug Abuse Act which allocated longer prison sentences for crack cocaine compared to powder cocaine, even when quantities are the same. A five-year sentence was automatically

triggered by 5 grams of crack compared to 500 grams of powder cocaine. This has been described as a 100-to-1 crack vs. powder cocaine sentencing disparity. Crack cocaine is more often used by Black Americans and powder cocaine is more often used by White Americans (Davis, 2011). This law stayed in place until 2010 when Congress passed the Fair Sentencing Act that reduced the disparity to 18:1. In total, the effect of the policies created for the War on Drugs have led to increased incarceration with longer sentences for people of color and no reduction in crime or drug use (Moore & Elkavich, 2008).

The opioid epidemic has created a shift in some communities from criminal justice responses using policing, arrests, and incarceration to a larger focus on creating opportunities to access healthcare and substance use treatment programs. While this shift does rely on fundamental public health strategies and policies, some have noted this approach has had a greater impact on White Americans (Netherland & Hansen, 2017). This highlights the need for antiracist public health practice which acknowledges racial and economic disparities created by historical U.S. health policy (Kunins, 2020).

Intersectionality

When we talk about intersectionality, we are talking about how different identities a person might hold that connect and influence the experience of an individual. Building on the work of Kimberlé Crenshaw, Bowleg (2012) defines intersectionality as, "… a theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, SES, and disability intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression (i.e., racism, sexism, heterosexism, classism) at the macro social structural level" (pp. 1267). When we look at discrimination, we often look at one identity at a time, such as sex or race. When we look at how some of those identities intersect, we begin to see forms of discrimination that may only impact individuals at the crossroads of those identities. Discrimination at multiple levels of identity can have profound impacts on health and there are often macro/structural factors at work. Some scholars have dubbed this "multiple jeopardy," where it is assumed that the more socially disadvantaged identities an individual holds, the poorer the health outcomes will be. Vu et al. (2019) point out that multiple scholars have questioned this narrative and that the concept of multiple jeopardy might be simplifying the situation too much. They state:

Frequently, studies in this research area do not include measures for discrimination, and many studies still treat disadvantaged statuses or minority identities as identical to, or an approximation for, experiences of discrimination… While it is logical and consistent with minority stress theory to posit that individuals with minority statuses will face stigma due to their membership in the minority groups, it is problematic to assume that these two domains (identity and experience) are interchangeable or synonymous.

Others, like Bowleg, talk of the "intersectionality paradox" (Bowleg, 2012), where a person who may hold an advantaged identity, such as being of a high socio-economic level, but may still have adverse outcomes in health due to another aspect of their identity, such as race. We see this with infant mortality rates, where Black women, regardless of economic level, continue to have more preterm births and infants with lower birth weights than White women. When socioeconomic status is considered, higher socioeconomic status only provides modest improvements to infant health in Black women whereas it cuts the rate of low birth weight in half for higher income White women (Smith et al., 2018, p.3). Bowleg (2012) maintains that there are macro-level factors that maintain these disparities and that when we study these different identities individually instead of together, we miss the nuances of the data.

Assimilation, Acculturation, Enculturation

As mentioned earlier, no culture is a monolith and when different cultures intermix, a number of results are possible. One is assimilation. This is the losing/leaving behind of one's culture and adapting that of another. Assimilation in some cases has been forced, for example in the case of Native Americans with Indian Boarding Schools and laws that outlawed their spiritual practices (Pasternak, 2011). Forced assimilation can cause anger, depression, poor self-esteem, and trauma. It also results in disconnection from family and community, if the individual no longer can speak the language or is familiar with the beliefs and traditions of the community (Garrett & Pichette, 2000). Numerous Native communities have included a reintegration of their traditional practices as part of their approach to addressing trauma and substance misuse (Duran, 2019; Gorman, B. & Yellow Horse Brave Heart, 2013; NPAIHB, 2019). This process of learning one's culture and traditions is enculturation. Acculturation refers to taking on some of the culture of the dominant group, but still retaining parts of one's original culture. Some studies have indicated that individuals who are bicultural, that navigate with ease two cultures, experience improved mental health outcomes (Allen et al., 2013; Walters, 2019).

What does this have to do with a ROSC? The level of assimilation, acculturation and enculturation of an individual can have a strong impact on what they might expect or want out of SUD treatment, what activities they expect a ROSC to undertake, or even what factors they believe lead to SUDs. For example, due to forced assimilation, many Native Americans converted to Christianity. It would not be safe to assume that that a Native American individual is familiar with their tribal community's traditional spiritual practices or would want that to be an integrated into their treatment for SUDs. For individuals who identify as LGBTQI+ (Lesbian, Gay, Bisexual, Trans, Queer/Questioning) and have experienced rejection based on that identity, learning about their tribe's word for two-spirit individuals in their original language and their traditional role, a type of enculturation, could be healing because it offers a route to acceptance within their tribe.

Conclusion

Working on diversity, equity, and inclusion can be fraught with interpersonal dynamics, community histories of oppression, and modern-day disparities. Some people will not want to work with you and some will not trust you immediately. This work is worth it and even if it is going slow, do not lose heart. You are helping your community learn new ways to interact with each other that will lead to growth, and learning how to do new things often takes time.

Continue your journey of learning about DEI as well. There is always space to learn more and become more skilled at communicating across differences. Be patient with yourself, seek out more advanced practitioners to be your mentors, and take time for self-care and reflection.

CHAPTER 4

Trauma and Trauma-Informed Care

This chapter is not intended to make you as an Extension professional an expert in trauma-informed care, nor provide any clinical expertise. The intention is to provide background knowledge on trauma and trauma-informed care so that you can have more meaningful conversations in your community.

Trauma is pervasive and must be kept in mind as you explore how to create an inclusive culture in your ROSC. The Substance Abuse and Mental Health Service Administration (SAMHSA) website defines individual trauma as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (https://www.samhsa.gov/trauma-violence, SAMHSA, 2019). Trauma is a response that manifests emotionally and physically from incidents like childhood bullying; sociocultural stress; xenophobia; a severe accident that causes massive injuries; a catastrophic weather event, like a hurricane, flood, or a drought; a reaction to being involved in or witnessing live combat; or from experiences that have created intergenerational trauma due to sociocultural events that include racism, discrimination, oppression, intergenerational poverty; and lastly, any form of repeated sexual, physical, and emotional abuse or neglect (Loomis et al., 2019; (SAMHSA, 2014). In a project such as this, if you are doing it right, there will be multiple individuals who have experiences with substance misuse and trauma at the table, possibly yourself included. While there may be some people who have had positive interactions with the recovery system, a number of individuals will very likely have had poor interactions with law enforcement, treatment providers, case workers, landlords, employers, and others at some point during their journey. Some of these interactions in and of themselves may have been traumatic. You are asking them to sit elbow to elbow with these individuals and share their experiences. That is a big ask and it entails risk as well as courage on the part of the person.

Practice Questions for the Facilitator

A fellow professional in the local drug free coalition emailed Liz after she announced the date and time for the first ROSC meeting. He shared how he had lost multiple family members to substance misuse in recent years and how their stories needed to be told. Liz had not anticipated community members sharing so openly about personal stories and was a little taken aback and overwhelmed.

- **How comfortable are you discussing trauma or difficult topics with others? Do you have your own trauma that might be triggered when doing this work? What will you do to manage that?**

It is very likely that many of the individuals who participate in the ROSC who are in recovery came to use substances to begin with due to trauma. Adverse childhood experiences (ACEs) are any event in childhood resulting in stress or trauma (Centers for Disease Control and Prevention (CDC), 2022). These traumas can include child abuse, neglect, poverty, or parents with a mental health diagnosis or substance misuse disorder. Chronic exposure to trauma can affect cognitive ability and resilience, often leading to coping through the use of substances or other self-destructive behaviors (SAMHSA, 2015). Unfortunately, ACEs are far too common in our society. A recent study of college students found that over 50% reported at least one ACE and nearly 20% reported 3 or more (Windle et al., 2018). ACEs have been shown to increase the likelihood of alcohol use among adolescents and lead to an increased risk of developing substance use disorders and mental health issues in adulthood (Choi et al., 2017; Rothman et al., 2008). In the original study on Adverse Childhood Events , the researchers found that, "Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, *had 4- to 12-fold increased* health risks for alcoholism, drug abuse, depression, and suicide attempt" (Felitti et al., 1998, p. 245). Layered on top of this, youth and adults who are in active addiction tend to be at more risk for trauma due to homelessness, risky behaviors, incarceration, financial instability, etc.[3]

Beyond the personal trauma, there might be groups who have experienced historical trauma in your community. Boarding schools for Native Americans, Japanese internment camps, redlining of neighborhoods, and terror campaigns from white supremacists are all examples of historical traumas that continue to leave ripple effects through our communities (Mohatt et al., 2014). Many of these continue to go unacknowledged and result in affected communities often distrusting institutions and leaders (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). In order to bring people in, as a facilitator you will need to acknowledge these traumas and name them. You might need to do more listening to the community about what happened so that they feel heard. Part of healing is acknowledging what has happened. Creating a collective understanding of history and acknowledging the harm brings healing (Hooker & Czajkowski, n.d.). Many Native communities have additionally embraced a return to traditional cultural practices as a critical piece in substance abuse disorder treatment (Duran et al., 2008; NPAIHB, 2019). They see their history of oppression as tied directly to issues of substance misuse in their

Practice Questions

Liz was discussing programming with a local school when one of the administrators mentioned they had lost two staff and two students in one year due to suicide and substance misuse. They had lost a student or staff person multiple years in a row and now have mental health professionals from an agency housed in the school to provide support.

- **How will you respond to secondary trauma? What resources could you provide or share with community members?**
- **Consider Mental Health First Aid training (offered by many Extension offices) or identifying local resources where you can refer people seeking help.**

[3] If you are unfamiliar with the original ACE study through Kaiser and the CDC, we recommend that you read it- Felitti, V.J. et al. (1998) Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults, American Journal of Preventive Medicine, 14(4) from https://www.ajpmonline.org/action/showPdf?pii=S0749-3797%2898%2900017-8

communities (Yellow Horse Brave Heart, 2003). Working on a ROSC could be a way to address some of these traumas and undo disparities.

Trauma-Informed Care

Trauma-informed care (TIC) is an evidence-based best practice to treat people suffering from a substance or alcohol use disorder (SAMHSA, 2019). The idea is that trauma is pervasive and that people are more likely to recovery from SUDs when they feel safe, are in relationship with others, and have a sense of control. There are actions and approaches that need to be implemented to truly be "trauma-informed".

4 R's of Trauma-informed Care:

Key Assumptions of Trauma-informed Care:

1. **Realization** that the trauma someone reports is real.
2. **Recognition** of the symptoms of trauma.
3. **Response** through creating programs based on the 6 principles.
4. **Resist re-traumatization** by creating environment and treatments that consciously avoid traumatization.

Treating a person with an SUD from a TIC approach, moves away from viewing substance use as a moral defect or stemming from a lack of motivation to recognizing that past experiences may have much to do with the person's substance use. TIC does not ask, "What is wrong with you?", but instead takes a person-centered approach by asking, "What happened to you?" (Goodman, 2017).

In creating a ROSC, you will need to include individuals with histories of trauma and this will have implications for how you communicate, how you facilitate the meetings, and even mundane concerns, such as how you arrange the room. In doing this work, we do not want to retraumatize individuals. Integrating elements of TIC can do much to mitigate the risk of retraumatization.

Trauma can cause a variety of symptoms, including hypervigilance (always being on alert), being easily startled, sleeping too much or too little, experiencing flashback, having difficulties concentrating, and more. There are some simple things you can do to be more accommodating and foster an environment of safety, trustworthiness, transparency, and support (Center for Behavioral Health Statistics and Quality, 2018).

Key Principles for Trauma-informed Care

SAMHSA's six (6) key principles for trauma-informed care; a resilience-based approach to enhanced coping (2014):

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender issues

Safety	• Allow individuals to choose their own seats. Some individuals may want to sit where they can see the exits or monitor the whole room. This allows people to choose to sit where they feel safest. • Provide transitions between activities and explain the agenda for the day so that all participants know what to expect and there are no surprises. • When developing the group agreements, ask if there are any ideas that people want to add that will make it feel safer to participate. • Create routines, such as sharing agendas ahead of meetings and notes after the meetings. There are fewer "surprises" and participants know what to expect.
Difficulties concentrating/ processing	• Give short, uncomplicated instructions. Provide them in more verbal and written formats. • When eliciting feedback, allow the group time to brainstorm individually before taking time to share as a larger group.
Self-care	• Consider opening with a grounding or mindfulness exercise. • Provide refreshments or a meal at your meetings. • Have breaks during longer meetings. • Be mindful of asking people to repeat their story. Telling your story can be therapeutic, but it can also be traumatizing to both the storyteller and to listeners.
Collaboration, Mutuality, and Empowerment	• Discuss trauma and the impacts it can have on individuals. • Make it clear that all are welcome at meetings and have skills and wisdom to offer the group, including those who are in addiction, have mental health or development disabilities, or other neurodivergence. • Make space for people to move around or take space as needed. It can be very hard to stay still.

