# STONE AND TANEY COUNTIES COMMUNITY ASSESSMENT

5/1/17

## Towards a Holistic Approach to Substance Abuse

This community assessment contains information on behaviors, consequences, risk factors, protective factors and community capacity for Stone and Taney Counties, Missouri. Sponsored by the Skaggs Foundation and CoxHealth, the report indicates two key areas to address: alcohol and prescription drug abuse. The report also reveals a community with multiple assets and a strong desire to create an effective continuum of care for substance abuse.

# Stone and Taney Counties Community Assessment

**TOWARDS A HOLISTIC APPROACH TO SUBSTANCE ABUSE**

## ORIGINS OF THIS REPORT

In November, 2015, Heather Zoromski, Grants Administrator for the Skaggs Foundation and Mr. William Mahoney, President of Cox Medical Center Branson in Branson, Missouri, reached out to Dr. William Geary with a desire to formulate a community wide plan for addressing substance abuse in Stone and Taney Counties. That conversation led to a Webinar for the Foundation in December 2015, and an initial site visit by Dr. Geary on January 20-21, 2016. During that visit, Heather Zoromski and Dr. Geary interviewed a variety of community stakeholders (N=13) to gather their views on substance abuse issues in Stone and Taney Counties. The resulting report (Developing a Prevention Plan in Branson, Missouri: Findings from Key Informant Interviews) described three important conclusions:

1. Based on these interviews, the likelihood of high levels of cooperation (among community stakeholders) is high.
2. …the community should focus on substance abuse for their initial planning efforts.
3. …the Skaggs Foundation, working closely with the hospital (Cox) would be an ideal fit to lead the implementation of a self-sustaining community plan for substance abuse. (Geary, 2016:5)

The Report also recommended a 16-step process for implementing collective community action. Those steps included:

1. Convene community stakeholders
2. Hold dialogue about issues, community context and available resources
3. Facilitate community outreach specific to goals
4. Determine if there is consensus/urgency to move forward
5. Identify champions and form cross-sector group
6. Map the landscape and use data to make the case
7. Facilitate community outreach
8. Analyze baseline data to identify key issues and gaps
9. Create infrastructure (backbone organization and processes)
10. Create a common agenda (common goals and strategies)
11. Engage community and build public will
12. Establish shared metrics (indicators, measurement, and approach)
13. Facilitate and refine goals and metrics
14. Support implementation (alignment to goal and strategies)
15. Continue engagement and conduct advocacy
16. Collect, track, and report progress for learning and improvement

Based on this information, the Skaggs Foundation decided to move forward. Working with Cox Medical Center Branson, the Skaggs Foundation agreed to fund the next steps of what is now called the Substance Abuse Initiative (SAI). After hiring a "Project Coordinator" (Marietta Hagan), a new contract was developed with Dr. Geary beginning in December 2016 and ending April 2017. This community assessment provides a key piece to moving through the 16-step process described in the "Developing a Prevention Plan in Branson" report.

## PURPOSE OF THIS REPORT

The purpose of this report is to provide a tool for the SAI to move through the 16 steps to improve their substance abuse infrastructure. The report begins with an explanation for systems of prevention. These models provide a way to sort and organize data. These data can then be used to create models based on probable causation. In addition, these models can provide a way to assess a community's current approach to managing health issues, including substance abuse. The report includes sources and data on behaviors and consequences related to substance abuse in Stone and Taney Counties. The reports also include information on identified risk factors and protective factors and community capacity. Finally, recommendations for next steps are provided.

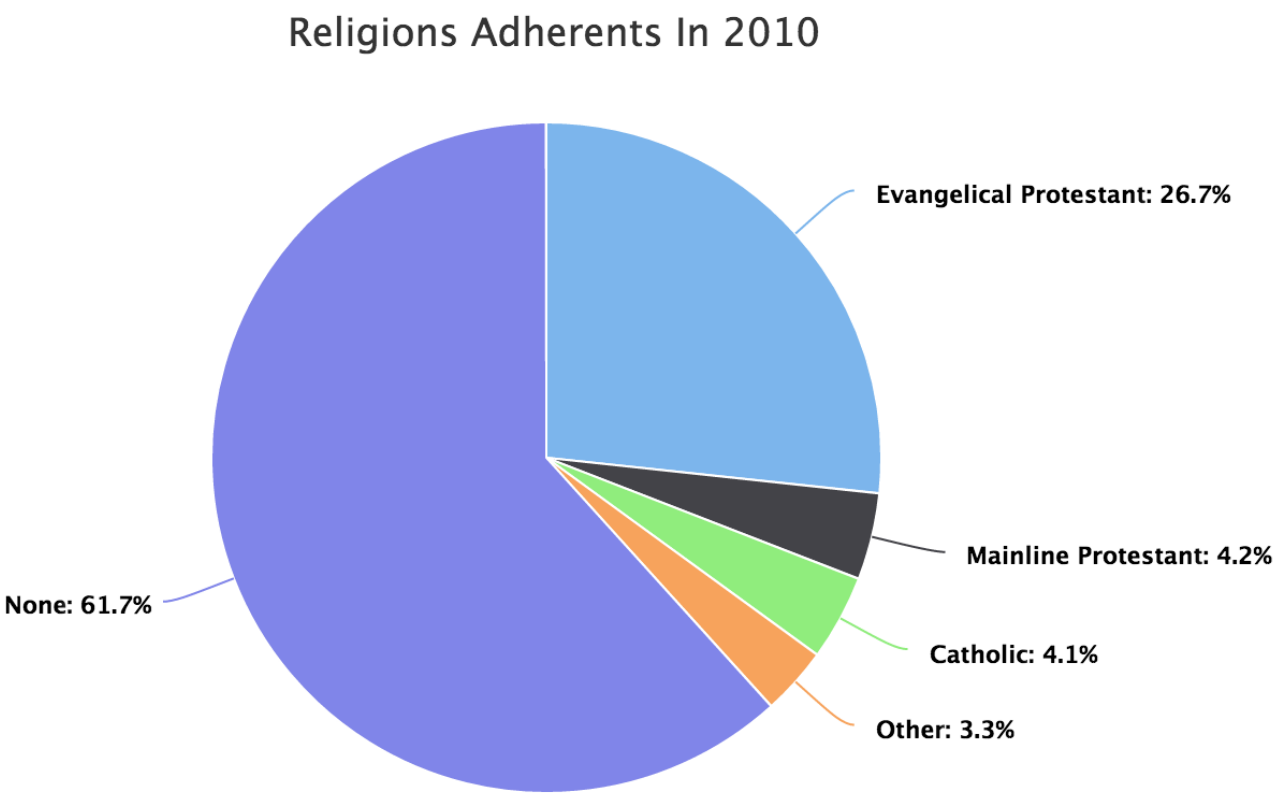
## STONE AND TANEY COUNTIES

Stone and Taney Counties are bordering counties located in southwestern Missouri and are considered part of the Branson, Missouri Micropolitan Statistics Area. Both counties share a border with Arkansas. While the grant covers both counties, it is important to remember that each county, while unique, shares certain characteristics with the other. This assessment offers information on both counties.

Stone and Taney Counties are both primarily rural, white communities that have similar educational attainment. About 81% of total residents have at least a high school diploma and about 14% have 4 or more years of college. In addition, about 12% of the total population in these counties is below the poverty line, and the median household income for each county is just over $21,500. It is also worth noting that both counties have seen significant increases in their populations since 1990. Stone County's population has increased by 69% while Taney County has increased by 114%.

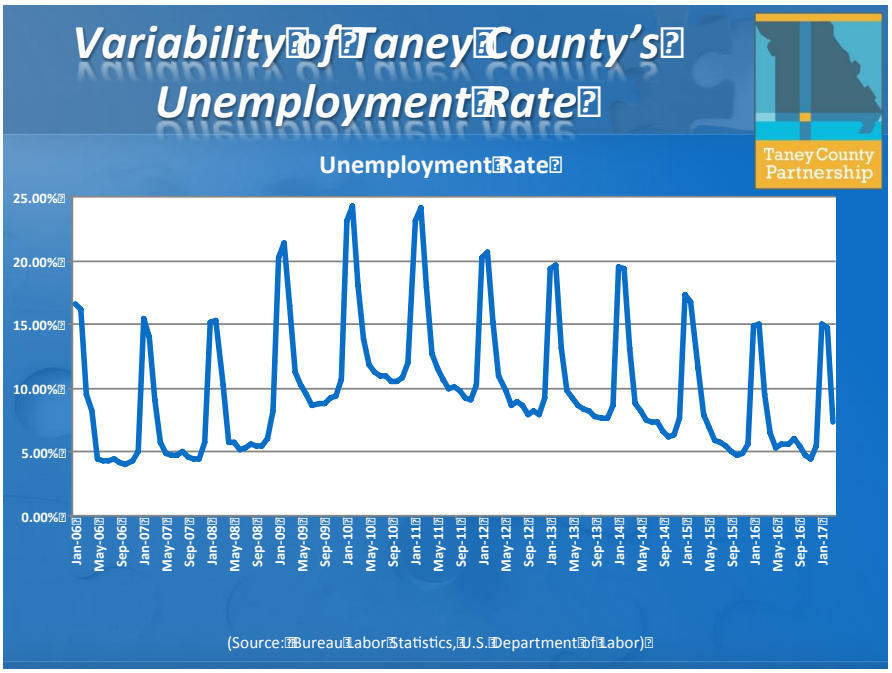
Some important differences between the two counties include the age distribution and household income. Stone County is slightly older than Taney County. Youth under 18 make up about 17% of Stone County's population and about 21% of Taney County's population. In addition, more than one out of every four residents in Stone County is over 65 (28%), and one out of every five Taney County residents is over 65 (20%). The U.S. Department of Census points out that the median household income for Stone County is 17.3% higher in Stone County when compared to Taney County.

In addition, Stone and Taney Counties have a relatively low (when compared to the Missouri state average) significant religious footprint. Approximately 39% of the population claims a religious preference (compared to about 42% for the state). However, interviews with key stakeholders reveals a strong influence of religion in the region. The following Chart is from the Department of Census for 2010.



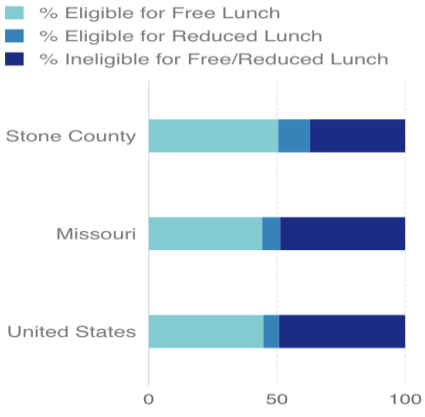

The region's economy is driven primarily through tourism. Branson has more than 200 shops, 16,500 lodging rooms, and 95 acres of shopping, dining, lodging, and entertainment. The region also has a variety of outdoor and family activities. While the tourist season generally runs in the warmer months, beginning in April and ending in November, it is estimated that Branson hosts more than 7 million visitors each year (http://www.bransontourismcenter.com/articles/bransonarticle87). There are relatively few job opportunities that fall outside of the tourism industry and a high demand for relatively low skilled, tourist driven employment. In fact, it is estimated that about 45% of employment opportunities are in "accommodation and food services" and "arts, entertainment and recreation". This leads to a perceived wealth of relatively low skilled, low paying jobs in the region that attracts hundreds of people each year looking for easy employment opportunities. It also leads to steady, oscillating unemployment rates. The result is relatively high levels of employment opportunities during the peak tourist seasons and significantly lower levels of employment opportunities during the off season. The Table below summarizes this pattern.

