Arizona Department of Health Services

Overdose Data to Action (OD2A)

A Multiyear Comprehensive Analysis Regarding Community Readiness and Compassion Fatigue Resiliency

August 2023

Acknowledgments

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Executive Summary

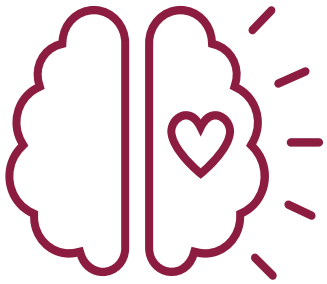
The Arizona Department of Health Services (ADHS) contracted with the Arizona State University, Southwest Interdisciplinary Research Center (SIRC) to evaluate the readiness, collaborative efforts, compassion fatigue, and partnerships of the county health departments who were Overdose Data to Action (OD2A) subgrantees. The FY 2023 evaluation consisted of three methods focused on collaboration, readiness, and compassion fatigue, through the utilization of The Wilder Collaboration Factors Inventory, (WCFI) Community Readiness Assessment Questionnaire, and Professional Quality of Life Survey (ProQOL).

Collaboration

Collaboration was evaluated through the WCFI. The WCFI was sent to ADHS stakeholders and participants of the Key Informant interviews**.** Thirteen ADHS individuals completed the WCFI, with the findings showing an overall decrease in collaboration from years 2 and 3. However, the perception of social and political climate readiness did increase. While participant scores were lower in 2023 compared to 2019 and 2020, participants believed the OD2A program and collaborative efforts were beneficial and needed.

Compassion Fatigue Training

The compassion fatigue trainings were a two-part Zoom session focused on understanding and preparing for compassion fatigue. Attendees received information regarding the signs, symptoms, and identifying features of compassion fatigue. The training concluded with a discussion of various strategies to reduce compassion fatigue symptoms, increase job satisfaction, and overall well-being. Data were also collected via the ProQOL and analyzed by pre- and post-tests subscale mean comparisons. Results showed a 22.7% decrease in burnout**,** and a 3.1% decrease in secondary traumatic stress symptomology, while compassion satisfaction increased by 6.6%.



Community Readiness

To measure community readiness, ADHS key stakeholders provided 36 potential contacts to participate in key informant interviews exploring community knowledge, climate, resources, and leadership in their community. A total of 13 interviews were conducted, yielding a 36.1% response rate. The community readiness model was used in 2019 and 2020, with the initial stage of readiness being in the preparation stage (Stage 5). However, in 2020 and 2023, findings showed that Arizona was in the preplanning stage (Stage 4). Despite this decrease, community knowledge of efforts and knowledge of the issue did increase in 2023.

Introduction

Since 2015, the Arizona Department of Health Services (ADHS) began collaborating with six counties, Gila, Maricopa, Mohave, Navajo, Pima, and Yavapai, to implement the Rx Community Toolkit. In FY 2018, the collaboration work expanded to include three additional county health departments (Coconino, Cochise, and Pinal), the Arizona Board of Pharmacy, and the University of Arizona, Center for Rural Health. The collaboration efforts grew in FY 2019 with four additional county health departments (Graham, La Paz, Santa Cruz, and Yuma). In FY 2020, the Maricopa County Department of Public Health received its own funding from the Centers for Disease Control and Prevention (CDC) to continue addressing the opioid epidemic throughout Maricopa County.

With ongoing funding from the CDC, the ADHS further expanded its partnerships throughout the state to address the opioid epidemic. In FY 2020, the project included 12 county health departments (Cochise, Coconino, Gila, Graham, La Paz, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma), the Arizona Board of Pharmacy, Banner Health, and the University of Arizona, Center for Rural Health. The Southwest Interdisciplinary Research Center (SIRC) continued to serve as the contracted evaluator for ADHS with the evaluation of the Prevention for States (PFS) and the Overdose Data to Action (OD2A) program, examining and exploring the readiness, collaboration, and partnerships of the county health departments.

Expanding on the work from FY 2019 and FY 2020, the aim for FY 2023 project evaluated collaboration, community readiness, and compassion fatigue within ADHS. Previous findings from FY 2019 indicated that Arizona communities needed to grow their collaboration efforts, and that they were past the Preplanning phase and into the Preparation phase for addressing

the opioid epidemic. The FY 2020 evaluation found that Arizona regressed into Stage 4, Pre-planning, which was likely due to the COVID-19 world-wide pandemic, making it challenging to continue efforts during the stay-at-home mandate. The goal of increasing Arizona's readiness persisted into FY 2023, with this report evaluating the current state of collaboration and readiness of efforts to address the opioid epidemic. Additionally, the FY 2019 evaluation found a need to reduce compassion fatigue within OD2A subgrantees; this later extended to ADHS staff as the country was coming out of the quarantine into a different work environment based on unintended consequences of the pandemic. This finding prompted ASU SIRC to incorporate the Professional Quality of Life (ProQoL) measure into the FY 2023 evaluation and develop a two-part compassion fatigue training.

The goal of increasing Arizona's readiness persisted into FY 2023, with this report evaluating the current state of collaboration and readiness of efforts to address the opioid epidemic. Since Arizona continued to be in Stage 4, Pre-planning, in FY 2020, the movement towards Stage 5, Preparation, was the goal for FY 2023. This report also explores the current level of compassion fatigue within ADHS and evaluates any changes following the two-part compassion fatigue training. Finally, with the FY 2023 concluding the five-year project timeline, this report compares collaboration and readiness, identified changes, and future directions for Arizona to continue improving efforts to address the opioid epidemic in Arizona.

Literature Review

Collaboration

Developing and sustaining collaborative partnerships is an important aspect when organizations need to come together with the community to address an issue that requires personnel beyond what the organization can deliver on its own. The Wilder Collaboration Factors Inventory (WCFI) is a tool that was developed to assess factors in the success of community collaboration, including categories such as community resources, structure, and communication (Perrault et al., 2011). The tool has been used in research initiatives and to evaluate the efficacy of program implementation tactics (Wells et al., 2021). For example, it was used as a measure for analyzing the success of community action teams seeking to improve maternal and child mental health, and the authors considered it to be a promising tool for such evaluations (Wells et al., 2021). Wells et al. (2021) suggested in their article that the WCFI would be useful for other communities that are trying to implement new collaborative interventions. Utilizing the inventory, they evaluated their collaboration and progress across several years and were able to measure the positive or negative changes in the stakeholder's and participants' collaborative processes (Wells et al., 2021). In another study in Arizona, researchers were able to use the WCFI to evaluate the collaboration factors for improving community health disparities related to the SNAP program (Orzech et al., 2020).

Compassion Fatigue

Compassion fatigue is a phenomenon that occurs when a helping professional's capacity to care for others exceeds their resources, emotional or otherwise (Lopez et al., 2022). It differs from burnout in that it is specifically related to the caregiving role, whereas burnout can be

related to other conditions, such as understaffing or poor leadership (Lopez et al., 2022). The ultimate consequences of compassion fatigue can range from multi-level exhaustion, both psychologically and physically, to anxiety, to being unable to maintain compassion towards patients (Lopez et al., 2022). This can not only cause emotional distress, but it can impact the quality of care and influence the outcomes of the work (Lopez et al., 2022). Compassion Fatigue can also lead to workers struggling to cope with their emotional reactions to often traumatic and stressful work, such as palliative care, where professionals are exposed to high levels of human death and suffering (Galiana et al., 2022).

This experience is opposed to compassion satisfaction, which is often the motivation for people to enter helping professions in the first place (Lopez et al., 2022). The "satisfaction" comes from the caregiver knowing that their work has influenced the patient's experience in a meaningful and positive way (Lopez et al., 2022). In fact, compassion can be a protective factor against compassion fatigue if it is supported properly by mitigating actions such as self-care and self-awareness (Galiana et al., 2022).

In addition to these symptoms of compassion fatigue, some research suggests that there is a relationship between compassion fatigue, compassion satisfaction, and alcohol use (Brooks et al., 2023). One such study surveyed dental hygienists to discover whether their drinking habits changed after the COVID-19 pandemic, an event that led to burnout in staggering numbers; about a fifth of the participants reported that their consumption of alcohol had changed, and about a quarter of them qualified as binge drinkers (Brooks, et. al, 2023).

Professional Quality of Life Scale

The Professional Quality of Life (ProQOL) scale is a measurement that is used to assess an individual's emotions, whether positive or negative, that they experience during their employment (Lopez et al., 2022). The ProQOL assesses various subcategories, including burnout, compassion satisfaction, and secondary traumatic stress, all of which can affect individuals in helping professions (Lopez et al., 2022). The data from the scale can be used to analyze correlations between each of these categories as well as to compare scores as they relate to other participant qualities, such as demographics (Lopez et al., 2022). One of the benefits of the scale is that it is open access, making it widely available to be used by researchers of these issues as well as others, and can be easily distributed electronically (Lopez et al., 2022).

Further, according to Keesler & Fukui (2020), the most recent iterations of the scale have improved the validity of the three subcategories that it evaluates. The ProQOL as an instrument of interpretation is particularly applicable to the helping professions and has great potential as a valid and reliable tool for promoting solutions to compassion fatigue (Keesler & Fukui, 2020). Hemsworth et al. (2018) supported this as a compassion satisfaction measurement, though they expressed concerns regarding the other two subcategories (Hemsworth et al., 2018). Ultimately, they expressed that with a few improvements, the ProQOL would be a satisfactory measure (Hemsworth et al., 2018).

Community Readiness

Community readiness models (CRM) are used to address specific issues within a community by joining community knowledge and resources with engaging community members

and leaders to effect change on a specific issue. The community comes together to address the issue with a common goal in mind. The Tri-Ethnic Center for Prevention Research Hub (TECPRH) defines community readiness as “the degree to which a community is ready to take action on an issue” (2014, para. 4). The model is intended to help identify resources and obstacles to provide an assessment of how ready the community is with respect to accepting a given issue as something that needs doing; identify types of efforts that are appropriate to initiate, depending on the stage of readiness; and help build cooperation among systems and individuals. This information can be collected by interviewing six to twelve community key informants. Some of the benefits of using a CRM include measuring a community’s readiness for change, identifying strengths, weaknesses, and obstacles, identifying appropriate actions, working within the community climate to find solutions, assisting with securing funding, establishing partnerships, and working with leadership (TECPRH, 2014).

Methodology

This evaluation involved multiple data collection methodologies. Data were collected using one qualitative survey and three quantitative questionnaires: The Professional Quality of Life Scale (Appendix A), the Wilder Collaboration Factors Inventory (Appendix B), and the Community Readiness Assessment Questionnaire (Appendix C). The Community Readiness Assessment entailed a 45–60-minute audio-recorded interview via Zoom. The two quantitative surveys were all self-report and provided to participants via a Qualtrics link. Recruitment for each instrument consisted of contacting stakeholders and subgrantees, and soliciting of referrals by existing ADHS contacts. Contacts were from 15 counties in Arizona, the University of Arizona, Center for Rural Health, and the Arizona Department of Pharmacy. Data were exported into IBM SPSS and Excel for descriptive and demographic analysis. Specific details of each survey used are described in the following paragraphs.

Wilder Collaboration Factors Inventory

For ADHS sub-grantees, the Wilder Collaboration Factors Inventory (WCFI) survey was accessible for 30 calendar days, and a reminder email was sent two weeks after the survey was opened and then again three days before the survey closed. Key Informants who participated in the Community Readiness Assessment were sent the survey link following their interview with a reminder email one week following their interview. Respondents rated their level of agreement to 44 statements based on a five-point Likert-type scale. The five ratings included: 1=strongly disagree, 2=disagree, 3=neutral, 4=agree, and 5=strongly agree. In addition, many county program coordinators also separately completed the WCFI to produce statewide results. The survey asked respondents to assess how well interagency collaboration was doing in areas

critical to success. The survey also captured a current snapshot as to how the collaboration was functioning overall by assessing twenty-two factors that were grouped into six categories: (1) environment, (2) member characteristics, (3) process and structure, (4) communication, (5) purpose, and (6) resources. Wilder is a 44-item inventory established originally in 1992, currently in its fourth edition.

Professional Quality of Life Scale

Members of the ADHS were provided with the Professional Quality of Life Scale (ProQOL) survey link one week prior to the first compassion fatigue training and then 6-weeks following the second compassion fatigue training. The ProQOL is intended for any helper such as health care professionals, social service workers, teachers, attorneys, or emergency responders. The survey consists of 30 statements, with respondents being asked to select the number that honestly reflects how frequently they experienced these things in the last 30 days. The number system of the ProQOL is scored where 1=never, 2=rarely, 3=sometimes, 4=often, and 5=very often, and assesses levels of compassion satisfaction, burnout, and secondary traumatic stress.

Community Readiness Assessment

SIRC evaluators asked program coordinators in county health departments who were participating in the PFS OD2A to provide program names and contact information of individuals who could potentially serve as key informants. Interviews were conducted over three months between March and May 2023 via Zoom. The interview consisted of asking the CRM key informants 36 questions related to knowledge of efforts, leadership, community climate, issues, and resources. All interviews were conducted by an evaluator and recorded. Interviews were then transcribed and scored.

Demographic Questionnaire

Respondents for the Professional Quality of Life Scale, Wilder Collaboration Factors Inventory, and the Community Readiness Assessment were all asked to complete a demographic questionnaire at the end of their respective surveys. The content of the demographic survey asked respondents about the Arizona County in which they currently reside, the type of agency and how long they have been employed within their specific profession, and additional gender, ethnicity, and personal characteristics. Data for the demographic surveys were optional and were used to allow SIRC researchers the opportunity to evaluate any trends or commonalities across various agencies and personnel, as well as provide ADHS stakeholders with an overall view of the various roles and perspectives that were obtained for this report.

Key Informants and Wilder Collaboration Factors Inventory Findings

In addition to the statewide coordinator analysis of the Wilder Collaboration Factors Inventory (WCFI), key informants of the community readiness assessment were also asked to complete the survey. Of the 13 key informants who were sent the survey, 4 participants completed it, resulting in a response rate of 30.7%. Demographic factors, including education, years worked in the current profession, and gender were also assessed. A total of 50.0% of participants have been employed in their current profession for longer than 15 years. With regards to education, 75.0% of participants reported having completed at least a bachelor's degree, with 25.0% having completed some college. Regarding gender, 75.0% of respondents were male, and 25.0% were female. Lastly, 75.0% of respondents described being employed in the police force. Table 1 shows the participants demographics.

Table 1

Key Informants and WCFI – Demographics (n=4)

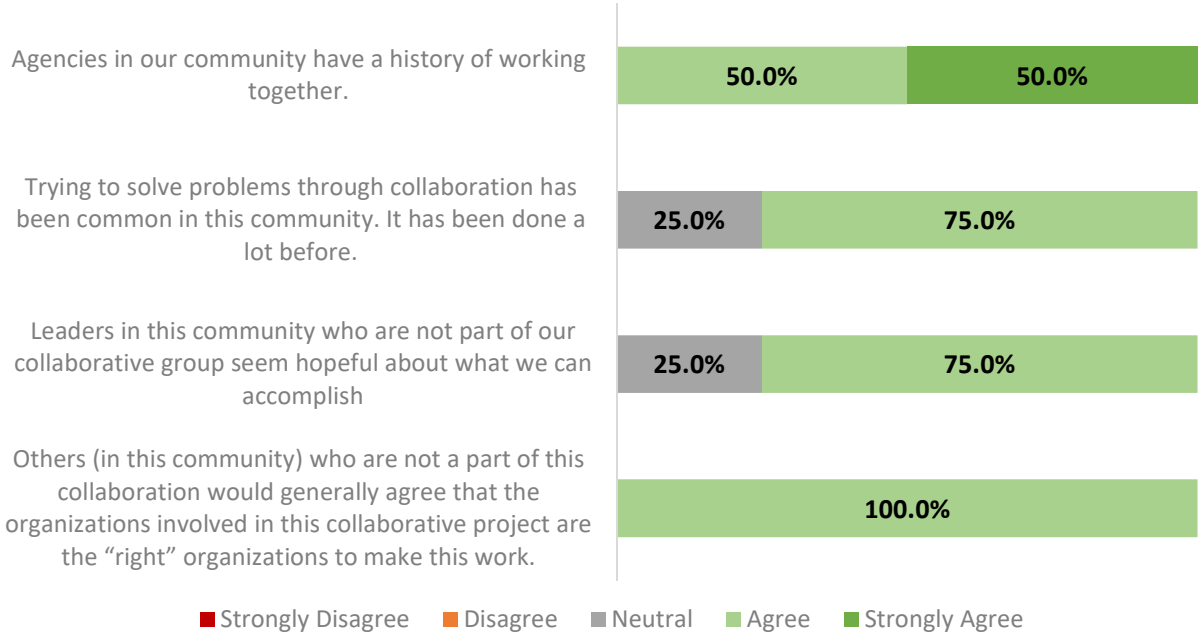
Years in Current Profession	Frequency	Percent
Gender		
Female	1	25.0%
Male	3	75.0%
Education		
Some College, No Degree	1	25.0%
Bachelor's Degree or More	3	75.0%
Years in Current Profession		
More than 1, less than 3 years	1	25.0%
More than 10, less than 15 years	1	25.0%
More than 15 years	2	50.0%
Employment Type		
Law Enforcement	3	75.0%
County Government	1	25.0%

Statements 1 through 4: Leadership and Historical Collaboration

According to respondents, agencies have a strong history of working together (50.0% agree and 50.0% strongly agree), and 75.0% of respondents believed collaborative problem-solving occurs. Similarly, 75.0% of respondents also agreed that external leaders were hopeful about the work being done and the goals being pursued. Additionally, when asked about external organization's perspectives on the collaborative's efforts to address opioids in Arizona, 100.0% of respondents agreed that the organizations comprising the collaborative group were essential members. Figure 1 shows responses to each of the inventory statements in this section.

