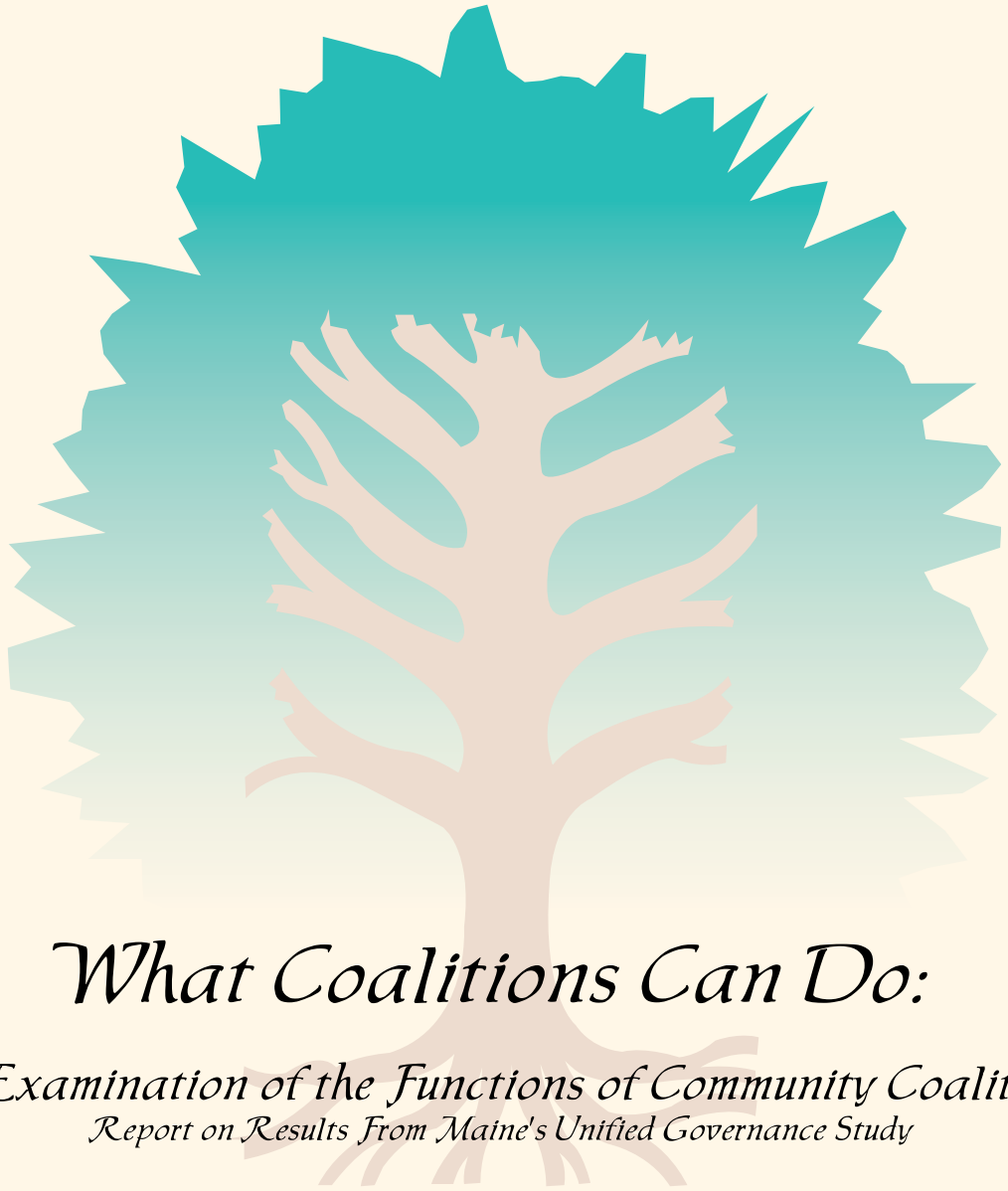


What Coalitions Can Do:

An Examination of the Functions of Community Coalitions

Report on Results From Maine's Unified Governance Study

September 2006

THE TIP OF THE ICEBERG: A Partial List of What Study Coalitions Have Done

Community Wellness Coalition **: Community Connection Conferences, Planning Processes, Networking Mee**tings, and **"InfoShares"** annually; **Community Needs & Resources Assessments/Reports** 1999 and 2004 ✸ **Community Resource Center** "co-location" Initiative ✸ **Agamenticus Arts and Heritage Directory** listing over 500 local resource people ✸ **KEYS Region website** ✸ **KEYS Coordinating Council** ✸ **Initiation and Incubation** of now independent projects/collaboratives**:** *Communities for Children and Youth* in each KEYS town; 7 years of *AmeriCorps*VISTA* service in region; *Community Asset Builders Project & KEYS for Prevention Project (merged into KEYS of Promise)*; *Healthy Maine Partnership; Mental Health Task Force; Senior Leadership Coalition* ✸ **Support for projects and collaborations:** *Community Health Connection; Environmental Networking; S. Berwick Teen Center; Alternative Education Needs Assessment, York Schools; Seacoast Region Needs and Resources Assessments; York County Prevention Collaborative planning; State Indicators GIS-mapping Project (IM4C).*