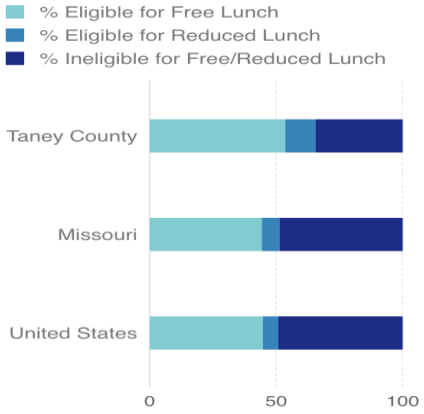
According to key stakeholder interviews, this employment pattern results in a significant and stable disenfranchised population of low skilled laborers. With the average cost of a family home a little over $200,000 (in 2015), this creates a housing issue for this population. The solution to the housing issue for this group is found in the fluctuating hotel industry. Like the employment rate, demand for hotel space fluctuates with the tourist season. These two patterns, employment and bed space, creates an environment where some local motel owners rent monthly to the low skilled labor workforce. According to multiple stakeholders, it is not uncommon to see entire families (numbering anywhere from 2 to 7) living in small, single motel rooms. In addition, many (if not most) of these families have unreliable transportation, inadequate health insurance (for example, about one-third of adults in Taney County do not have insurance- about double the state average) poor diets, and unsanitary daily living conditions. Interviews with Branson police reveal a significant number of calls for service to these locations, and are a primary focus of substance abuse issues.



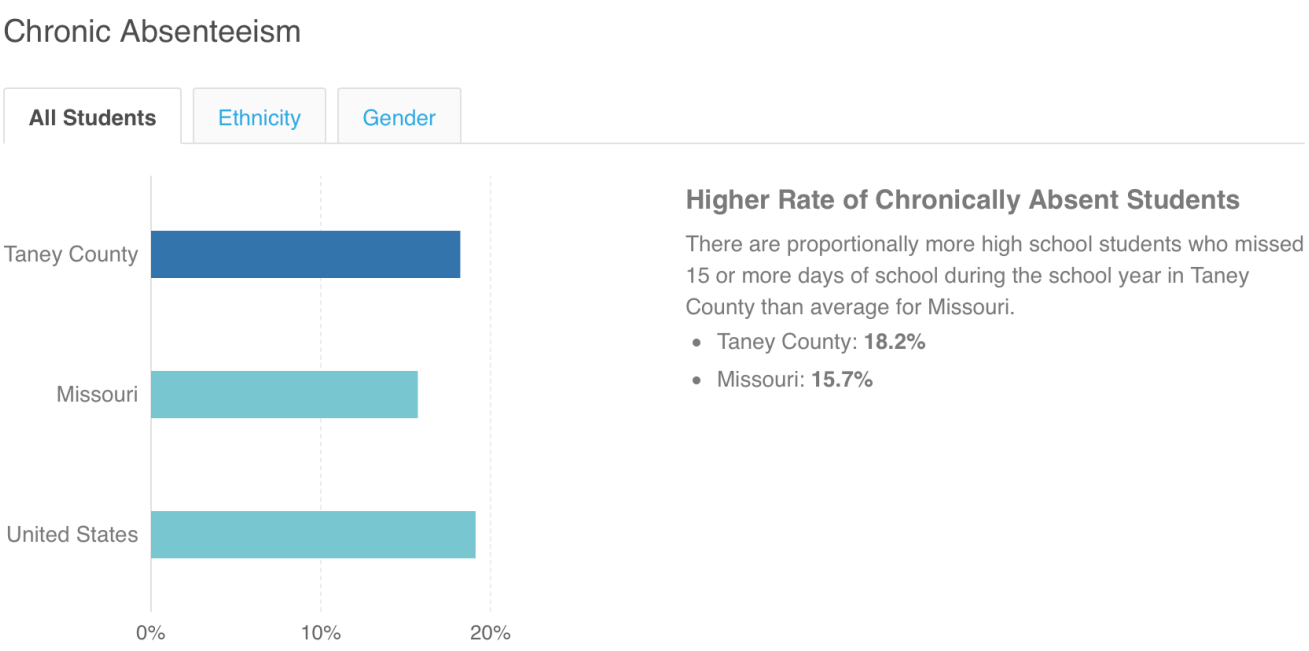

## STONE AND TANEY COUNTY SCHOOL SYSTEM

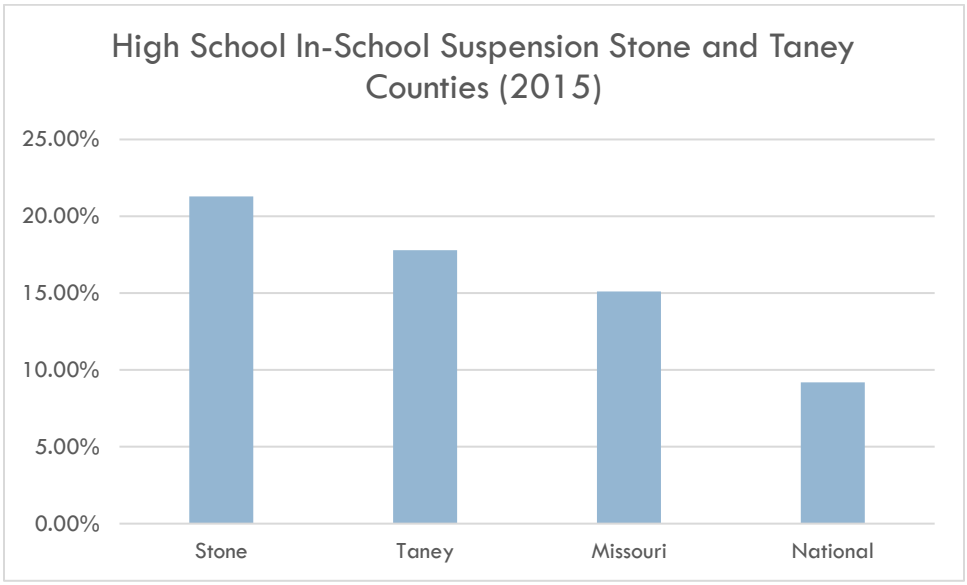
This fluctuating employment system also has an impact on the school system. Both Stone and Taney County have free or reduced lunch rates higher than both the state and national averages.




Discussions with school district personnel also revealed two data points that are related to the cyclical poverty rate; chronic absenteeism and suspensions. Taney County has higher than the national average rates in chronic absenteeism, which is one indicator of "community attachment". In addition, both Stone and Taney Counties have high school suspension rates above both the state and national averages (http://education-places.startclass.com/l/2381/Stone-County-MO#Public%20High%20Schools&s=gPhyn).




While in-school suspensions are much lower than the state averages at the middle and elementary levels, high school suspensions, are higher than both the state and national levels.

School stakeholders also consistently reported high levels of student transfers between schools during the school year. All of this leads to a relatively unstable teaching and learning environment for students. The school stakeholders identify economic issues as one of the core causes of these data.

## MODELS OF CAUSATION

Prevention requires a clear understanding of the factors that can create or hinder substance abuse. The goal of any prevention effort is to increase the factors that hinder substance abuse (protective factors) and

decrease the factors that promote substance abuse (risk factors). However, not all groups are impacted equally by scientifically-derived risk and protective factors. Therefore, it is also important to understand how various groups or individuals are likely to be affected by various approaches and strategies. Finally, it is important for communities to have a clear understanding of how their system of prevention works. Given this, there are three models that are important for understanding how to develop effective, data-driven approaches to substance use and abuse. The first model, the social ecological model, describes how social factors impact individual behaviors. The second model, the Continuum of Care, maps out all the stages of substance use. The third model, the Centers for Disease Control Health Pyramid, describes how costs can be utilized most effectively.

The social ecology model describes the interaction between individual behaviors and social forces. The model can be used to understand the extent of risk and protective factors in a community.

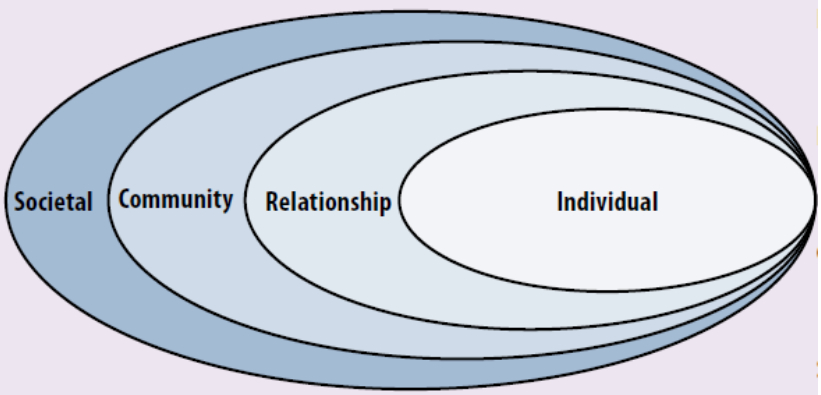
**Summary of Each Level for Social Ecology**

*Individual*= biological and personal history

*Relationship*= close personal associations

*Community*= social settings

*Societal*= broader regional/national




The Individual level identifies biological and personal history factors that increase or decrease the likelihood of substance abuse. These might include a family history of substance abuse, age, education, or history of physical or psychological abuse.

The Relationship level examines close relationships that may increase the risk of engaging in substance abuse. A person's closest social circle, including family members and peers, influences behavior and contributes to a person's range of experience. Risk and protective factors here include parental and peer attitudes towards substance abuse and friends who engage in substance use/abuse.

The Community level explores social settings in the community such as schools, workplaces, and neighborhoods. Each of these settings impacts both relationships and individual behavior. Identity is an important concept here, since each of these settings will be associated with norms, values and behaviors. Risk and protective factors at this level might include availability of substances, community norms for use, and neighborhood attachment. Also included here would be the community's capacity to impact or change risk and protective factors at the individual, relationship, and community-level.

Finally, Societal level indicators refer to broadly accepted standards, values, beliefs, and practices that impact the community. These can include certain economic indicators, national media and national educational and social policies. Often community prevention initiatives are unable to influence factors at this level. However, it is important for a community to understand how societal factors might be impacting their community.

A Risk and Protective Factor list is included at the end of this report. The social ecology model is a proven-effective approach to help community members identify and categorize risk and protective factors as well as providing a better understanding of how these factors may influence each other in the community. This understanding can be used to help community members identify the appropriate approaches to managing

substance abuse in their community. Once identified, relevant factors can be tracked and appropriate programs, approaches and practices can be put into place.

The social ecology approach is primarily concerned with outcomes data and is an important tool for creating effective models of change. The process includes identifying current outcomes, hypothesizing how to improve those outcomes and then monitoring progress to adjust and measure successes and challenges. Most community-based prevention efforts focus on the "community" level. This is because local communities often have little control over societal level factors. It is also true that prevention efforts simply cannot control some relationship or individual level factors. The goal then is to impact community level factors in order to make an impact at both the relationship and individual level if possible.

Keeping that in mind, the social ecology approach asks for two types of data. The first are the actual outcomes currently being seen in a community. For example, how many people binge drink or smoke marijuana. The second type of data involves existing risk factors that are associated with the first type of data. For example, "community norms favorable to marijuana use" would impact relationship level factors and individual level factors. Having said that, appropriate data collection would include both the outcomes currently being manifested, as well as the factors that influence that manifestation.