Figure 1

Statements 1-4: Perceptions of History and Leadership-A

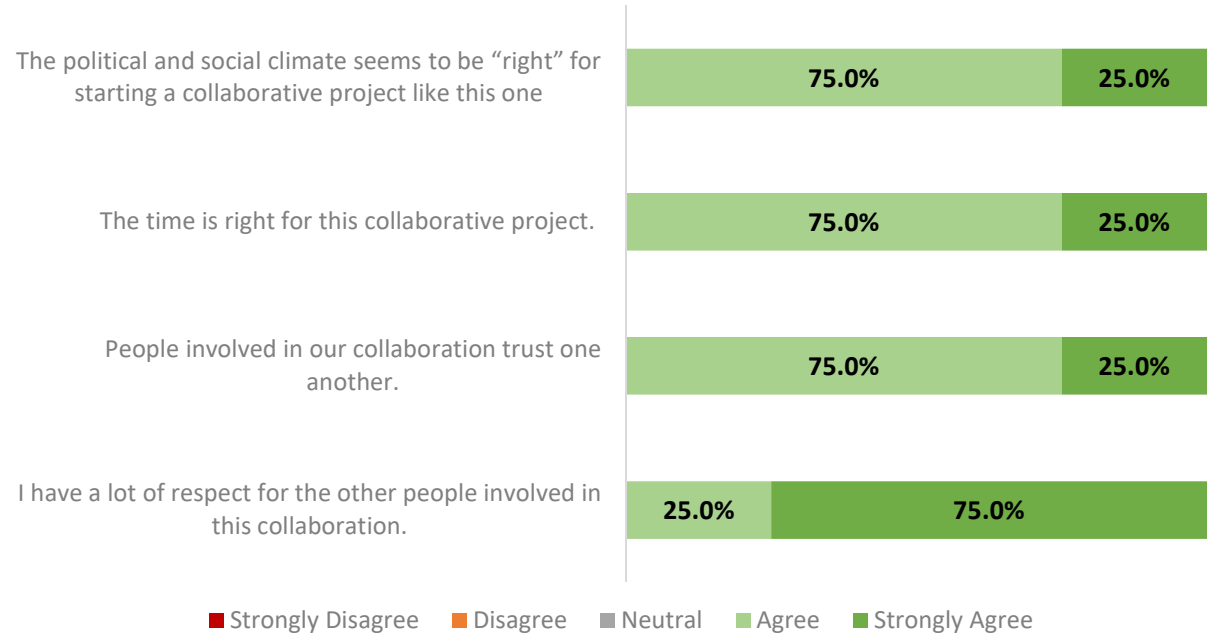


Statements 5-8: Perceptions of Timing, Trust, and Respect

All respondents agreed or strongly agreed that trust and the political climate were in a positive place for addressing opioid use in their communities. Additionally, 75.0% of respondents strongly agreed that there was mutual respect for other organizations and people involved with addressing opioid use in Arizona. Similarly, 100.0% of respondents agreed or strongly agreed that collaborative members trusted one another and that the collaboration continued to function at the appropriate time. Figure 2 shows responses to each of the inventory statements in this section.

Figure 2

Statements 5-8: Perceptions of Timing, Trust, and Respect

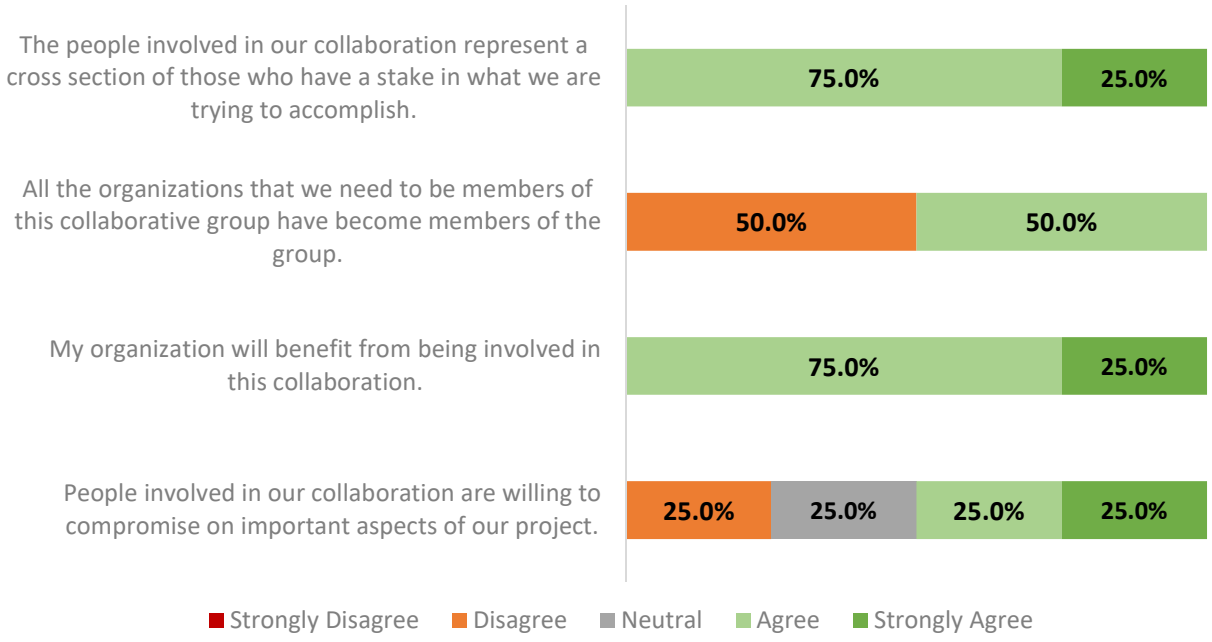


Statements 9-12: Perceptions of Representation, Engagement, and Compromise

Respondents had mixed opinions when asked about representation, engagement, and compromise. First, 50.0% of participants believed other organizations not involved in the collaborative efforts were still needed. Additionally, all respondents felt differently when asked about partners within the collaborative's efforts and willingness to compromise, in which 50.0% of respondents disagreed with collaborative members being open to comprise. However, 100.0% of respondents agreed or strongly agreed that their organization benefited from being a part of the collaborative group. Figure 3 shows responses to each of the inventory statements in this section.

Figure 3

Statements 9-12: Perceptions of Representation, Engagement, and Compromise

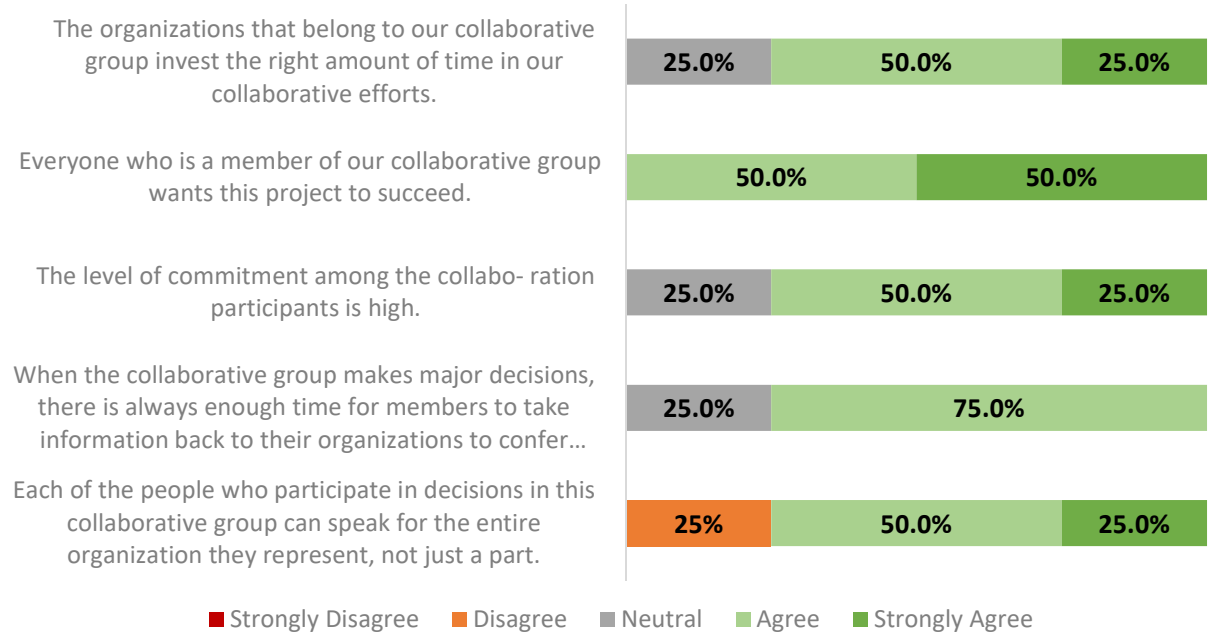


Statements 13-17: Perceptions of Commitment, Enthusiasm, and Decision Making

Overall, participants mostly agreed that organizations within the collaborative were committed, enthusiastic, and in line with the decisions that should be made. Specifically, 100% of respondents agreed and strongly agreed that all collaborative members want the project to succeed. Finally, 25.0% of respondents did not think everyone in the collaborative group could represent the entire organization. Figure 4 shows responses to each of the inventory statements in this section.

Figure 4

Statements 13-17: Perceptions of Commitment, Enthusiasm, and Decision Making

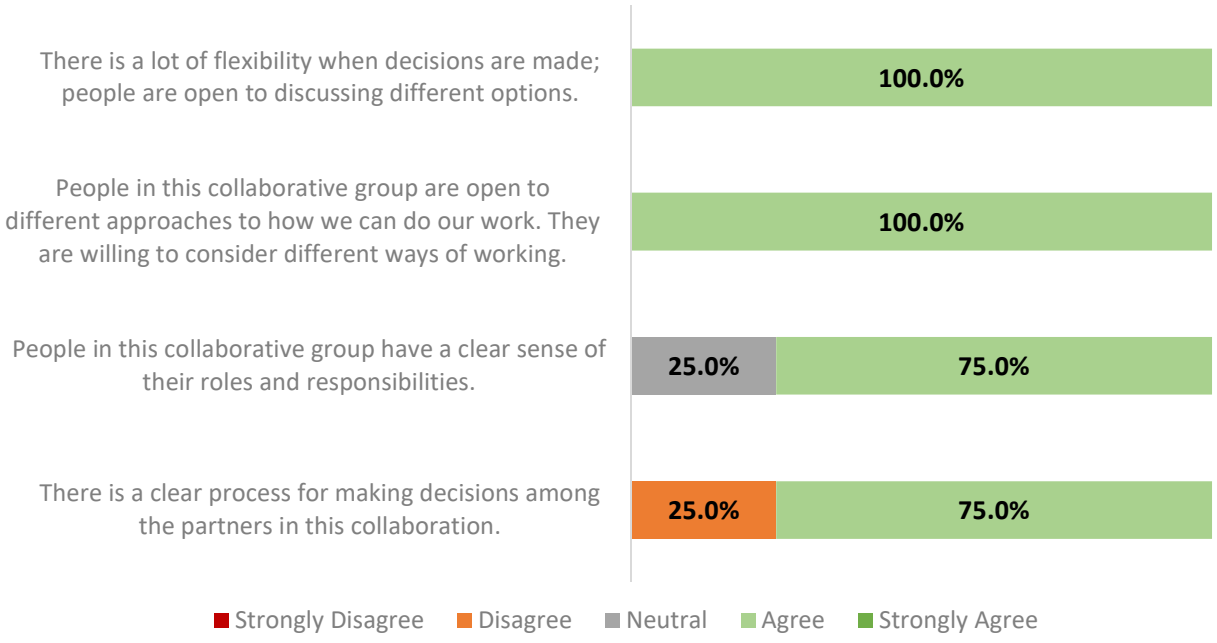


Statements 18-21: Perceptions of Flexibility and Developing Processes

All respondents felt that the collaborative group was flexible and willing to discuss multiple ways to accomplish their goals. Additionally, 75.0% of participants believed that the sense of direction and responsibility for developing processes was clear. However, 25.0% of respondents did not agree that the processes by which the partners of the collaborative group made decisions were clear. Figure 5 shows responses to each of the inventory statements in this section.

Figure 5

Statements 18-21: Perceptions of Flexibility and Developing Processes

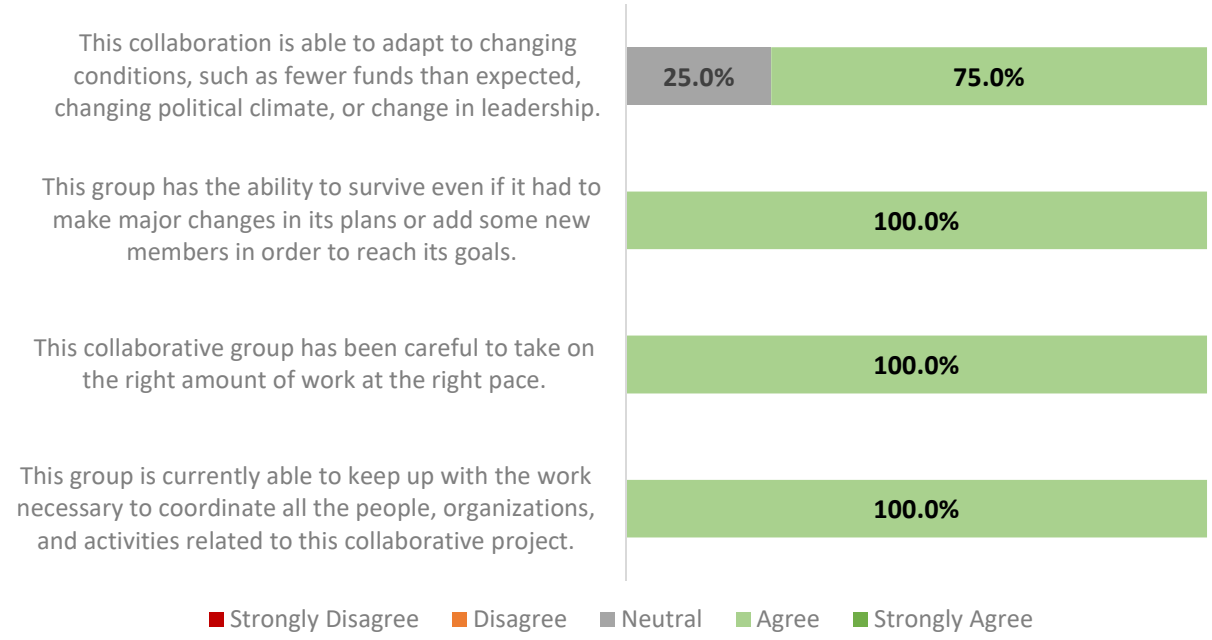


Statements 22-25: Perceptions of Resiliency and Pacing

When asked about the collaborative group's resiliency, 75.0% of respondents reported that the collaborative could adapt to changing conditions. Additionally, 100.0% of participants strongly agreed that the collaborative group would persist if major changes occurred. All respondents strongly agreed that the pace at which the collaborative group operated and functioned was positive. Figure 6 shows responses to each of the inventory statements in this section.

Figure 6

Statements 22-25: Perceptions of Resiliency and Pacing



Statements 26-31: Evaluation, Learning, and Communication

Respondents had mixed perspectives about communication, evaluation, and learning within the collaborative group. Specifically, 25.0% of respondents were unsure about how progress and activities were monitored and how outcomes should have been communicated. However, 100.0% of respondents agreed or strongly agreed that communication occurs effectively within and between organizations and collaborative group partners. Figure 7 shows responses to each of the inventory statements in this section.