Greater Waterville PATCH: **Coalition Development:** helped form ***Southern Kennebec Healthy Communities*****;** formed ***Tobacco Free Coalition; Dental Coalition*** ✸ **Kennebec Valley Indicators Project** ✸ **Fairfield Health Assessment Project** ✸ **Healthy Maine Partnership** ✸ **Move More**: physical fitness and weight group; maps of outdoor walking trails; resource guide ✸ **Mid-Maine Worksite Wellness Council** ✸ **Diabetes Care Initiative** ✸ **Cancer Initiative –** developed women's health screening program, including mammograms and clinical exams ✸ **Mammogram legislation** ✸ **Diabetes Care Initiative** ✸ **Cessation Initiative –** includes providers and patients ✸ **Adolescent access to care** ✸ **Smokeless Saturdays** ✸ **Substance Abuse Prevention Services:** sponsor for *Greater Waterville Prevention Coalition*; environmental strategies include CMCA, Boomerang and Olweus Bullying Prevention**.**

Healthy Androscoggin**:** Technical assistance for **Central Maine Medical Center tobacco free hospital policy** ✸ Healthy Androscoggin provided the technical assistance for the **Auburn Housing Authority to be the third housing authority in the nation to become tobacco free in all units** ✸ Healthy Androscoggin implements annual **Get Fit & Win and Quit & Win programs**: The Quit and win program has quit rates as high as 30% ✸ Over 15,000 **community resources guides** on physical activity opportunities in the region, tobacco cessation resources, and nutrition resources have been designed, printed and distributed by Healthy Androscoggin ✸ Healthy Androscoggin created a **Diversion Program for first time juvenile offenders caught with tobacco, alcohol or marijuana: o**ver 120 students have completed.

Healthy Community Coalitions (Farmington): **Youth-To-Youth** substance abuse prevention and teen mentoring; 8% reduction in 11th graders smoking and 6% reduction in grades 6-12 in smoking and 2% reduction in marijuana use ✸ **Tobacco-Free Franklin Families:** 300 professionals trained; 1200 families participated; smoking during pregnancy among low-income mothers reduced from 33.3% to 27.5% ✸ **Audit of the Community Effectiveness in Responding to Domestic Violence** resulted in the creation of the Domestic Violence Response Plan ✸ **STRIDES: Walk Around the World** ✸ 3400 pounds of produce from the **Hope Harvest Garden** distributed ✸**Community Building:** 8,432 hits to the Community Connector since 2004; 960 assisted through the Franklin Resource Network ✸1,500 engaged in the **Community Health Visioning Process** ✸**Breast and Cervical Care Program:** created Martha B. Webber Breast Care Center; reduced the days between findings and date of biopsy, diagnosis and treatment; 60% increase in women receiving mammograms.

Healthy Hancock: **Lose & Win –** exercise, healthy eating, healthy lifestyle choices and weight loss; businesses and schools across the county form teams, and participate in weekly meetings, group exercise events, incentives, and more - approximately 400 participants each year ✸ **"Common Health" –** monthly radio program on WERU 89.9 FM ✸ **Annual Legislative Breakfasts** ✸ **Smart Growth Programming –**"Save our Land, Save our Towns" events and environmental strategies to create public spaces including trails, parks, gardens and playgrounds.✸ **Hancock County Food Pantry Network** ✸ **Comprehensive Service Area Health Assessments:** some available online ✸ **Tobacco Free Hospital Policies** with the three Hancock County hospitals ✸ **DA Diversion Program for juvenile tobacco offenders –** countywide ✸ **OSA programs and environmental strategies –** "Communities Mobilizing for Change on Alcohol" and "Creating Lasting Family Connections" institutionalized across the county.

One Maine One Portland: 705 community members (380 youth) responded to the **Portland Community Prevention Plan Assessment Survey.** Survey results, public forum and subsequent work groups will help develop a 5-year, community-wide Substance Abuse Prevention Strategic Plan for Portland ✸ **Implementation of Reconnecting Youth in Portland's High Schools** ✸ **The Overdose Prevention Project** credited as playing a role in the decline in fatal overdoses in Portland; 50% reduction from record high in 2002 ✸
OMOP member Portland CMCA (through Medical Care Development) has been a force in **Changing Portland's Policies and Norms: s**trengthening underage drinking enforcement; increased adult awareness of costs of furnishing alcohol to minors; increased press coverage of prevention issues and increased collaboration; since 2003, the number of citations for minors in possession of alcohol has more than tripled, and the number of citations for adults furnishing alcohol to a minor has more than doubled.

River Valley Healthy Communities**: Comprehensive Community Health Assessment** ✸ **Healthy Maine Partnership** ✸ **One ME Coalition** ✸ Assisted in creating **tobacco free environments** in schools, municipalities, parks, the local ski area and local hospital; "Tar Wars" and "Samantha Skunk" programs to elementary schools ✸ S**moking cessation classes** and free "quit kits" ✸ Created **walking maps of all towns of the River Valley** ✸ Distribute **"Baby Kits"** to new mothers; **Dental Sealants** to school districts and **"Lead Test Kits"** to residents ✸ **Workplace Wellness Program** ✸ **Teen Center for River Valley youth** ✸ **Conference for elders** ✸ **"Camperships"** to River Valley children for Black Mountain Day Camp ✸ **Directory and web site listing the existing arts and cultural activities** ✸ **Hosted a national Work Camps project -** US and Canadian youth did home repairs for elderly, low income and disabled River Valley residents ✸ **Household Hazardous Waste Education and Collection Program.**