In Branson, the social ecology model can be used to help create a data needs list as well as develop effective models for change. Ideally, a coherent data plan would include indicators from the individual, relationship and community levels. Using the attached Risk/Protective Factor chart, there are some risk factors that are consistent across all three prevention approaches. These common risk factors are:

**Individual**
Early onset
Favorable attitudes towards abuse (risk or harm)

**Relationship**
Family history of substance abuse
Family conflict or management issues
Peer attitudes towards substance abuse

**Community**
Attachment to school/work/neighborhood
Ease of access of substances
Community laws and norms that favor substance abuse
Employment stability

**Societal**
Unemployment/underemployment
Stability of employment
Pro-drug messages

It is worth noting that typically "employment" would be a societal level indicator only. However, data clearly identifies employment stability as an important community-level factor in Stone and Taney Counties. While skills training would help alleviate some of this, it is also clear that tourism trends are generally outside the control of local area employers. However, tracking these trends at both the local and regional levels will help policy makers in Stone and Taney Counties plan for improving prevention and understanding the impact that these trends have on the community.

Finally, at a basic level, **protective factors** are often the **opposite of risk factors**. For example, "attitudes favorable to substance use" as a risk factor would speak to the protective factor of "attitudes unfavorable to substance abuse". However, the prevention research indicates other approaches to protective factors. One of the key protective factors is consistency of messaging around the acceptability of substance abuse in a community. Messaging on this issue should be consistent at all four levels if possible. Too often, local community members can feel overwhelmed about national messaging (for example, commercials on nationally televised events). It is important to remember that national messaging can be used in two ways to create consistent messaging at the community level. First, positive messaging about substance abuse found in the national media can be "fact checked" or countered at the local level. Positive messages about substance abuse can be targeted and deconstructed for distribution in the local media. For example, many popular shows have main characters that use alcohol with high frequency. The message here is that alcohol use is acceptable and popular. This messaging can be countered with letters to the editor pointing out that about half the U.S. adult population reports not having an alcoholic drink in the past 30 days. That fact could then be followed up with a list of alcohol health effects along with a message about the types of treatment available in the area.

**Institutionalizing SORS as a Protective Factor:** The Communities That Care model, with its accompanying "Social Development Model" is driven by the SOR concept that has been accepted in all three Risk/Protective Factor models. SOR stands for skills, opportunities, and recognition. The SOR approach can be easily institutionalized in school, work, and family settings. The approach focuses on providing the skills necessary for someone to complete a task, giving the opportunity to successfully complete those tasks and receiving recognition for successful completion. This approach provides positive messaging that enhances **attachment** and **social bonding**, which are two critical protective factors.

## TOWARDS A DATA COLLECTION PLAN

By focusing on those risk and protective factors that are shared across various models, a community can begin to narrow the scope of data collection. Good data plans only include data that is necessary and impactful. Good indicators should also be accurate (valid), consistent over time (reliable) and relatively easy to access. Some of the risk factors listed above have indicators that are easier to collect than others. For example, school survey data collects almost all the individual, relationship, and community indicators listed. However, that data obviously only applies to youth who are in school to take the survey. Greater challenges might be faced in collecting this same data for adult populations.

**Decreasing Local Availability Leads to More DWI Crashes?** In one community, there was clear data linking underage liquor sales to binge drinking for youth. The local coalition worked with local vendors who increased how strictly they carded potential customers. The risk factor of availability decreased significantly within 6 months, but DWI crashes dramatically increased. After more research the coalition discovered that local youth were now driving to neighboring communities where they were not carded and thus increased the number of crashes as they drove home while drunk.

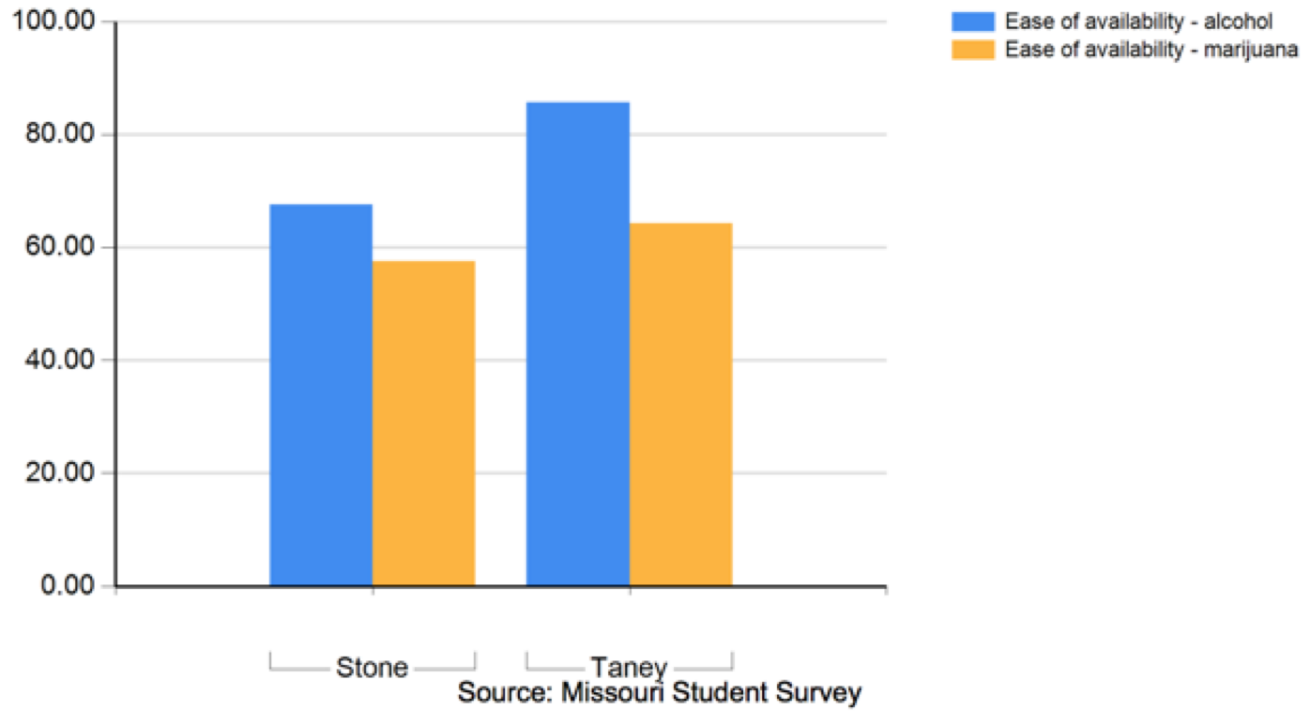
In addition to **collecting risk and protective factor data**, it is also useful to collect **consequence data**. Consequence data is an excellent way to measure the overall impact of any prevention strategy. Too often, prevention programs are measured by behavioral outcomes such as "number of people who regularly binge drink". While decreasing amount of binge drinking is important at multiple levels, prevention science is interested in community impact as well. For example, suppose there is a decrease the amount of drinking but an increase in the number of drunk driving incidents and fatalities? This might indicate a needed shift in the

prevention strategy. This conversation about shifting strategies is only possible if both the behavior (drinking) and some of the consequences of drinking (driving while intoxicated) are being monitored.

It is up to communities to decide the kinds of consequences that are worth tracking. In general, there are two characteristics to consequences that draw discussion; qualitative impact and quantitative impact. Some behaviors are relatively rare but have a significant negative impact on the community, while other behaviors may be frequent but have only a small impact on the community. Communities need to measure out their resources and apply them in ways that are appropriate to their community goals.

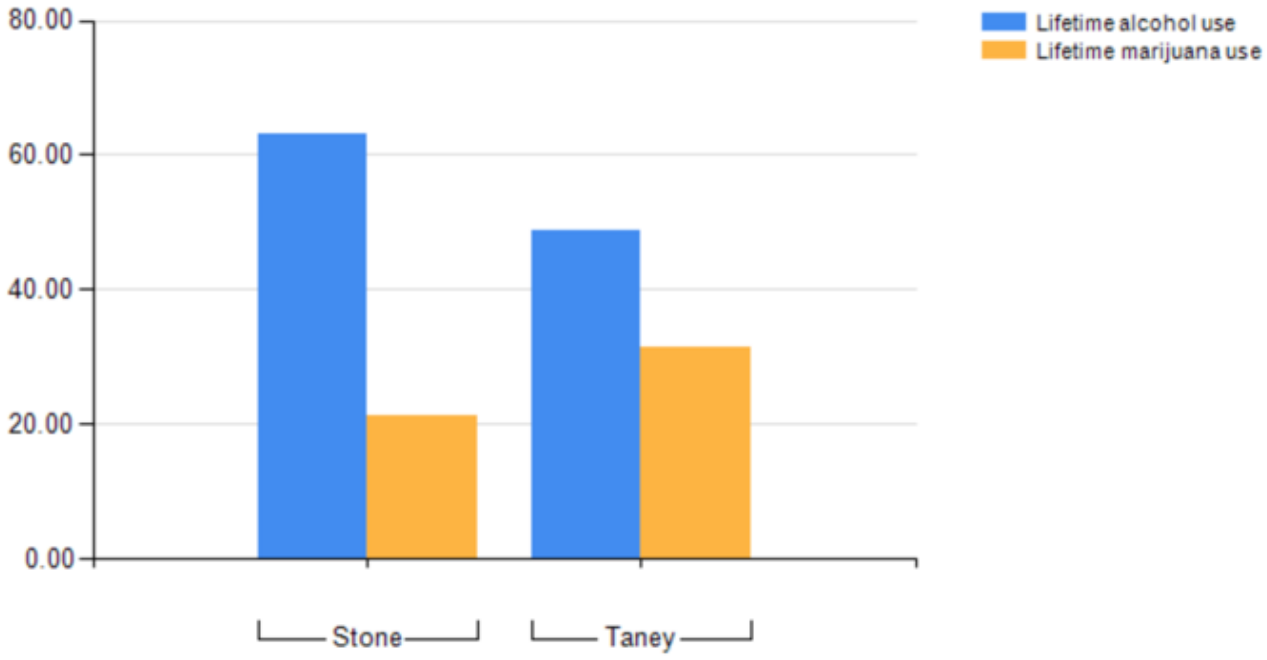
**What is Community?**
It is difficult to "force" people to view themselves as part of community. This often leaves prevention specialists wondering how to define the "community" for action. In general, there are some key questions to help with this process. The first is, "Do community members identify themselves as being one community?" And "Are members of this community willing to sacrifice some of their own resources (time, money, skills, etc.) in defense of the community?" If either of these answers is "no" then it might be best to begin with a campaign demonstrating how much they have in common and allow them to maintain their own identities as "'sub-communities" within a larger "community."

So far, the discussion has been specific only to the risk and protective factors. A data collection plan also needs to focus on certain substances for tracking. Some substances may demonstrate their impact in qualitative ways, while others do so in quantitative ways. For example, national data indicates that alcohol is used more often than methamphetamine, but one could argue that the social impact of meth users makes it worthy of strategic resources. It's also true that certain strategies are effective for one type of substance abuse, but not another. For example, the chart below summarizes data collected from the Missouri Student Survey for Stone and Taney Counties. As you can see there is a noticeable difference in students' perception of marijuana and alcohol availability. This difference in perception may significantly impact any strategies developed to decrease the use of marijuana and alcohol. Narrowing the risk factor discussion to specific substances allows for a more complex conversation around the fact that 12th grade students in Taney County are slightly less likely than students in Stone County to report lifetime use of alcohol, but MORE likely to report easy availability of alcohol. This data also reveals that while students in both counties are very similar in reporting easy availability of marijuana, students in Taney County were almost 30% more likely to report lifetime use of marijuana. One final point to be made here is that these two counties have very different lifetime use rates for both alcohol (Taney is about 50% and Stone is about 65%) and marijuana. This creates a challenge when prioritizing the substances to be addressed. As previously stated, the purpose of the SAI is to develop a holistic prevention system in both Stone and Taney Counties. This type of data makes those prioritization conversations much more complex.




Source: Missouri Student Survey

Suggested Citation: Missouri Behavioral Health Epidemiology Workgroup. [Website]
Retrieved from: https://seow.dmh.mo.gov on 5/1/2017

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The Project Coordinator for the Substance Abuse Initiative (SAI) has actively been developing a comprehensive set of data from available archival sources. Much of this data deals with consequences of

substance abuse including death, arrest, emergency room incidents, etc… Other sources directly speak to the factors described in the social ecology model discussion above.