Figure 7

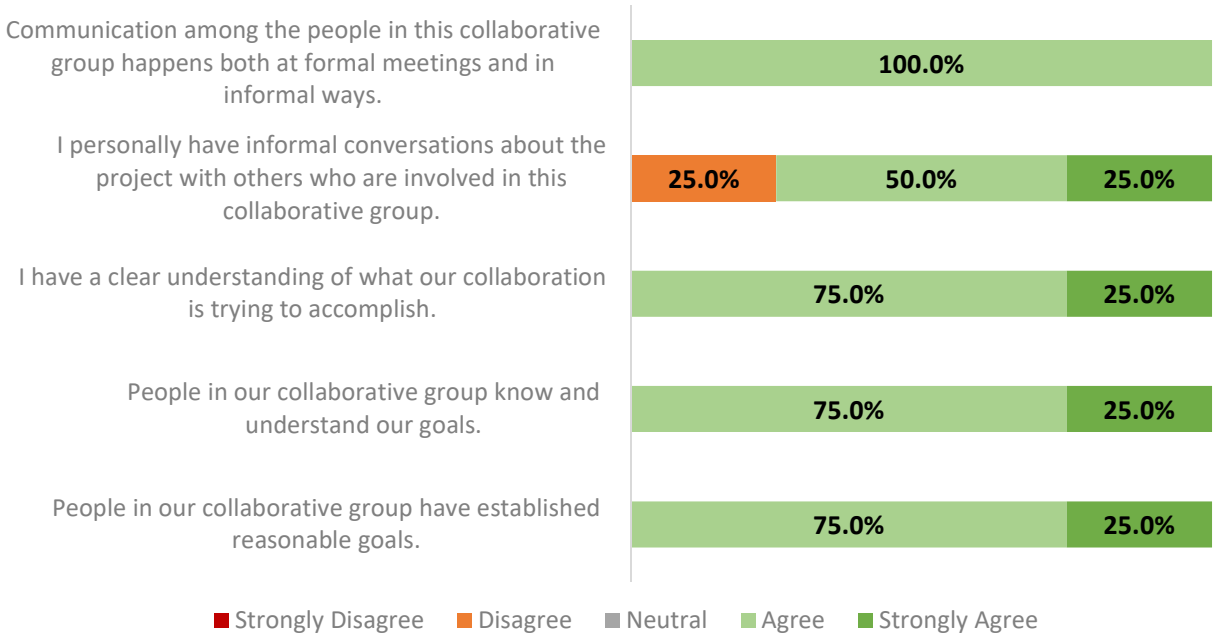
Statements 26-31: Evaluation, Learning, and Communication

Statements 32-36: Camaraderie and Strategic Planning

When asked about camaraderie and strategic planning, 25.0% of respondents disagreed with having informal conversations about the project with group members. However, 100.0% of respondents agreed that communication among group members occurs formally and informally. Additionally, 100.0% of respondents agreed or strongly agreed that planning, goals, and direction was clear and focused. Figure 8 shows responses to each of the inventory statements in this section.

Figure 8

Statements 32-36: Camaraderie and Strategic Planning



Statements 37-40: Shared Vision and Purpose

Respondents reported a widespread belief that shared vision and purpose were present in the collaborative group. Specifically, 100.0% of respondents agreed that the purpose of the collaborative group aligned with their ideas about what needs to be accomplished. Additionally, 75.0% of participants agreed, and 25.0% strongly agreed that the collaborative group members were dedicated to the project's success. Figure 9 shows responses to each of the inventory statements in this section.

Figure 9

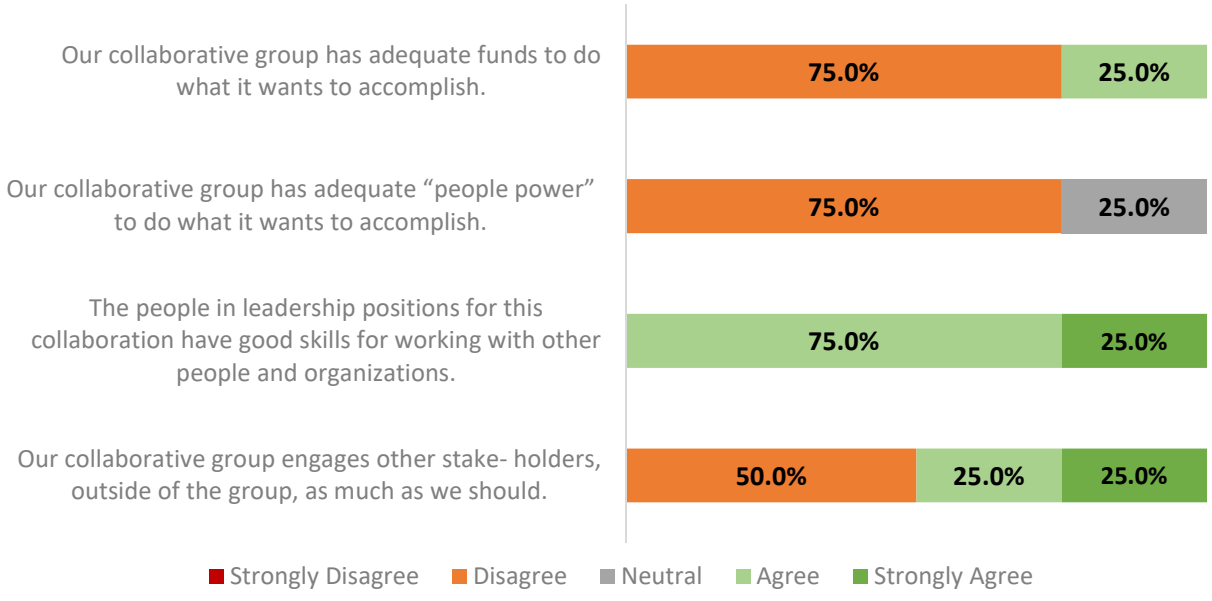
Statements 37-40: Shared Vision and Purpose

Statements 41-44: Perceptions of Resources, Skills, and Relationships

Most respondents expressed disagreement with items relating to funding, resources, and outside engagement. Specifically, 75.0% of respondents did not believe that adequate funds were present, and 75.0% of participants also disagreed with having enough people to accomplish the goals of the collaborative group. Respondents answers were also mixed, with 50.0% who disagreed and 50.0% who agreed or strongly agreed, as to whether external members and stakeholders were involved to the necessary extent. While respondents did report disagreement with three of the four statements, they more positive that the leadership of the collaborative group possess the necessary skills for working with other people and organizations on the 75.0% of respondents agreed, and 25.0% strongly agreed. Figure 10 shows responses to each of the inventory statements in this section.

Figure 10

Statements 41-44: Perceptions of Resources, Skills, and Relationships



Key Informant Collaboration Discussion

Respondents had an overall positive sense of collaboration from the perspective of their organization. Following the Wilder Collaboration Factors Inventory scoring criteria, a score of 4.0 (agree) to 5.0 (strongly agree) is a collaborative strength and does not require special attention or could be leveraged as an asset. A score of 3.0 to 3.9 indicates a borderline area that deserves some discussion. A score between 1.0 and 2.9 is an area of concern that should be collaboratively addressed.

As shown in Table 2, over half of the factors (54.5%, 12 of 22) were scored at or above a 4.0, indicating no need for intervention or alteration. Notable areas that were seen as strengths include mutual respect, understanding and trust, skilled leadership, effective communication, and clear, attainable objectives. Conversely, 40.9% of factors (9 of 22) were scored between 3.0 and 3.9, indicating that a discussion to address or improve these areas was warranted. Specific areas that scored among the lowest within this cut-off were stakeholder engagement, the ability to compromise, and continued evaluation and learning. Finally, respondents strongly believed that available funding, staff, and materials were areas of immediate need that warrant collaborative discussion and problem-solving. It should be mentioned that while this data set represents only four individual perspectives, each participant was associated with a different county. The four counties that this sample represents were Navajo, Coconino, Cochise, and Mohave. Given the limited sample size for this data set, future evaluation should seek to obtain perspectives from the remaining Arizona counties. In somewhat of a remedy, the statewide analysis may provide a more in-depth and encompassing perspective on the collaborative efforts found between organizations and ADHS.

Table 2

Key Informants WCFI Mean Collaboration Factor Scores

Collaboration Factor	Mean Score *(n=4)*
1. Mutual respect, understanding, and trust	4.5
2. Unique purpose	4.4
3. Concrete, attainable goals and objectives	4.3
4. Favorable political and social climate	4.3
5. Members see collaboration as being in their self- interest	4.3
6. Skilled leadership	4.3
7. Members share a stake in both process and outcome	4.2
8. Open and frequent communication	4.2
9. History of collaboration or cooperation in the community	4.1
10. Shared vision	4.1
11. Appropriate pace of development	4.0
12. Flexibility	4.0
13. Adaptability to changing conditions	3.9
14. Collaborative group seen as a legitimate leader in the community	3.9
15. Established informal relationships and communication links	3.9
16. Multiple layers of participation	3.8
17. Appropriate cross section of members	3.6
18. Development of clear roles and policy guidelines	3.6
19. Evaluation and continuous learning	3.6
20. Ability to compromise	3.5
21. Engaged stakeholders	3.3
22. Sufficient funds, staff, materials, and time	2.4

Statewide Coordinators and Wilder Collaboration Factors Inventory Findings

Program Coordinators statewide responded to an online questionnaire to determine the state's collaborative success in the prevention and treatment of opioid use and abuse. The Wilder Collaboration Factors Inventory (WCFI) was selected for use as it is a validated instrument, and the factors measured within the inventory are well aligned with the goals of the Overdose Data to Action program. The survey was sent to 36 individuals, with 13 responses collected. This yielded an initial response rate of 36.1%. Two respondents did not complete the survey in its entirety, resulting in 11 completed surveys for a final response rate of 30.5%.

WCFI Participant Demographic Characteristics

Respondents reported they resided and worked in the following Arizona counties: Cochise, Coconino, Gila, La Paz, Mohave, Maricopa, Navajo, Pima, Yavapai, and Yuma. All respondents were from government-based agencies. The 11 respondents indicated the number of years they had been in their current position; more than one-fourth (27.3%) were in their current position for more than one year, but less than three year and almost half (45.5%) of respondents were in their current position for more than 10 years. Ten respondents provided educational information with nine respondents (90.0%) reporting a bachelor's degree or more. Two respondents (18.2%) were male and nine (81.8%) were female. Only 10 respondents indicated their race, with all (100.0%) responding that their race was White. All 11 respondents (100.0%) indicated that their ethnicity was not Hispanic or Latino. Tables 3 presents the respondents' demographics with regards to race, ethnicity, education, and number of years in their current profession.

Table 3

Statewide Coordinator Respondents and WCFI – Demographics

Years in Current Profession	Frequency	Percent
Gender		
Female	9	81.8%
Male	2	18.1%
Race		
White	10	100.0%
Ethnicity		
Not Hispanic or Latino	11	100.0%
Education		
Some College, No Degree	1	10.0%
Bachelor's Degree or More	9	90.0%
Years in Current Profession		
Less than 1 year	1	9.1%
More than 1, less than 3 years	3	27.3%
More than 3, less than 5	1	9.1%
More than 5, less than 10	1	9.1%
More than 10, less than 15 years	2	18.2%
More than 15 years	3	27.3%

Participant Perspectives on Collaboration

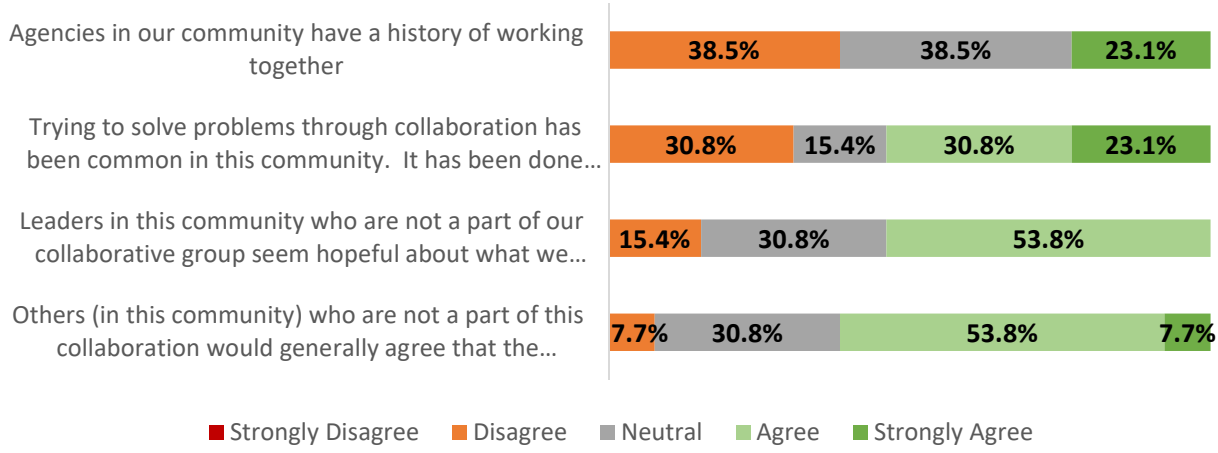
The WCFI is comprised of 44 statements which are grouped into 22 factors (areas of collaboration), to which the respondents selected their level of agreement. For the purposes of presentation and analysis, the results are divided into ten sections of themes with at least four questions each. As there were 13 total responses to the inventory but only 11 of which were complete, an in-depth statistical analysis was not warranted. Therefore, responses were reported and visualized according to the number of respondents who selected a particular response. Each figure in this section depicts the number of respondents who selected each category, ranging from strongly disagree to strongly agree for each inventory item measured.

Statements 1 through 4: Leadership and Historical Collaboration

Respondent outcomes yielded mixed results. Respondents generally disagreed or were neutral regarding agencies in their communities having a history of working together, although three respondents strongly agreed that there was a history of working together. Respondents were also somewhat divided on whether collaborations were common. Specifically, 30.8% of respondents disagreed, 15.4% felt neutral, 30.8% agreed, and 23.1% strongly agreed that collaborative problem-solving had occurred before. Just over half of respondents (53.8%) agreed that leaders in the community who were not part of the collaboration seemed hopeful about what could be accomplished. Finally, 61.5% either agreed or strongly agreed that others in the community who were not a part of the collaboration believed that the organizations involved in the collaboration were the right ones. Figure 11 shows responses to each of the inventory statements in this section.

Figure 11

Statements 1-4: Perceptions of History and Leadership-B

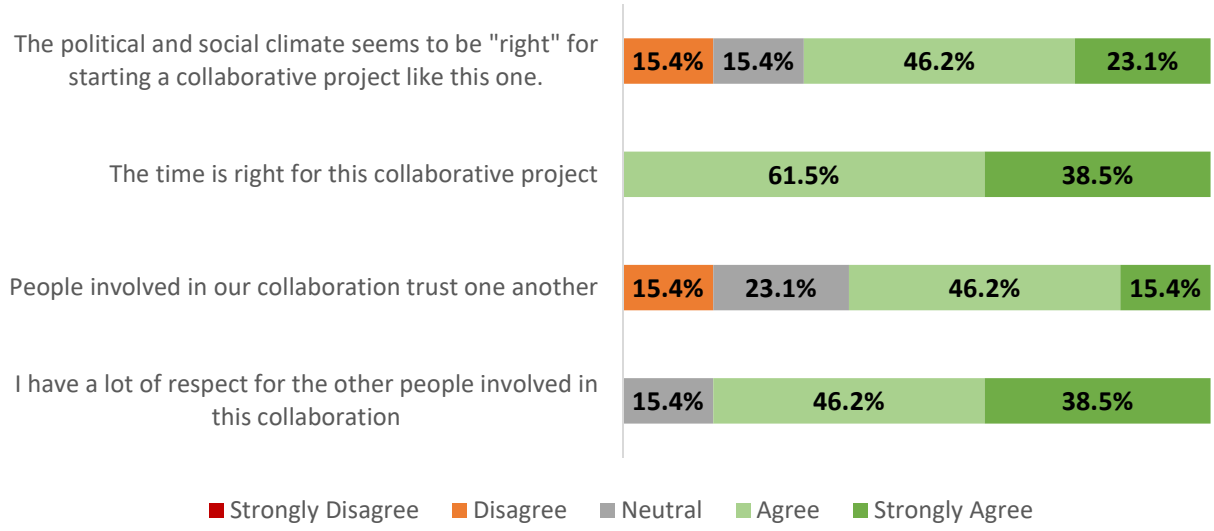


Statements 5 through 8: Respect, Trust, and Political and Social Climate

Respondents largely agreed (46.2%) or strongly agreed (23.1%) that the political climate was favorable to address opiates. However, two respondents (15.4%) disagreed with this stance. All respondents either agreed (61.5%) or strongly agreed (38.5%) that the time was right for this collaborative project. Most respondents also trusted (61.6%) and respected (84.7%) others involved in the collaboration. Figure 12 depicts the responses for this section.