CHAPTER 5

From Substance Use to Recovery

You may notice that this chapter is written in a more clinical tone. We have attempted to provide you with background information in order to improve your ability to have discussions with clinicians. The information here is not intended to make you an expert in the clinical aspects of substance use disorder.

As you begin to work on developing your role within the coalition, you will need some practical knowledge about substance use and recovery. This will help you when faced with myths and long-held false beliefs about substance use and misuse. The following information is supported by research and provides accurate clinical information in an easy-to-understand format.

Substance use disorder (SUD, often called addiction) is characterized by the misuse of either legal or illegal substances by an individual. SUD occurs when the use of these substances interferes with relationships and the ability to complete the requisite tasks of daily life. It is a clinical diagnosis made by a licensed provider using the criteria designated in the Diagnostic and Statistical Manual of Mental Disorders, Version 5 (DSM-5). For most people, moving from substance use to recovery requires substantive changes in their lifestyle and significant social support.

The Transtheoretical Model, more commonly known as *the Stages of Change Model*, was first introduced in the 1970s by Prochaska and DiClemente based on the experience of cigarette smokers. Studies were conducted to explore why some people could quit smoking on their own. Studies found that people quit smoking when they are ready, and that it is not a single event. The Stage of Change Model functions by assuming that change is not rapid nor does it occur in a step-wise fashion, but that changes in habits occur cyclically with returns to previous steps (Lamorte, 2019). The habitual behavior of an individual that smokes is comparable to an individual that uses substances, so the six stages of change from the Stages of Change Model have been applied to individuals with a substance use disorder that seek recovery. This model promotes providing an assessment to measure the stage of change an individual is currently in while considering an individual's decision if they relapse.

Stages of Change

Pre-contemplation	A person in this stage is deciding whether they have a problem. They are unsure they have a substance use disorder requiring attention. The pleasure of using substances outweighs consequences.
Contemplation	A person in this stage recognizes they have an issue with alcohol or drugs and begin considering treatment but find reasons to justify not taking that first step. For example, employment may be a perceived barrier for not going to treatment.

Preparation	When a person gets to this stage, they decide they have a problem and initiate treatment. The person will get their affairs in order, tell family and friends to gain support, and create a plan they can put into action.
Action	A person in this stage has accepted they have a SUD and put their plan into action. The person engages in treatment services with the support of family and friends. They are committing to changing their lifestyle.
Maintenance	This stage is vital in preventing relapse because it requires an individual to maintain a healthy lifestyle incorporating mind, body, and soul. Attending mutual aid support groups, finding a mentor, going to the gym, and spirituality are ways to maintain recovery.
Termination	Living in recovery from a SUD is a lifelong process and maintaining the healthy lifestyle becomes normal routine. The person is changing their perception of using substances and have moved on from their substance misuse.

Defining recovery

Around the turn of the millennium, the Connecticut Department of Mental Health and Addiction Services became the first publicly funded state agency supporting substance use treatment and recovery services. For the first time, leaders from the recovery community and the treatment community were intentionally brought together to develop core values and principles. This led to a definition of recovery:

> "A process of restoring a meaningful sense of belonging to one's community and a positive sense of identity apart from one's condition while rebuilding a life despite or within the limitations imposed by that condition."
>
> – Davidson et al., 2007, p.25

There are other definitions of recovery by other major organizations like the Betty Ford Institute (BFI), The American Society of Addiction Medicine (ASAM), Center for Substance Abuse Treatment (CSAT), and Alcoholics Anonymous (AA). Each definition has similar principles where the term recovery is in its definition. For example, AA describes its program as abstinence, whose 12-step process exemplifies spirituality and guarantees a new way of life. ASAM mentions reaching a "state of recovery" when psychological and physical health is achieved, maintained through abstinence from drugs with a propensity for dependency. The BFI defines recovery as a state of sobriety that is voluntary where individuals maintain a lifestyle change indicative of good health and community. Lastly, CSAT has a similar version to the most recent SAMHSA definition where individuals experience a change process of attaining abstinence leading to better health, quality of life, and wellbeing (Borkman et al., 2016). SAMHSA used CSAT'S definition expanding on it by adding the phrase "live self-directed lives and strive to reach their full potential" (SAMHSA, 2018). Although all of these definitions suggest recovery is an end-point, the reality is that recovery requires life-long maintenance and is therefore more of a process. As a facilitator, you need to recognize that recovery is a self-determined state and be accepting of each person's definition.

Most definitions of recovery mention concepts like spirituality, community, wellbeing, and living a better life abstinent from all substances. However, recovery definitions differ for everyone who has had a previous substance use disorder. In one study of people in recovery found that people in recovery identify in various ways. For example, not everyone that has had a previous issue with substance misuse identifies

as being in recovery. Some people preferred to focus instead on their lifestyle changes. The experience of recovery is highly individualized and internal values and morals influence both the process and the individual's outlook (Borkman et al., 2016). Abstinence is a common theme in most definitions of recovery. However, abstinence is no longer considered a requirement for recovery since the acceptance of harm reduction strategies. Harm reduction strategies may include focusing on decreasing the consumption of substances to reduce the issues that come with misuse (Borkman et al., 2016).

Principles of Recovery

When developing a ROSC, you may be questioned about the value or origin of the concept of recovery. SAMHSA has created many documents to define and present evidence to support these ideas. They have defined the principles of recovery as hope, person-driven, multiple pathways, holistic, peer support, relational, culture, and address trauma, strengths and responsibility, and respect (SAMHSA, 2010).

Hope	It is a must that people in recovery believe that they can cope and overcome their SUD and other mental health issues.
Person-driven	People in recovery are autonomous and in charge of setting goals and creating a way to accomplish them.
Multiple Pathways	People in recovery have different personal beliefs, and this should be honored when figuring out the best path.
Holistic	To sustain long-term recovery, a person in recovery needs to fulfill every aspect of their life from medication management to physical well-being, employment, and spiritual health. Mind, body, and soul.
Peer support	People in recovery need a person to follow that model a recovery type lifestyle. A person who has lived experience that they can share and use as a support.
Relational	Consists of family, friends, and peers who believe in the recoveree. They provide support and help the recoveree persevere.
Cultural	Services for a person in recovery should be culturally sensitive and competent, respecting their unique values.
Addresses trauma	Abandonment, sexual, physical, and emotional abuse must be acknowledged and treated throughout the recovery process.
Strengths and responsibility	The community, family, and the person in recovery are responsible for the recovery of that person. Family needs to provide support for the person in recovery, and the community is responsible for ensuring fair opportunities in employment, housing, and education for them.
Respect	Recovering from a substance use disorder or mental health issue is complex, and people that reach out for help exhibit courage. The sooner a community recognizes this, the quicker the stigma can begin to lose its strength, and this creates an atmosphere where a recoveree can get better and begin to give back.

Multiple Pathways to Recovery

There are multiple pathways to recovery because no one treatment modality or support system for addressing substance misuse works for everyone. Example of pathways include options with mutual aid support groups, various treatment modalities, medicated-assisted means for treatment, complete abstinence, and harm reduction methods (White, 2008) among others.

Mutual aid support groups espouse various philosophies around recovery. Faith-based support groups use religion as the foundation of support, while other support groups may incorporate cognitive behavioral therapy. The most well-known are the 12-step programs like narcotics anonymous and alcoholics anonymous (White, 2008). These mutual aid support groups are steeped in spiritual awakening and abstinence for recovery and span many countries across the globe. All of these groups are built on the concept that non-clinical individuals support one another in the recovery process to become healthier and improve their lives. Because of its long history and popularity, it has been accepted and recommended by many clinicians and people suffering from SUD (McLellan and White, 2012), although there are clinicians and people in recovery who do not find these programs beneficial.

One of the most important, yet controversial, treatment components for substance use disorder is medication-assisted treatment (MAT). MAT has been around for over sixty years (Mclellan & White, 2012). For opioid use disorder there are currently three medications available. Methadone and buprenorphine (brand name Suboxone and Subutex) are opioids that do not cause euphoria and sedation in the same way as other opioids and are opioid replacement therapies. Naltrexone (brand names Vivitrol and Revia) is a long-acting opioid blocker. This medication is not an opioid and instead blocks the opioid receptors not allowing opioids to bind thereby preventing euphoria, sedation, and overdose. MAT as part of a comprehensive treatment program which include counseling and behavioral therapy can be an effective pathway for recovery (McLellan and White, 2012). Recovery encompasses a change in lifestyle that requires more than treatment, with or without medication. MAT is controversial because some people believe that you are not in recovery with the use of medications. When developing a ROSC it is important to accept all pathways to recovery, including those that involve medications.

Harm reduction describes a variety of interventions which reduce the negative consequences of chronic substance misuse (Tsemberis, 2011). Harm reduction strategies are most often provided by community agencies or clinicians, however there are some that a person can access on their own, such as mobile apps for moderation management to reduce alcohol consumption. Another harm reduction strategy may be substituting one substance or method of consumption for another with fewer health impacts, for instance using marijuana instead of heroin or snorting instead of injecting. Community agency provided harm reduction can include needle exchange programs, providing fentanyl test strips, or providing Narcan (Ashford et al., 2019). These strategies can impact substance use and the spread of communicable diseases like HIV/AIDS and hepatitis C (Sawangjit et al., 2017). Harm reduction interventions by community agencies also open the door to opportunities to provide education and referrals for treatment. The state of Missouri opened the first peer-run hybrid recovery community organization (RCO) and syringe services program. While individuals receive new syringes to reduce their risk while using substances they also are met with peer-led services that help motivate individuals to initiate recovery (Ashford et al., 2019). It has long been established that individuals using heroin who utilize syringe exchange programs enter treatment programs at a higher rate than those who do not (Hagan et al., 2000).

Another form of harm reduction is the *Housing First Model*, which seeks to provide housing to those experiencing homelessness without requiring abstinence from substance use (Watson, et al., 2013). According to Tsemberis (2011) providing housing gives individuals hope, one of the core principles of recovery. You may find your ROSC coalition is interested in addressing housing as it relates to substance use but they may be opposed to the Housing First Model.

Despite evidence showing that harm reduction strategies are effective and lead to decreases in substance misuse, this model is still controversial. Many adversaries of harm reduction believe that this approach promotes protracted substance misuse (White et al., 2013). The resource guide at the end of this handbook provides additional sources of information related to the tension between those who see harm reduction as good public health and those who view it as endorsing substance misuse.

Building upon these concepts, recovery-oriented systems began to emerge among those whose primary responsibility is to support people seeking recovery. The system is there for each of the four stages of the recovery process (Lamb et al., 2009).

Four Stages of Recovery

1. Pre-recovery recognition, commitment and facing substance use.
2. Initiating recovery, beginning treatment
3. Transition of managing stable recovery
4. Continuation of recovery, ie long term recovery

CHAPTER 6

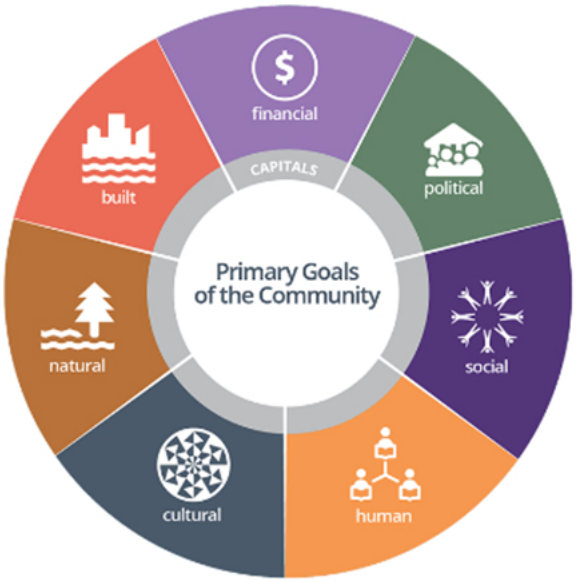
Recovery Capital and Recovery Supports

Recovery capital[4] refers to the assets someone has which make them successful in recovery (Granfiled & Cloud, 1999; White & Cloud, 2008). As people move from early recovery to long-term recovery, they build their recovery capital and their propensity for avoiding relapse. Recovery capital is divided into four categories: personal, community, social, and cultural capital (White & Cloud, 2008). Personal capital refers to those attributes and possessions of a single person, including housing, clothing, food, health, employment, financial stability, education, as well as intangible possessions such as hope and purpose. Community capital refers to attributes of the community that facilitate recovery and encompasses local laws, the actions and beliefs of elected officials, the justice system, and stigma

Community Capital

Note that community capital in the context of recovery capital is not the same as the Community Capitals Framework (CCF)[5] traditionally used in community development. For more information about CCF, please refer to Flora and Flora (2013). *See below.*

Community Capital Framework



Recovery Capital

[4] We use the definition created by White and Cloud (2008) in our approach which is not related to the community capitals framework from Flora and Flora (2013). SAMHSA also has a definition of recovery capital with four domains: health, home, community, and purpose (SAMHSA, 2010).