Youth Promise of Lincoln County: Helped design **Mentor Assisted Community Service (MACS)** program and later expanded MACS into Knox County ✸Created a **Healthy Maine Partnership** ✸ Became a **Communities for Children and Youth** partner✸ Brought the **Jump Start** program into Lincoln County ✸ **Smokeless Saturdays** ✸ Healthy Maine Partnership developed **"Winter Exercise Program"** ✸ Youth Promise collaborated with **Lincoln County Weed & Seed** program ✸ **MACS-SAYS** program was designed to assist schools with suspended students ✸**Forums on underage drinking.**

Introduction

Purpose and Methods

Purpose of the Study: *What Coalitions Can Do* describes results from Maine's "Unified Governance Structure Study" (UGS), a participatory case study of eight very different community-based coalitions located throughout the state. The purpose of the study was to provide ideas and models to help communities in Maine develop their own infrastructure and thus strengthen Maine's prevention capacity.

This booklet focuses on how the functions that coalitions choose to perform influence the capacities they need, the participants they enlist, and the structures they develop to carry out these functions. It is structured around four functions: coalition maintenance; program and service development and integration; community-level/environmental strategies; and community capacity building. For each function, tables, diagrams and "stories" from one or more of the coalitions studied provide exemplars to illustrate the topic. The last chapter provides lessons learned and implications for Maine's prevention and health promotion system.

Study Methods and Dimensions Identified for Study: The study was conducted as part of Maine's Strategic Prevention Framework – SIG (SPF-SIG) Grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). It was facilitated by Dr. Paul Florin, a Professor of Psychology at the University of Rhode Island and Adjunct Professor of Community Health at Brown University. Dr. Florin has been involved with citizen participation and community development as a researcher and practitioner for more than 20 years. Meredith Fossel, a program specialist with Maine SPF-SIG Project, assisted with the study. As the study was participatory, substantial input and direction came from the study sites themselves. The coalitions studied were the Community Wellness Coalition of Southern York County; Greater Waterville PATCH; Healthy Androscoggin; Healthy Community Coalition (Farmington); Healthy Hancock; One ME One Portland; River Valley Healthy Communities; and Youth Promise of Lincoln County.

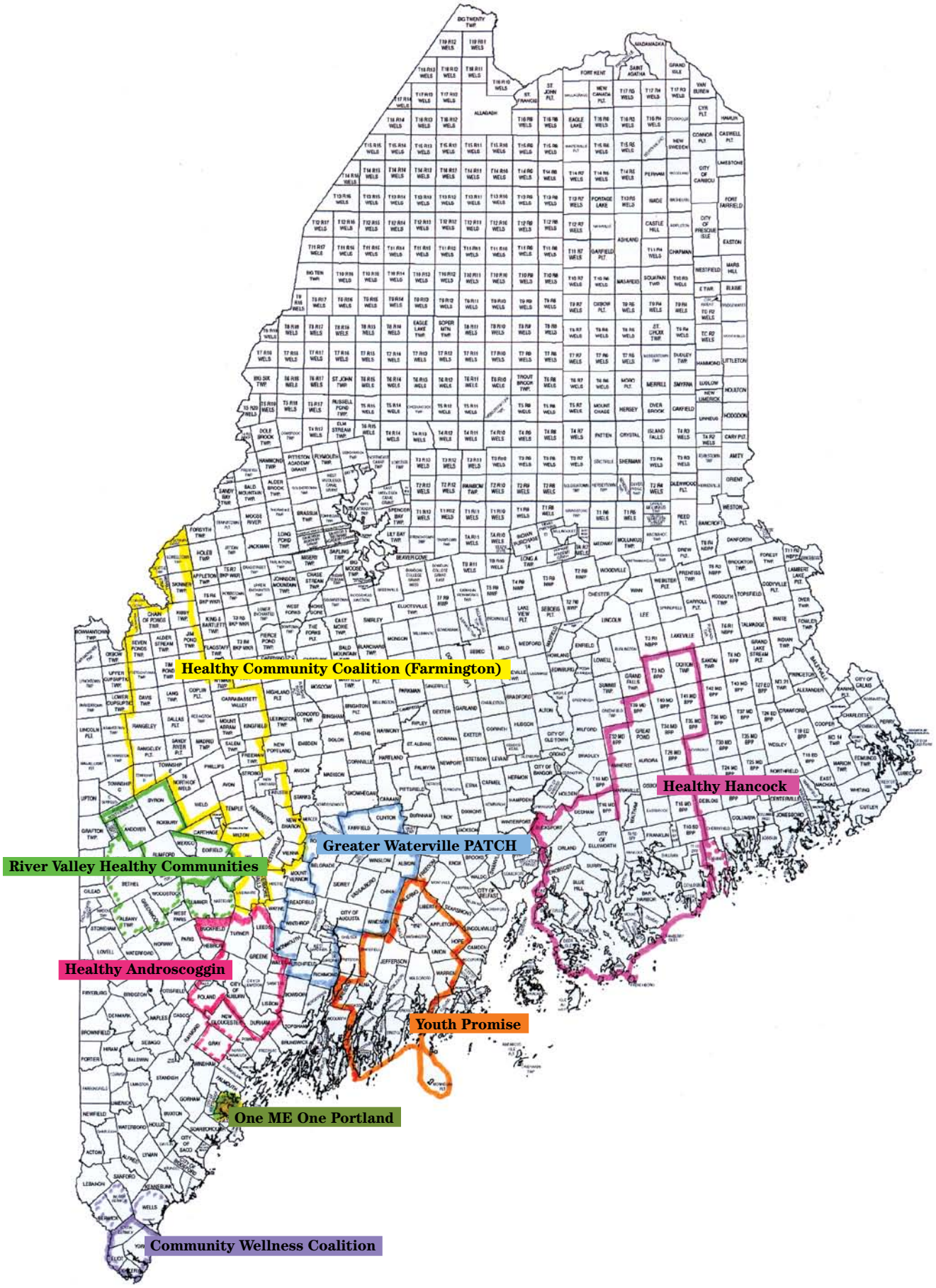
In the early stages participants identified dimensions to structure the study: *history; mission/vision; governance; resources (time, people and places); strategies to effect change; and sustainability.* Monthly meetings and the gathering of materials and stories focused on the dimensions. The information collected is incorporated throughout this booklet.