Keeping in mind the purpose of this report, it is important to focus on data that helps the community identify the substances that should be prioritized, the risk and protective factors present in the community, and the community's readiness to address these prioritized substances. There are some general recommendations that flow from this discussion.

The first recommendation is the creation of a clear set of data sources that will be used to create a baseline and measure progress throughout the project. This recommendation flows from Step 12: Establish Shared Metrics. Keeping in mind that good data plans include metrics or measures that are valid, reliable and sustainable, there are certain types of data that are more useful than others. Given that this is a community initiative, it is also important to gather information on both youth and adults.

The second recommendation is the creation of a data dashboard where community members and partners can have access to up-to-date data from the initiative. The dashboard serves a few functions. First, any agencies or organizations seeking grant funds will have easy access to community data. This data will help set a standard of data driven grant applications. Second, the dashboard can be used by the initiative to provide feedback to the community about the strategies being implemented and funded. Third, the dashboard will act as an important evaluation tool providing up-to-date metrics and measurements pertaining to the strategic objectives.

## WHAT WE KNOW ABOUT THE DATA SO FAR

To be sure, there is a substantial amount of health data available that covers Stone and Taney Counties. The Stone and Taney County Health Departments have both recently released county health reports, and have a data tool online. The Missouri Student Survey data is available online and can generate charts and tables relevant to a range of risk and protective factors, as well as some consequence data for youth. The Missouri State Highway Patrol has an online data tool allowing for county level reports on a variety of arrest data. These are just some of the archival data that is easily available. As is true with most communities, the data is vast and the sheer volume of it can be overwhelming. The first step in deciding what data to track is to help focus the data collection process.

A series of interviews and a Stakeholder Summit were held with two goals. The first goal was to inform key stakeholders about the SAI and make sure partners were clear about the initiative's goals. The second was to gather firsthand information about perceptions relating to substance abuse in the two counties.

Most of the interview data was captured in January 2016 and resulted in a written report referenced earlier in this document.

The Key Stakeholder Summit occurred on Thursday, February 9, 2017 (9 AM to 12 PM). The training occurred at the Tree Rooms (Magnolia, Dogwood, and Redbud) at Cox Medical Center Branson, 525 Branson Landing Blvd, Branson, MO. This was a no-cost training for participants and included light food and beverages. There were 75 attendees, including representatives from treatment, schools, business, service providers, law enforcement, county health, local health, local providers and others. The goals and objectives Summit participants were as follows:

1. An introduction to Prevention:
    a. How Prevention differs from Treatment
    b. The morality of prevention
    c. Prevention expenditures and cost savings
2. An introduction to the grant

3. Understanding the Community Assessment
4. Causes and Correlates of Substance Abuse
    a. The importance of substance abuse as a social issue
    b. Some preliminary local data
    c. Social Ecology Model and Prevention
    d. Defining Risk and Protective Factors
    e. Identifying Risk and Protective Factors
5. Addressing Substance Abuse
    a. Two Important Models for Understanding
        i. Continuum of Care
        ii. CDC Health Pyramid
    b. The important role of coalitions and community action
6. Clarifying next steps

The results of the Summit were overwhelmingly positive. Post-Summit evaluations, done immediately after the event, showed overwhelming satisfaction with the event. In addition, the event created media attention on the SAI and substance abuse. Some examples include a full length video of the event (https://vimeo.com/206427848), and several new pieces in the local media including: http://www.ozarksfirst.com/news/stopping-substance-abuse-before-it-starts/660969794, as well as articles on KY3 and KSPR .

Most importantly, from a data perspective, this event was used to collect stakeholder perceptions on factors such as substances that should be prioritized for action, prioritized risk and protective factors, and consequences of substance abuse in the community. Stakeholders were given assignments at their tables intermittingly throughout the event. The first exercise was to create a prioritized list of substances that should be addressed. Participants were given time for conversation and told to come to an agreement. They then recorded their findings on large newsprint that was posted on the wall for debriefing. This same process was used for the other prioritized lists. After the event, the newsprints hanging on the wall were photographed. All the information was then entered into a database, coded and analyzed.

Responses were categorized by Dr. Geary and coded for prioritization. Since there were 18 tables, and since participants created ranked lists, the information was coded in such a way to account for the number of tables that mentioned each substance and their ranking of each substance. In all, 9 substances were mentioned in the exercise and scored so that higher scores represented higher prioritization from the group.

| Prioritized Substances Table | |
|---|---|
| **Substance** | **Weighted Score** |
| Alcohol | 4.14 |
| Prescription Rx | 3.43 |
| Marijuana | 3.07 |
| Meth | 2.50 |
| Heroin | 1.50 |
| Tobacco | 0.43 |
| Synthetics | 0.29 |
| Phentanyl | 0.14 |
| Cocaine | 0.07 |

As the "Prioritized Substances Table" demonstrates, the top four substances prioritized by the entire group were alcohol, prescription drugs, marijuana, and methamphetamine. In the debrief that followed this exercise, participants were asked why tobacco was not a higher priority. It was explained to them that during the initial stakeholder interviews in January, 2016, very few people discussed tobacco until they were asked. Summit participants commented that, while tobacco is an important issue for the community, the feeling was that a recent "Tobacco Initiative" was successful in decreasing smoking in the community. That success was equated with a lower priority since it was felt that other substance abuse was not receiving enough attention.

Participants were then asked about the consequences of use. Since consequences were not prioritized by each table, the data was analyzed using the number of times the consequence was mentioned. What is most

important here is that participants' observation about consequences may indicate the concepts that will interest community members. Overwhelmingly, the most often cited consequences were health (including death, overdose, and illness), financial (including loss of jobs, inability to get jobs and poor performance at work), and family conflict.

The next exercise involved risk and protective factors. Participants were given the Risk/Protective Factor list located at the end of this document. They were then asked to prioritize the factors that they felt were most important in order of priority. Again, the risk factors were coded allowing for both the number of times a risk factor was listed and its ranking. Participants offered a wide variety of ranked risk factors. Clearly family management issues were ranked by the group as the most important risk factor. This was followed by socioeconomic status and availability. Of the top three, only availability is considered a community-level risk factor. Family management is a relationship-level risk factor and socioeconomic status is a societal-level (or at least regional) risk factor. This presents a challenge when attempting to provide a holistic model of prevention, which will be discussed later.

| Risk Factor | Weighted Score |
|---|---|
| Family conflict/management | 1.29 |
| Socio-economic status | 1.19 |
| Availability | 0.86 |
| Peers Support for Use | 0.64 |
| Lack of Education | 0.54 |
| Individual Factors | 0.43 |
| Community Norms Favorable to Use | 0.36 |
| Mental Illness | 0.29 |
| Transportation | 0.21 |
| Lack of Evidence-Based Interventions School | 0.21 |
| Community Trauma | 0.21 |
| Constitutional Factors | 0.21 |
| Hotels as "hot spots" | 0.14 |
| Lack of bonding to community | 0.14 |
| Early Onset | 0.07 |

Finally, participants were asked to rank protective factors using the same Risk/Protective Factor list and again the scores were weighted by the number of times mentioned and rank. The local school system was ranked by the group as the most important protective factor, closely followed by "Strong Families", and then the values based actors of "Faith-Based Community" and "Community Values". Obviously, what's most interesting here is to have Family listed as both a top risk AND protective factor by the same group. In the discussion following each exercise, and in subsequent key informant interviews, it became obvious that the stakeholders were referring to two different sections of the community. In describing risk factors, stakeholders thought of the sub-community of poor families that provide low skill labor and congregate in the extended stay motels. However, when describing protective factors, the stakeholders were thinking of the more affluent and permanent families that they tended to represent. In this way, "family" was thought of as both a risk and protective factor. Family is a risk factor for one sub-population and a protective factor for another.

| Protective Factor | Weighted Score |
|---|---|
| School System | 1.08 |
| Strong Family | 1.00 |
| Faith-Based Community | 0.92 |
| Community Values | 0.75 |
| Effective Ordinances | 0.67 |
| Cultural Norm of High Expectation | 0.58 |
| Jobs Availability | 0.50 |
| Community Resources | 0.33 |
| Peer Influence | 0.33 |
| Feelings of Success | 0.25 |
| Willingness to address issues | 0.25 |

The session was considered a success in a few ways. First, attendees reported that they were very satisfied with the ability to interact with others and openly discuss these topics. Second, this session provided community stakeholders with accurate information about the SAI. The high level of interaction combined with the consistent messaging should promote buy-in during the next phases of the plan. Third, the session provided a wealth of perception data that was used to set priorities and provide insights regarding marketing decisions. Finally, the media coverage of the event provided the community with information about the SAI. That kind of media coverage should help with community buy-in during the implementation phase.

# COMMUNITY READINESS

Community readiness is a concept used in a variety of community change frameworks. The basic idea is that community initiatives are more likely to be successful when community members are well informed about the issue that needs to be addressed. Research indicates that **community readiness** correlates with successful community initiatives. This fact has revealed itself in the most popular models of community health including the Social Development Model, the Strategic Prevention Framework, Developmental Assets and more. Each of these accepted models begins with understanding and preparing the community for impending changes. Accurately and objectively assessing a community's readiness for change is an important planning tool.


The Substance Abuse Mental Health Services Administration (SAMHSA) recommends *community readiness* as a critical part of capacity building. The Strategic Prevention Framework (SPF) is one of the most popular planning tools used by community coalitions.

While there are many tools available to assess community readiness, the research supports the use of the Tri-Ethnic Community Readiness Assessment. Developed by the Tri-Ethnic Center for Prevention Research, this tool has been validated and is considered one of the most useful and accurate measures of community readiness (Kostadinov, et al. 2015).

The Tri-Ethnic Center Community Readiness Tool is a questionnaire freely available online (http://triethniccenter.colostate.edu/communityReadiness_home.htm) and is accompanied by a complete set of instructions and suggestions for planning. The basic steps for using the tool is to identify key members of the community who have some knowledge of both the issue to be addressed and what community members may or may not know about that issue. Once participants are identified, the instrument is delivered either face-to-face or through an adapted self-administered instrument. The Center suggests anywhere from 6 to 12 respondents. Once administered, complete instructions are provided for scoring. Scores are based on direct scores provided by participants in combination with a detailed text analysis for the face-to-face interviews and by scores provided by participants for the self-administered version. The data is then used to identify the community's stage of readiness. There are nine possible stages of readiness and a community's likelihood of success directly correlates with their stage of readiness. In other words, higher readiness scores are correlated with likelihood of success. The Tri-Ethnic Center has created a list of the Readiness Stages and roughly defined each stage with a quote:

**Stage 1**: No Awareness: *"Kids drink and get drunk."*

**Stage 2**: Denial/Resistance: *"We can't (or shouldn't) do anything about it."*

**Stage 3**: Vague Awareness: *"Something should probably be done but what? Maybe someone else will work on this."*

**Stage 4**: Preplanning: *"This is important. What can we do?"*

**Stage 5**: Preparation: *"I will meet with our funder tomorrow."*

**Stage 6**: Initiation: *"This is our responsibility; we are now beginning to do something to address this issue."*

**Stage 7**: Stabilization: *"We have taken responsibility."*

**Stage 8**: Confirmation/Expansion: *"How well are our current programs working and how can we make them better."*

**Stage 9**: High Level Community Ownership: *"These efforts are an important part of the fabric of our community."*

A community receives a Readiness Score by relying on key respondents who are asked their views on five key dimensions. The Survey asks respondents about their views on:

**Community Knowledge of Efforts**- asks respondents how much the community knows about current efforts to address the issue and where they get the information from.