Figure 12

Statements 5-8: Perceptions of Timing, Trust, and Respect

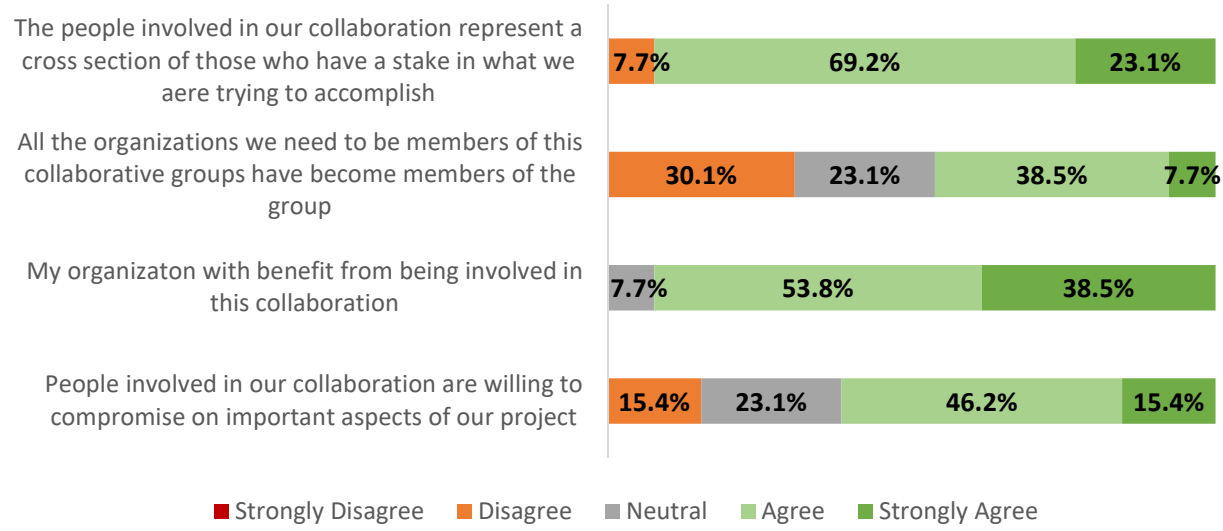


Statements 9 through 12: Stakeholders, Engagement, and Compromise

Most respondents agreed (69.2%) or strongly agreed (23.1%) that the representation of the collaboration was strongly representative of a cross section of stakeholders. However, respondents indicated that more organizations were needed to be a part of the collaborative group. Nearly all respondents (92.3%) felt that their organizations benefited from the collaboration. Most also agreed (46.2%) or strongly agreed (15.4%) that people involved in the collaboration were willing to compromise, although five respondents (38.5%) disagreed or were neutral. Figure 13 shows the responses for this category of the inventory.

Figure 13

Statements 9-12: Perceptions of Representation, Engagement, and Compromise

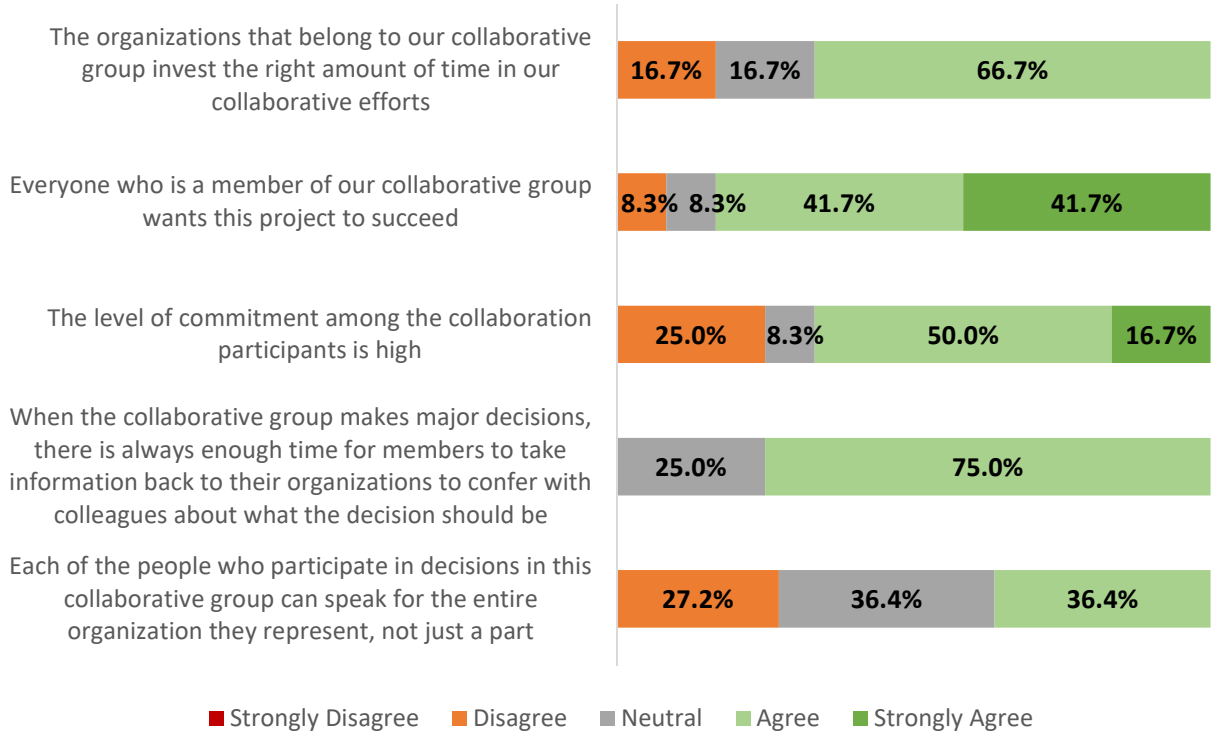


Statements 13 through 17: Commitment, Enthusiasm, and Decision Making

Overall, perceptions of commitment and enthusiasm were high among respondents. Specifically, 66.7% felt that commitment was high among participants in the collaboration. Additionally, 66.7% felt that the right amount of time was invested by organizations in the collaboration, and 83.4% felt like every member of the collaboration wants the group to succeed. Regarding decision-making, 75.0% of respondents felt like there was enough time to take information back to their organizations. However, 63.6% did not feel or were neutral about whether people who participate in the collaboration can speak for their entire organizations. Figure 14 shows the responses for this category.

Figure 14

Statements 13-17: Perceptions of Commitment, Enthusiasm, and Decision Making

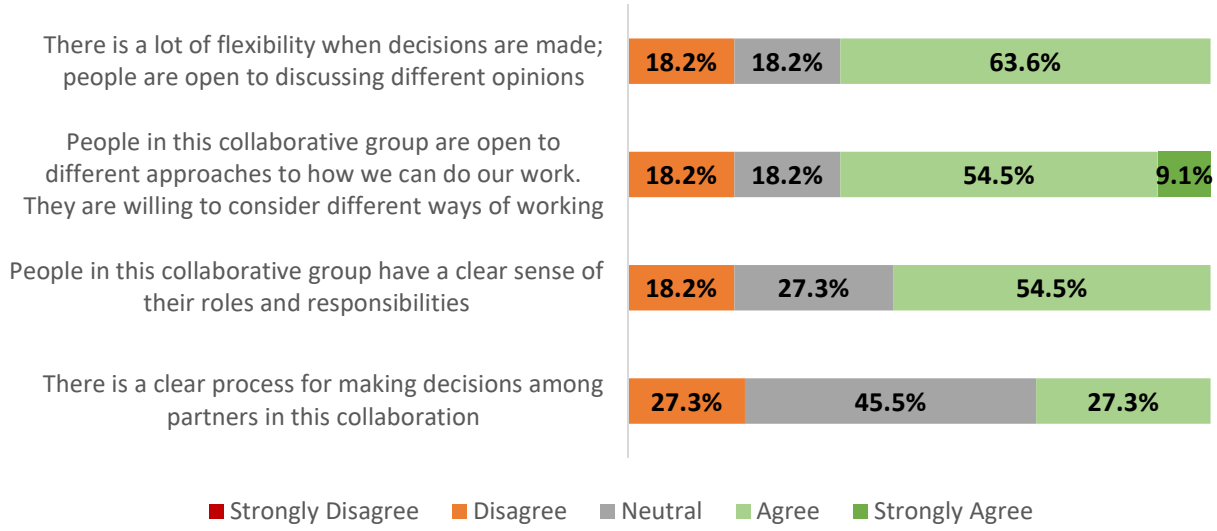


Statements 18 through 21: Flexibility and Developing Processes

Most respondents felt generally positive regarding flexibility, openness to different approaches, and a clear sense of roles and responsibilities within the collaboration. Respondents indicated that there was room for improvement regarding processes for making decisions among partners in the collaboration. Interestingly, 45.5% of respondents reported a neutral perspective regarding decision making process. Additionally, 27.3% of respondents disagreed on clarity for decision making and another 27.3% of respondents agreed that there was a clear process for decision making. Figure 15 displays the responses for this category.

Figure 15

Statements 18-21: Perceptions of Flexibility and Developing Processes

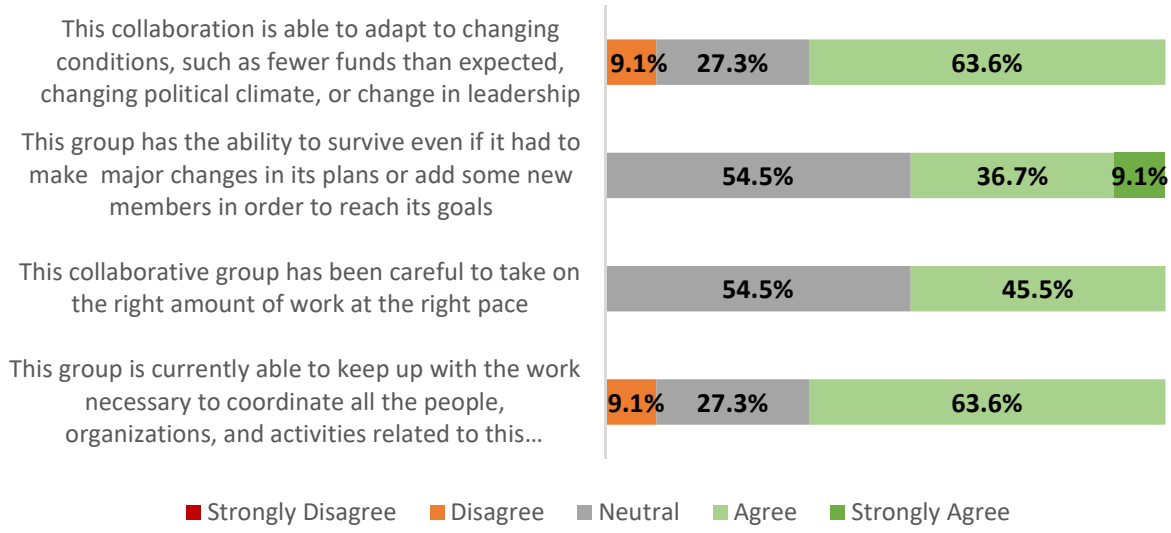


Statements 22 through 25: Resiliency of Collaborative Group and Pacing

Respondents felt that their group demonstrated adaptability to changing conditions and could generally keep up with the work necessary for the collaboration. However, 54.5% of the respondents expressed skepticism about the group being able to survive major changes or added new members, as well as being careful to take on the right work at the right pace. This suggests room for improvement regarding aspects of resiliency and pacing within the group. Figure 16 depicts the responses for this category.

Figure 16

Statements 22-25: Perceptions of Resiliency and Pacing

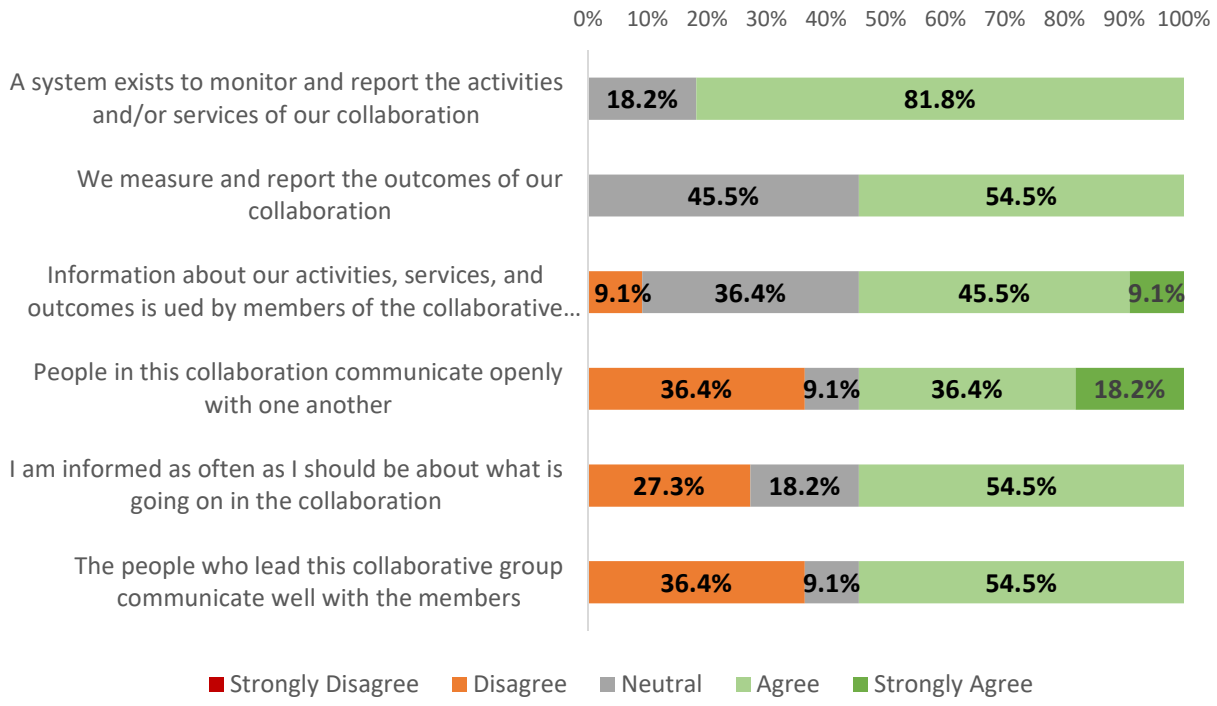


Statements 26 through 31: Evaluation, Learning, and Communication

The respondents' overall opinion of project evaluation was generally high. The findings indicated that evaluation was seen as being meaningful and useful, though it was suggested that collaborative communication could be improved. Just over half (54.5%) of respondents agreed or strongly agreed, while 45.5% were neutral or disagreed that people in the collaboration communicated openly with one another. Similarly, 54.5% agreed they were informed about what was going on in the collaboration and that people who led the collaborative group communicated well, while the other 45.5% of respondents disagreed or were neutral. Figure 17 depicts the number of respondents selecting each level of agreement pertaining to this set of statements of the inventory.

Figure 17

Statements 26-31: Evaluation, Learning, and Communication

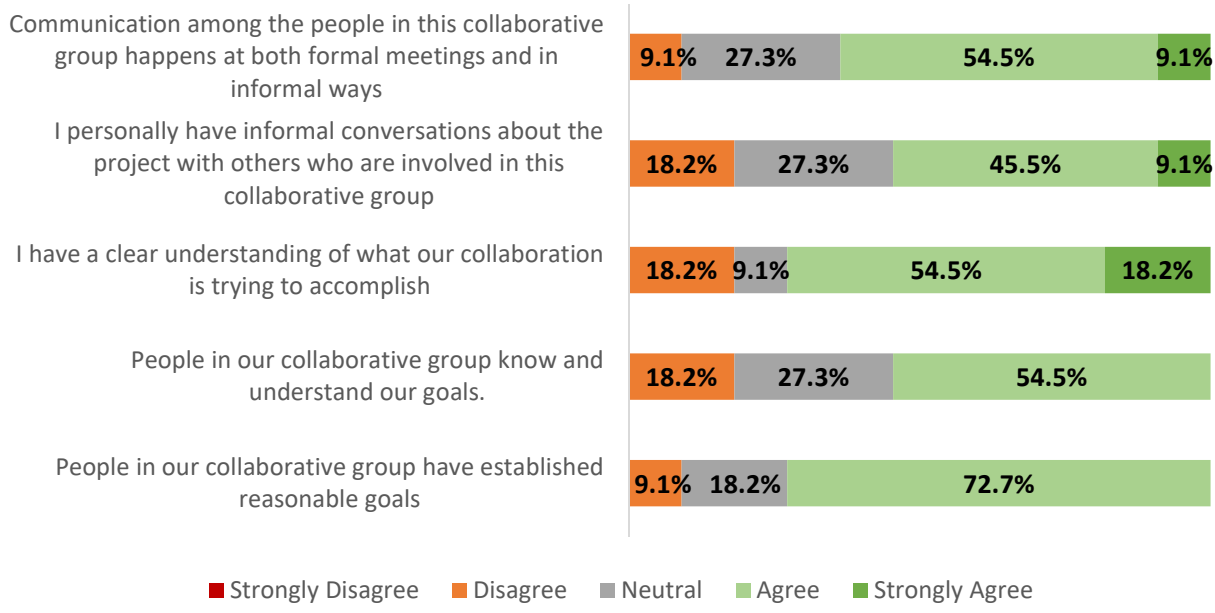


Statements 32 through 36: Camaraderie and Strategic Planning

Reported camaraderie was generally positive. The majority of respondents (72.7%) felt they had a clear understanding of what the collaboration was trying to accomplish. Most respondents also agreed or strongly agreed that communication occurs in both formal and informal ways (63.6%), and that they had informal discussions (54.5%). Respondents also favorably perceived the establishment of reasonable goals (72.7%). Finally, 54.5% of respondents agreed that the people in the collaborative group knew and understood the desired goals, while 45.5% disagreed or were neutral. Figure 18 depicts the responses for this category of the inventory.