[5] For more information on the Communities Capitals Framework, see BEAULIEU (2015), https://extension.purdue.edu/cdext/thematic-areas/community-planning/_docs/evps-cc1.pdf

in the community. Social capital refers to friends, family, a place to belong, and activities that do not involve alcohol or drugs. Cultural capital draws on the morals and values and membership in a group to which they identify (Hillios, 2013). Culture can be different things to different people; cultural capital refers to resources that are sensitive to someone's cultural beliefs. Personal and community assets often fall into multiple categories of recovery capital.

Personal Capital

Healthcare	• Health
Social Services	• Housing • Food • Transportation • Clothing • Insurance
Business/ Employers	• Employment • Finances
Peer Support	• Hope • Purpose • Meaning • Self-esteem
Educators	• Skills • Education

Community Capital

Elected Officials, Law Enforcement, and Justice System	• Policies • Attitudes toward recovery • Recovery Community Organizations
Peers (people in recovery)	• Recovery Community Organizations • Substance free social activities
Health Department	• Community spaces
Substance Use Disorder Treatment Providers	

Cultural Capital and Family/Social Capital

Cultural Capital	• Treatment/recovery programs and events that are culturally responsive
Family and Social Capital	• Community Leaders • Familial Relationships • Friendships • Social Networks: School, Workplace, Athletics, Clubs • Faith-based leaders and places of worship

PEER SUPPORT AND RECOVERY CAPITALS

A burgeoning new role in the field of substance use treatment is the peer support specialist. They can have many titles and various certifications, but a fundamental requirement is having the lived experience of recovering from a SUD. Although some licensed treatment providers also have lived experience and may become peer support specialists, licensure is not required, not is any counseling training or formal education for providing treatment or therapy (SAMHSA, 2022). Peer support specialists serve as a conduit between the person needing services and clinical staff or service agencies. Peer support specialists help individuals build their recovery capital. They can connect in a different way than clinicians and

social workers because of their similar history (White & Evans, 2014). Studies suggest that peer support specialists have a positive impact on recovery, from treatment initiation to recovery management, including reducing the rate of relapse while being cost-effective (Ashford, Curtis, et al., 2018; Hymes, 2015; Laudet & White, 2010).

Certified peer specialists are trained in a multiple pathways to recovery ideology and give the person seeking recovery the opportunity to be autonomous. The peer support specialist offers some of the same support of a 12-step sponsor, a mentor, and an addictions counselor (White & Evans, 2014). In the 12-step paradigm, a person serves as a mentor (sponsor) to guide others through the process of recovery. Sponsors volunteer their time and work one-on-one with people through a 12-step program, adhering closely to the philosophy of abstinence. Although peer support specialists may volunteer their time, they often find employment with healthcare organizations and substance use treatment providers. Their services are billable under a licensed provider in many states, but they cannot act independently. The peer support specialist may provide non-clinical assistance (e.g., filling out job applications, finding housing or transportation). Peer support services are subject to the same or similar ethical boundaries as licensed addictions counselors, where there are consequences for a breach in their ethical and legal duties (Hymes, 2015; White, 2006).

CULTURAL HUMILITY

Cultural humility is the ability of a person to understand and recognize their biases toward other groups, and the realization that none of us can be experts in the culture of others. It is a commitment to self-reflect and grow, with the goal of creating mutually beneficial partnerships among community organizations and members. It is ultimately the ability to remain "other-oriented" and open to the cultural identity of others (Peer Cultural Cooperative, 2020). Organizations that use this philosophy also believe in a client-centered approach to care (Fisher-Borne et al., 2015).

RCOS: RECOVERY COMMUNITY ORGANIZATIONS

The RCO, or recovery community organization, is a not-for-profit, stand-alone organization led by people in recovery. Their purpose is to support people in recovery, from providing direct peer services to advocacy and policy change. Currently, many RCOs are run by people in recovery and all the services are provided by peers (Ashford et al., 2019; Bassuk et al., 2016; Hay et al., 2017; Hayashi et al., 2010).

The benefit of a RCO is that it can serve under-resourced communities of people who have no insurance, are under-insured, are experiencing homelessness, have no job, and are unable to get treatment for their SUD by traditional means (Ashford et al., 2019). RCOs are supported through grants, the donations of people in recovery, and the support of other organizations in the community. Often, the organization will be unable to offer all the services that it would like to provide (Ringey, 2020).

RCOs are much different than a ROSC, as a ROSC consists of agencies, stakeholders, people in recovery, treatment providers, and other support service providers necessary to help on their pathway from prevention prior to exposure to use to treatment and recovery. RCOs are an important piece of the ROSC and, if present in the community, should be invited to participate in ROSC development.

STIGMA

In his 1963 book, Stigma: Notes on the Management of a Spoiled Identity, Goffman describes stigma as any "attribute that can be discrediting" in the eyes of the greater society impacting access to things that others in society have access to (Clair, 2018). Studies reveal five kinds of stigma exist related to substance misuse- public stigma, enacted stigma, structural stigma, self-stigma, and perceived stigma (Luoma et al., 2010; Tsai et al., 2019). Public stigma describes the attitudes of people in the community toward substance users. Enacted and structural stigma are related to organizational attitudes toward people with a SUD. These attitudes commonly appear in the criminal justice system and healthcare organizations. Self-stigma, or internalized stigma, is how substance users view themselves and perceived stigma is how people with a SUD feel the community views them. Perceived stigma and internal stigma are both harmful to individuals and communities (Adams, 2020a).

Goffman explored the concept of a "spoiled identity" where someone is identified and labeled by their illness instead of as a person. Stereotyping and labeling people with terms such as 'addict' may elicit negative responses based to beliefs about the term (Ashford, Brown, et al., 2018; Link & Phelan, 2001). Pairing self-stigma with community stigma around a label perpetuates stigma in society and can affect recovery capitals such as employment and housing (Brown, 2008).

Healthcare providers are not immune to stigma against people with SUD. Healthcare providers have reported that people with SUD are "non-compliant" as patients, are untrustworthy, mismanage medications, are viewed as reluctant to modify their high-risk behaviors, are out of control and have no support within their community (Earnshaw et al., 2013). Even worse, healthcare providers that perceive substance misuse as controllable are more likely to discriminate against IV drug users (Brener et al., 2010). Licensed professionals, such as physicians and nurses, may view people using substances as threatening, dirty, having infectious diseases, and/or of low character (Natan et al., 2009).

There have been concerted efforts to reduce stigma in healthcare by changing the language used to describe substance misuse. Person-first language is another way to address stigma, as this type of language has a destigmatizing effect (Kelly & Westerhoff, 2010). For example, rethink the use of words to describe a person, such as "clean" and "dirty," in reference to substance misuse, when they are not used to describe other chronic diseases such as diabetes or heart disease. The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Version 5) reference guide for diagnosing mental health conditions, including substance misuse, has removed the term addiction from the diagnostic criteria for substance use disorder and purposefully removed dependence as a diagnosis to further distinguish the mental health diagnosis of substance use disorder from medical diagnosis of physiological dependence (American Psychiatric Association, 2013).

Recovery journeys are not the same from person to person, but share similarities, even in how people identify themselves as being in recovery, have recovered, or are still in recovery with symptoms that manifest (Brown, 2008). The term substance use disorder is a clinical term that has been promoted to reduce stigma; however, some people in recovery have difficulty accepting the term. Some people in recovery embrace the word addict, as a way for it to lose its power. If a person calls themself an addict, then the word can lose its power to be hurtful or shameful. Words and their meanings change over time, so it is important for people working with those with SUDs and in recovery to be reflexive, intentional, and considerate about the language they use and always defer to the preferences of the people with

whom they are working. If someone in recovery has decided to join the coalition to represent a voice from firsthand experience, then more than likely, they are not going to be offended if asked about how they identify.

People with a substance use history may experience stigma from family, friends, and co-workers. Stigma in the workplace is linked to lower wellbeing and elevated stress levels for people with an ascribed status (Earnshaw et al., 2013). Structural stigma can be found in government agencies and policies. ROSC coalitions which include members from across the community, including policy makers, can be effective in addressing all forms of stigma. New research supporting person-centered approaches to recovery, acceptance of multiple pathways to recovery, and changes in public health policy are making the development of ROSCs more common.

Practice Questions

- **What approach does your local justice system (from law enforcement to the courts and corrections) take towards justice involved individuals with substance use issues?**
- **Is public safety the sole focus or are they incorporating public health?**
- **Is the goal to punish people into rehabilitation or provide personal capital to help them change their lives?**
- **Is recidivism a problem and are they trying to address it?**
- **What services are provided in jail?**
- **Does law enforcement have Crisis Intervention training? Do they carry Narcan?**

CHAPTER 7

Learning About Your Community

For the most effective ROSC, all stakeholders must be encouraged to participate, and to feel comfortable contributing from their perspective. Inviting participation from all segments of the community, especially those who have felt marginalized or who have not had a voice in community conversations, is an important role for the Extension educator working to facilitate involvement and engagement. The following sections list options for soliciting participation which will provide robust information about the community in all its facets, from the people who live there.

When starting to learn about your community, you should keep two main concepts in mind. The first concept is the Principles of Good Practice from the Community Development Society. These principles provide overarching guidelines on how to conduct yourself and your work in a community.

Principles of Good Practice

The Community Development Society has established and embraces the following Principles of Good Practice for the field of community development:

- Promote active and representative participation toward enabling all community members to meaningfully influence the decisions that affect their lives.
- Engage community members in learning about and understanding community issues, and the economic, social, environmental, political, psychological, and other impacts associated with alternative courses of action.
- Incorporate the diverse interests and cultures of the community in the community development process; and disengage from support of any effort that is likely to adversely affect the disadvantaged members of a community.
- Work actively to enhance the leadership capacity of community members, leaders, and groups within the community.
- Be open to using the full range of action strategies to work toward the long-term sustainability and well-being of the community.

Second is the Phased Planning Model. The Community Development Library (CDExt Library, https://cdextlibrary.org/), home to the *Taking Action to Address Substance Use in Your Community* (TASC) program, describes a phased planning model consisting of six phases. Learning about your community encompasses the first three phases. The first phase is Initiating and Scoping, followed by Organizing and

Assessing. What follows is a description of each phase and a list of questions. While general in nature, these questions are important to consider in the context of TASC, especially when you are learning about the community and, at the same time, determining whether TASC is a good fit for the community and whether the community is a good fit for TASC.

Source: Community Development Library (CDExt Library, https://cdextlibrary.org/)

INITIATING & SCOPING

Concept: Preliminary planning before you even know if you will be working with the group.

Questions to ask yourself:

- Does this fit into one of the program priorities in our Extension system [state]? Do I need to talk to my program leader/supervisor to better understand our program priorities?
- Do I have the time and expertise needed?
- Does the community have the commitment (time, administrative capacity, etc.) to work in partnership with us?
- Does the community have the financial resources to engage Extension? If not, can they acquire the resources elsewhere (with or without our help)?
- What is my role? What is the community's role?
- Is the community willing to adhere to our principles of practice, including an inclusive, open process that is sensitive to issues of race, LGBTQ inclusion, etc.?
- Do you feel well connected with the organizational structures, individuals important to this process?
- Has a needs assessment been conducted in this community that will inform the process?
- Is there trust between Extension and the community?
- Are we aware of all the agendas [power dynamics] present in the community?
- Are there partners that the community is not aware of that we could bring to the process?
- What will it take to move the community to the next phase?

Questions to ask the community:

- Who is involved?
- What do you see as the issue?
- Who do you see as key stakeholders?
- What are you hoping to accomplish?
- What is your timeline?

- What has been done in the past?
- Are there plans or other documents, organizational structures, individuals in place that must be brought in that aren't here now?
- What do you see Extension's role to be?

Check-out questions to make sure you are in sync with community expectations:

- Shared expectations?
- New stakeholders?
- New assets external/internal?

ORGANIZING

Concept: Preparing to do the work, determining how we will work together and being intentional about defining desired impacts.

Questions to ask yourself:

- What will be my (Extension professional) role in this process?
- What impacts are appropriate? (Look to the impact indicators)
- How will we measure impact?
- To determine next steps (what will it take for the community to take the next step):
  - Do you have clearly articulated shared expectations with the community?
  - Do you have tools in place to carry out the work effectively (facilitation techniques, meeting management techniques)? competencies
  - Do you need to involve other colleagues (other Extension personnel) to bring independence or expertise?
  - What are our shared expectations with the community? (should be asked in all phases) Ground rules

Questions to ask the community:

- Who should be/must be involved (stakeholders)?
- How will these stakeholders be organized?
- Who is the point of contact with Extension? Is it a committee, an individual? Is the need for a single point of contact understood by the community?
- Define roles and responsibilities for each stakeholder or each stakeholder group.
- What is the project timeline?
- How will we manage logistics? (setting meeting times, taking notes, sharing information and updates, finding the meeting place, etc.)
- How will we make decisions?
- What are our shared expectations with Extension? (should be asked in all phases) Ground rules

Check-out questions to make sure you are in sync with community expectations:

- Shared expectations?
- New stakeholders?
- New assets external/internal?