**Community Knowledge of the Issue**- asks respondents how much the community knows about the issue and where they get that information from.

**Community Climate**- asks respondents about the community's general attitudes towards the issue.

**Leadership**- asks respondents about the attitudes of community leaders towards the issue.

**Resources**- asks respondents to identify and assess current or potential resources related to the issue.

As previously mentioned, the Tri-Ethnic Readiness Tool can be delivered as either an interview based or paper and pencil questionnaire. Both approaches were utilized for this assessment. Marietta Hagan conducted all face-to-face interviews and helped with scoring. In addition, the computer-based tool was created in Survey Monkey and requests for participation, with appropriate instructions and guidance, were emailed to community members participating in the Stakeholder Summit. Respondents were randomly assigned to one of four substance abuse issues that were identified as most important at the Summit. Respondents were asked about community readiness for the substance abuse categories of marijuana, alcohol, prescription drug, and methamphetamine. Respondents were also allowed to select a substance abuse category if they felt more knowledgeable or comfortable with a category other than the one randomly assigned to them. One respondent completed answers in two substance abuse categories by their own request.

## Online Survey

The online survey went live on February 21, 2017 and closed on March 28th. The response rates are as follows:

**Response Rates for Online Community Readiness Questionnaire**

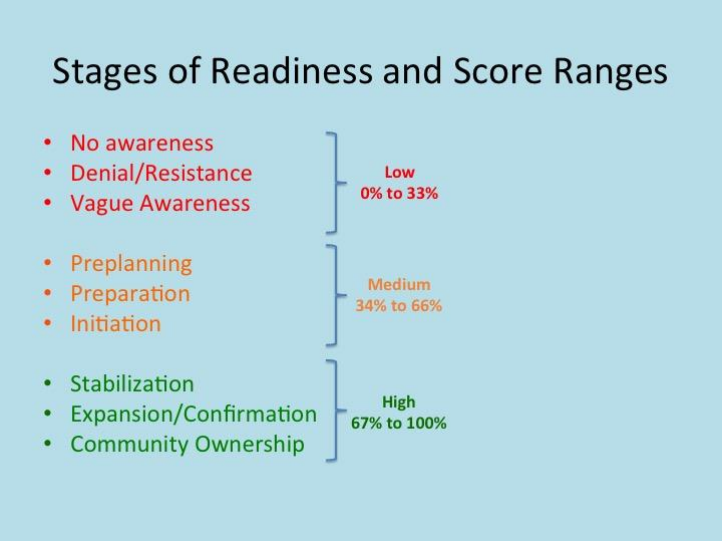
| | Assigned | Responded | Rate |
|---|---|---|---|
| Marijuana | 19 | 14 | 73.7% |
| Alcohol | 19 | 11 | 57.9% |
| Rx Abuse | 18 | 8 | 44.4% |
| Meth | 18 | 7 | 38.9% |

A copy of the online instrument is attached to the Appendix. The questionnaire consisted of 6 questions focusing on readiness. The rest of this section compares each of the four substances according to the five dimensions of readiness.

## Community Knowledge of Efforts

Community Knowledge is an important indicator of the future success of new community initiatives. Communities that are accurately informed about an issue find it easier to allocate resources and identify the reasons for community engagement on the issue. Respondents were asked about their perception of community knowledge about existing programs and other efforts undertaken on each issue.

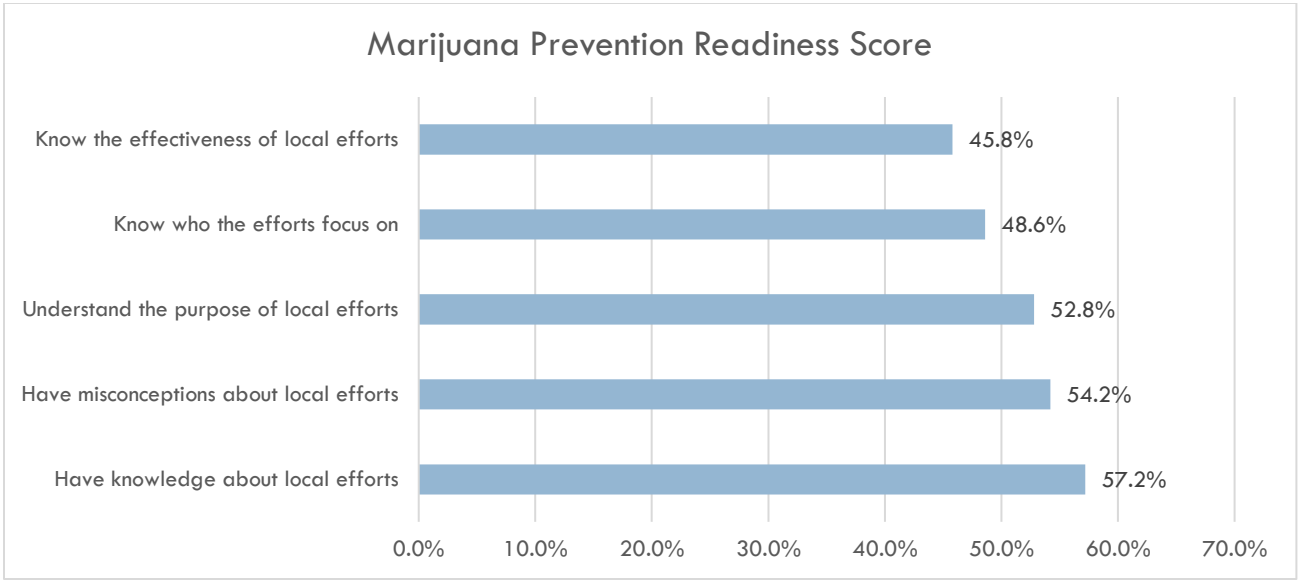
Respondents were asked to identify how many community members (ranging from "No Community Members" to "Most Community Members") are associated with each statement (listed below). One item was recoded for comparison purposes. In the original instrument, all items are coded from 1 (lowest) to 5 (highest). With one exception, higher numbers are associated with higher levels of readiness. This is referred to as a direct correlation. The item "Have misconceptions about local efforts" is an inverse correlation since higher levels of misconception is associated with lower readiness. To make this item a direct correlation the answers for this item were recoded so that low levels of knowledge corresponded to low levels of readiness. Items were also recoded so as to signify a percentage of the highest possible score. Recoding in this way allowed for consistent interpretation across all questions. For example, a score of 46% means that the average for that item represented 46% of the total possible 100% score. With that in mind, the readiness scores below can be categorized with certain levels of readiness. This section will examine the first category of questions in some detail. This will be followed by the data tables for each set of responses to the other categories.




### Marijuana

Respondents were asked the following about community knowledge of programs and services for marijuana:

*Please indicate your perception of the community's knowledge of programs, activities and services pertaining to marijuana use at the local level. Please indicate how many community members (No community members, only a few, at least some, etc…) are associated with each statement. Please only mark one response per row.*

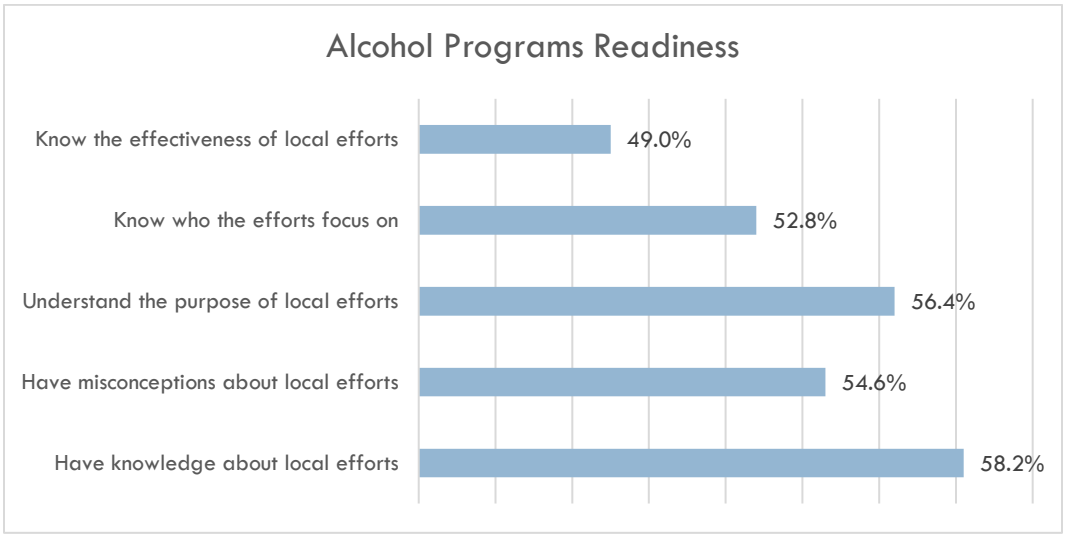



Overall, this data reveals most respondents answering either "Only a Few" or "At least some" community members when reporting on community knowledge of efforts pertaining to marijuana use. According to respondents, the largest challenges to readiness for future marijuana initiatives involve community perceptions of effectiveness of efforts, the focus of efforts, and the purpose of efforts. Higher levels of readiness were reported for misconceptions about efforts and knowledge of efforts. **Overall, this data indicates a MEDIUM level of readiness for addressing marijuana issues in Stone and Taney Counties.**

### Alcohol

Respondents were also asked about community knowledge pertaining to programs and services available pertaining to alcohol use. Again, the item on "misconceptions" was recoded from the original data collection.

*Please indicate your perception of the community's knowledge of programs, activities and services pertaining to alcohol use at the local level. Please indicate how many community members (No community members, only a few, at least some, etc…) are associated with each statement. Please only mark one response per row.*



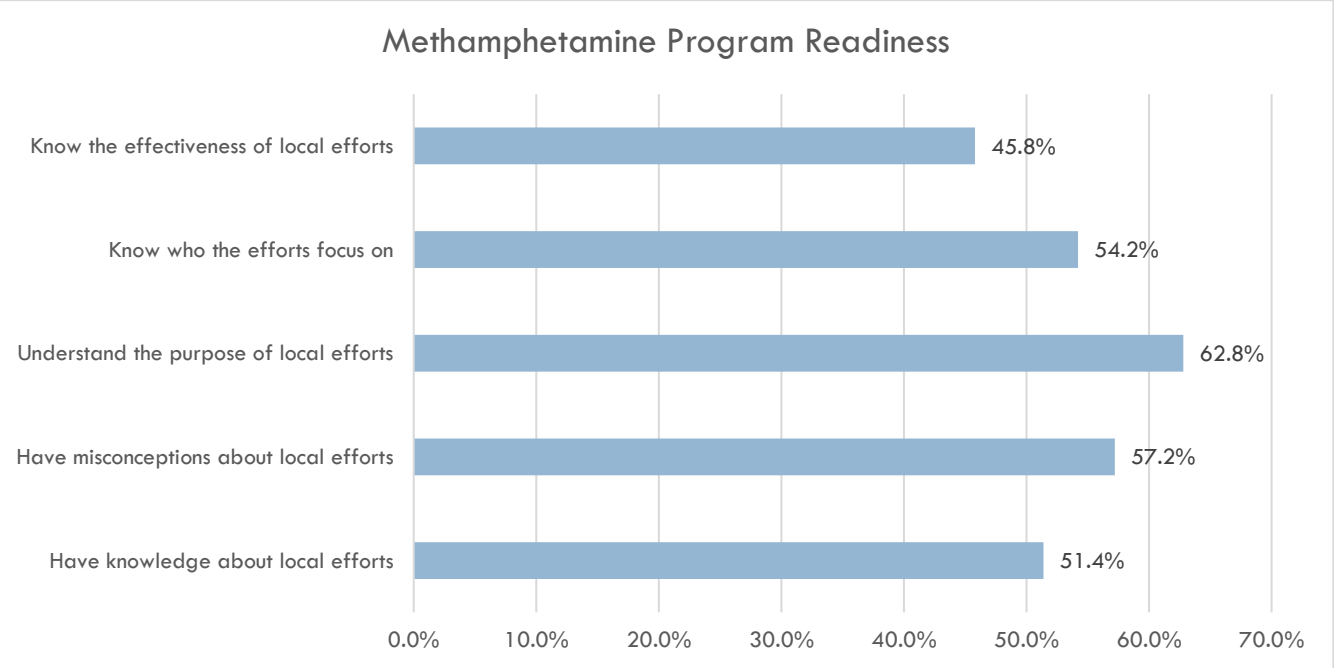
Respondents here indicated relatively high levels of knowledge about local efforts to address alcohol issues and a relatively low score for knowing the effectiveness of these local efforts. **Again these scores reflect a MEDIUM level of community readiness for addressing alcohol issues.**