Definitions:
"Prevention" and "Coalition"

*For purposes of this booklet, "**prevention** is the active, assertive process of creating conditions that promote well-being."*[i] *The definition is broad and inclusive. Many different entities fit under such a definition and it is hoped that the lessons from the eight study coalitions can apply to activities undertaken by a wide variety of coalitions and collaborative organizations.*

*Although there are many definitions of "**coalition**," most of which would fit at least some of the coalitions in the study, the definition of coalition chosen for this booklet is basic. "A coalition is an organization of individuals representing diverse organizations, factions or constituencies who agree to work together in order to achieve a common goal."*[1]

[i] Definition of prevention adopted by Maine Coordinated School Health Program and endorsed by the Maine Office of Substance Abuse Prevention Team in 2003.


Healthy Community Coalition (Farmington)
Healthy Hancock
Greater Waterville PATCH
River Valley Healthy Communities
Healthy Androscoggin
Youth Promise
One ME One Portland
Community Wellness Coalition

The Coalitions, the Places and the People

1

This chapter introduces the eight study coalitions, the settings, and their leaders.

The Coalitions, the Places

The **Community Wellness Coalition** (CWC) was formed in 1996-7 by leaders from health care, education, business, social services, and the arts to address the fragmented resource map of these NH/ME border towns. In seeking to develop a regional identity and better connections among citizens and organizations, a 1997 "Future Search" led to the formation of work groups addressing gaps in resources. York Hospital has served as the fiscal agent and lead agency for most of the Coalition projects, and staffing has varied from one PT position to 3 FT positions, with most work accomplished by partnering organizations and work groups. Key affiliations have been with Maine Healthy Communities and Maine Communities for Children and Youth.

The four KEYS towns (**Kittery, Eliot, York, South Berwick**), have a population of about 36,000 in 2004, and cover 126 square miles in Southernmost York County, forming a "V" between the Piscataqua River and the ocean. An hour south of Portland, and an hour north of Boston, these rapidly growing "suburbs" of Portsmouth and Dover NH have a population density of about 320 persons per square mile, and the largest town, York, with its beaches and tourist attractions, grew by 30% between 1990 and 2000.

In 1987 the Maine Bureau of Health made a proposal to gather core groups of volunteers to be guided by the Centers for Disease Control in a process called PATCH (Planned Approach to Community Health). After 18 months of assessment and planning the PATCH community health board emerged with a set of community health priorities. PATCH was incorporated as a 501c3 entity in 1989. **Greater Waterville PATCH** has never been seen as just a program, an agency, or a coalition. It has instead created "space" in a community for people to come together and examine collectively what's good, and what more needs to be done to improve the health of the community. PATCH has always discussed openly the importance of avoiding duplication of effort, and asking those best suited, and with the capacity in the community to address the identified needs. PATCH continues to be a fiscal sponsor for grants that meet the identified priorities.

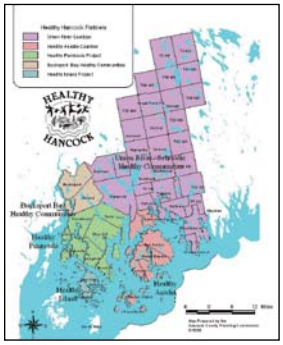
The "**Greater Waterville Area**" in Northern Kennebec County includes the city of Waterville and a collection of small surrounding communities for whom Waterville is a hub of employment, recreation and education. Home to nearly 60,000 residents, with a median household income of $35,841, it is a rural area located in central Maine on the banks of the Kennebec River with many surrounding lakes.

Healthy Androscoggin began in 1995 as a grassroots initiative with a handful of dedicated community members working to prevent youth tobacco use and was known as "Tobacco Free L-A." Over the course of the past 12 years, the organization has grown to over 280 members and has expanded its focus solely from tobacco to a broad health promotion organization with a variety of wellness initiatives designed to improve overall health and prevent chronic disease. Healthy Androscoggin is widely recognized as a public health resource for Androscoggin County.