ASSESSING

Concept: Gathering and analyzing data to inform decisions and actions. Making data informative/ understandable to all.

Questions to ask yourself:

- What will be my role in this process?
- What primary data is available and useful?
- What secondary data is available and useful?
- What does the analysis say about past, present and future trends?
- What tools are available and appropriate for the situation? Which should you use?
- How do we 'do' the analysis?
- Who is already collecting data in the community and how do we access it?
- What will it take to have the community move to the next step?
- Who is still not at the table?

Questions to ask the community:

- What primary and secondary data have you already collected?
- What input would you like to add regarding the data presented?
- Which anecdotal data and stories add to the overall picture presented?
- What intangibles need to be considered and which are affecting current outcomes and how?
- What barriers need to be considered and which are affecting current outcomes and how?
- How do we interpret the analysis? What does it mean?

Check-out questions to make sure you are in sync with community expectations:

- Shared expectations?
- New stakeholders?
- New assets external/internal?

Source: Community Development Library (CDExt Library, https://cdextlibrary.org/)

Answering these important questions and developing a plan to move TASC forward requires using community assessment tools. While there are many tools to choose from, here are descriptions of several tools that should be considered.

Community conversations

Through community conversations, coalition members or the facilitator can explore perspectives of residents and subgroups within the community. These conversations are useful at the beginning of the coalition to help establish expectations and build awareness, or later, to gauge how the community perceives or experiences the changes that take place. Community conversations are useful for engaging people who don't take an active role in coalition meetings, for meeting with groups who don't usually participate, or for exploring perspectives within a sector or population. For example, a conversation with health professionals, compared to one with leaders of faith organizations, will provide different insights and identify similarities between the groups as well. Community conversations demonstrate that these issues are relevant across all sectors of society, and help build a culture of recovery and hope. Community conversations can add legitimacy to the work, by identifying what community members care about and what changes they want to see.

Storytelling

Through storytelling, people share their experiences, identify specific scenarios that the current system is unable to address, and shed light on community perceptions of the current system. Storytelling is a major component of the ROSC mapping process using a CAS model, as the experiences of community members form the pathways of the ROSC map. Storytelling contributes to the development of the ROSC by breaking down stigma and building stronger connections between people. For some, this may be the first time they share their experiences publicly, which can be empowering and allows others to witness their struggles. It can be especially powerful when local leaders share their experiences with substance use, tearing down stereotypes (Kennedy, 2022). Community members see evidence that this issue can affect anyone, and that there is hope for recovery.

Community assessments

Assessing the community, using qualitative and quantitative analyses to find patterns and trends in the community, can inform projects and identify areas or topics that need attention. A community health assessment, or health needs assessment, is something many communities do regularly. County and state health departments, existing coalitions, and government agencies or non-profits may have information to share. The resource guide at the end of this handbook has links to some sources of community level data.

Resource maps

A resource map lists needs and resources. It is often the first tool that coalition members want to create and must be updated often. A comprehensive list of resources at the beginning of the project can help identify stakeholders for the ROSC, and frequently updating the list will create a current list for new members to use. Format the resource map with the understanding that maintaining the list will require time and attention.

Stakeholder interviews

Stakeholder interviews are a key component of the CAS map of the ROSC. The facilitation guide provides a step-by-step guide to leading the coalition through interviews to gather the data to produce a robust map which reflects the values of the community and can be used to guide project work. Interviews are important for understanding how a stakeholder is affected by issues, how they see the community, how they feel about the system and the problems they encounter, what they would be willing to contribute to a solution, and what ideas they might have for reaching a solution. These interviews provide an opportunity to build trust and connections with stakeholders and the coalition.

Journey Mapping

Journey mapping shows the path a person follows as they navigate their community to access various resources (Bearnot & Mitton, 2020). Think of the CAS map of the ROSC as a journey map of everyone in a community, showing how community resources are connected, how people travel through the system, and where they get stuck. The mapping process gives coalition members an opportunity to reflect on the experiences in their community and identifies what is working and what is not working in the current system. These experiences are data that can be coded and themed to be used in brainstorming solutions and identifying critical process points in the community system.

CHAPTER 8

Putting Concepts into Action

Previous chapters reviewed the foundational concepts needed to facilitate coalition work. The first goal of the coalition is to create a complex adaptive system (CAS) map of their community recovery-oriented system of care (ROSC). This begins with identifying the components in the system made up of organizations and agencies, such as law enforcement, key players in the criminal justice system, elected officials, community members, community leaders, business leaders, community partners, social service providers, SUD treatment providers, religious leaders, peer support specialists, and other people in recovery. In an ideal ROSC, there is "no wrong door," meaning that anyone looking for substance use recovery or related resources could locate resources regardless of where they start, because organizations are linked and can refer people to other relevant, involved organizations. In diagramming a ROSC, drawing connections between components indicates a personal connection between organizations which provide a "warm hand-off" instead of a resource list. The direct connection or warm hand-off allows the person seeking assistance to focus on recovery instead of on finding help.

The CAS map helps people see how processes are working, how people move through the system, where the barriers, gaps, or limitations are, and what entities perform certain functions and roles and the relationships among entities. Details of creating the CAS map are found in the facilitation guide. The map allows people to quickly absorb the scope and function of a system, whereas describing it in words would take much longer. The system map can be critical in helping stakeholders and coalition members understand what the group and community is trying to achieve. It has also been critical in building buy-in and helping individuals and agencies recognize their role in the process and next steps for action. These can often be described as "ah-ha" moments that bring clarity of purpose.

Step-by-step instructions on leading the coalition through the process of creating a CAS ROSC map are in the facilitation guide.

CHAPTER 9

An Asset-based Approach to Action Planning

With the CAS map of their ROSC, the coalition can use it to plan action strategies. The strategies are most effective when they build on existing resources or assets, rather than waiting for external investment. A traditional approach to addressing a problem in a community is to conduct a needs assessment, identify the problems, and then devise solutions. Historically, needs assessments can prove useful in identifying problems, gaps, and barriers and rarely focus on solutions or assets. When communities focus on what they are lacking, they can become mired in trying to attract new organizations and discouraged by the problems in their community.

Recently, more assessments are asset-based, and focus on existing resources and community-driven plans. There are many asset-based approaches, but all follow the same fundamental tenets of using the resources which are available. Several asset-based publications and programs are on the resource list. Improving communication among stakeholders in a community can lead to innovative approaches and improvements using resources and assets available within the community (Wilcox, 2015). The key components of the appreciative inquiry process, an asset-based approach, are *appreciating* assets and leveraging *inquiry* to think differently about the community. An asset-based approach asks, *What do we have*? instead of *What are we missing*?

Asset-based approaches include a robust assessment of the community, which includes a review of past conditions, assessment of current conditions, and a look toward the future. Attention must be paid to acknowledging those assets that are producing positive outcomes in the community and work to preserve and even augment those assets.

STEPS TO USING AN ASSET-BASED APPROACH AND THE CAS MAP OF THE ROSC

1. **Use the CAS ROSC map to identify projects**
   The CAS map illustrates how organizations interact and how a person seeking recovery moves between organizations. Red dots and red arrows on the map, representing the gaps and barriers in the ROSC, can identify your first projects. Small action groups form around a red dot or arrow (or a few dots/arrows if they are related) which represent gaps and barriers in the system. These action groups must include representation from the organizations on both ends of the red dot/arrow. Once the project is completed, the small group disbands, and members may join a different action group. Coalition members may be part of several action groups at once. The facilitator can help organize these groups and ensure that the target organizations have representation.

2. **Imagining the future**
   Once the action groups have formed, they begin visioning, imagining what the system or experience would be like without those red dots/arrows, phrased in a positive way. For example: *Imagine if in our community, everyone had transportation to treatment.* This is a more positive way to say: *Imagine if in our community, transportation was not a barrier to treatment.*

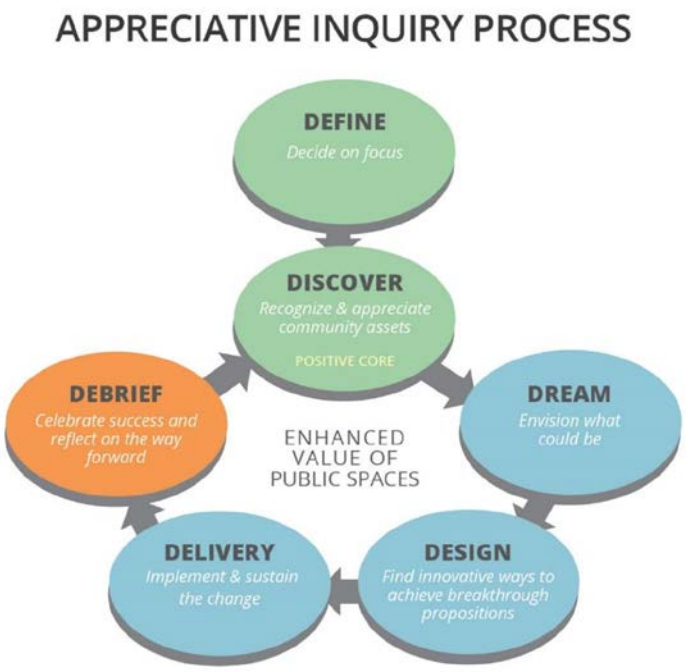
3. **Identifying assets**
   Identify assets, starting with community assets. Keep the focus on assets, not deficits. For example, instead of *we don't have enough treatment providers*, focus on those that do exist, *we have three treatment providers in our community*. Next, we focus on the assets that belong to individuals in the coalition. Each person in a workgroup will list the assets they can dedicate to a project. These may be tangible or intangible assets and may or may not immediately seem related to the goal. For example, a business owner may have a parking lot that is not used on Sundays, where an event could be held (tangible) or the mayor has the authority to change a policy under city control (intangible). List only those assets which the person can provide to a project.

4. **Think creatively and design a project**
   Once assets have been identified and listed for everyone to see (using a whiteboard, Google Jamboard, projection screen, etc.), everyone needs to think creatively about how the assets could be organized into a project related to the goal. The question is, *what can we do with what we have?* It may be helpful to have the facilitator look at the board with a fresh perspective. The project that develops from these assets should be accomplished in 90-120 days and must not require the contributions of people or assets not in the action group. If the initial project requires additional contributors or is ambitious, a planning project may be the best first step. Planning in small, short-term increments is an effective approach. These projects can seem simple or trivial, but by completing many small projects, change happens. After participating in these projects, organizational leaders may shift their thinking and make changes in their own organizations. More importantly, effective lines of communication are being developed.

5. **Determine measures**
   Decide how you will measure the success of your project. Publicly available data or data provided by one of the action group members can be used as a measure, or it might be necessary to create a new tool or measurement. For example, the coalition may choose to measure overdose mortality, arrests with drug charges, or 911 calls for overdose. Other coalitions may choose to count the number of organizations represented in their meetings, connections between the organizations, or projects completed. Make sure that data is available for the measures you select, and that the measures provide meaningful information to the coalition. The facilitation guide provides more information on determining which measures would be appropriate for your community.

6. **Timeline, meetings, and begin**
   The final step in this process is to develop a timeline of activities, to complete the project within 90 to 120 days. Sometimes you will have a small group which wants to address an issue, but they don't have all of the key players and need time to coordinate the right people. In this case, a 30- to 60-day timeline may be appropriate to bring everyone together. The group must decide how often to meet

(at least once a month), and what they will do in those meetings. They must also decide how they will communicate with each other. The meeting agendas can include a reminder of the goal, an update to keep everyone on track (takes 30 minutes or so), and homework assignments (about one hour of homework to be completed before the next meeting). The facilitation guide contains some tools that you can use to create a visual timeline.



CHAPTER 10

Sustained Systems Transformation

The coalition will operate most effectively when participants feel comfortable and confident to speak from their perspective, candidly and without hesitation. The facilitator's role is to create an environment that supports broad participation with a focus on the coalition goals. Prior to the first meeting, develop a "recommended" or "suggested" set of rules and ideal practices to guide group social dynamics. Include expectations of how people will treat one another, and that the coalition workspace is meant for resolving divisions, addressing concerns, and forging partnerships as equals. Suggest that members add, delete, or revise rules and ultimately confirm, as a group, the rules that will govern the coalition. These rules should be modified as needed and as the coalition grows, but it is important for everyone to know the expectations for the group. Post the rules at each meeting. The goal is to establish an environment where all participants, with their various experiences and perspectives, are treated with respect and encouraged to participate.