### Methamphetamine

Missouri has a relatively long history of being associated with methamphetamine abuse. In fact, Missouri led the nation in the number of methamphetamine drug busts for 10 years straight in the early 2000's ending in 2013. (http://www.stltoday.com/news/local/crime-and-courts/missouri-is-no-longer-the-meth-capital-of-the-u/article_358b8c90-29ba-5c8f-acba-2bdaf5d6523f.html)

Since that time, it seems that methamphetamine use has gone down in Missouri. The article above cites a dramatic decrease in methamphetamine drug busts from 2013 to 2014, and data from the Missouri Student Survey indicates over a 65% reduction in youth reporting lifetime use of methamphetamine from 2012 to 2016 (http://dmh.mo.gov/ada/countylinks/). Missouri's reputation of methamphetamine abuse may have an impact on the Community Readiness Scores for this substance.

Respondents were asked: *Please indicate your perception of the community's knowledge of programs, activities and services pertaining to methamphetamine abuse at the local level. Please indicate how many community members (No community members, only a few, at least some, etc…) are associated with each statement. Please only mark one response per row.*

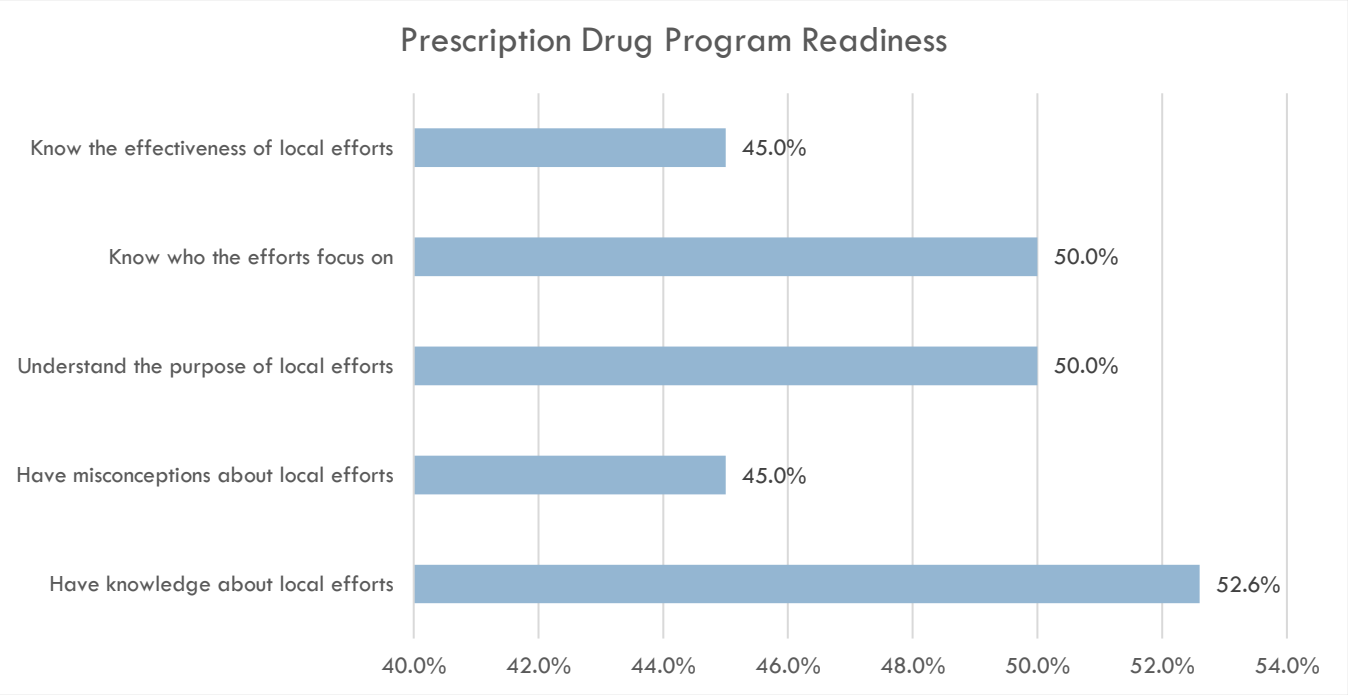



This survey data again indicates relatively low scores in knowing the effectiveness of local efforts. The highest area of readiness for methamphetamine is "Understand the purpose of local efforts." This data might be the result of the large amount of media coverage that accompanied the methamphetamine issue during the 10-year period discussed earlier. **In any event, this data also reveals a MEDIUM level of community readiness.**

**Prescription Drugs**

Respondents were also asked about the nationally growing epidemic of prescription opioids and the related issue of heroin use. The Centers for Disease Control indicates that from 2000 to 2015 more than half a million people died from overdoses and that prescription opioids are a "driving factor" for this problem (https://www.cdc.gov/drugoverdose/epidemic/).

Survey respondents were asked the following: *Please indicate your perception of the community's knowledge of programs, activities and services pertaining to prescription drug abuse at the local level. Please indicate how many community members (No community members, only a few, at least some, etc.) are associated with each statement. Please only mark one response per row.*



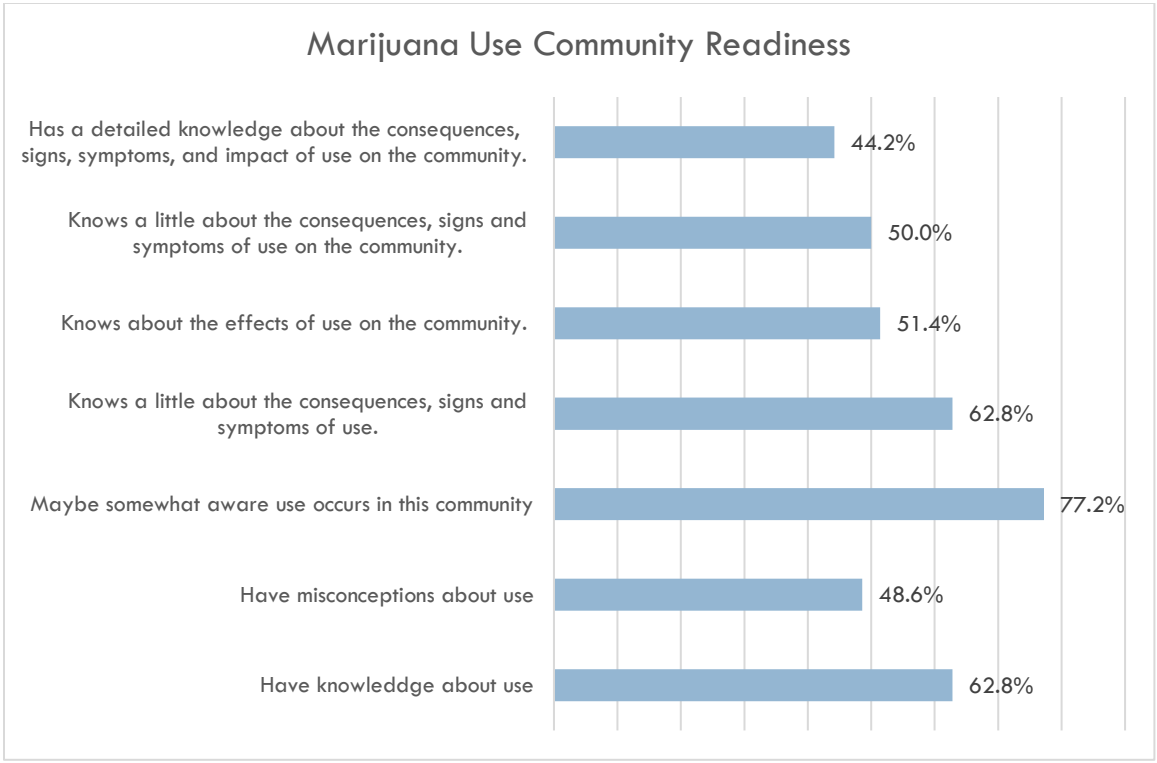

As with other substance, the lowest score was found in "Know the effectiveness of local efforts". Similarly to alcohol and marijuana, the highest score was "Have knowledge about local efforts", albeit at a lower score. **As with all of the other substances, this score represents a MEDIUM level of community readiness.**