Androscoggin County is the second largest urban center in the state with a population of 103,793 (U.S. Census, 2000). Located across from each other on the Androscoggin River, the twin cities of Lewiston and Auburn are the central hub of the region and are often thought of as one entity (L-A). The county is working hard to transform the downtown area from vacant textile mills and abandoned shoe factories to a region known for progressive health care, tourism, high-precision manufacturing, telemarketing and financial services. Lewiston and Auburn are also home to a large Franco-American population as well as an increasing number of Somali refugees. The rest of the county is comprised of small rural towns covering a total of 470 square miles and an average population of 220.7 persons per square mile.

The **Healthy Community Coalition** came about as a result of community leaders creating a formalized structure aimed at bringing preventive health to people in all settings of life with initial funding from a Bingham Program grant. The coalition formed a series of task forces to address issues of concern to the community. As HCC grew, the board and management strategically realigned efforts to focus on a smaller number of initiatives and begin to measure and account for results. HCC maintains two core strategies: health prevention/promotion and community building.

The **Greater Franklin** region is an inland region of 17,000 square miles of lakes and mountains stretching from central Maine north to the Canadian border. The Franklin Country Seat is Farmington, a town in the southern third of the region with a population of 8,000. With an average population of only 17.4 persons per square mile, this is among the most rural regions of the country.



Healthy Hancock began when the PATCH (Planned Approach to Community Health) programs at several Hancock County hospitals began collaborating on health-promotion activities. The partnering organizations knew that by working together they could expand the reach and impact of certain programs, while bringing a broader range of expertise and resources to bear on initiatives in their local service area communities. By the late '90s several other groups had joined the county-wide collaborative including two healthy community coalitions representing separate parts of the county, the regional planning commission, and another health service organization. When the Healthy Maine Partnerships (HMP) RFP was issued, the partners wrote into their separate grant applications language that formalized Healthy Hancock. Their powerful vision provided a foundation for the next six years of collaborative public health planning, research, advocacy and programming, By 2001, three HMP grants had been awarded, and the partnership directors and school health coordinators joined the Healthy Hancock team.

Hancock County is made up of 36 towns with a land area of approximately 1,500 square miles. Its population of approximately 53,660 is concentrated along the coast, with most economic activity occurring in five service centers, Bucksport, Ellsworth, Blue Hill, Southwest Harbor and Bar Harbor. The northern interior of the county is primarily industrial forest land and sparsely populated. Hancock County's population has been growing approximately 1% per year (more than twice the state rate of growth), largely due to the influx of retirees to the coastal towns. Young families are moving inland away from high cost coastal communities and school enrollments are declining in many parts of the county. The county's

two largest employers are International Paper and Jackson Laboratory, a genetics research facility. With about 3,000,000 visitors per year to Acadia National Park, tourism generates a large number of seasonal jobs and is part of a general trend toward a service economy.

One Maine One Portland came about as a result of a Maine Office of Substance Abuse One Maine grant in 2003. With the City of Portland as the lead agency, the original plan stated, "With the City of Portland as the lead agency, the One Maine One Portland Coalition is made up of five successful and well-established coalitions representing all of the substance abuse prevention and health promotion organizations in the Greater Portland area." A Steering Committee serves as the governing body of OMOP, and meets monthly. The coalition's original mission focused on 12-17 year olds and was "grant driven." It is in the process of being revised to represent a more comprehensive and holistic prevention approach. We are trying to establish our role as "conveners" who help foster collaborations and partnerships while serving as a sounding board for the community of Portland.

Portland is located in Cumberland County on Maine's southern coast and is unlike any other municipality within the state. With a population of 63,635 (U.S. Census, 2003 estimate), its districts exhibit characteristics that typify inner city urban life. It is Maine's business, financial and retail capital and the largest city in the state. A study released by American City Business Journals in January 2005 found that the Portland metropolitan area has the strongest small-business sector (defined as companies with 100 or fewer employees) of any large metropolitan area in the United States. Portland has a much greater cultural and ethnic diversity than any other city in the state. The city has double the proportion of minorities than the rest of Maine. At last count, there were 59 spoken languages in Portland Schools.

The **River Valley Healthy Communities Coalition** (RVHCC) grew out of the Northern Oxford County Coalition (NOCC), a pioneering effort to address the detrimental effects of environmental pollution on physical health, particularly cancer and lung disease. In 1997 NOCC officially "passed the torch" to RVHCC who obtained non-profit status in 1998, and which has since been a leader at the forefront of broadly defined health issues.

The **River Valley Region** is located in the northern part of Oxford County and includes the towns of Andover, Byron, Canton, Dixfield, Hanover, Mexico, Peru, Roxbury and Rumford, a combined population of approximately 17,000. According to the 2000 census, the River Valley area's median household income level ($34,389) is above that of Oxford County ($33,435) and below that of the State ($37,240). Since 1990, the population in the River Valley has dropped 6.37%. However, the area is in a time of transition, envisioning and planning for the move from dependence upon the paper industry, to a more diversified economy.

Youth Promise was the brain child of Judge Michael Westcott to design and implement resources for youth in the juvenile justice system. Since 1994, the organization has put three programs in place to serve this population of youth in our communities. Today, Youth Promise works with youth and their families not only in regard to their contact with juvenile justice system, but to their overall wellness. Youth Promise is the lead agency for one of Maine's Healthy Maine Partnership and is dedicated to reducing tobacco use, improve nutrition and increase physical exercise. Youth Promise is also involved in the reduction of substance abuse for all community members.