Figure 18

Statements 32-36: Camaraderie and Strategic Planning

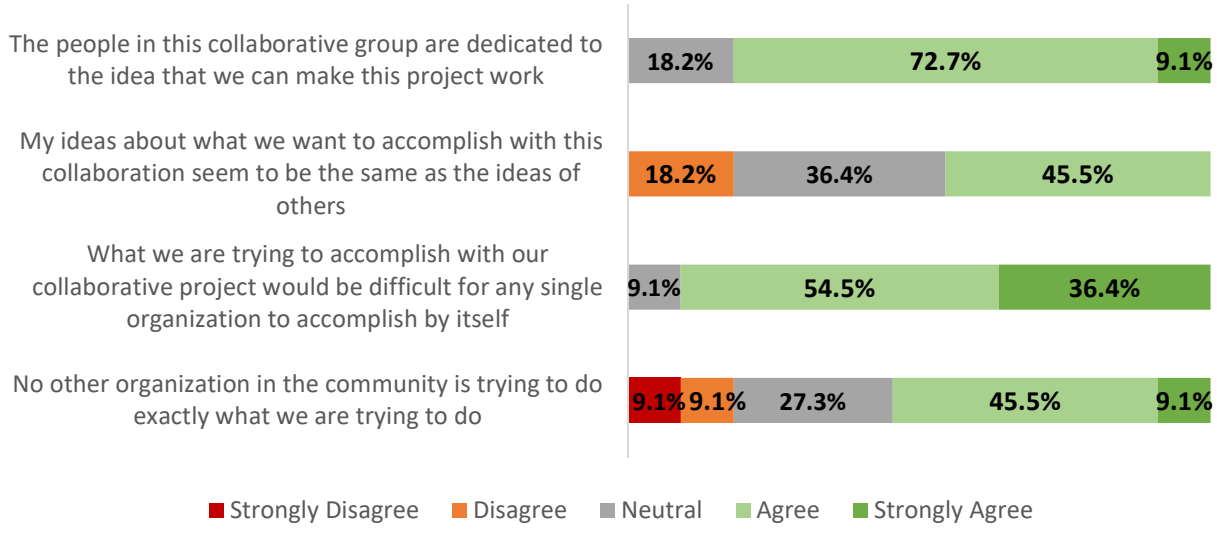


Statements 37 through 40: Shared Vision and Collaboration Unique Purpose

When asked about shared vision and unique purpose, 36.4% of respondents strongly agreed and 54.5% agreed that it would have been difficult for any single organization to accomplish the collaboratives goals, pointing to the fact that the collaboration served a unique purpose. Additionally, 81.8% of respondents also felt that members of the collaboration were dedicated to the idea that this collaboration could work. Regarding the overlap between the similarity of their ideas and those of others in the collaboration, 18.2% of respondents disagreed with the presence of overlap and 18.2% strongly disagreed that the work they were doing was being done by other organizations. Both these areas of disagreement showed a varied perspective among collaborative participants regarding shared vision and unique perspective. Figure 19 depicts the responses by participants for this category of the inventory.

Figure 19

Shared Vision and Purpose

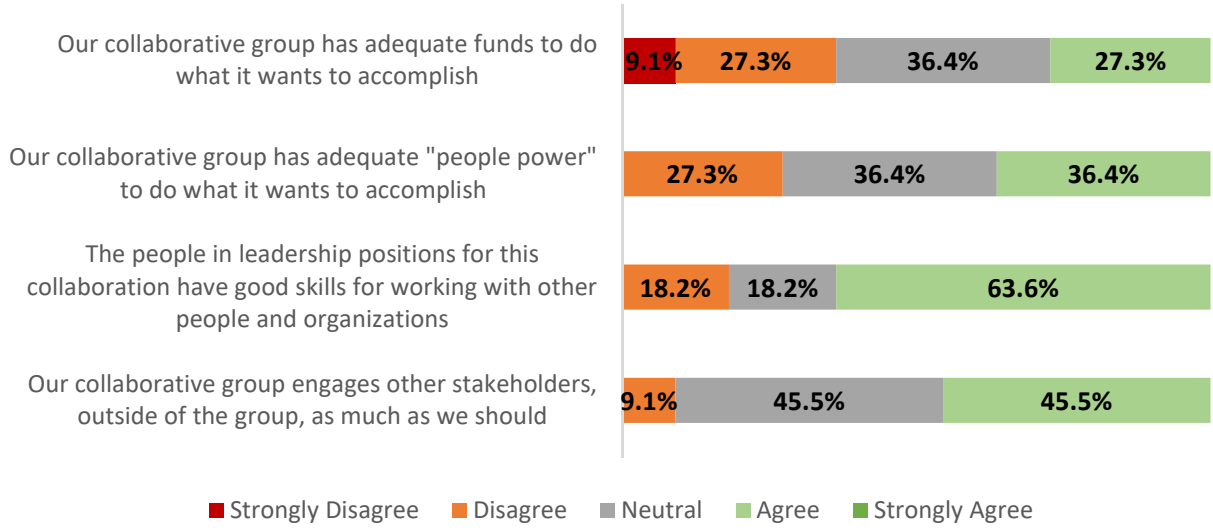


Statements 41 through 44: Resources, Skills, and Relationships

In the areas of resources, skills, and relationships, respondent perceptions were generally mixed, with room for improvement. Regarding the presence of enough "people power" to do what the collaborative group wanted to accomplish, 27.3% of respondents disagreed that adequate "people power" existed. Similarly, 27.3% and 9.1% of respondents disagreed and strongly disagreed that adequate funds were present to accomplish the collaborative's goals. Most respondents (63.6%) agreed that there was skilled leadership. Respondents also disagreed regarding their perceptions of how well the collaborative group engages stakeholders, where 45.5% were neutral, and 45.5% agreed that external stakeholder engagement was sufficient. Figure 20 shows the number of responses for each category.

Figure 20

Statements 41-44: Perceptions of Resources, Skills, and Relationships



Statewide Coordinators Wilder Collaboration Evaluation

The Wilder scoring method yields a score on 22 factors (areas of collaboration). Generally, a score of 4.0 (agree) to 5.0 (strongly agree) is a collaborative strength, and does not require special attention, or could be leveraged as an asset. A score of 3.0 to 3.9 indicates a borderline area that deserves some discussion. A score between 1.0 and 2.9 is an area of concern that should be collaboratively addressed. The mean (average) scores for all respondents are presented in Table 4.

Table 4

Statewide Coordinators WCFI Mean Collaboration Factor Scores

Collaboration Factor	Mean Score *(n=11)*
1. Members see collaboration as being in their self-interest	4.3
2. Favorable political and social climate	4.1
3. Mutual respect, understanding and trust	3.9
4. Unique purpose	3.8
5. Members share a stake in both process and outcome	3.8
6. Appropriate cross-section of members	3.7
7. Evaluation and continuous learning	3.6
8. Concrete goals and objectives	3.6
9. Shared Vision	3.6
10. History of collaboration or cooperation in the community	3.5
11. Collaborative group seen as a legitimate leader in the community	3.5
12. Ability to compromise	3.5
13. Adaptability to changing conditions	3.5
14. Flexibility	3.5
15. Appropriate pace of development	3.5
16. Established informal relationships and communication links	3.5
17. Skilled leadership	3.5
18. Multiple layers of participation	3.4
19. Engaged stakeholders	3.4
20. Open and frequent communication	3.3
21. Development of clear roles and policy guidelines	3.2
22. Sufficient funds, staff, materials, and time	3.0

Two areas had a mean (M) score between 4.0 and 5.0, indicating these were collaborative strengths. The top two collaborative strengths were members seeing the collaboration as being in their self-interest (M=4.3) and favorable political and social climate (M=4.1). The remaining 20 factors had a mean score between 3.0 and 3.9, indicating that these areas deserve some attention. There were no areas that scored between 1.0 and 2.9, indicating that there were no areas of immediate concern.

Multiyear Collaboration Discussion

This section examines how participants' responses to the 22 items on the Wilder survey have changed over time regarding the state's collaborative success in the prevention and treatment of opioid misuse and abuse. Mean scores for each factor were compared across three time points: 2018-19, 2019-20, and 2022-23. The Wilder survey in 2018-19 had 6 respondents, the survey in 2019-20 had 11 respondents, and the one conducted in 2022-23 had 11 completed surveys. As stated earlier, areas of collaboration with scores between 4.0 (agree) to 5.0 (strongly agree) describe a strength of the collaboration. Areas of collaboration with scores between 3.0 to 3.9 (neutral) indicate borderline areas which could use further discussion and exploration. Finally, areas of collaboration that score between 1.0 to 2.9 indicate areas of concern. The mean (average) scores for all respondents over the three time periods are presented in Table 5.

Table 5

Multiyear WCFI Mean Collaboration Comparison Factor Scores, 2018-19, 2019-20, 2022-23

Collaboration Factor	Mean Score 2018-19 *(n=6)*	Mean Score 2019-20 *(n=11)*	Mean Score 2022-23 *(n=11)*
1. Members see collaboration as being in their self-interest	4.7	4.6	4.3
2. Favorable political and social climate	3.9	3.8	4.1
3. Mutual respect, understanding and trust	4.4	4.0	3.9
4. Unique purpose	4.0	4.4	3.8
5. Members share a stake in both process and outcome	3.8	3.9	3.8
6. Appropriate cross-section of members	3.3	3.8	3.7
7. Evaluation and continuous learning	3.3	4.1	3.6
8. Concrete goals and objectives	3.7	4.3	3.6
9. Shared Vision	4.2	4.5	3.6
10. History of collaboration or cooperation in the community	4.4	4.0	3.5
11. Collaborative group seen as a legitimate leader in the community	3.8	3.6	3.5
12. Ability to compromise	3.8	3.7	3.5
13. Adaptability to changing conditions	3.8	4.2	3.5
14. Flexibility	4.1	4.2	3.5
15. Appropriate pace of development	3.8	3.9	3.5
16. Established informal relationships and communication links	3.9	4.4	3.5
17. Skilled leadership	3.3	4.1	3.5
18. Multiple layers of participation	3.4	3.9	3.4
19. Engaged stakeholders	3.7	4.1	3.4
20. Open and frequent communication	3.9	4.1	3.3
21. Development of clear roles and policy guidelines	3.5	3.5	3.2
22. Sufficient funds, staff, materials, and time	2.8	4.1	3.0

Overall, the multiyear analysis showed that respondents perceived collaborative efforts as having some strengths, with many areas demonstrating the need for further discussion. The factor of sufficient funds, staff, materials, and time was of most concern across all three time

points. In 2018-19, respondents reported sufficient funds, staff, materials, and time (M= 2.8) was as an area of concern. However, this factor increased to become a strength in 2019-20 (M= 4.1), and declined in 2022-23 (M=3.0) to a borderline area, warranting further discussion.

Several trends emerged among collaborative factors over time: (a) factors that remained strengths across all time points (scores between 4.0-5.0), (b) factors that increased over time points (going from borderline to strengths), (c) factors that remained borderline across all time points (scores between 3.0-3.9), (d) factors that decreased over time points (going from strengths to borderline), and (e) factors that fluctuated across time (going from borderline to strengths back to borderline). Each of these trends is discussed in further detail.

Factors that Remained Strengths Across Time Points

The multiyear analysis showed that respondents across all time points generally agreed or strongly agreed that the collaboration was in their self-interest (2018-19 M=4.7; 2019-20 M=4.6; 2022-23 M=4.3). This emerged as the greatest consistent strength in the state's response to the prevention and treatment of opioid misuse and abuse, demonstrating that collaboration around issues of opioid misuse and abuse was highly valued by respondents and was seen as serving the interests of the organizations they represent.

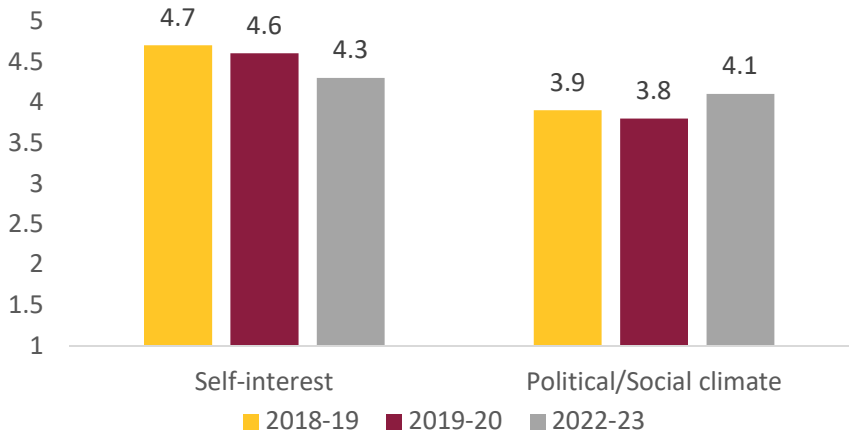
Factors that Increased Over Time

This section describes factors that increased from borderline scores (3.0-3.9) to a strength (4.0-5.0). One factor, favorable political and social climate, increased over the multiyear analysis, going from a borderline score in the first two years (2018-19, M=3.9; 2019-20, M=3.8), to a strength in the third time period (2022-23, M=4.1). This suggests that respondents felt a favorable shift in the social and political climate toward supporting efforts addressing the

prevention and treatment of opioid misuse and abuse. This showed a positive trend towards having larger support in the state for this issue. Future efforts should focus on maintaining the strength of these factors and leverage their effects to improve and support additional areas in need of support. As shown in Figure 21, factors of self-interest and optimal political/social climate remained or became a strength within the collaborative group.

Figure 21

Factors that Remained or Became Strengths



Factors that Remained Borderline Across Time Points

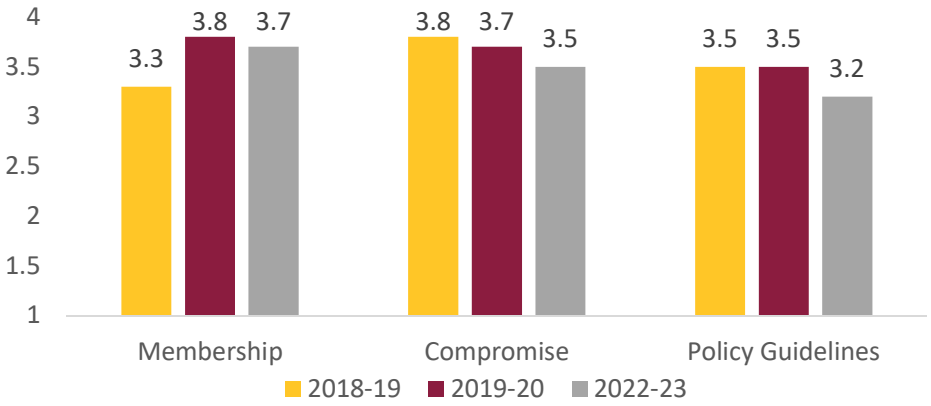
Seven factors had borderline scores (3.0-3.9) across all three time points of the multiyear analysis. The respondents indicated that issues around collaboration processes and member selection could use additional discussion or examination. In terms of process issues, respondents consistently felt that collaboration members should share a greater stake in both process and outcome (2018-19, M=3.8; 2019-20, M=3.9; 2022-23 M=3.8). Having the ability to compromise was also an area in need of further examination (2018-19, M=3.8; 2019-20, M=3.7; 2022-23, M=3.5), as were the development of clear roles and policy guidelines (2018-19, M=3.5; 2019-20, M=3.5; 2022-23, M=3.2). Figure 22 shows the changes between membership,

compromise, and policy guidelines from time 1 to time 3. Finally, respondents showed that the appropriate pace of development continued to be an area in need of further exploration, with scores declining in 2022-23 (2018-19, M=3.8; 2019-20, M=3.9; 2022-23, M=3.5).

In terms of member selection issues, respondents indicated that more efforts were needed to create an appropriate cross-section of members, although scores did improve after the first year (2018-19, M=3.3; 2019-20, M=3.8; 2022-23, M=3.7). Respondents also expressed concerns regarding multiple layers of participation, with scores improving in 2019-20 (M=3.9) but declining again in 2022-23 (M=3.4). Finally, respondents demonstrated that there was room for discussion around the collaborative group being seen as a legitimate leader in the community, with scores declining over the three time periods (2018-19, M=3.8; 2019-20, M=3.6; 2022-23, M=3.5).

Figure 22

Factors That Remained Borderline Over Time



Factors that Decreased Over Time

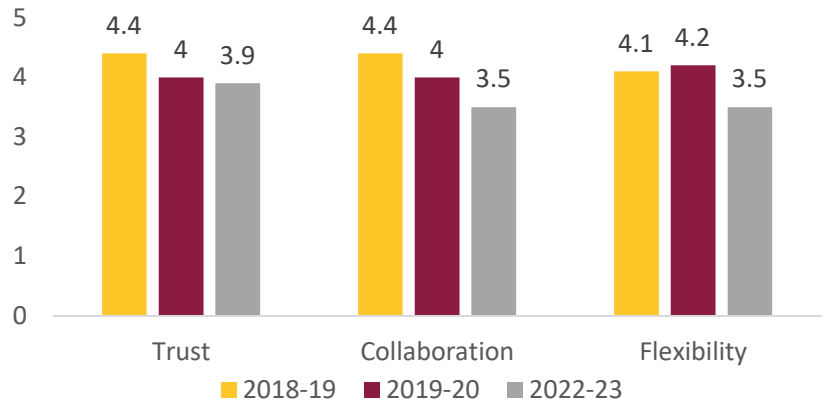
This section highlights factors that were strengths, with scores between 4.0-5.0, which then declined to become borderline factors, with scores between 3.0-3.9. Five factors followed this trend. All five factors remained strengths during time 1 and 2 but declined in time 3. It is

possible to speculate issues related to the COVID-19 pandemic may have negatively impacted the opioid prevention and treatment efforts which caused this shift. The factors which declined were related to relationships among collaboration members and with the larger community.