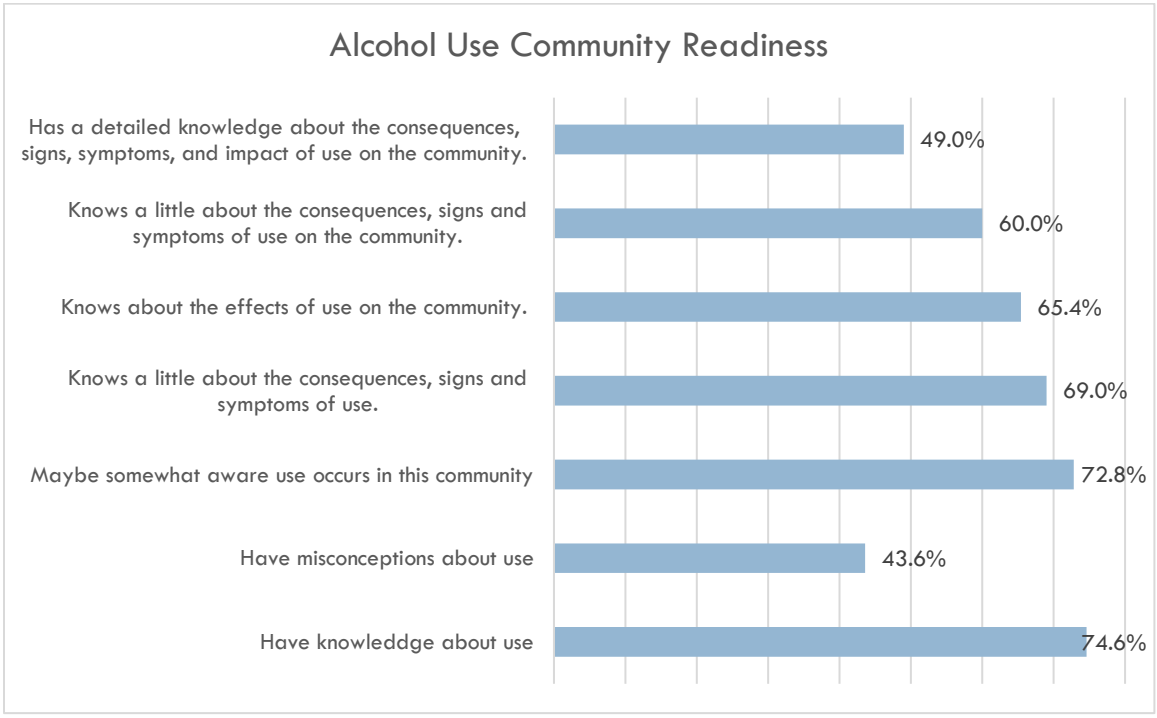
## Community Knowledge of the Issue

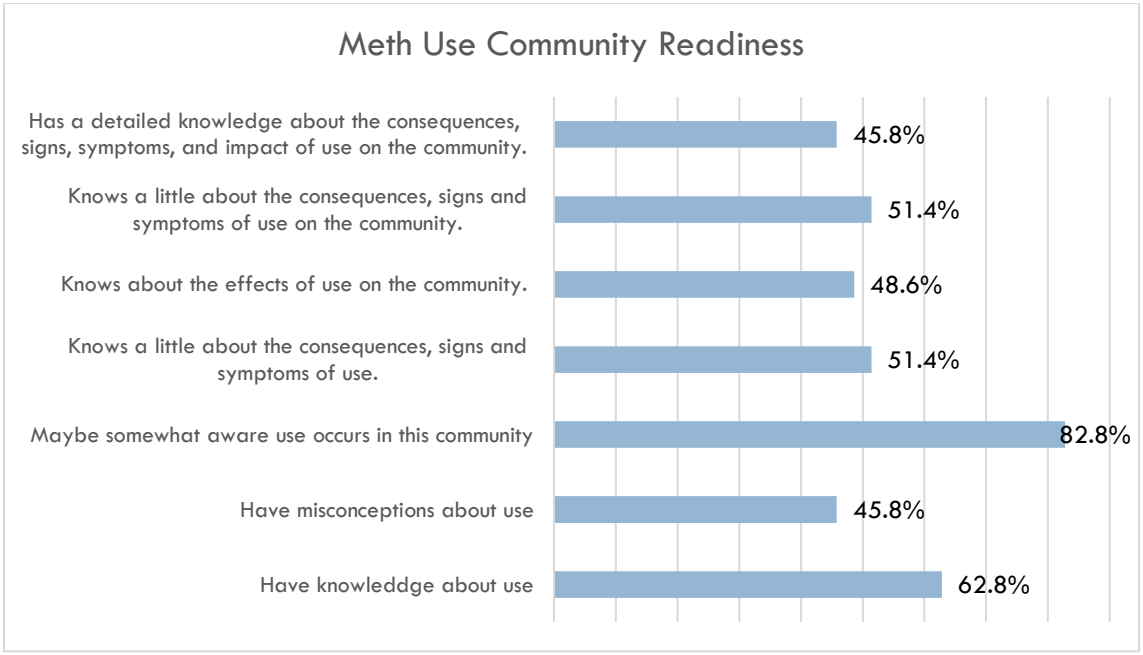
Respondents were also asked about their perceptions of the community's basic knowledge about each substance. Specifically they were asked:

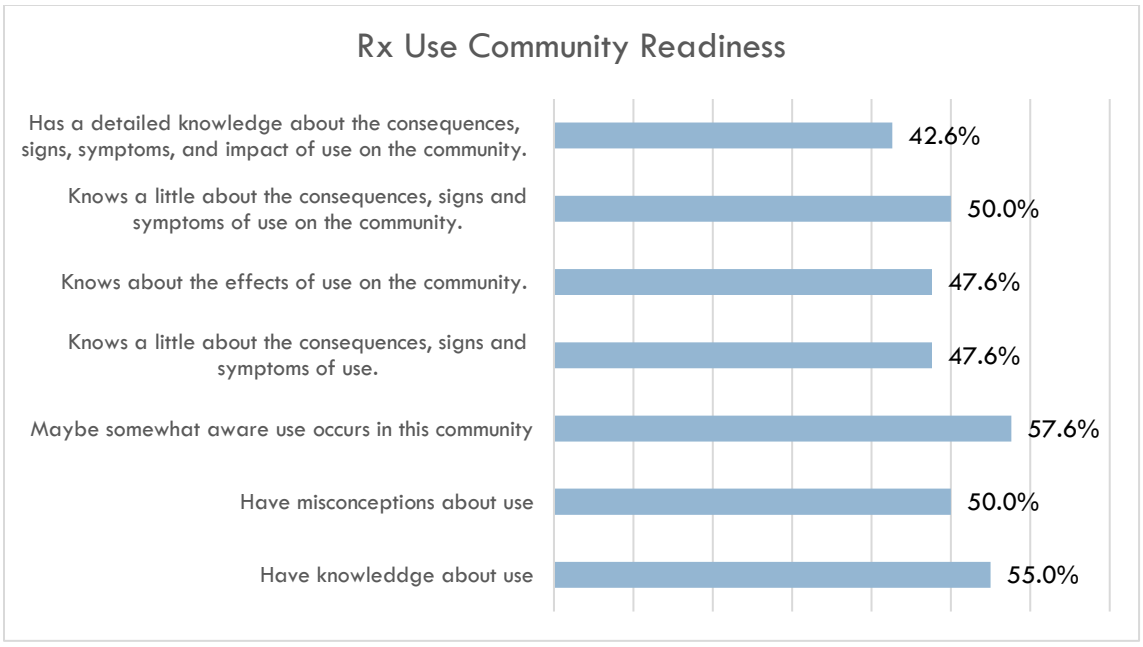
*Please indicate your perception of the community's knowledge about marijuana (or alcohol, or methamphetamine, or prescription drug) abuse. Please indicate how many community members are associated with each statement. Please only mark one row per response.*

Interpretation of this data is slightly different from the previous section. In general, this section asks respondents about the level of knowledge or misconceptions of use. The specific questions are detailed in the graphs below.


Marijuana Use Community Readiness
Has a detailed knowledge about the consequences, signs, symptoms, and impact of use on the community.
44.2%
Knows a little about the consequences, signs and symptoms of use on the community.
50.0%
Knows about the effects of use on the community.
51.4%
Knows a little about the consequences, signs and symptoms of use.
62.8%
Maybe somewhat aware use occurs in this community
77.2%
Have misconceptions about use
48.6%
Have knowleddge about use
62.8%


Alcohol Use Community Readiness
Has a detailed knowledge about the consequences, signs, symptoms, and impact of use on the community.
49.0%
Knows a little about the consequences, signs and symptoms of use on the community.
60.0%
Knows about the effects of use on the community.
65.4%
Knows a little about the consequences, signs and symptoms of use.
69.0%
Maybe somewhat aware use occurs in this community
72.8%
Have misconceptions about use
43.6%
Have knowleddge about use
74.6%




This data is consistent in that the lowest levels of awareness occur in the area of "detailed knowledge". The data also reveals a consistently higher score in the area of "Maybe somewhat aware that use occurs". When comparing substances to each other, alcohol abuse scores highest (49%) while prescription drug abuse scores lowest (42.6%) in the area of "detailed knowledge".

Data also reveals that misconceptions are highest for prescription drug abuse (50%) and lowest for alcohol (43.6%). It is also worth noting that the methamphetamine issue described earlier is revealed in this question as well. Among all substances, methamphetamine receives the highest score in the entire section on awareness (82.8%).

## Community Climate, Leadership and Community Resources

The next three categories are scored differently than the first two. Respondents addressing Community Climate, Leadership, and Community Resources are asked to identify which one of nine statements most accurately reflects their perception of the community's views. To score this section, each statement was assigned a number ranging from 1 (demonstrates lowest possible readiness assessment) to 9 (demonstrates highest possible readiness assessment). The average score was then converted to a percentage for comparison purposes with the other sections. Respondents were asked to select one of the following for the substance they were assigned:

| Level | Community Climate Statements |
|---|---|
| 1 | Community members believe that the issue is not a concern. |
| 2 | Community members believe that this issue may be a concern in this community, but don't think it can or should be addressed. |
| 3 | Some community members believe that this issue may be a concern in the community, but it is not seen as a priority. They show no motivation to act. |
| 4 | Some community members believe that this issue is a concern in the community and that some type of effort is needed to address it. Although some may be at least passively supportive of efforts, only a few may be participating in developing, improving or implementing efforts. |
| 5 | At least some community members are participating in developing, improving, or implementing efforts, possibly attending group meetings that are working toward these efforts. |
| 6 | At least some community members play a key role in developing, improving, and/or implementing efforts, possibly being members of groups or speaking out publicly in favor of efforts, and/or as other types of driving forces. |
| 7 | At least some community members play a key role in ensuring or improving the long-term viability of efforts (e.g., example: supporting a tax increase). The attitude in the community is —We have taken responsibility. |
| 8 | The majority of the community strongly supports efforts or the need for efforts. Participation level is high. —We need to continue our efforts and make sure what we are doing is effective. |
| 9 | The majority of the community are highly supportive of efforts to address the issue. Community members demand accountability. |

| Level | Leadership Statements |
|---|---|
| 1 | Leadership believes that the issue is not a concern. |
| 2 | Leadership believes that this issue may be a concern in this community, but doesn't think it can or should be addressed. |
| 3 | At least some of the leadership believes that this issue may be a concern in this community. It may not be seen as a priority. They show no immediate motivation to act. |
| 4 | At least some of the leadership believes that this issue is a concern in the community and that some type of effort is needed to address it. Although some may be at least passively supportive of current efforts, only a few may be participating in developing, improving or implementing efforts. |
| 5 | At least some of the leadership is participating in developing, improving, or implementing efforts, possibly being a member of a group that is working toward these efforts or being supportive of allocating resources to these efforts. |
| 6 | At least some of the leadership plays a key role in participating in current efforts and in developing, improving, and/or implementing efforts, possibly in leading groups or speaking out publicly in favor of the efforts, and/or as other types of driving forces. |
| 7 | At least some of the leadership plays a key role in ensuring or improving the long-term viability of the efforts to address this issue, for example by allocating long-term funding. |
| 8 | At least some of the leadership plays a key role in expanding and improving efforts, through evaluating and modifying efforts, seeking new resources, and/or helping develop and implement new efforts. |
| 9 | At least some of the leadership is continually reviewing evaluation results of the efforts and is modifying financial support accordingly. |

| Level | Community Resources |
|---|---|
| 1 | There are no resources available for (further) efforts. |
| 2 | There are very limited resources (such as one community room) available that could be used for further efforts. There is no action to allocate these resources to this issue. Funding for any current efforts is not stable or continuing. |
| 3 | There are some resources (such as a community room, volunteers, local professionals, or grant funding or other financial sources) that could be used for further efforts. There is little or no action to allocate these resources to this issue. |

| | |
|---|---|
| 4 | There are some resources identified that could be used for further efforts. Some community members or leaders have looked into or are looking into using these resources to address the issue. |
| 5 | There are some resources identified that could be used for further efforts to address the issue. Some community members or leaders are actively working to secure these resources; for example, they may be soliciting donations, writing grant proposals, or seeking volunteers. |
| 6 | New resources have been obtained and/or allocated to support further efforts to address this issue. |
| 7 | A considerable part of allocated resources for efforts are from sources that are expected to provide stable or continuing support. |
| 8 | A considerable part of allocated resources for efforts are from sources that are expected to provide continuous support. Community members are looking into additional support to implement new efforts. |
| 9 | Diversified resources and funds are secured, and efforts are expected to be ongoing. There is additional support for new efforts. |

## SUMMARY TABLES AND DISCUSSION OF COMMUNITY READINESS

The data from the readiness survey contains some consistent themes. First, **overall community readiness for all substances falls in the "medium" range.** This indicates that much of the groundwork for addressing these substances has been laid and there is still more to be done to help ensure community buy-in, initiative success and sustainability. Another important theme is that **knowledge about the effectiveness of current initiatives is relatively low.** This would indicate a great need to publicize the results of current efforts more effectively.

A closer look at the data reveals other discussion points as well.