Lincoln County is located in the Midcoast region of the State. There are nineteen towns in the county with three rivers and multiple lakes creating a wondrous attractive landscape. It is a small county with a population of just over 35,000. The county has the grayest population in the state as many people are retiring to our communities to take advantage of great medical services and the small town appeal of our communities. Though the impact of the retirees is financially positive for our merchants and other businesses our local residents are having problems purchasing land and housing at a reasonable cost. Most jobs available locally are service related and do not pay well.

The People

Diane Brandon studied social sciences, mathematics, education, and the arts on her way to working in child welfare, family mediation, and substance abuse prevention in Vermont, Arizona, NH, and Maine. She credits her years of marriage, mothering, and community service for grounding her in "kitchen table" style conversations that used collaboration and a positive attitude to address individual, family, and community problems in her work with **Community Wellness Coalition**. *"I love what happens when caring people sit down to talk honestly about local issues, figure out what needs to be done, and then go do it."*

Janet Sawyer started her professional career as a registered dental hygienist and worked in many types of settings. She then began providing services as a dental public health consultant. This led her to the broader field of public health and her position as the first Coordinator for **Greater Waterville PATCH**. Janet says *"…being associated with a community coalition provides me an opportunity to continue along in my professional career with prevention and education at the core of what I do. While I started out educating and providing care on an individual basis, I feel like I now am a part of a group that does that on a community basis."*

Angela Cole Westhoff specialized in health communication and public relations in graduate school. After working in college career counseling, she took a position at a Healthy Maine Partnership site where she developed skills in community assessment, coalition building, and policy change. Angela worked briefly at the state level before taking her current position as Executive Director of **Healthy Androscoggin**: *"I must say that I find much more personal satisfaction being involved in prevention work at the local level – there is just something extremely rewarding about working in the community!"*

Leah Binder began her career in health policy as special assistant to the CEO and later public policy director for the National League for Nursing. She holds MS degrees in communications and government administration from the University of Pennsylvania and a BA in Politics from Brandeis. Before arriving in Farmington, Leah served as senior policy advisor in New York City Mayor Rudolph W. Giuliani's Office of Health Services, where she developed and administered programs to improve care of the uninsured. Currently, Leah serves as Vice President of Franklin Community Health Network as well as Executive Director of **Healthy Community Coalition and Franklin Health Access**.

Healthy Hancock participants, L-R - Michelle O'Meara - Coastal Hancock Healthy Communities, Iris Simon - Health Link, Doug Michael - Healthy Acadia, Heather Albert-Knopp (Consultant to Healthy Acadia, Healthy Peninsula, Healthy Hancock), Mary Jane Bush - Bucksport Bay Healthy Communities, Barbara Peppey - Healthy Peninsula, Helena Peterson - Coastal Hancock Healthy Communities, Jim Fisher - Hancock County Planning Commission.

As a federation of community-based coalitions and organizations, **Healthy Hancock** has no staff of its own. Rotating co-chair positions and committee work are shared among staff of the member organizations. Healthy Hancock participants come from a diverse range of backgrounds including social work, nursing, public health, exercise physiology, community planning, substance abuse treatment and prevention, management of hospital patient care systems, education (experiential and classroom), and community organizing. Healthy Hancock participants find their work "dynamic," "challenging," and "creative," citing the importance of "authentic community involvement" in their work to create systemic changes to support individual and community health, now and in the future.

Ronni Katz began her career as a High School English teacher and after a stint as a professional musician, she started working in the drug prevention field in a New York City High School. She spent five years as the Project Director for a program that operates free, neighborhood based after school centers in Nashville schools before moving to Maine in 2002. As Program Coordinator, she has been able to use her skills in fostering collaborations and her background in substance abuse prevention, Ronni was able to help the **One ME One Portland** coalition create their shared vision and bring it to fruition. *" I have come to the realization that the most effective way to change the world is to change my little corner of it by reaching one person at a time."*

Patty Duguay served her communities in a variety of venues from free-lance writer, to regional recycling coordinator to her current position as Executive Director of the **River Valley Healthy Communities Coalition**. She considers forming and maintaining relationships crucial to coalition building. *"The work is about informing, educating and empowering – with many trails to blaze."*

Mary Trescot has served her communities in a variety of ways including twenty-six years in county law enforcement to Executive Director of **Youth Promise**. Mary believes that the relationships she develops is crucial to the success of Youth Promise's programming and keeping the coalition strong so the organization can continue to grow and continue to build the necessary bridges between a youth and his or her community. *"Change in our communities starts from the ground up and it is only through working with concerned residents who have a stake in the problem that we begin to see small cultural shifts appear."*

What Coalitions Can Do: Functions and a Framework

Coalitions form when people share a passion about an issue. Coalitions assemble people and organizations to assess community issues and assets, create solutions using community resources, measure progress and find new opportunities to build and strengthen relationships in the community.

However, lasting coalitions don't just happen; ask any of the coalition leaders you met in chapter one. This chapter provides a brief description of four major coalition functions and introduces a Coalition Functions Matrix that will be used in chapters three through six.