Practice Questions

A community member saw Liz's flyer in the local paper about the ROSC workgroup and called the Extension office for more information. She quietly attended the second meeting and later emailed the educator to say that she was interested in sharing her story about a family member who had passed from substance misuse but was concerned about confidentiality. The educator told her that the interviews were confidential and that names would not be shared, though if she were still nervous, she could be interviewed by the educator. She agreed to do that and set a time and date.

- **How will you protect the confidentiality of others, both in your words and actions?**
- **How will you help people feel safe sharing?**

Hierarchies exist among community organizations and leaders. Some organizations may have multiple people involved who have an established power structure within their organization. Some individuals know more about issues or aspects of the community, and others will defer to them for their perspectives and judgments. As the facilitator, it will be up to you recognize uneven power dynamics and work to dismantle them (at least in the meetings; you cannot control what they do when they leave). Take time to open each meeting with an icebreaker or sharing activity to help build a more social and collaborative group. The sharing activity should not establish or reinforce the hierarchy. For example, instead of asking "what did your organization accomplish?" ask, "what important or inspiring events or changes happened in your community this past week?" As facilitator, you may also purposefully elicit divergent perspectives. In online meetings, you might ask people to respond to a question in the chat, but not

submit their response until the facilitator asks everyone to do so at once. Then, no one is influenced by other responses. Anonymous polls are useful because no one knows who chose what.

Representatives of agencies or businesses might be reluctant to share with coalition members whom they view as competitors. The facilitator can help them strike a balance between sharing and security. In some communities, members have existing disagreements. Understanding these dynamics will help clarify conflict or hesitancy among coalition members. When it seems that people are being difficult, they may be trying to protect themselves or their agency.

People from the recovery community may be stepping out of their comfort zone to contribute to the coalition work. Since this is a new experience for many of them, it will require a conscious effort to encourage them and give them opportunities to share their views and perspectives. Their voices inform the group about what is going on in the community, how recovery is experienced, and what can be done to improve it.

There may be differences in language and communication culture among coalition members. Be mindful of words, terms, and assumptions. Some terms may be unfamiliar to the group, others may be hurtful, and some engender multiple forms of interpretation. Spend time to ensure that coalition members and stakeholders can understand one another and work together with minimal misunderstandings and mutual respect. The objective is to create an environment where each person can contribute to the shared goals of the coalition.

Same Word; Different Meaning

The word "diversion" is often heard in discussions about substance use but does not always describe the same activity. It is important to define the word and the context in which it is used.

In the criminal justice system, diversion is a positive activity and refers to diverting someone from jail to community-based services.

In healthcare diversion is a negative activity and refers to diverting medication away from the intended patient for illicit use.

A ROSC approach transforms, rather than replaces, most traditional recovery systems. When creating a ROSC, it is not about replacing current services and organizations; a robust ROSC represents strong connections among existing resources which improve the system. The approach described in this handbook is based on a hybrid version of an asset-based action planning approach using a Complex Adaptive Systems (CAS) model (See Chapter 7 and 8). These concepts will be described and their application in this model explained in this chapter. The model functions as an inclusive system thinking approach, focused on a collective vision, action steps, and projects based on the assets available to make change. ROSC, an asset-based approach, and CAS foundations work well together when putting theory into practice and producing results.

Facilitating for Sustainability

Your goal as a facilitator is to work yourself out of a job. If you are successful in building capacity, other community leaders will be able to sustain the process without your guidance. Your role is to help the ROSC develop and teach community leaders about systems thinking and self-reflection on the efficacy of the process. Are we still missing stakeholders from our coalition? Were the right people involved in projects? Is the community changing? Where did we start and where do we go next?

There are different ways to create capacity in communities. As you get to know your community through this coalition, you will be able to identify their needs for further trainings. This requires a moderate understanding of what skill sets and character traits are helpful for the community to accomplish its goals. For example, some people may not understand addiction and recovery, while others may not understand how to plan projects that involve multiple organizations. Your role as facilitator is to identify these needs and training activities, which may involve finding local and state level content experts to present to the coalition. The information in this handbook can be very helpful in understanding what skills will likely need to be leveraged, but information must be transformed into action. It requires searching for literature, programs, mentors, and other similar resources that can help cultivate personal skill sets and knowledge.

Useful Tools for Measuring Impact

Many tools and products can be used to guide the process and identify effective strategies. Develop an understanding of the community landscape to gauge readiness and to establish baseline data of current conditions, and assess what the community needs prior to starting transformational work. The baseline data or starting point is important, both in moving forward with effective work and when looking back to determine the impact of that work. The facilitation guide includes tools and resources for finding data and calculating local estimates. There are also tools for measuring how the coalition functions.

Collecting information about the community, and from the community, will be one of the most important stages of the transformation process. At the core of the strategic use of the local community oriented and grassroots tools is the application of as asset-based approach. This is a fantastic method to develop an understanding of the experiences, attitudes, and resources of a broad range of community members and stakeholders. An asset-based approach should be part of the process when using the tools listed below. It will help develop understanding and guide the group to develop and implement equitable and effective solutions.

Overcome Challenges

Overcoming challenges does not only require strategy, but a mentality which accepts the inevitability of challenges and barriers and retains the fortitude and creativity to address them. The coalition's work should be framed around what can be done, it should not dwell on what cannot be done or what the limitations of the group are. This means thinking in a strategic and aspirational way. However, aspirations can sometimes be miscalculated or overreaching for the moment. It does not mean pursuing them is a waste of time, it just may require a different perspective or a reorganization of assets to achieve the desired result. Do not let the failure of one approach end the pursuit of the desired outcome.

To address challenges think of three strategic approaches: manage, avoid, and resolve (Brennan Ramirez et al., 2008). The foundation of this work is managing challenges. Substance use is a complex social issue that will never be resolved; however, it can be managed to have a lesser impact on the community. This may require asking questions to reframe the challenge and focus on achievable goals and not the enormous challenge of substance use. You will likely also need to manage the expectations of some of the coalition members who come to the meetings expecting only to advance their own organization, rather than contribute to the community efforts.

Although it may seem counterintuitive, or at the very least unfruitful, to avoid a challenge, that may not be the case. For example, a missing community sector may mire the coalition in negativity and focus their work on attracting a specific stakeholder. However, projects can still be completed and have positive impact without every stakeholder participating. As the coalition begins to have influence in the community, additional stakeholders may become interested in participating.

Resolving may be the most desirable way to achieve a goal, but it may also be most difficult if the challenge is too complex. Again, the emphasis is on determining what can be done. Resolving a challenge like substance use is not a realistic goal. However, setting goals which are achievable and contribute to addressing the larger challenge can help the coalition accomplish change. The smaller the units the easier it will be to solve challenges through resolution.

To summarize, looking at solutions on a spectrum is about not giving up but working to find other solutions. Furthermore, transformation is a collective effort that involves many people working addressing different challenges and over time a problem that must be avoided at the beginning of a transformation effort could become one that can eventually be resolved (Brennan Ramirez et al., 2008).

Group Dynamics

Groups go through different stages and making those dynamics clear to the group can contribute to the sustainability of the coalition. Tuckman (1965) devised a model which posits that groups go through four stages. These stages have come to be known as forming, storming, norming, and performing. At the beginning, when the group is forming, participants are excited to be working on a project and they bring energy to the group. As the group continues working together, norms start to develop. However, when they move into the storming phase, they may get stuck. During this stage, there might be differences over direction, how to address a problem, or even what problems to address. Conflict may ensue if the group does not have solid norms for positive interaction. While productive, this stage can also feel uncomfortable and frustrating. Calling out this dynamic can normalize the discomfort and the facilitator can encourage the group to trust the process.

Succession Planning

For Extension Educators, a time will come when they need to transition from non-stakeholder leader to general member or completely out of the coalition. This requires identifying another organization or person to take over the role of primary facilitator. Once the new leader is identified, a smooth handoff should take place over the course of one to two meetings. When this transition should occur is difficult to predict and will vary from community to community.

Same Word; Different Meaning

If you answer "yes" to most of these questions, you are likely ready for succession.

- Are meetings routinely scheduled and well attended?
- Have several projects been completed?
- Are there natural leaders emerging within the group?
- Are there a wide variety of people represented on the coalition?
- Have all major organization in the community joined the coalition?

Conclusion

This guide should be able to paint a broad picture of what the work ahead will look like in general. Keep in mind this material should be used as a guide but allow the community to shape how transformation will happen. Each community will have its own unique needs and character that will require flexible approaches and solutions. Remember, the process of transformation is as important as the end result (White, 2011). In a complex adaptive system, the process will largely be defined through what the community desires and is able to do.

The content provided throughout this guide should offer an arsenal of knowledge, strategies, and tools to use as a facilitator. If all this content causes some head spinning, do not worry. This material constitutes years of work condensed for preparation purposes. Transformations take time and will inevitably involve delays and challenges but allow the community to guide the process. Take time to sharpen techniques and skills and focus on learning how to support those who want to make positive changes. We hope this guide will impart insight and enhance recognition of what to expect and what can be done as the transformation process unfolds.

Case Study: Tippecanoe County, Indiana

To effectively convey the impetus of using a CAS approach for ROSC development, it is best to examine the case of Tippecanoe County. Tippecanoe County is considered an urban county in west central Indiana, containing the cities of Lafayette and West Lafayette, but surrounded by agricultural land and smaller rural communities. The 2021 estimated population falls just below 200,000 people. According to census data (U.S. Census Bureau, 2021), approximately 40% of residents possess a bachelor's degree or higher and median household income is $49,352. However, 22.3% of residents, age 18-64, live in poverty and 6.5% of residents are without health insurance. Tippecanoe County and the Greater Lafayette area serve as resource hubs for the surrounding counties and communities. Many people travel to Tippecanoe for shopping, healthcare, government offices, and education. Furthermore, it is the home of Purdue University, and since people depend on resources and systems in Tippecanoe County for a wide variety of needs, it is an ideal place to set up a ROSC using a CAS approach.

In Tippecanoe County, the United Way of Greater Lafayette (UWGL) had been conducting community conversations and collecting information on what the community felt the most pressing issues were through 2016 and 2017. Mental health and substance use were consistently rising to the top, with highlights on opioids as particularly life threatening and damaging to the wellbeing of the community. Similarly, at the state level, Indiana United Ways (IUW) was hearing similar information throughout the state. IUW then gathered resources and implemented a program in conjunction with AmeriCorps in the fall of 2017 to address these issues. It provided personnel and support to local United Ways in interested counties; this improved UWGLs ability to focus its Community Impact department's efforts on substance use and mental health issues. Meanwhile a grassroots group called the Heroine Task Force had assembled in Tippecanoe County. It was an independent group that was made up of participants of the Drug-Free Coalition of Tippecanoe County (DFC) and their extended network. It was not a subset of the DFC, but it did share information, volunteers, and meeting space. The Heroine Task Force completed several individual projects, though it did not focus on system transformation or continued efforts, and many of its members had moved on from the work. By late 2017 it had become a discussion group about opioid issues in the county.

In the fall of 2017, UWGL began more direct networking and engagement, moving beyond conversations and landscaping to asset mapping and partnership building. Through outreach, UWGL began to identify champions in the community and start a dialogue about transforming the system and expanding capacity. The Heroin Task Force members became aware of UWGLs involvement and they desired to restructure their group with stronger facilitation. They asked UWGL to take over its facilitation and begin action-oriented work. UWGL agreed and rebranded the group as the Opioid

Task Force (OTF). In the winter and spring of 2018, the OTF started assembling a larger group of participants and began conducting some processes to identify some different projects that subcommittees could work on. The group was broken into four categories- prevention, law enforcement, treatment, and recovery. As the number of participants grew, each of these groups was able to create smaller more focused work groups within themselves. The skill sets of the facilitators included appreciative inquiry; this was the main tool used in the project identification process. Facilitators had some experience in collective action strategies and collaborative community partnership-based projects. This experience was used to guide the early trial-and-error process, seeking effective strategies and projects. This approach was primarily an open-source project identification process where community partners listened and brainstormed with each other. In addition to growing the OTF, research and discussion with recovery champions led UWGL to conclude that achieving a ROSC was the desirable outcome of the work. The intention to achieve a ROSC was a major development in the process because it helped the community identify a shared vision. There was significant conversation about how to build a ROSC. The first approach focused on identifying and connecting resources to implement a hub and spoke model.

Meanwhile, the state legislature was rolling out new policies and funding opportunities. The expansion of treatment options and the opening of the methadone clinic, access to Recovery Works dollars, and trainings for community and organizational leaders were just a few of ways the state's efforts contributed to the work in Tippecanoe County. Furthermore, through the winter of 2017 and into 2018, UWGL kept an eye on opportunities at the state level, applied, and was awarded grant and pilot opportunities. These efforts ran parallel with the work the OTF was doing and included several of the same stakeholders. One of the biggest successes was the development and launch of the county Quick Response Team (QRT) in late 2018. The UWGL and its partners subsequently obtained a $1.7-million grant to maintain the activities of the QRT. A key partner was Phoenix Paramedic Solutions and their community paramedicine model. Phoenix worked with community partners to design a process where peer recovery support specialists were teamed up with a paramedic or EMT. This also operated in partnership with the sheriff's department, which provided overdose reports to help the QRT reach individuals in need of their service. The model was a success and QRT expanded to offer more services in more counties. For example, they provided transportation to clients that lived in one of three counties that the grant served. Transportation was provided for people that were being released from jail, seeking treatment or detox, to help clients get set up with services, doctors' appointments, court, and even food pantries. They also created a 24-hour hotline that connected many clients, who might otherwise not know how to navigate the system, to treatment services.