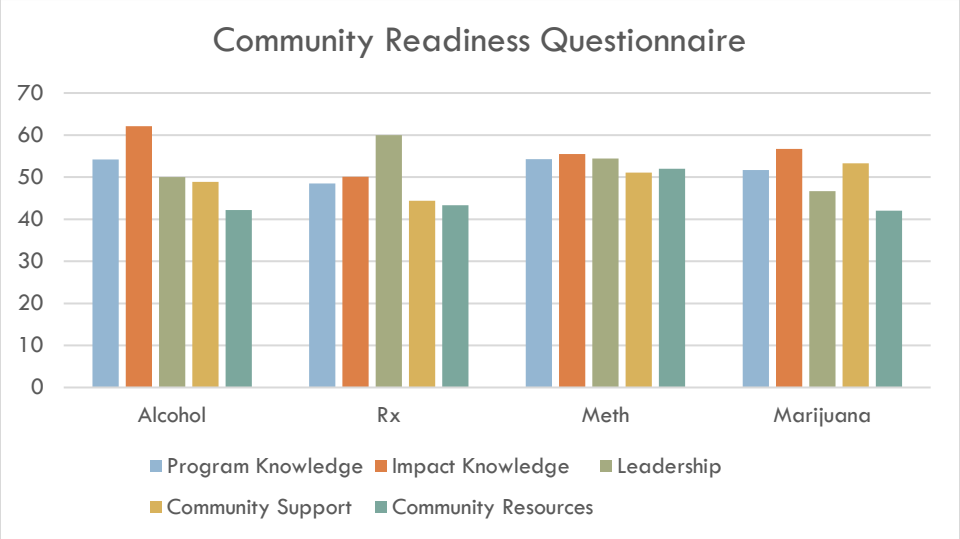
| Content Area | Alcohol | Rx | Meth | Marijuana | Total Average |
|---|---|---|---|---|---|
| Knowledge of Efforts | 54.2 | 48.5 | 54.3 | 51.7 | **52.18** |
| Knowledge of Impact | 62.1 | 50.1 | 55.5 | 56.7 | **56.10** |
| Leadership | 50 | 60 | 54.4 | 46.7 | **52.78** |
| Climate | 48.9 | 44.4 | 51.1 | 53.3 | **49.43** |
| Resources | 42.2 | 43.3 | 52 | 42 | **44.88** |
| **Total Average** | **51.48** | **49.26** | **53.46** | **50.08** | |

This table reveals all five content areas in all four substances. The last column, "Total Average" indicates the average readiness score by area of content for all four substances combined. This data reveals that the **community's highest area of readiness is in the content area of "Community Knowledge of Impact" and the lowest readiness score is in "Community Resources".** Keeping in mind the context of these content areas, the data reveals a community that has higher levels of knowledge regarding the signs, symptoms, and impacts of substance use than it has knowledge of current or potential resources dealing with substance abuse.

The last row, also "Total Average", provides an indicator of the average level of community readiness for addressing each substance. All scores clearly indicate that the community is in the Medium level of readiness. With a high score of 53.46 (methamphetamine) and a low score of 49.26 (Prescription Drugs), there is little

range between substances. At first glance, these scores reveal little about which substances to prioritize but a closer look at the data provides more to consider.

For example, the highest "Leadership" score is found for prescription drug abuse. Interestingly, prescription drug abuse also reveals the lowest scores for "Knowledge of Impact" and "Knowledge of Efforts". Further, alcohol indicates the highest score in the table (62.1) in the content area "Knowledge of Impact" and at the same time has one of the lowest scores in the areas of "Resources", "Leadership", and "Climate". Finally, the scores associated with methamphetamine have the most consistent scores with a low to high range of 4.4 points. Compare this to alcohol's range of 19.9 points. Given the consistency of the data, and the fact that all of these average scores fall into the medium range, it seems that this analysis is more useful in identifying clear gaps in readiness than it is strengths in readiness. Examining a visual representation of the data is revealing.




This data visualization demonstrates consistent and relatively high readiness for methamphetamine, relatively high readiness content areas for alcohol and prescriptions drugs, along with highly unstable scores for these same two substances. This indicates higher levels of readiness for these substances in some areas than for either methamphetamine or marijuana.

### Other Data Sources

Other data will help reveal which substances should be the focus on the SAI in it's early stages of development. Specifically, data comparing methamphetamine, alcohol and prescription drug abuse are relevant here. While there is a paucity of data on 30-day use for adults in Stone and Taney Counties there is data on 30-day use for youth that can help identify areas of need.

| Missouri Student Survey Data Ending 2012 to 2016 | | |
|---|---|---|
| **Indicator** | **Stone** | **Taney** |
| 30 Day Alcohol | 9.5% Decrease | 10.9% Decrease |
| 30 Day Rx | 85% Increase | 40% Increase |
| 30 Day Meth | 38.5% Decrease | 65.5% Decrease |
| 30 Day MJ | 8.6% Decrease | 49% Increase |

This data reveals a significant decrease in 30-day methamphetamine use, a smaller but significant decrease in alcohol use and a significant increase in reported 30-day use of illegal prescription drug abuse by youth in

both Stone and Taney Counties. This data, coupled with data presented earlier by the CDC, seems to indicate that methamphetamine use is on the decline while prescription drug abuse (and associated opioid abuse) is clearly on the rise.

It is also interesting to note that while alcohol use has decreased, data from the Missouri Department of Health and Senior Services indicates an increase in alcohol outlets in both Stone and Taney Counties during this same 4-year period. In addition, participants in both the face-to-face interviews, as well as the input from the Stakeholder Summit, reveals that alcohol abuse remains an important issue in Stone and Taney Counties.

# RECOMMENDATIONS

## Prioritizing Substances for Focus

When deciding where to start, it is important to consider many factors. This report summarized information from key stakeholders, archival data sources and the community readiness assessment. The following findings can be used to make a determination of the substances that should be the focus of the SAI over the next two years:

1. This SAI initiative is new and needs to support and take advantage of existing resources.
2. The ADAPT DFC coalition has identified alcohol as a top priority.
3. National, state and local data indicates that methamphetamine is on a significant decrease in Stone and Taney Counties.
4. National, state and local data indicates that prescription drug abuse, including heroin and other opioid abuse, is a growing issue with severe consequences.
5. Marijuana use has increased in Taney County over the past four years, but decreased in Stone County during this same time.
6. Stakeholders ranked marijuana as a relatively low priority in Stone and Taney Counties.
7. Missouri does not have a Prescription Drug Monitoring System to help track prescription drug abuse.

The data collected over the past year suggests that the **SAI should initially focus on two substance abuse issues:**

1. **Alcohol**
2. **Prescription Drug Abuse**

## Organizing for Success

The next step is deciding how to organize and how to implement a plan for these substances. Interviews with key stakeholders received relatively strong pushback when the concept of forming a new coalition was raised. Stone and Taney Counties have the same issues that many other communities have in that relatively few people actively spend their time volunteering for community initiatives. Based on that feedback, and on the fact that at least two coalitions currently describe substance abuse as a key issue for their work, the **initial phase of the SAI should not involve the creation of a new coalition**. That recommendation is based on the following:

1. Key stakeholder interview data indicating a lack of enthusiasm for the creation of a new coalition.
2. The existence of at least two coalitions that currently have substance abuse prevention on their agenda.
3. Best practices and research demonstrating the effectiveness of utilizing a "backbone" agency for community prevention efforts.
4. The current active role and positive reputation of CoxHealth in the Branson Community.
5. The role and reputation of the Skaggs Foundation as an important funder for community health initiatives.

**Collective Impact** is an approach to community health that requires cross-sector coordination led by a "backbone organization" that takes an active leading role in facilitating change. For an up-to-date examination of the roles and responsibilities for organizations playing this role, please see "Backbone Organizations in Collective Impact" at https://www.napequity.org/nape-content/uploads/NSF_backbone-memo_FINAL_03-02-17_kjf.pdf

Based on the data presented here, the recommendation for organization of this initial phase would be for a **continued collaboration between the Skaggs Foundation and CoxHealth** and the maintenance and growth of the currently funded "Project Coordinator for Population Health" who will serve as the primary point of contact for the project. The strong relationship and skills sets between this position and the current Wellness Supervisor under CoxHealth is working well and should be augmented.

## Initial Strategies

While it is clear that this report describes a project in it's infancy (having only really started since December 2016), there are steps that can be taken now to help assure success as the initiative begins to grow. Those step are as follows:

1. Develop and monitor key partnerships with individuals and organizations who can provide support as the initiative grows.
2. Play a key role as an information facilitator for the community, including the creation of data access points (such as websites, data dashboards, etc…) for community and local organizational use.
3. Focus on research-based, or promising practices using tools such as SAMHSA's National Registry of Evidence-Based Programs Practices (NREPP) as a guide when deciding on strategies.
4. Utilize, as soon as possible, an effective evaluation that focuses on process, outputs, and outcomes.
5. Take a lead role in the introduction and growth of research-based programming in the schools addressing youth and family needs.
6. Take a lead role in the introduction and/or growth of research-based practices for intervention and treatment initiatives based in the community.

## Three Final Points

As a part of the strategies presented above, there are three major recommendations. **The first is to work with the school districts to implement an effective NREPP program in the school system, utilizing a full-time prevention specialist for program delivery.** This recommendation is based on the following:

1. The need for more evidence-based approaches in the school districts.
2. The need for school-based initiatives. The school system, as mentioned earlier, has been identified as one of the community's top assets. This indicates strong leadership and community buy-in for school-based initiatives. In addition, the data in this report indicates that many youth in need of help are transitory - moving from school to school during the same school year. Evidence-based programming

that is embedded within the entire school system is a way to address the universal needs of youth in the community.

3. Discussions with administrators from Stone and Taney Counties' school districts indicates that any initiative should:
    a. Occur at the school as part of a school day, even if that means directly after school.
    b. Should be facilitated by someone who is not a teacher or counselor since workloads are already viewed as very high.
    c. Should be relatively low cost to ensure sustainability.
    d. Address the needs of younger, as opposed to older, school populations.
    e. Include proven outcomes for pro-social behavior, school/community bonding, and parental attentiveness.

A recent publication by SAMHSA indicates that the return on investment (ROI) for the All Stars curriculum is 34 to 1. They estimate that for every $1 spent, the curriculum returns $34 in cost savings for communities. The ROI is based on the community savings derived from youth living healthier lifestyles as they age.

Based on these recommendations and a careful search of the NREPP website, the initiative entitled "All Stars" seems to address all of these needs. **The All Stars curriculum is cost-effective, addresses multiple issues, and includes various models for wide implementation, including a parent component.**

Stone and Taney Counties have multiple resources and multiple data sources. All of these various data sources can be utilized to develop and track effective substance abuse related initiatives. However, it would be more beneficial to everyone involved with substance abuse issues to have a centralized point of access for data pertaining to risk/protective factors, causes, consequences and behaviors. **Therefore, the next recommendation is that the SAI work with local partners to develop a "data dashboard" for information pertinent to the initiative.**

The third recommendation involves the existence of community-based recovery programs in Taney County that recruit people with substance use disorders from other parts of the country to the local area. Key informant interview data indicates that many stakeholders view this as an important issue, however, relatively little is known about the actual impact of the programs on the community. When considering the existence and placement of any community-based recovery programming, it is important to understand that discharging clients out of the program for failure to comply with the program rules is logical and expected. In fact, many experts in addiction medicine consider this to be an important part of the rehabilitative process and according to the National Institute on Drug Abuse, 40-60% of people will relapse after a period of recovery. **This final recommendation is to work with local recovery programs to evaluate and better understand the impact the programs have on the community, as well as how to manage those discharged from the programs more effectively.**

Kostadinov, I., Daniel, M., Stanley, L., Gancia, A., & M. Cargo (2015). A Systematic Review of Community Readiness Tool Applications: Implications for Reporting. International Journal of Environmental Research on Public Health, 12 (3453-3468).