Coalition functions fall into four general categories:

- **Coalition development and maintenance**
- **Program and service development and integration**
- **Community-level/environmental strategies**
- **Community capacity building**

Coalition development and maintenance is an ongoing function. All sustaining coalitions deal with *internal* operations such as building and maintaining participation, structuring the organization and implementing procedures. The coalition must also build its own capacity for action by ensuring that its members have sufficient knowledge and skills to both participate in the coalition (participation skills) and make informed decisions about particular interventions (specific content skills). Coalition leaders are also responsible for "nuts and bolts" such as bookkeeping, contract writing, reporting, hiring and supervising employees. In fact, our eight coalition leaders told us that they spent at least twenty-five percent of their time on "nuts and bolts" activities.

Coalitions form when people show a passion about an issue.

Notably, coalition development cannot be accomplished once and then forgotten. There is a normal "cycling" over time as part of coalition maturation (e.g., training of new staff and coalition members). Cycling also occurs when a task is not competently completed. For example, if decision-making procedures are not initially well specified and agreed to by the membership, later disagreements or conflicts may necessitate revisiting this aspect of the coalition foundation.

While establishing its internal functions, a coalition is also simultaneously working on *external* functions. The coalition chooses/develops an array of prevention programs and strategies appropriate to the diversity of the community, choosing the most locally appropriate combination of the following three external functions.

Coalition functions fall into four general categories:

- *Coalition development and maintenance*
- *Program and service development and integration*
- *Community-level/ environmental strategies*
- *Community capacity building*

Program and service development and integration: Here the coalition identifies community needs and resources through compiling and analyzing data, prioritizes needs by the magnitude of health burden and chooses an array of prevention programs and services it will deliver. Coalitions must then of course develop capacities that match the programs chosen, as well as construct implementation plans specifying responsibilities, timelines and evaluation activities. Prevention programs and services in a community are designed for specific populations and often consist of a standardized curriculum focused on individual risk and protective factors. In any particular community there might be one specific program or there might be several prevention programs intended to produce cumulative or synergistic effects.

Over the past decade, coalitions have also increasingly been encouraged to employ "evidence-based" programs. This is because ineffectual and inadequately implemented programs not only waste resources, but they may also cause disillusionment among implementers and policymakers who see no impact. Therefore, interventions that influence the dissemination of evidence-based prevention programs are necessary at the local community level. A natural starting role or function for many coalitions is the development and integration of evidence-based prevention programs and services.

Community-level/environmental strategies: Here the coalition focuses not on changing aspects of individuals but on changing aspects of the community environment. Community-level/environmental strategies have been receiving increasing emphasis in recent years, as theory and practice in prevention and health promotion have articulated a distinction between prevention strategies that attempt to alter individuals and those that attempt to alter the shared community environment that shapes both positive (healthy) and negative (health-compromising) behaviors for entire populations. Such distinctions can be thought of in terms of the traditional public health model consisting of an interacting triangle of host, agent and environment. Programs and services are primarily aimed at changing the host (the user), while community-level strategies are aimed at changing aspects of the agent (alcohol and other drugs) and the community environment (the drinking or drug using context). The agent can be changed by changing access, increasing the cost or difficulty of obtaining alcohol, marijuana or tobacco. The community environment can be changed by changing norms, regulations/policies and enforcement. Norms are basic orientations concerning the acceptability of specific behaviors. Regulations are formalized laws

or policies (of governments, public agencies or private organizations) which codify norms and specify sanctions. Enforcement is the consistent and systematic application of existing policies and laws. Coalitions are an ideal vehicle for Community-level/Environmental strategies because, unlike program delivery that can often be accomplished by one organization, policy initiatives are difficult to implement and often require multi-sector collaboration.

Community-capacity building: Community capacity has been defined as "the interaction of human capital, organizational resources, and social capital existing within a given community that can be leveraged to solve collective problems and improve or maintain the well being of a given community."[2] Some coalitions work explicitly at the level of community capacity building, rather than or in addition to working on specific programs or environmental strategies. Such coalitions may evolve into a full fledged "community support organization" (CSO).[ii] A CSO focuses on the general conditions and context in which community improvement initiatives (including prevention and health promotion) are developed, implemented and evaluated. That is, the CSO works to build generalized professional, organization, and systemic capacity to tackle any issue that might be identified locally.

A CSO may convene organizations for joint assessment and planning activities; organize or sponsor training programs for skills development; provide telephone and on-site consultation; produce publications and other public education materials; provide referral services, and establish mechanisms for communication including newsletters or websites. Some components may have an economy of scale that is best implemented by the CSO (e.g. a regional media campaign or publication of reports from data gathered centrally and then disseminated to local users). The CSO also may advocate to bureaucratic systems such as state agencies for policies and procedures more supportive of its constituency, and in general may supply information to the local community from relevant regional, state, national or even international sources.

The Coalition Functions Matrix (Table 1)

Chapters three through six take a more detailed look at each coalition function using The Coalition Functions Matrix shown in Table 1 as a reference. The Coalition Functions Matrix displays the four coalition functions as rows while the columns are organized according to the five steps of the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Strategic Prevention Framework. The Strategic Prevention Framework was developed by SAMSHA to guide community coalitions as they organized themselves to mount diverse prevention interventions. It is organized into five "steps" or areas of activity:

1) **Profile population needs, resources and readiness:** collecting and analyzing data to identify community problem(s) and conditions requiring intervention.
2) **Mobilize and / or build capacity to address needs:** broadening the types and levels of coalition knowledge, skills and resources.
3) **Develop a comprehensive strategic plan:** outlining a logical sequence of steps for progress toward community-level outcomes.