Respondents indicated a decline in mutual respect, understanding and trust (2018-19, M=4.4; 2019-20, M=4.0; 2022-23, M=3.9), shared vision (2018-19, M=4.2; 2019-20, M=4.5; 2022-23, M=3.6), and flexibility (2018-19, M=4.1; 2019-20, M=4.2; 2022-23, M=3.5). Respondents also described a decline in the history of collaboration or cooperation in the community (2018-19, M=4.4; 2019-20, M=4.0; 2022-23, M=3.5) and the unique purpose of the collaboration (2018-19, M=4.4; 2019-20, M=4.0; 2022-23 M=3.8), as shown in Figure 23. The fact that these five factors were strengths at one time suggests that state collaborations were succeeding in these areas at one time and could be successful again.

Figure 23

Factors that Decreased Over Time



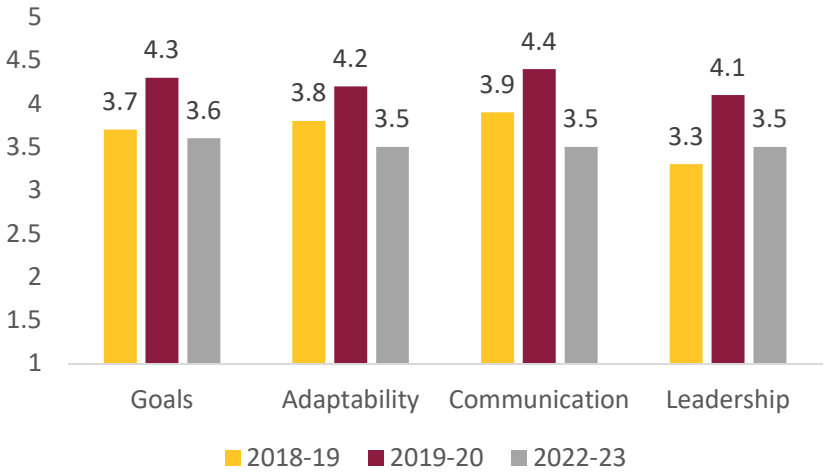
Factors that Fluctuated Across Time

The following eight factors were borderline areas at time 1, increased to strengths in time 2, and then decreased back to borderline areas in time 3. Once again, factors related to the COVID-19 pandemic may explain the fluctuation that occurred among these factors. In fact,

adaptability to changing conditions declined between 2018-19 (M=4.2) and 2022-23 (M=3.5). The fluctuations suggest that these factors, like those in the previous section, were areas where collaborations around the prevention and treatment of opioid misuse and abuse had been successful and could be successful again. As shown in Figure 24, collaborative factors of goals, adaptability, communication, and leadership saw an initial increase from time 1 to time 2 with a marked decrease in time 3.

Figure 24

Factors that Fluctuated Over Time



The remaining factors represented in this section span a variety of collaborative areas, including evaluation, goals, and objectives, established informal relationships and communication links, open and frequent communication, skilled leadership, and engaged stakeholders. Lastly, as previously stated, respondents demonstrated that sufficient funds, staff, materials, and time were an area of concern in 2017-18 (M=2.8), an area of strength in 2018-19 (M=4.1), and a borderline area in 2022-23 (3.0), indicating that more resources were needed to support and sustain these collaborations.

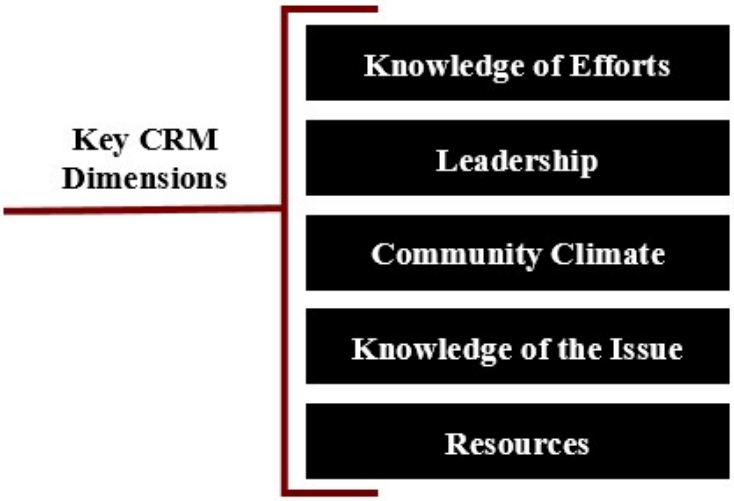
Final Consensus and Future Steps

Overall, the results of the multiyear analysis of the Wilder survey demonstrate that respondents felt value in collaboration efforts around the prevention and treatment of opioid misuse and abuse in the state of Arizona. Furthermore, respondents also perceived that the social and political climate was right for such collaborations. This demonstrates a positive sentiment among respondents towards these collaborations, showing they were needed and valued. However, respondents also indicated a consistent need for improvements in collaborative processes, as well as augmenting efforts toward member selection and participation. Also, time 3 data showed a decline in relationships among collaboration members and with the larger community compared to times 1 and 2.

Lastly, the multiyear analysis showed increases in eight areas between times 1 and 2, showing positive progress in Arizona around opioid prevention and treatment collaborations. However, these gains were reversed during time 3, highlighting the need for additional discussion, exploration, and resources to be directed toward these factors. Moving forward, collaborative discussion to identify the steps needed to support the collaboration between OD2A partners could be a first step toward continued efforts to address opioid use in Arizona.

Community Readiness Model (CRM)

The Community Readiness Model (CRM) measures attitudes, efforts and activities, knowledge, and resources of community members and leadership to assess a community's readiness to address an issue on five key dimensions with 36 questions: (1) community knowledge of the issue, (2) community knowledge of the efforts, (3) community climate, (4) leadership, and (5) resources (see Appendix C). SIRC evaluators solicited the agency names and contact information from the program coordinators. The request yielded the names and contact information of 36 individuals from a variety of disciplines (e.g., nonprofits, probation, police, health departments, treatment centers, jail, medical centers, faith-based organizations, and government agencies). Thirteen individuals participated in the interview. Six is the recommended minimum number of interviews for the CRM. CRM key informants represented the northeast, northwest, southern, and central regions of Arizona. On average, each interview lasted 45 minutes.



CRM Key Informant Demographic Characteristics

The 13 respondents were asked a series of demographic questions related to the number of years in their current profession, gender, race, ethnicity, and their highest level of education. Due to recording difficulties, the answers of one key informant were not entirely collected. From the demographics provided by the 13 individuals, 42.0% had worked in their

profession for more than 10 years and 50.0% had a bachelor's degree or higher. Most key informants were White (83.0%). Seven (50.0%) were male, five (41.7%) female, and one (8.3%) identified as non-binary. Table 6 shows the key informants' demographic information.

Table 6

CRM Key Informant Respondent Demographics

Years in Current Profession	Frequency	Percent
Gender (n=13)		
Female	5	41.7%
Male	7	50.0%
Non-Binary	1	8.3%
Race (n=12)		
Mixed race	1	8.3%
White	10	83.3%
Hispanic	1	8.3%
Ethnicity (n=10)		
Not Hispanic or Latino	10	83.3%
Hispanic or Latino	2	16.7%
Years in Current Profession (n=12)		
More than 1 year, but less than 3	1	8.3%
More than 3 years, but less than 5	3	25.0%
More than 5 years, but less than 10	2	16.7%
More than 10 years, but less than 15	2	16.7%
More than 15 years	4	33.3%
Employment Type (n=12)		
Non-profit	3	25.0%
Government Agency	1	8.3%
Law Enforcement	3	25.0%
Healthcare	3	25.0%
Judiciary	1	8.3%
Social Services	1	8.3%

Stages of Readiness

The community readiness model defines nine stages of readiness. A community's readiness level for an issue can increase and decrease depending on the environment and efforts. The stages include: (1) no awareness, (2) denial/ resistance, (3) vague awareness, (4) preplanning, (5) preparation, (6) initiation, (7) stabilization, (8) expansion/ confirmation, and (9) community ownership. The Tri-Ethnic Center for Prevention Research (2014) explains each stage as follows:

9 Stages of Readiness

1. **No Awareness**
2. **Denial/Resistance**
3. **Vague Awareness**
4. **Preplanning**
5. **Preparation**
6. **Initiation**
7. **Stabilization**
8. **Expansion/ Confirmation**
9. **Community Ownership**

- **Stage 1** consists of no awareness. The community has no knowledge about local efforts addressing the issue; leadership believes that the issue is not much of a concern; the community believes that the issue is not a concern; community members have no knowledge about the issue; and there are no resources available for dealing with the issue. An example would be that "teenagers drink and get drunk."
- **Stage 2** consists of denial and resistance. Leadership and community members believe that this issue is not a concern in their community, or they think it cannot or should not be addressed; community members have misconceptions or incorrect knowledge about current efforts; only a few community members have knowledge about the issue and there may be many misconceptions among community members about the issue, and community members and or leaders do not support using available resources to address this issue. An example would be that community members are saying "We can't (or shouldn't) do anything about it!"
- **Stage 3** consists of vague awareness. A few community members have at least heard about local efforts, but know little about them; leadership and community members believe that this issue may be a concern in the community; they show no immediate motivation to act; community members have only vague knowledge about the issue (e.g. they have some awareness that the issue can be problem and why it may occur); and there are limited resources (such as a community room) identified that could be used for further efforts to address the issue. An example would be that something should probably be done, but not sure what, or that maybe someone else will work on the issue.
- **Stage 4** consists of preplanning. Some community members have at least heard about local efforts but know little about them; leadership and community members acknowledge that this issue is a concern in the community and that something has to be done to address it; community members have limited knowledge about the issue;

and there are limited resources that could be used for further efforts to address the issue. An example would be that community members believe the issue is important and want to know what they can do.

- **Stage 5** consists of preparation. Most community members have at least heard about local efforts; leadership is actively supportive of continuing or improving current efforts or in developing new efforts; the attitude in the community is — we are concerned about this and we want to do something about it; community members have basic knowledge about causes, consequences, signs and symptoms; there are some resources identified that could be used for further efforts to address the issue; and community members or leaders are actively working to secure these resources. An example would be that meetings are occurring with funders.
- **Stage 6** consists of initiation. Most community members have at least basic knowledge of local efforts and about the issue; leadership plays a key role in planning, developing and/or implementing new, modified, or increased efforts; some community members are involved in addressing the issue; and resources have been obtained and/or allocated to support further efforts to address this issue. An example would be taking responsibility and beginning to do something to address this issue.
- **Stage 7** consists of stabilization. Most community members have more than basic knowledge of local efforts and the issue, including names and purposes of specific efforts, target audiences, and other specific information; leadership is actively involved in ensuring or improving the long-term viability of the efforts to address this issue; there is ongoing community involvement in addressing the issue; and a considerable part of allocated resources for efforts are from sources that are expected to provide continuous support. An example would be that the community has taken responsibility.
- **Stage 8** consists of confirmation/expansion. Most community members have considerable knowledge of local efforts, including the level of program effectiveness; leadership plays a key role in expanding and improving efforts; the majority of the community strongly supports efforts or the need for efforts; participation level is high; community members have more than basic knowledge about the issue and have significant knowledge about local prevalence and local consequences; a considerable part of allocated resources are expected to provide continuous support; and community members are looking into additional support to implement new efforts. An example would be examining how well the current programs are working and asking, “how can they be improved?”
- **Stage 9** consists of a high level of community ownership. Most community members have considerable and detailed knowledge of local efforts; leadership is continually reviewing evaluation results of the efforts and is modifying financial support accordingly; most major segments of the community are highly supportive and actively involved; community members have detailed knowledge about the issue and have significant knowledge about local prevalence and local consequences; and diversified resources and funds are secured, and efforts are expected to be ongoing.

CRM Key Informant Comments and Perceptions

The 13 CRM key informants provided valuable insights regarding drug abuse throughout Arizona communities. Some of the information received from them indicated that although many leaders support the efforts to address the opioid epidemic, more active engagement on the part of leaders was needed to promote and advance current efforts to bring awareness to their communities about the resources available for individuals and families who struggle with substance abuse and misuse. Following are some representative CRM key informant quotes and descriptions of the status, impact, and perceptions of how the opioid epidemic has been addressed across Arizona communities.

Community Efforts and Knowledge of the Efforts

"We've been doing a prescription drug takeback since 2008, if I think about that, and have collected tens of thousands of pounds of medication. We have 15 Dropbox locations. We have done a lot of work with our medical community. We've gotten our hospitals to change their policies, implemented what we called a sign-up to save lives campaign, getting doctors and medical practitioners to use the controlled substance monitoring program. We worked, got legislation passed at the state level."

"We actually got State Opioid Response funding to develop a fentanyl toolkit. And, so with that, there's PowerPoint presentations, there's school education components, there's TV, radio, billboard, social media messaging. And so all of the coalitions around the state are now working on that project. We track the number of presentations. We've been in front of thousands of kids in the schools, parenting education, again, TV spots, radio spots, billboard messaging."

"But our health department is educating in schools. [Name] County themselves, we have a Facebook for [county} drug stories, and we tell those stories of the person who was drug addicted, the parent who had to deal with the drug addiction, that type of thing. And we interviewed nurses and different people like that in these drug stories, and we try to get that out to the community to educate them."

"So, I think the overall feeling is everybody's in support of what we're trying to do. Like we put articles out in the paper and people can comment online. We haven't gotten negative comments about it. We haven't gotten negative comments about our drug stories. It seems like everybody, even our fire department members, our police, they're all on board to help these people."

"But we have community members that listen to like our Board of Supervisors meetings, and they hear what's going on, and you hear the feedback that they're like, yay, you know, thank you for doing this. I've had community members come up and thanked me for getting somebody a lesser sentence based on their history and their background of substance use or mental health because we might have gotten him a lesser center and got him into treatment. I've had people that we've gotten into treatment that have said, my whole life has changed now, that are now turning around and applying to become peers and get active in the community. We have hired several peers."

Leadership

“But I think that one of the strengths that we had was that we all had the same motivation and we wanted to stop seeing people die of overdoses, and we were willing to think outside the box and think of how we could get more tools into the hands of the community that is using or experimenting or abusing drugs so that their experience didn't turn into a life-ending experience and that it wasn't a life sentence to have an addiction.”

"Yes. The leadership, everything that I've brought to him, and everything that I've brought to the sheriff, and every time another program, this Leave Behind program is a great example, every time we bring something to them, they're like 100% let me know what you need, we want you to do it. There's no one who is saying, hey, hold on, you know, maybe we need to put the brakes on any of this stuff. They're all if I had a great idea of how to get Naloxone to every person in [city name] and get them trained, they would be 100% behind it. I have no doubt.”

“So, we've had a number of conversations, like I said, with the local care providers in trying to get interest and gauge the level of need for expanding resources for inpatient services, and that's involved all of the directors from those various organizations. And again, it is a partnership that's been there since 2017. But it's also involved our council members, our mayor and our city manager. So, the interest and being willingness is definitely there.”

Community Climate

“The overall feeling is that it's definitely a concern and a problem and actually a crisis in our state and it's something that we all need to do, everything that we can to help get it under control.”

“I think most people are scared of; even if they don't use drugs, they're scared of their children being at a party and making a bad decision or somehow coming in contact with an opioid and then losing their loved one. I think most people are scared of that. So, I would say that for the most part, that's why they would support the efforts that we've done. I haven't heard anyone say that we need to not talk about this, not teach our kids about fentanyl and the dangers of opioids. None of those people have come and talked to me.”

“Yeah, I mean, people come to us to volunteer super regularly. In general, I think the general community is like very concerned or fearful about the issue. So, I feel like there's a lot of, a lot of interest in volunteering and helping other causes here. We get more volunteers than we really have capacity to manage or more like prospective volunteers, I guess, I should say”

Knowledge About the Issue

"I think there's a basic understanding of the issue. Again, I think a lot of people recognize it for what it is. I think there's still more effort that need to be done in terms of educating them as to the realities of the opioid epidemic and it's not always self-induced. It's not always a choice about how that addiction gets started, like I just explained. So, I think those efforts need to continue as well as our efforts to find additional resources.

"Like a strategy that we did last year was to send out from our fentanyl toolkit, family fact sheets to the hairdressers and ask them to hand them out to people. We're always trying to think of new ways to hit individuals that might not have access or attend a presentation. So, we're always doing whatever that we can. But the fact is that people are on information overload and there's always people that don't pay attention to, because of maybe not of interest or not understanding the problem, whatever. So, I think that we're above average, but I think we got to keep working at it and we got to keep doing what we can."

"I know that our police departments now have sections where they're putting out brochures and flyers from the behavioral health, from the reentry, people providing services, stuff like that, to tell people that there's information out there. But I know there's not enough. And people don't even realize that 65% of our prisoners are actually diagnosed with a substance use disorder. People don't know that."