In a matter of months, a transformation began to take shape. By summer 2018, there were many tangible changes. Partnerships across the community were beginning to form or strengthen, service capacity had increased, the objective of a ROSC was identified, and attitudes about people with substance use disorders were generally improving. The community was seeing a burst of energy around its systems work and had workgroups comprised of people in recovery, law enforcement, faith organizations, educational institutions, mental health and treatment providers, families, and many more working in conjunction on a multitude of projects. However, it still struggled at moving toward the comprehensive ROSC model and was continuing to hit road blocks. One big reason is that the group was continuing to try and pull together resources to implement a hub and spoke model to operate the ROSC. However, the facilitators and champions were not discouraged from trying to achieve a ROSC. They realized a strategy shift needed to take place. Seeing how the piecemeal grassroots efforts had been,

and continued to be, successful, they pushed forward. Additionally, they were provided an opportunity for help through Purdue Healthcare Advisors (PHA). The PHA team consulted with the core strategy group as well as with agencies and partners and provided feedback on what was undergirding the big picture transformation. In short order, PHA had prepared a map of the community systems and networks. It documented how people flow through each of the resources and organizations that made up the area's services delivery processes. The community was then able to identify the gaps, barriers and what was working well. This was critical in showing stakeholders what role they play and how they could improve capacity based on their resources and potential operational changes they had authority over. This allowed the collective group to begin to adopt a system thinking approach and to document how each of the changes and developments were impacting the system overtime as projects were being implement locally and at the state level. This is when the community was able to start combing its grassroots appreciative inquiry approach with system thinking and adaptive project design. The community was beginning to develop a CAS approach to ROSC development.

By the end of 2018 the community had an understanding of its systems, the means to track changes, and tools and partnerships to transform its system with intention. The OTF with facilitation by UWGL had become the focal point of system changes efforts. Coordination between agencies and projects was more manageable and service capacity had increased. By 2019 the effort to develop and implement a central hub of operations was discontinued. OTF had collectively acknowledged and agreed that the hub and spoke model was impractical, unnecessary, and even brought with it new risks that could derail the collective process that was serving the community so well. Earlier in 2018 a few individuals went to visit another community that had adopted a hub and spoke model. This team observed that there were some admirable programs in operation but the community being studied had experienced a usurpation of individual organizations and programs by one large organization that now ran and operated a majority of the treatment and recovery resources in the community. Upon reflection, it was concluded that there were too many major players in Tippecanoe County to pursue this model. Doing so would alienate, financially imperil, and disempower critical partners. This would hurt the momentum of the current system transformation and even put new roadblocks in place for collaboration. Furthermore, there were also risks of having a hub model for the treatment and recovery systems; if something were to happen to the hub or if an organization were to take majority control of community resources, it would pose a high risk for a single point of failure. By having a dynamic network of partners, it creates a situation more akin to a hydra. It cannot be stopped even if its head it removed, two more will take its place. By abandoning the hub and spoke model and pursuing a CAS model, it allowed Tippecanoe County to be much more adaptable, collaborative, and creative in how it would bridge its gaps and remove barriers, presently and in the future.

By spring 2019, many projects were underway and some had been completed. The community had identified a system transformation strategy, the vision of a ROSC had taken shape with numerous partners defining the vision, and work groups had grown exponentially. The UWGL and PHA felt there was still room for improving the transformation operations. PHA connected UWGL and OTF leadership with training opportunities on implementing a process that would allow the OTF and its partners to be much more intentional about its system vision, action plans, and transformational outcomes in a CAS model. The processes taught the facilitators and leaders team-oriented steps to create a collective vision, identify opportunities, and engage all participants with deliverable action items to produce outcomes and finished projects within defined timeframes. This took the OTF's work

to the next level and brought stronger control to the CAS approach that Tippecanoe had adopted for its transformation process. These successes had continued to draw in additional community partners and strengthen ties across the community. Through 2019, the OTF continued to connect projects throughout the community and use the processes it had learned to develop and implement projects which had a positive impact on its opioid overdose statistics, notably a 24% reduction in opioid overdose deaths from 2018. By this time the OTF had felt its impact was far beyond just opioids included mental health and other substances; it rebranded as the Resilience and Recovery Network (RRN) in 2020. Transformation work continued unhindered until it experienced a slowdown in 2020 due to the COVID-19.

Despite COVID-19 many of the projects that were previously developed continued to expand through support in the community and the OTF/RRN. For example, between January 2020 and March 2021, the QRT successfully helped 92 individuals get into formal clinical treatment programs for a SUD. The QRT provided many services including an expansion of funding for people that suffered from an opioid use disorder to include people with a stimulant use disorder and assist people with funding for recovery housing. There were other QRT services which helped cover the cost of treatment for individuals and funding was also set aside for childcare. Another set of projects that continued was data collection via surveys and a youth summit developed by the prevention subcommittee of the OTF/RRN. The surveys were conducted at events and through outreach. They focused on the public's understanding of substance used disorder and Adverse Childhood Experiences (ACEs). The ACEs survey was designed for parents and adults meanwhile the youth summit was held for the students, providing them a platform to have their voices heard. The students were given surveys and once that data was collected, the subcommittee extracted and analyzed the data, and invited all community members, and the parents, to a meeting where they revealed the results. They shared insights on what they and their peers struggle with, what substances are most commonly used, why they think their peers use them, what supports they have or need, and what changes they would like to see. This summit included schools from across the county. The data was analyzed and sent to the coalition, and the results were presented to community members and parents in the fall. The summit is now a yearly goal for the prevention subcommittee.

These are only a few examples of specific projects that kept moving during the challenges of 2020. Some of the projects had impacts that are less tangible but continued to help the system continue to evolve and increase in effectiveness and capacity. Partnerships continue to grow; stakeholders continue to expand services. Administrative decisions with recovery resources and treatment providers are more attentive to the principles of the ROSC system that is continuing to develop in Tippecanoe County, and the negative impact of substance use disorder has been lessened and prevented thanks to the work that has occurred and continues to happen. At the time of this writing, provisional data for 2020 is predicting a 33% increase in all drug overdose deaths in Indiana (Kaiser Family Foundation (KFF), 2021). The Tippecanoe County Coroner's report shows a 0% increase in all drug overdose death for 2020. UWGL has been a critical component to the transformation efforts and the success of the CAS approach over the years. It is a respected and responsible neutral party that has the ability to motivate stakeholders and stabilize the processes. They have been able to adapt to what the community needs. Additionally, they have no hidden agendas and are able to function in a neutral role which allows them to prioritize the system as a whole and not their own agency, in the transformation context. This is important because a neutral facilitator is critical in the arbitrating the transformation process and helping bridge partnerships and unbiasedly assessing ROSC operations.

References

Adams, N. (2020a). Beyond narcan: comprehensive opioid training for law enforcement. *Journal of Substance Use, 00*(00), 1–8. https://doi.org/10.1080/14659891.2020.1838639

Adams, N. (2020b). Using community engagement to map pathways of opioid use and recovery. *Journal of Community Health Nursing, 37*(1), 1–8. https://doi.org/10.1080/07370016.2020.1693089

Allen, J., Mohatt, G. V., Rasmus, S. M., Hazel, K. L., Thomas, L., & Lindley, S. (2013). The tools to understand: Community as co-researcher on culture-specific protective factors for alaska natives. *Community Action Research: Benefits to Community Members and Service Providers*, *9780203051,* 41–59. https://doi.org/10.4324/9780203051443

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (5th ed.). American Psychiatric Association.

American Society of Addiction Medicine. (2019). *Definition of Addiction Background* (pp. 1–2). www.ASAM.org

Amnesty International. (2021). *Discrimination*. https://www.amnesty.org/en/what-we-do/discrimination/

Apostolopoulos, Y., Lemke, M. K., Barry, A. E., & Lich, K. H. (2017). Moving alcohol prevention research forward — Part I : introducing a complex systems paradigm. *Addiction, 113,* 353–362. https://doi.org/10.1111/add.13955

Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Substance use, recovery, and linguistics: The impact of word choice on explicit and implicit bias. *Drug and Alcohol Dependence, 189*(June), 131–138. https://doi.org/10.1016/j.drugalcdep.2018.05.005

Ashford, R. D., Brown, A. M., Dorney, G., McConnell, N., Kunzelman, J., McDaniel, J., & Curtis, B. (2019). Reducing harm and promoting recovery through community-based mutual aid: Characterizing those who engage in a hybrid peer recovery community organization. *Addictive Behaviors, 98*(June). https://doi.org/10.1016/j.addbeh.2019.106037

Ashford, R. D., Curtis, B., & Brown, A. M. (2018). Peer-delivered harm reduction and recovery support services: Initial evaluation from a hybrid recovery community drop-in center and syringe exchange program. *Harm Reduction Journal, 15*(1), 1–9. https://doi.org/10.1088/1004-423X/6/11/008

Baltimore Racial Justice Action. (2021). *Our definitions.* Baltimore Racial Justice Action. https://bmoreantiracist.org/resources/our-definitions

Bandes, S. A., Pryor, M., Kerrison, E. M., & Goff, P. A. (2019). The mismeasure of Terry stops: Assessing the psychological and emotional harms of stop and frisk to individuals and communities. *Behavioral Sciences and the Law, 37*(2), 176–194. https://doi.org/10.1002/bsl.2401

Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016). Peer-delivered recovery support services for addictions in the United States: A systematic review. *Journal of Substance Abuse Treatment, 63*(2016), 1–9. https://doi.org/10.1016/j.jsat.2016.01.003

Bearnot, B., & Mitton, J. A. (2020). "You're Always Jumping Through Hoops": Journey Mapping the Care Experiences of Individuals With Opioid Use Disorder-associated Endocarditis. *Journal of Addiction Medicine, 14*(6), 494–501. https://doi.org/10.1097/ADM.0000000000000648

Borkman, T. J., Stunz, A., & Kaskutas, L. A. (2016). Developing an Experiential Definition of Recovery: Participatory Research With Recovering Substance Abusers From Multiple Pathways. *Substance Use and Misuse, 51*(9), 1116–1129. https://doi.org/10.3109/10826084.2016.1160119

Bowleg, L. (2012). The problem with the phrase women and minorities: Intersectionality-an important theoretical framework for public health. *American Journal of Public Health, 102*(7), 1267–1273. https://doi.org/10.2105/AJPH.2012.300750

Brener, L., Hippel, W. Von, Kippax, S., & Preacher, K. J. (2010). The role of physician and nurse attitudes in the health care of injecting drug users. *Substance Use and Misuse, 45*(7–8), 1007–1018. https://doi.org/10.3109/10826081003659543

Brennan Ramirez, L. K., Baker, E. A., & Metzler, M. (2008). Promoting health equity: A resource to help communities address social determinants of health. *A Resource to Help Communities Address Social Determinants of Health.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. https://doi.org/10.1136/bmj.e4881

Brown, W. (2008). Narratives of Mental Health Recovery. *Social Alternatives, 27*(4), 42–49.

Center for Behavioral Health Statistics and Quality. (2018). *2016-2017 National Survey on Drug Use and Health: Model based prevalence estimates (50 states and the District of Columbia).* https://www.samhsa.gov/data/report/2016-2017-nsduh-state-prevalence-estimates

Centers for Disease Control and Prevention (CDC). (2022). *Fast Facts: Preventing Adverse Childhood Experiences.*

Choi, N. G., Dinitto, D. M., Marti, C. N., & Choi, B. Y. (2017). Association of adverse childhood experiences with lifetime mental and substance use disorders among men and women aged 50+ years. *International Psychogeriatrics, 29*(3), 359–372. https://doi.org/10.1017/S1041610216001800

Clair, M. (2018). Stigma. In J. M. Ryan (Ed.), *Core Concepts in Sociology* (pp. 318–321). Wiley-Blackwell. https://scholar.harvard.edu/files/matthewclair/files/stigma_finaldraft.pdf

Cooper, H. L. F. (2015). War on Drugs Policing and Police Brutality. *Substance Use and Misuse, 50*(8–9), 1188–1194. https://doi.org/10.3109/10826084.2015.1007669

Davidson, L., Rowe, M., DiLeo, P., Bellany, C., & Delphin-Rittmon, M. E. (2021). Recovery-oriented systems of care: a perpective on the past, present, and future. *Alcohol Research, 41*(1), 1–11. https://doi.org/10.35946/arcr.v41.1.09

Davidson, L., & Schmutte, T. (2020). What is the meaning of recovery? In H. Goldman, R. Frank, & J. Morrissey (Eds.), *The Palgrave Handbok of American Mental Health Policy.* (pp. 71–100). Palgrave Macmillan. https://doi.org/10.1007/978-3-030-11908-9_4

Davidson, L., Tondora, J., O'Connell, M. J., Kirk, T., Rockholz, P., & Evans, A. C. (2007). Creating a recovery-oriented system of behavioral health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal, 31*(1), 23–31. https://doi.org/10.2975/31.1.2007.23.31

Davis, L. (2011). Rock, {Powder}, {Sentencing}-{Making} {Disparate} {Impact} {Evidence} {Relevant} in {Crack} {Cocaine} {Sentencing}. T*he Journal of Gender, Race, and Justice; Iowa City, 14*(2), 375–404. http://search.proquest.com/docview/870360651/abstract/251CBB2D3FCD4B47PQ/2

Duran, E. (2019). *Healing the Soul Wound: Trauma-Informed Counseling for Indigenous Communities* (2nd ed.). Teachers college Press.