"…but there are a lot of people that are still in the dark about what to do if there's an overdose, what opioids are, what fentanyl is. I think there's a lot of public knowledge that people is lacking."

Resources for Prevention Efforts

"We've had a lot of different resources attend these fairs so that the community can be knowledgeable about what's out there for them. We also had a bunch of assistance from businesses to help put together a resource spreadsheet that is on our reentry on their website of all the different resources for housing, food, veterans, any services, anything like that, everybody helped to put this all together. So, we do have a lot of people in our community that want to help."

"So currently [county name], we received the $1.3 million BJA grant that we are using for a cop program, which is a comprehensive opioid program where we send them to treatment. We also received money from the ACJC, the Arizona Criminal Justice Commission to help with our law enforcement diversions. Our re-entry program is funded by the [county name] reentry program. They're just kind of a sub-reentry program, I guess, they're funded under [county name] grant. So basically, a lot of the efforts that we do are grant funded."

"So, all of our funding comes from individual donors, basically, and corporate donations. We don't get any grant money. We don't get any money from the government. Nothing comes from any public resources. So, we get individual donations from individuals. I think the smallest donation I ever got was like $3.53 from an ASU student, and that's all he had, and he PayPal-ed me. And then we've gotten checks for 10,000 before from different organizations, foundations around the valley that like what we do and want to support us. So that's where the funding comes from."

Scoring the CRM Interviews

To determine the readiness of a community, two evaluators independently reviewed the interview transcripts and scored each interview by dimension. After reviewing the transcripts,

the evaluators discussed their ratings and arrived at an agreed-upon score. The scores were totaled, and the total was used to determine the level of readiness by dividing each dimension by the number of interviews conducted (n = 13). The scoring of the interviews is weighted and therefore requires that respondents provide information in all five domains (knowledge of efforts, leadership, community climate, knowledge of the issue, and resources).

The scores correspond with the numbered stages and are rounded down, rather than up. Therefore, a score between 1.0 and 1.99 would be the first stage, a score of 2.0 to 2.99 would be the second stage, and so forth. Table 7 shows the scores from 2019, 2020, and 2023. Table 8 outlines the calculated readiness score from 2019, 2020, and 2023.

Table 7

CRM Key Informant 2019, 2020, and 2023 Combined Scores

Dimension	2019 Total	2020 Total	2023 Total
Community Efforts	32	36	63
Community Knowledge of Efforts	28	19	59
Leadership	37	30	58
Community Climate	29	20	50
Knowledge About the Issue	24	20	54
Resources for Prevention Efforts	33	31	55

Table 8

CRM Key Informant 2019, 2020, and 2023 Calculated Readiness Score

	2019 Stage Score	2019 Rounded Down	2020 Stage Score	2020 Rounded Down	2023 Stage Score	2023 Rounded Down
Community Efforts	5.33	5	6.00	6	4.85	4
Community Knowledge of Efforts	4.67	4	3.17	3	4.52	4
Leadership	6.17	6	5.00	5	4.46	4
Community Climate	4.83	4	3.33	3	3.85	3
Knowledge About the Issue	4.00	4	3.33	3	4.18	4
Resources for Prevention Efforts	5.50	5	5.17	5	4.26	4
Round Down Total:	**5.08**	**5**	**4.33**	**4**	**4.35**	**4**

The 2023 CRM yielded a readiness score of stage 4 preplanning, as the community's readiness to address the issue of misuse and abuse of opioids in Arizona. This indicates the community members and leadership have at least heard about the opioid epidemic but know little about it; they believe something should be done about it, but limited resources were available to further the efforts of the issue.

Community Readiness Discussion

In 2015, the ADHS began collaborative efforts to address the opioid epidemic with six Arizona counties. Prior to 2015 with little or no funding, each of the 15 counties throughout Arizona addressed this epidemic on its own. Rural parts of Arizona struggled the most, as resources were extremely limited. With federal funding, the ADHS was able to expand the

collaborative efforts throughout the state. As of FY 2023, all 15 counties were involved in the efforts to combat the opioid epidemic.

Utilizing the Community Readiness Model, in 2019 Arizona's readiness was at Stage 5, Preparation, and decreased to Stage 4, Preplanning, in 2020. The findings from this analysis indicated that Arizona's readiness remained at Stage 4 in 2023. An empirical decrease from one stage of growth to another, or no change at all, may occur even if the community was advancing through stages of readiness. As the community becomes more aware of the opioid epidemic, the perception of progress toward community readiness may initially worsen or remain unchanged rather than improve. This could be due to stakeholders learning more about the scope of the problem and adjusting their perception of severity accordingly. Perceptions of readiness can be influenced by the type of key informant and community factors such as substance use norms. Additionally, existing environmental factors can negatively impact respondents' perceptions related to community efforts and awareness. The key informant interviews took place after the end of both the Covid-19 public health emergency and the national state of emergency in the United States as well as the general dissipation of fears of contagion, which might have lifted the limitations of public health efforts to address the opioid epidemic on the ground. It is likely that some elements of the community efforts may have been on hold during the Covid-19 pandemic and now were being resumed. Thus, key informants' professional and community perceptions might have been influenced by the relaunched of the community efforts.

Importantly, respondents believed the work was continuing and worthwhile for their communities. An examination of the rankings across 2019, 2020, and 2023 demonstrates

general consistency; the items that were top-ranked in 2019 and 2020 were also top-ranked in FY 2023 (leadership and community efforts). Those items ranked less favorably in 2019 and 2020 (community climate and knowledge of the issue) were also ranked low in 2023.

Recommendations

Moving forward, the OD2A grantees should continue to put an additional focus on their efforts for the low-scoring dimensions. Some efforts might include the following:

- introduce information about the issue through community presentations and public events,
- conduct community surveys to assess the community's perceptions of the issues as well as their knowledge of current efforts and available resources,
- conduct local focus groups with community members, including law enforcement members, schoolteachers, and local business owners, to discuss the issue and develop strategies from the grassroots level, and
- increase media exposure via TV public service announcements, social media, and radio.

The CRM is not a one-time use measurement of readiness and should instead be re-administered periodically. As communities and organizations undergo inevitable changes, gathering community members and essential employee perspectives that assist those suffering from opioid misuse will change as well. As described within the CRM Key Informant interviews, counties, agencies, and organizations will have varying levels of struggles and success. Ongoing evaluation of perspectives and experiences could lead to strengthening efforts and community engagement.

Compassion Fatigue Training

Following the FY 2018 evaluation, a gap in assessment and support was found concerning compassion fatigue. More specifically, most compassion fatigue research focused on healthcare and first responders, while the literature was sparse for support and administrative staff. To remedy this, ASU-SIRC implemented two compassion fatigue trainings: (1) awareness and intentionality, and (2) practical applications, along with an assessment of ADHS staff members Professional Quality of Life.

Part 1: Awareness and Intentionality

The two trainings were comprised of two parts, with each session focusing on various components of compassion fatigue and resilience. Part 1 of the training focused primarily on attendees understanding the various factors and symptoms of compassion fatigue and secondary traumatic stress, areas of work that can increase symptomology, and the steps to build resilience. Most notably, attendees were introduced to the concepts of self-awareness and

intentionality. These concepts were essential conversation points as attendees learned the natural processes of the sympathetic and parasympathetic nervous systems. They were then encouraged to begin allowing the emotions, experiences, and frustrations of stressful work situations to arise rather than ignore them. The process of attendees understanding the concept of awareness allowed for the creation of intentional responses to situations seen as stressful or overwhelming. As discussed in the Professional Quality of Life section of this report, attendees who gained awareness and intentionality had improved quality of life outcomes.

Part 2: Practical Applications

In the second training session, attendees were invited to learn and identify individual strategies for coping with stressful workplace situations. Attendees were reminded about awareness and intentionality from session 1 and were encouraged to provide any existing strategies that they used to cope with stressful situations. The exploration of coping strategies propelled the training into education and evidence-based strategies proven to support positive and effective self-care. Sharing various self-care strategies provided attendees with the room to process and begin developing their own repertoire of skills and strategies that would work best for their specific areas of need. Finally, all attendees were provided presentation handouts via email that outlined numerous physical, social, emotional, and daily strategies that can be incorporated into their daily lives.

Future Directions

In conjunction with the compassion fatigue training, attendees were encouraged to complete the Professional Quality of Life Survey (ProQOL). The specific outcomes of the ProQOL were addressed in the subsequent section, yet the connection between these trainings and the

ProQOL is essential. As a self-report survey, respondents who complete the ProQOL and follow the scoring instructions will be provided with immediate results regarding their current level of burnout, secondary traumatic stress, and compassion satisfaction. By utilizing the ProQOL results and strategies taught in the compassion fatigue trainings, individuals could recognize and place emphasis on incorporating coping mechanisms that support the alleviation of specific compassion fatigue factors, namely burnout and secondary traumatic stress.

Moving forward, modifications to these trainings and bi-annual or periodic refresher trainings where attendees retake the ProQOL could provide organizations with insights into growth areas and employee support. One step towards continued support for ADHS employees is the development of the aforementioned compassion fatigue trainings into a two-part video presentation with coping skills handouts, embedded mindfulness activities, and the ProQOL to provide participants with the autonomy to gauge the factors addressed by the ProQOL. Through continued investment, encouragement, and support of Arizona's essential employees, satisfaction, positive outcomes, and overall professional work and personal outcomes can be improved through trainings such as these.

Professional Quality of Life Scale (ProQOL)

The Professional Quality of Life Scale (ProQOL) was utilized prior to and following compassion fatigue training for the AZDHS Linkages to Care team. The first survey was sent to participants via Qualtrics on April 3, 2023. Participants had two weeks to complete the instrument, which resulted in 20 participants completing the survey before the first training. The second survey was sent out six weeks following the final compassion fatigue training. It was open from July 2 and closed on July 16, 2023, with nine (n=9) participants completing the post-

survey. Participants were asked to complete both the pre-and post-training survey under the same alias to allow for ProQOL score changes to be analyzed. Data could not be analyzed under a repeated measures analysis due to a lack of paired alias usage for pre-and post-survey completion. A general comparison of score changes for the three subscales examined by the ProQOL was made, along with identifying occupational and county demographic data for the pre-and post-training participants.

Pre-Training Demographics

The participants who completed the pre-training ProQOL were from 10 counties across Arizona, resulting in 66.6% of Arizona's counties being represented by these data. As shown in Figure 25, two participants from Maricopa, four from Pima, three participants from Yavapai, three from Pinal, two from Yuma, and one from Navajo, one from Mohave, one from Gila, one from Coconino, and one from Cochise completed the ProQOL pre-training survey. One participant did not indicate their county. Additionally, an exploration into the various departments each participant was employed by was also examined. The most frequently reported department of employment was Healthcare being comprised of 60.0% of participants as shown in Figure 26.

Figure 25

Pre-training ProQOL Participants County of Residence

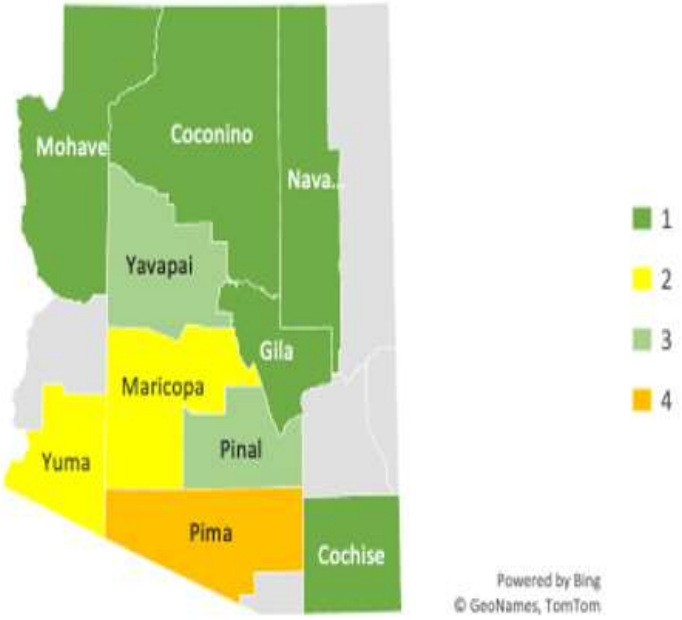
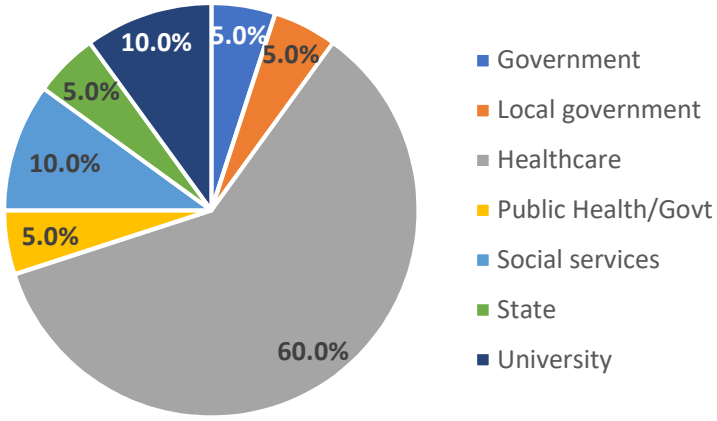


Figure 26

Pre-training ProQOL Participant Employment



Post-Training Demographics

Since it was not possible to correlate pre-training data with post-training data, the evaluation of similar demographic factors created the opportunity to interpret potential departments that specifically benefited from the compassion fatigue training. While the post-training survey only had nine responses, participants were from 7 of the 15 Arizona counties (46.6%). Further, the largest group of participants (44.4%) described their department of employment as Public Health.

ProQOL Data Analysis

The ProQOL is divided into three subscales: compassion satisfaction, burnout, and secondary traumatic stress. Each subscale is comprised of 10 questions with three cut-off scores that describe the respondent's level of experience for each topic. If a participant's scores add up to 22 or less, then they were experiencing low levels of burnout, secondary traumatic stress, and low levels of compassion satisfaction. Additionally, participants who scored between 23 and 41 were experiencing moderate levels of health for each subscale and high levels if they scored

above 42. Table 9 delineates the scoring criteria. Ideally, respondents will have higher levels of compassion satisfaction and lower levels of burnout and secondary traumatic stress.

Table 9

ProQOL Scoring Table

Sum of Subscale Questions	Level of Subscale Experienced
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

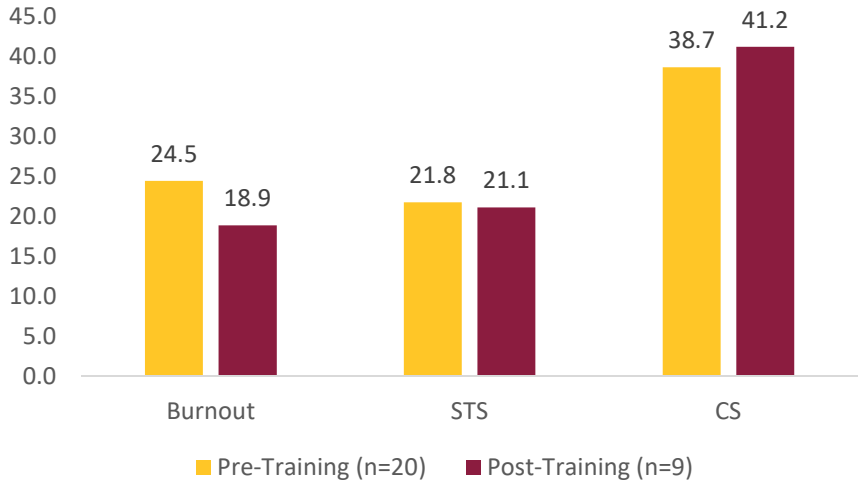
Briefly describing each subscale, compassion satisfaction is the measure of pleasure and satisfaction people receive by doing their work. In contrast to compassion satisfaction, burnout is feelings of hopelessness or challenge that come with trying to conduct one's work effectively. Burnout can often result from repetitive situations or experiences where negative feelings occur gradually and build up to where a person feels their work is no longer making a difference. Finally, secondary traumatic stress is similar to PTSD in its symptomology and manifestation, with the main difference being that the source of the trauma comes from hearing, reading, and being exposed to traumatic situations of another person. Collectively, the symptoms and scores of burnout and secondary traumatic stress make up what is known as compassion fatigue (Tri-Ethnic Center for Prevention Research, 2014).

As shown in Figure 27, for the AZDHS Linkages to Care team, burnout and secondary traumatic stress scores decreased, with respondents reporting an average 22.7% decrease in burnout symptomology following the compassion fatigue trainings. Similarly, participants reported an average decrease in secondary traumatic stress symptomology by 3.1%.

Additionally, participants reported a 6.6% increase in compassion satisfaction scores. These positive results indicate that respondents experienced a reduction in negative symptoms of burnout and STS while increasing their levels of compassion satisfaction. Most notably, participants in the pre-training group experienced moderate levels of burnout. However, following the two compassion fatigue trainings, participants experienced low levels of burnout. As for compassion satisfaction, participants reported an increase in overall satisfaction, with scores almost reaching high levels of satisfaction.

Figure 27

ProQOL Pre-Post Score Comparison



Professional Quality of Life Summary

Collectively, the AZDHS Linkages to Care team participants in the compassion fatigue training appeared to experience positive outcomes. However, the direct interpretation of participant experience of burnout, secondary traumatic stress, and compassion satisfaction cannot be drawn due to incomplete pre- and post-training participant identification.

Participants were instructed to only complete the post-training survey if they completed the pre-training survey, participants of both trainings were a part of the same organization, and the trainings were held and hosted by the same organization. Additionally, only participants who could have attended the two trainings received the survey link. Considering these factors, there was a strong possibility that some participants completed both the pre- and post-training. However, without certainty of which participants completed the surveys, direct connections between individual participant score change could not be made.

Moving forward, periodic assessment and administration of the ProQOL could be done by individuals or the ADHS to monitor employee levels of burnout, compassion satisfaction, and secondary traumatic stress. Supporting employees and continued efforts to identify areas of growth, strength, and difficulty could result in additional symptom improvement. Similarly, understanding that all participants who completed the survey attended the compassion fatigue trainings, periodic refresher trainings, or skill/strategy reminders could continue supporting employees to have the most positive experiences and best performance when working with sensitive, difficult, and challenging topics and clients.

Summary

The entire state of Arizona has experienced the impact opioids have on individual, family, and community levels. The efforts described in this report all focus on evaluating current opioid efforts and the status of communities, organizations, and employees at the forefront of the opioid epidemic in Arizona. Fluctuations in productivity, effectiveness, and strategies to address opioids are inevitable, and the results of this evaluation further reinforce this notion. However, employees showed resiliency and continued desire to improve the efforts in place as

well as identify additional new efforts that can promote further change and support for those struggling with opioid misuse. By increasing community engagement, improving organizational flexibility, communication, and willingness to collaborate and compromise, the state of Arizona can continue strengthening the efforts necessary to combat the ongoing opioid epidemic impacting Arizona and its invaluable residents.

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Appendix A

Professional Quality of Life Scale (ProQOL): Version 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often

1. I am happy.
2. I am preoccupied with more than one person I *[help]*.
3. I get satisfaction from being able to *[help]* people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I *[help]*.
7. I find it difficult to separate my personal life from my life as a *[helper]*.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
9. I think that I might have been affected by the traumatic stress of those I *[help]*.
10. I feel trapped by my job as a *[helper]*.
11. Because of my *[helping]*, I have felt "on edge" about various things.
12. I like my work as a *[helper]*.
13. I feel depressed because of the traumatic experiences of the people I *[help].*
14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a *[helper].*
20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
21. I feel overwhelmed because my case [work] load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
24. I am proud of what I can do to *[help]*.
25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a *[helper]*.
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

Appendix B

The Wilder Collaboration Factors Inventory Survey

The Wilder Collaboration Factors Inventory

Name of Collaboration Project _____ Date _____

Statements about Your Collaborative Group:

Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
History of collaboration or cooperation in the community	1. Agencies in our community have a history of working together.	1	2	3	4	5
	2. Trying to solve problems through collaboration has been common in this community. It has been done a lot before.	1	2	3	4	5
Collaborative group seen as a legitimate leader in the community	3. Leaders in this community who are not part of our collaborative group seem hopeful about what we can accomplish.	1	2	3	4	5
	4. Others (in this community) who are not a part of this collaboration would generally agree that the organizations involved in this collaborative project are the "right" organizations to make this work.	1	2	3	4	5
Favorable political and social climate	5. The political and social climate seems to be "right" for starting a collaborative project like this one.	1	2	3	4	5
	6. The time is right for this collaborative project.	1	2	3	4	5
Mutual respect, understanding, and trust	7. People involved in our collaboration trust one another.	1	2	3	4	5
	8. I have a lot of respect for the other people involved in this collaboration.	1	2	3	4	5
Appropriate cross section of members	9. The people involved in our collaboration represent a cross section of those who have a stake in what we are trying to accomplish.	1	2	3	4	5
	10. All the organizations that we need to be members of this collaborative group have become members of the group.	1	2	3	4	5
Members see collaboration as being in their self-interest	11. My organization will benefit from being involved in this collaboration.	1	2	3	4	5
Ability to compromise	12. People involved in our collaboration are willing to compromise on important aspects of our project.	1	2	3	4	5

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Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
Members share a stake in both process and outcome	13. The organizations that belong to our collaborative group invest the right amount of time in our collaborative efforts.	1	2	3	4	5
	14. Everyone who is a member of our collaborative group wants this project to succeed.	1	2	3	4	5
	15. The level of commitment among the collabo- ration participants is high.	1	2	3	4	5
Multiple layers of participation	16. When the collaborative group makes major decisions, there is always enough time for members to take information back to their organizations to confer with colleagues about what the decision should be.	1	2	3	4	5
	17. Each of the people who participate in decisions in this collaborative group can speak for the entire organization they represent, not just a part.	1	2	3	4	5
Flexibility	18. There is a lot of flexibility when decisions are made; people are open to discussing different options.	1	2	3	4	5
	19. People in this collaborative group are open to different approaches to how we can do our work. They are willing to consider different ways of working.	1	2	3	4	5
Development of clear roles and policy guidelines	20. People in this collaborative group have a clear sense of their roles and responsibilities.	1	2	3	4	5
	21. There is a clear process for making decisions among the partners in this collaboration.	1	2	3	4	5

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Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
Adaptability to changing conditions	22. This collaboration is able to adapt to changing conditions, such as fewer funds than expected, changing political climate, or change in leadership.	1	2	3	4	5
	23. This group has the ability to survive even if it had to make major changes in its plans or add some new members in order to reach its goals.	1	2	3	4	5
Appropriate pace of development	24. This collaborative group has been careful to take on the right amount of work at the right pace.	1	2	3	4	5
	25. This group is currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.	1	2	3	4	5
Evaluation and continuous learning	26. A system exists to monitor and report the activities and/or services of our collaboration.	1	2	3	4	5
	27. We measure and report the outcomes of our collaboration.	1	2	3	4	5
	28. Information about our activities, services, and outcomes is used by members of the collaborative group to improve our joint work.	1	2	3	4	5
Open and frequent communication	29. People in this collaboration communicate openly with one another.	1	2	3	4	5
	30. I am informed as often as I should be about what is going on in the collaboration.	1	2	3	4	5
	31. The people who lead this collaborative group communicate well with the members.	1	2	3	4	5
Established informal relationships and communication links	32. Communication among the people in this collaborative group happens both at formal meetings and in informal ways.	1	2	3	4	5
	33. I personally have informal conversations about the project with others who are involved in this collaborative group.	1	2	3	4	5

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Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
Concrete, attainable goals and objectives	34. I have a clear understanding of what our collaboration is trying to accomplish.	1	2	3	4	5
	35. People in our collaborative group know and understand our goals.	1	2	3	4	5
	36. People in our collaborative group have established reasonable goals.	1	2	3	4	5
Shared vision	37. The people in this collaborative group are dedicated to the idea that we can make this project work.	1	2	3	4	5
	38. My ideas about what we want to accomplish with this collaboration seem to be the same as the ideas of others.	1	2	3	4	5
Unique purpose	39. What we are trying to accomplish with our collaborative project would be difficult for any single organization to accomplish by itself.	1	2	3	4	5
	40. No other organization in the community is trying to do exactly what we are trying to do.	1	2	3	4	5
Sufficient funds, staff, materials, and time	41. Our collaborative group has adequate funds to do what it wants to accomplish.	1	2	3	4	5
	42. Our collaborative group has adequate "people power" to do what it wants to accomplish.	1	2	3	4	5
Skilled leadership	43. The people in leadership positions for this collaboration have good skills for working with other people and organizations.	1	2	3	4	5
Engaged stakeholders	44. Our collaborative group engages other stake- holders, outside of the group, as much as we should.	1	2	3	4	5

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Appendix C

Community Readiness

A. COMMUNITY EFFORTS (programs, activities, policies, etc.)
AND
B. COMMUNITY KNOWLEDGE OF EFFORTS

1. Using a scale from 1-10, how much of a concern is opioid misuse and abuse in your community (with 1 being “not at all” and 10 being “a very great concern”)? Please explain.

(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)

2. Please describe the efforts that are available in your community to address opioid misuse and abuse. (A)

3. How long have these efforts been going on in your community? (A)

4. Using a scale from 1-10, how aware are people in your community of these efforts (with 1 being "no awareness" and 10 being "very aware")? Please explain.
(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.) (B)

5. What does the community know about these efforts or activities? (B)

6. What are the strengths of these efforts? (B)

7. What are the weaknesses of these efforts? (B)

8. Who do these programs serve? (Prompt: For example, individuals of a certain age group, ethnicity, etc.) (A)

9. Would there be any segments of the community for which these efforts/services may appear inaccessible? (Prompt: For example, individuals of a certain age group, ethnicity, income level, geographic region, etc.) (A)

10. Is there a need to expand these efforts/services? If not, why not? (A)

11. Is there any planning for efforts/services going on in your community surrounding Opioid misuse and abuse? If yes, please explain. (A)

12. What formal or informal policies, practices and laws related to Opioid misuse and abuse are in place in your community, and for how long? (Prompt: An example of “formal” would be

established policies of schools, police, or courts. An example of “informal” would be similar to the police not responding to calls from a particular part of town, etc.) (A)
13. Are there segments of the community for which these policies, practices and laws may not apply? (Prompt: For example, due to socioeconomic status, ethnicity, age, etc.) (A)

14. Is there a need to expand these policies, practices, and laws? If so, are there plans to expand them? Please explain. (A)

15. How does the community view these policies, practices, and laws? (A)

C. LEADERSHIP

16. Who are the "leaders" specific to Opioid misuse and abuse in your community?

17. Using a scale from 1 to 10, how much of a concern is Opioid misuse and abuse to the leadership in your community (with 1 being “not at all” and 10 being “of great concern”)? Please explain.

(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)

18. How are these leaders involved in efforts regarding Opioid misuse and abuse? Please explain. (For example: Are they involved in a committee, task force, etc.? How often do they meet?)

19. Would the leadership support additional efforts? Please explain.

D. COMMUNITY CLIMATE

20. Describe _____ (name of your community).

21. Are there ever any circumstances in which members of your community might think that Opioid misuse and abuse should be tolerated? Please explain.

22. How does the community support the efforts to address Opioid misuse and abuse?

23. What are the primary obstacles to efforts addressing Opioid misuse and abuse in your community?

24. Based on the answers that you have provided so far, what do you this is the overall feeling among community members regarding the issue?

E. KNOWLEDGE ABOUT THE ISSUE

25. How knowledgeable are community members about Opioid misuse and abuse? Please explain. (Prompt: For example, dynamics, signs, symptoms, local statistics, effects on family and friends, etc.)

26. What type of information is available in your community regarding Opioid misuse and abuse?

27. What local data is available on Opioid misuse and abuse in your community?

28. How do people obtain this information in your community?

F. RESOURCES FOR PREVENTION EFFORTS
(Time, money, people, space, etc.)

29. To whom would an individual affected by Opioid misuse and abuse turn to first for help in your community? Why?

30. On a scale from 1 to 10, what is the level of expertise and training among those working on this issue (with 1 being "very low" and 10 being "very high")? Please explain.
(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)

31. Do efforts that address Opioid misuse and abuse have a broad base of volunteers?

32. What is the community's and/or local business' attitude about supporting efforts to address Opioid misuse and abuse , with people volunteering time, making financial donations, and/or providing space?

33. How are current efforts funded? Please explain.

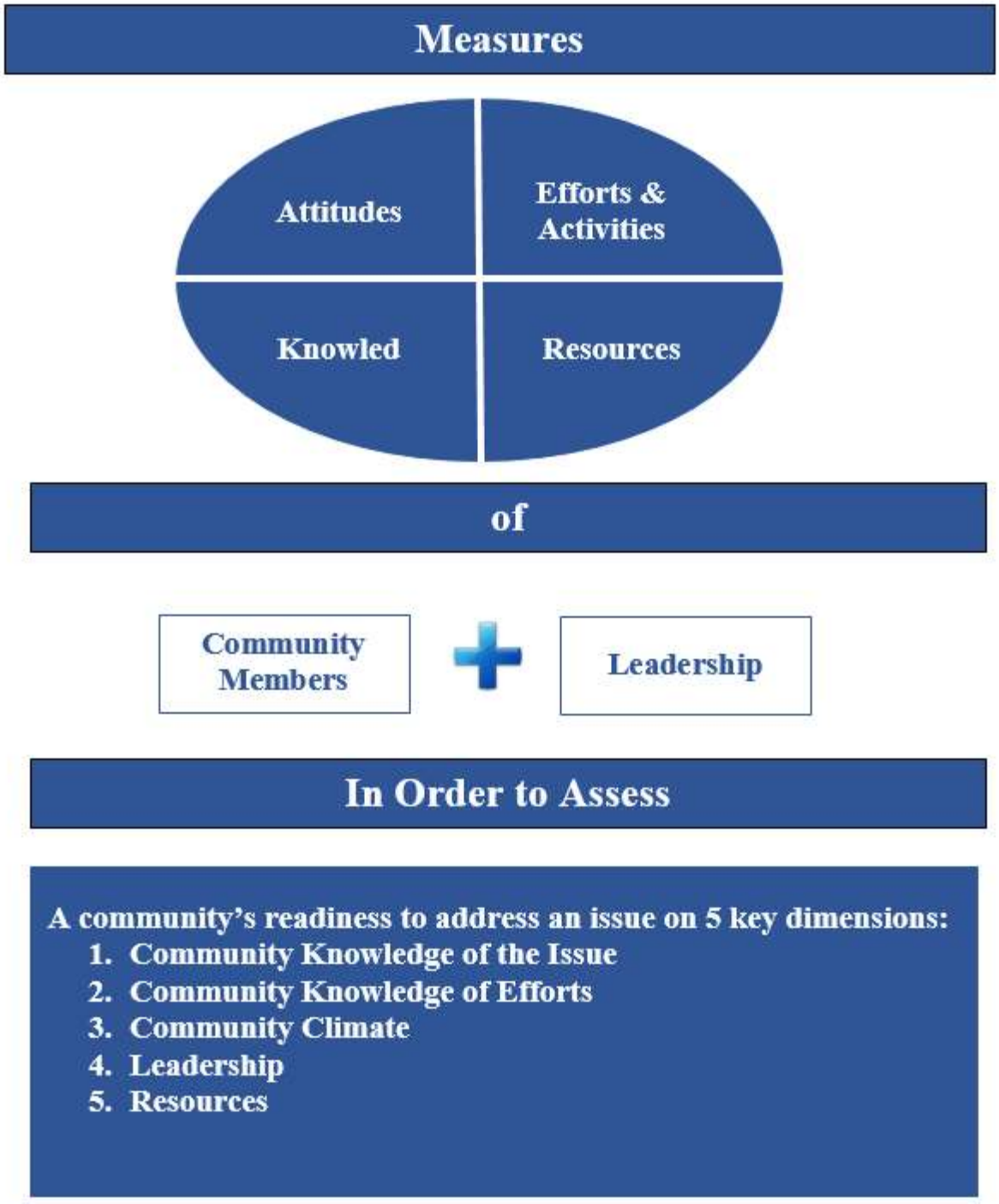
34. Are you aware of any proposals or action plans that have been submitted for funding that address Opioid misuse and abuse in your community? If yes, please explain.

35. Do you know if there is any evaluation of efforts that are in place to address Opioid misuse and abuse? If yes, on a scale of 1 to 10, how sophisticated is the evaluation effort (with 1 being "not at all" and 10 being "very sophisticated?")?
(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)

36. Are the evaluation results being used to make changes in programs, activities, or policies or to start new ones?

Appendix D

Community Readiness Model



Source: Tri-Ethnic Center for Prevention Research. (2014). Community Readiness Model 2nd Ed. Sage Hall, Fort Collins, CO

Appendix E

Demographic Questionnaire

The following information will be used for reporting purposes only and is optional. This information WILL NOT be used to identify you in any way. Thank you.

1) Which county do you reside in? _____

2) What is the type of agency that you work for? (Select only one)

- College
- Faith-based
- Non-Profit
- Police
- Probation
- School
- Sheriff's Office
- Social Services
- University
- Other:_____

3) What is your current working title? _____

4) How many years have you worked in your current profession? (Select only one)

- Less than 1 year
- More than 1 year, but less than 3
- More than 3 years, but less than 5
- More than 5 years, but less than 10
- More than 10 years, but less than 15
- More than 15 years

5) What is your gender? • Male • Female • Transgender

• Other_____ • Prefer not to answer

6) What race do you consider yourself to be? (Select all that apply)

- AI/AN: What Tribe_____
- Asian
- Black/African American
- Native Hawaiian / Pacific Islander
- White
- Don't/Know or Prefer Not to Answer
- Other_____

7) What is your ethnicity? • Hispanic or Latino • Not Hispanic or Latino

8) What is the highest level of education you have completed? (Select only one)
Some high school/GED Some college, Associate Bachelor's degree school no degree or more.

- Some High School / GED
- Some College
- Associate Degree
- Bachelor Degree or higher
- Some College No Degree