Duran, E., Firehammer, J., & Gonzalez, J. (2008). Liberation psychology as the path toward healing cultural soul wounds. *Journal of Counseling and Development, 86*(3), 288–295. https://doi.org/10.1002/j.1556-6678.2008.tb00511.x

Earnshaw, V., Smith, L., & Copenhaver, M. (2013). Drug addiction stigma in the context of methadone maintenance therapy: An investigation into understudied sources of stigma. *International Journal of Mental Health and Addiction, 11*(1), 110–122. https://doi.org/10.1007/s11469-012-9402-5

Ellis, L. A., Churruca, K., & Braithwaite, J. (2017). Mental health services conceptualised as complex adaptive systems: What can be learned? I*nternational Journal of Mental Health Systems, 11*(1), 1–5. https://doi.org/10.1186/s13033-017-0150-6

Elrod, J. K., & Fortenberry, J. L. (2017). The hub-and-spoke organization design: An avenue for serving patients well. *BMC Health Services Research, 17*(Suppl 1). https://doi.org/10.1186/s12913-017-2341-x

Fabricant, M. C. (2011). WAR CRIMES AND MISDEMEANORS : UNDERSTANDING " ZERO-TOLERANCE " POLICING AS A FORM OF COLLECTIVE PUNISHMENT AND HUMAN RIGHTS VIOLATION ABSTRACT A fundamental principle of criminal law is that individuals may only be punished for offenses which they have pe. *Drexel Law Review, 3*(2), 373–414.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education, 34*(2), 165–181. https://doi.org/10.1080/02615479.2014.977244

Flora, C. B., & Flora, J. L. (2013). *Rural Communities Legacy and Change* (4th ed.). West View Press.

Freire, P. (2012). *Pedagogy of the Oppressed.* Bloomsbury Academic.

Galea, S., & Vlahov, D. (2002). Social determinants and the health of drug users: Socioeconomic status, homelessness, and incarceration. *Public Health Reports, 117*(SUPPL. 1), S135–S145.

Garrett, M. T., & Pichette, E. F. (2000). Red as an apple: Native American acculturation and counseling with or without reservation. *Journal of Counseling and Development, 78*, 3–13. https://doi.org/10.1002/j.1556-6676.2000.tb02554.x

Goodman, R. (2017). Contemporary trauma theory and trauma-informed care in substance use disorders: A conceptual model for integrating coping and resilience. *Advances in Social Work, 18*(1), 186–201. https://doi.org/10.18060/21312

Gorman, B. & Yellow Horse Brave Heart, M. (2013, September 27). Feeling Invisible: Historical Trauma- Discrimination, Micro-Aggressions and Stereotypes in Native LGBTQ Communities [webinar]. *IHS.* https://ihs.cosocloud.com/p8x72o7y7g8/?proto=true

Granfield, R., & Cloud, W. (1999). *Coming Clean: Overcoming Addiction without Treatment.* New York University Press.

Guy-Evans, O. (2020). *Bronfenbrenner's ecological systems theory.* Simplypsychology.Org. https://www.simplypsychology.org/Bronfenbrenner.html

Hagan, H., McGough, J. P., Thiede, H., Hopkins, S., Duchin, J., & Alexander, E. R. (2000). Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors. *Journal of Substance Abuse Treatment, 19*(3), 247–252. https://doi.org/10.1016/S0740-5472(00)00104-5

Hay, B., Henderson, C., Maltby, J., & Canales, J. J. (2017). Influence of peer-based needle exchange programs on mental health status in people who inject drugs: A nationwide New Zealand study. *Frontiers in Psychiatry, 7*(JAN), 1–9. https://doi.org/10.3389/fpsyt.2016.00211

Hayashi, K., Wood, E., Wiebe, L., Qi, J., & Kerr, T. (2010). An external evaluation of a peer-run outreach-based syringe exchange in Vancouver, Canada. *International Journal of Drug Policy, 21*(5), 418–421. https://doi.org/10.1016/j.drugpo.2010.03.002

Heilig, M., Epstein, D. H., Nader, M. A., & Shaham, Y. (2016). Time to connect: bringing social context into addiction neuroscience. *National Review of Neuroscience, 17*(9), 592–599. https://doi.org/10.1038/nrn.2016.67

Hillios, J. S. (2013). *The influence of social recovery capital and stress on the health and well-being of individuals recovering from addiction* (UMI 3561346).

Holland, J. T. (1992). Complex adaptive systems. *Daedalus1, 121*(1), 17–30. https://www.jstor.org/stable/20025416

Hooker, D. A., & Czajkowski, A. P. (n.d.). *Transforming Historical Harms.*

Hymes. (2015). *A phenomenological study of the experiences of substance abuse peer recovery coaches career motivation and processional experiences* (ProQuest 3744300).

Jariego, I. M. (2016). Ecological settings and theory of community action: "There is nothing more practical than a good theory" in community psychology. *Global Journal of Community Psychology Practice, 7*(2), 1–6. https://doi.org/10.7728/0702201605

Kaiser Family Foundation (KFF). (2021). *Provisional 2020 Opioid Overdose Deaths as a Percent of All Drug Overdose Deaths.* State Health Facts. https://kff.org/other/state-indicator/provisional-opioid-overdose-deaths/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Kelly, J. F., & Westerhoff, C. M. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy, 21*(3), 202–207. https://doi.org/10.1016/j.drugpo.2009.10.010

Kennedy, N. (2022, November 11). Father and son share their stories of recovery as part of community effort to break the stigma of addiction. *Citrus County Chronicle.* https://www.chronicleonline.com/news/local/father-and-son-share-their-stories-of-recovery-as-part-of-community-effort-to-break/article_d5e7c179-2cb5-5d57-b945-c30414379a89.html

Kleinman, A. (1980). *Patients and Healers in the Context of Culture*. University of California Press.

Kunins, H. V. (2020). Structural Racism and the Opioid Overdose Epidemic: The Need for Antiracist Public Health Practice. *Journal of Public Health Management and Practice, 26*(3), 201–205. https://doi.org/10.1097/PHH.0000000000001168

Lamb, R., Evans, A. C. J., & White, W. L. (2009). *The role of partnership in recovery-oriented systems of care: The Philadelphia experience.* https://dbhids.org/wp-content/uploads/2015/07/2009-Philadelphia-Papers-The-Role-of-Partnership-in-Recovery-PartnershipPaper.pdf

Lamorte, W. W. (2019). *The Transtheoretical Model (Stages of Change).* Behavioral Change Models: Boston University School of Public Health. https://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/BehavioralChangeTheories/BehavioralChangeTheories6.html

Laudet, A. B., & White, W. L. (2010). What are your priorities right now? Identifying service needs across recovery stages to inform service development. *Journal of Substance Abuse Treatment, 38*(1), 51–59. https://doi.org/10.1016/j.jsat.2009.06.003

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review Sociology, 27*, 363–385.

Loomis, B., Epstein, K., Dauria, E. F., & Dolce, L. (2019). Implementing a Trauma-Informed Public Health System in San Francisco, California. *Health Education and Behavior, 46*(2), 251–259. https://doi.org/10.1177/1090198118806942

Luke, D. A., & Stamatakis, K. A. (2012). Systems Science Methods in Public Health : Dynamics , Networks , and Agents. *The Annual Review of Public Health, 33*, 357–376. https://doi.org/10.1146/annurev-publhealth-031210-101222

Luoma, J. B., O'Hair, A. K., Kohlenberg, B. S., Hayes, S. C., & Fletcher, L. (2010). The development and psychometric properties of a new measure of perceived stigma toward substance users. *Substance Use and Misuse, 45*(1–2), 47–57. https://doi.org/10.3109/10826080902864712

Madras, B. K., Ahmad, N. J., Wen, J., & Sharfstein, J. (2020). Improving Access to Evidence-Based Medical Treatment for Opioid Use Disorder: Strategies to Address Key Barriers Within the Treatment System. *NAM Perspectives.* https://doi.org/10.31478/202004b

McIntosh, P. (1989). White Privilege: Unpacking the Invisible Knapsack. *Peace and Freedom, July/August.* https://psychology.umbc.edu/files/2016/10/White-Privilege_McIntosh-1989.pdf

Mclellan, A. T., & White, W. L. (2012). Opioid maintenance and recovery-oriented systems of care: It is time to integrate. *National Treatment Agency for Substance Misuse, 1–3.* https://www.chestnut.org/resources/956420c1-fc0e-471e-9c6d-0af116fd267c/2012-percent-20NTA-Medications-in-Recovery-McLellanWhite-percent-20Commentary-0712.pdf

Mohatt, N. V., Thompson, A. B., Thai, N. D., & Tebes, J. K. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health. *Social Science and Medicine, 106,* 128–136. https://doi.org/10.1016/j.socscimed.2014.01.043

Moore, L. D., & Elkavich, A. (2008). Who ' s Using and Who ' s Doing Time. *American Journal of Public Health, 98,* 782–786. https://doi.org/10.2105/AJPH.2007.126284

Natan, M. Ben, Beyil, V., & Neta, O. (2009). Nurses' perception of the quality of care they provide to hospitalized drug addicts: Testing the Theory of Reasoned Action. *International Journal of Nursing Practice, 15*(6), 566–573. https://doi.org/10.1111/j.1440-172X.2009.01799.x

National Institute on Drug Abuse (NIDA). (2020). Drugs, brains, and behavior: The science of addiction. In *Science of Addiction* (Vol. 7, Issue 3). https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drugs-brain

Neal, J. W., & Neal, Z. P. (2013). Nested or networked? Future directions for ecological systems theory. *Social Development, 22*(4), 722–737. https://doi.org/10.1111/sode.12018

Netherland, J., & Hansen, H. (2017). White opioids: Pharmaceutical race and the war on drugs that wasn't. *BioSocieties, 12*(2), 217–238. https://doi.org/10.1057/biosoc.2015.46

NPAIHB. (2019). *49 Days of Ceremony : A Culturally Responsive Intervention to Wellness Conceptual Framework.*

Nunn, K. B. (2002). Race, Crime and the Pool of Surplus Criminality: Or Why the War on Drugs Was a War on Blacks. *J. Gender Race & Just., 6,* 381–445.

Nurjono, M., Yoong, J., Yap, P., Wee, S. L., & Vrijhoef, H. J. M. (2018). Implementation of integrated care in Singapore: A complex adaptive system perspective. *International Journal of Integrated Care, 18*(4). https://doi.org/10.5334/ijic.4174

Ohio Association of County Behavioral Health Authorities (OACBHA). (n.d.). *Recovery is Beautiful: A BluePrint for Ohio's Community Mental Health and Addiction System.* https://www.oacbha.org/docs/Recovery_is_Beautiful.pdf

Pasternak, J. (2011). *Yellow Dirt: A Poisoned Land and the Betrayal of the Navajos.* Free Press.

Peer Cultural Cooperative. (2020). *Cultural humility primer: Peer support specialist and recovery coach guide to serving and supporting diverse individuals and their recovery journeys.*

Peters, D. H. (2014). The application of systems thinking in health: Why use systems thinking. *Health Research Policy and Systems, 12*(51), 1–6.

Ringey, M. (2020). *Clark Digital Commons A Case Study on the Best Practices of the Facilitating Organization for Peer Recovery Support Services in the State of New Hampshire A Case Study on the Best Practices of the Facilitating Organization for Peer Recovery Support Services.*

Rothman, E. F., Edwards, E. M., Heeren, T., & Hingson, R. W. (2008). Adverse childhood experiences predict earlier age of drinking onset: Results from a representative US sample of current or former drinkers. *Pediatrics, 122*(2). https://doi.org/10.1542/peds.2007-3412

Salazar, K., & Wilcox, M. (Eds.). (2015). *Enhancing the value of public spaces.* Purdue Extension. https://mdc.itap.purdue.edu/item.asp?Item_Number=FNR-497-W#.VvGVEVUrLIV%0A

Santoro, T. N., & Santoro, J. D. (2018). Racial Bias in the US Opioid Epidemic: A Review of the History of Systemic Bias and Implications for Care. *Cureus, 10*(12). https://doi.org/10.7759/cureus.3733

Sawangjit, R., Khan, T. M., & Chaiyakunapruk, N. (2017). Effectiveness of pharmacy-based needle/syringe exchange programme for people who inject drugs: a systematic review and meta-analysis. *Addiction, 112*(2), 236–247. https://doi.org/10.1111/add.13593

Scott, V. C., & Wolfe, S. M. (2015). *Community Psychology: Foundations for Practice.* Sage. https://doi.org/http://dx.doi.org/10.4135/9781483398150

Smith, I. Z., Bentley-Edwards, K. L., El-Amin, S., & Darity, W. (2018). *Fighting at Birth: Eradicating the Black-White Infant Mortality Gap Report March 2018. March,* 1–17. https://socialequity.duke.edu/sites/socialequity.duke.edu/files/site-images/EradicatingBlackInfantMortality-March2018-DRAFT4.pdf

Stavros, J. M., Godwin, L. N., & Cooperrider, D. L. (2015). Appreciative Inquiry: Organization Development and the Strengths Revolution. *Practicing Organization Development: Leading Transformational Change: Fourth Edition, January,* 96–116. https://doi.org/10.1002/9781119176626.ch6

Substance Abuse and Mental Health Services (SAMHSA). (2012). *SAMHSA's working definition of recovery.* https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf

Substance Abuse and Mental Health Services Administration(SAMHSA). (2022). *Peer Support Workers for those in Recovery.* SAMHSA.Gov2. https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014a). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. July.*

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014b). *Tips for Disaster Responders : UNDERSTANDING HISTORICAL TRAUMA WHEN RESPONDING TO AN EVENT IN* (Vol. 7).

Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). *SAMHSA's Center for the Application of Prevention Technologies the Adverse Childhood Experiences Study the Relationship of Aces To Substance Use and Related Behavioral Health Problems. June 2018,* 1–6. http://www.samhsa.gov/capt/

Substance Abuse and Mental Health Services Administration (SAMHSA). (2018). *Recovery Support Tools and Resources.* https://www.samhsa.gov/brss-tacs/recovery-support-tools-resources

Substance Abuse and Mental Health Services Administration (SAMHSA). (2019). *Trauma and Violence.* https://www.samhsa.gov/trauma-violence

Tsai, A. C., Kiang, M. V., Barnett, M. L., Beletsky, L., Keyes, K. M., McGinty, E. E., Smith, L. R., Strathdee, S. A., Wakeman, S. E., & Venkataramani, A. S. (2019). Stigma as a fundamental hindrance to the United States opioid overdose crisis response. *PLoS Medicine, 16*(11), 1–19. https://doi.org/10.1371/journal.pmed.1002969

Tsemberis, S. J. (2011). Housing First: The pathways model to end homelessness for people with mental illness and addiction manual. *European Journal of Homelessness,* 5(2), 235–240.

Tuckman, B.W. (1965). Developmental Sequence in Small Groups, *Psychological Bulletin, 63*(6), 384-399. https://doi.org/10.1037/h0022100

U.S. Census Bureau. (2021). *Tippecanoe County, Indiana profile.* https://data.census.gov/cedsci/profile?g=0500000US18157

U.S. Department of, & Housing and Urban Development (HUD). (n.d.). *Diversity and Inclusion Definitions.* https://www.hud.gov/program_offices/administration/admabout/diversity_inclusion/definitions

Vrazel, J. (2020). *Health and Human Sciences 101.* PSE 101. https://purdue.brightspace.com/

Vu, M., Li, J., Haardörfer, R., Windle, M., & Berg, C. J. (2019). Mental health and substance use among women and men at the intersections of identities and experiences of discrimination: Insights from the intersectionality framework. *BMC Public Health, 19*(1), 1–13. https://doi.org/10.1186/s12889-019-6430-0

Walters, K. L. (2019). Urban American Indian identity attitudes and acculturation styles. *Voices of First Nations People: Human Services Considerations, 1359,* 174–179. https://doi.org/10.4324/9781315862378-11

Wendel, M. L., & Mcleroy, K. R. (2012). *Ecological Approaches - Public Health - Oxford Bibliographies -. August 2015.* https://doi.org/10.1093/OBO/9780199756797-0037

White, W. L. (2006). *Sponsor, recovery coach, addiction counselor: The importance of role clarity and role integrity.* https://www.bumc.bu.edu/care/files/2018/12/Recovery-Coach-Article_William-White.pdf

White, W. L. (2008). Toward a philosophy of choice: A new era of addiction treatment. *Counselor2, 9*(1), 38–43.

White, W. L. (2011). Building recovery-oriented systems of care: A view from the front an interview with Ijeoma Achara, Ph.D. *Selected Papers of William L. White,* 1–12. www.williamwhitepapers.com

White, W. L., & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor, 9,* 22–27.

White, W. L., & Evans, A. C. (2014). The recovery agenda: The shared role of peers and professionals. *Public Health Reviews, 35*(2), 1–15. https://doi.org/10.1007/bf03391703

White, W. L., Evans, A. C. J., & Lamb, R. (2013). *The Role of Harm Reduction in Recovery-oriented Systems of Care: The Philadelphia Experience.*

Whitter, M., Hillman, D. J., Powers, P., & Taitt, S. (2010). Recovery Oriented Systems of Care (Rosc) Resource Guide. In *Substance Abuse and Mental Health Services Administration (SAMHSA).* https://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf

Wilcox, M. (2015). Appreciative Inquiry Process. In *Enhancing the Value of Public Spaces* (pp. 13–21). Purdue Extension. https://www.extension.purdue.edu/extmedia/FNR/FNR-497-W.pdf

Windle, M., Haardörfer, R., Getachew, B., Shah, J., Payne, J., Pillai, D., & Berg, C. J. (2018). A multivariate analysis of adverse childhood experiences and health behaviors and outcomes among college students. *Journal of American College Health, 66*(4), 246–251. https://doi.org/10.1080/07448481.2018.1431892

Wing Sue, D. (2010). *Microaggressions in Everyday Life.* https://www.youtube.com/watch?v=BJL2P0JsAS4

World Health Organization (WHO). (2011). *Closing the gap: policy into practice on social determinants of health.*

Yellow Horse Brave Heart, M. (2003). The historical trauma response among natives and its relationship with substance abuse: A lakota illustration. *Journal of Psychoactive Drugs, 35*(1), 7–13. https://doi.org/10.1080/02791072.2003.10399988

Glossary

ACEs – Adverse childhood events which may cause trauma and impact long-term health outcomes.

Acute Care – immediate and short-term care for an illness.

Addiction – Replaced in most contexts by the term Substance Use Disorder. However, still used by some professional organizations, the general public, and is the preferred term by some people in recovery.

Chronic Care – long-term care of disease.

Cultural Humility – It is a commitment to self-reflection and growth towards creating mutually beneficial partnerships among community organizations and members; it represents a life-long learning process. This is different from cultural competence which implies expert knowledge of a culture.

Dependence – A physical reliance on a substance resulting in withdrawal with discontinuation of use. Substance dependence may or may not be associated with substance use disorder.

Discrimination – The unjust treatment of individuals based on some characteristic, such as race, age, sex, gender, sexual orientation, criminal history, or use of illicit substances.

Diversity – The breadth and depth of human experience and characteristics that make each of us unique. This can include, but is not limited to, sex, gender, religion, race, ethnicity, (dis)ability, veteran status, nationality, age, physical attributes, neurodiversity, religion, and more.

Equity – Not to be confused with equality, which is providing the same opportunities and services to all. Equity refers to providing the conditions and tools to individuals and communities to achieve equal outcomes. It acknowledges that there may be factors that negatively impact certain individuals and communities and that additional assistance, tools, or resources may be needed to put them on equal footing with others.

Evidence-Based Practice (EBP) – In healthcare, EBP is the thoughtful and methodical incorporation of research findings into day-to-day patient care to attain the best outcomes. It is the intersection of expertise, evidence, patient values, and the care environment. In community development Extension work, EBP is when rigorous evaluations have been conducted that demonstrate a program or intervention's effectiveness at meeting its stated.

Harm Reduction – A focus on the positive steps towards protecting and improving health by decreasing the negative consequences of activities. Examples of harm reduction include needle exchange programs, wearing sunscreen, and wearing a seatbelt.

Implicit bias – Implicit bias is when attitudes, stereotypes, and prejudices which are acted upon unconsciously and without intent.

Inclusion – Creating space for all individuals to feel welcomed, engaged, and heard. Inclusion must be cultivated and addressed proactively.

Intersectionality – The overlap between an individual's different identities and how they interplay, usually in regard to discrimination and oppression.

LGBTQI+ – Acronym that encompasses Lesbian, Gay, Bisexual, Trans, Queer/Questioning, and Intersex. Some say the Q stands for queer, a reclamation of a word previously used as a slur. Others state that the Q stands for questioning, as it can take people time to come to terms with their identity. The + indicates identities not listed, such as asexual, two-spirit, and others.

Medication Assisted Treatment (MAT) – Using medications for management of substance use. Currently available only for alcohol or opioid use.

Micro-aggressions – The everyday slights, indignities, put downs and insults that people of color, women, LGBT populations or those who are marginalized experience in their day-to-day interactions with people (Wing Sue, 2010).

Multiple Pathways to Recovery (MPR) – MPR allows people to choose the tools and resources that best suit their needs and support their recovery and change in lifestyle. In a ROSC, this may include social service agencies, SUD treatment providers, medication-assisted treatment providers, mutual aid support groups, recovery community centers, and harm reduction service providers, such as health departments.

National Institute on Drug Abuse (NIDA) – Formed in 1974, its purpose is to serve as a research institute for the federal government. The research on SUD and mental health is applied to public health practices in communities and promotes health and wellness of individuals.

Oppression – Impeding access to opportunities, services, and power of a group, usually based on some aspect of their identity.

Peer Support – A person in long-term recovery, with lived experience of substance use and/or mental illness, who can provide social support to people seeking recovery.

Person-first Language – Vernacular that addresses the person without defining the individual by their illness. For example, person with substance use disorder instead of drug addict; person in long-term recovery instead of ex-addict; and disease instead of drug abuser. However, defer to using the preferred language of the person; for example, some people prefer the term addict to refer to themselves.

Prevention – In the context of substance use, prevention includes upstream interventions and activities to reduce the risk of developing substance use disorders.

Protective Factors – In clinical practice, these are a person's assets and resources that support health and wellness and reduce the likelihood of adverse health outcomes. Examples include stable employment; education; access to health insurance; strong family support; stable marriage/partnership; engaging in positive physical health practices such as going to the gym, yoga, running, and having a medical care provider; consistent spiritual practices such as attending religious services or practicing meditation; and strong social support through friends and mentors.

Recovery – A self-identified state of being, in which a person has either stopped or lessened their use of substances to a degree where they have improved or optimal health (mental, physical, and spiritual) and quality of life.

Recovery Community Organization (RCO) – a not-for-profit organization led by people in recovery to provide support to others seeking to enter and/or maintain recovery.

Recovery-Oriented Systems of Care (ROSC) – An integrated network of organizations and agencies that support people with a SUD toward increasing health, wellness, and recovery.

Recovery Capital – The assets and resources available to a person which help them toward a successful recovery. These assets are classically organized into four categories: personal capital, community capital, social capital, and cultural capital.

Recovery Residence – Housing option for people in recovery working to re-establish themselves in society while abstaining from substance use. Services and supervision vary. Regulation and funding vary from state to state.

Resilience – How well people can recover from adverse circumstances, including using available resources to navigate difficult situations. This is mediated by an individual's protective and risk factors.

Risk Factors – In the context of clinical practice, these are events and circumstances in an individual's life that may increase the likelihood of adverse health outcomes. Examples include ACEs, trauma, and mental health diagnoses.

Substance Abuse and Mental Health Services Administration (SAMHSA) – A federal agency focused on providing behavioral health information. Formed in 1992, SAMHSA is a subsidiary of the Department of Health and Human Services.

Stigma – Stigma is the negative beliefs and behaviors toward a person or group of people based on their characteristics.

Substance Use Disorder (SUD) – A clinical diagnosis of problematic substance use. The diagnosis and severity of illness is determined using eleven criteria divided into four categories: Impaired control, social impairment, risky use, and pharmacological indicators such as tolerance and withdrawal.

Tokenism – Singling out an individual for a role based solely on one aspect of their identity and expecting them to represent their group.

Trauma – An event or circumstance which overwhelms a person's ability to cope and can have short- or long-term influence over daily life.

Warm Hand Off – A term used to describe how one service provider transitions an individual to another service provider, rather than leaving the onus on the individual seeking services. This approach is more relationship-based and collaborative, ensuring that the continuum of care is not broken as an individual moves between agencies.