The Strategic Prevention Framework

1) Profile population needs, resources and readiness

2) Mobilize and / or build capacity to address needs

3) Develop a comprehensive strategic plan

4) Implement evidence-based prevention programs and activities

5) Monitor process and evaluate

[ii] Also known under other rubrics such as "intermediary organizations", "enabling systems," and "training and technical assistance systems."

Table 1: Coalition Functions Matrix: What Coalitions Can Do[i]

Strategic Prevention Framework Steps[ii] → / *Coalition Functions* ↓	1. *Profile population needs, resources & readiness*	2. *Mobilize &/or build capacity to address needs*	3. *Develop a comprehensive strategic plan*	4. *Implement evidence – based prevention programs & activities*	5. *Monitor, evaluate, sustain & improve or replace those that fail*
Community Capacity Building	• Identify constituents for community capacity building services (e.g., individuals, organizations, networks)[iii] • Assess needs for community capacity building	• Identify cadre of personnel with training and technical assistance skills or… • Broker services from consultants or organizations outside the community	• Determine area to serve & scope of services to be offered • Establish an array of joint planning, training & TA offerings • Integrate with other relevant planning functions	• Establish an array of services such as convening, leadership training, organizational development, joint assessment and planning,, training and TA • Broker information/ resources from larger systems	• Monitor satisfaction / skill gains from services provided • Evaluate impact on outcomes from services provided • Integrate service array into ongoing community systems
Community - Level / Environmental Strategies	• Assess community level influences such as access, media influence, lack of enforcement • Measure compliance with local ordinances, extent of enforcement efforts	• Build knowledge of community level strategies among members • Develop skill sets such as social marketing, policy analysis, advocacy	• Selection of community level strategies & "best fit(s) • Conduct "political mapping" to determine allies / opponents	• Social marketing / media advocacy for community level strategies • Campaigns (e.g., for particular ordinances, policies, increased enforcement)	• Evaluate process of campaigns, revise strategies as needed • Monitor enforcement of adopted policies • Track impacts with social indicators
Program & Service Development & Integration	• Compile consequence & consumption data • Prioritize needs by magnitude of health burden • Identify program redundancies /gaps	• Build knowledge of evidence-based programs among members • Develop skills in program design & training	• Selection of evidence-based programs / best "fit(s)" • Strategic plan for programs / to produce combined or cumulative effects	• Implement program(s) with fidelity • Make necessary adaptations & refinements	• Conduct process / outcome evaluations • Identify programs / services for elimination/ retention • Secure sustained funding or promote institutionalization

Comprehensive Community Interventions integrate program & community level strategies for synergistic impact

Coalition Development & Maintenance					
• Assessing which members / organizations need to be at the table (which skills & resources will be required) • Assessing what has worked (in the past) & what will work in terms of coalition structure & operating procedures in your community • Assessing the types of data (internal to the coalition) needed for coalition development & management • Assessing desired training & TA skills relevant to building coalition structure & operations (e.g., meeting management) • "Nuts & bolts" issues such as bookkeeping, purchasing software, office equipment, etc.	• Provide training & TA around leadership, cultural competence & data / evaluation capacity. • Provide training & TA to build participation/ process skills (for interactions among members at coalition meetings) • Provide training & TA to build collaboration skills (for interactions of member organizations outside of coalition meetings) • Mobilize regular contacts between coalition & community sectors (relationships) • "Nuts & bolts" issues such as hiring new employees or vendors, contract writing, etc.	• Build consensus around the nature & purpose of the coalition • Develop mission statement & general goals for coalition • Plan for communication among members • Plan for member & leader succession • Draft evaluation plan for monitoring coalition internal operations • "Nuts & bolts" issues such as securing office space, establishing phone & internet systems, etc.	• Establish structure & operating procedures (e.g., committees, decision-making) • Establish meeting schedule / develop agendas • Facilitate discussions/ decision-making • Surface & address conflicts that may emerge • "Nuts & bolts" issues such as hiring & supervising employees, troubleshooting office issues, etc.	• Periodically assess member satisfaction (internal evaluation of coalition operations) • Periodically assess skill development among members (internal evaluation of capacity building) • Periodically assess collaborative relationship among member organizations & between coalition & wider community • Develop recommendations for quality improvement • Establish stable leadership (leadership succession) & standardize operating procedures & funding • "Nuts & bolts" such as conducting annual reviews of employees, preparing reports for board, etc.

i. Adapted with permission from the national evaluation of the Drug Free Communities Program of the Office of National Drug Control Policy (ONDCP)

ii. The Strategic Prevention Framework steps were created by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP) for the State Prevention Framework-State Incentive Grant (SPF-SIG) Project. The steps are, however, generic and applicable to a wider variety of program contexts.

iii. Bullets within each cell of the Coalition Functions Matrix represent coalition capacities, defined as "the actual knowledge, skill sets, participation, leadership and resources required by community groups to effectively address local issues and concerns." The definition is from the Ontario Prevention Clearinghouse (Spring 2002). Capacity Building for Health Promotion: More Than Bricks and Mortar.

4) **Implement evidence-based prevention programs and activities:** putting into action the steps identified in the planning process.

5) **Monitor process and evaluate:** measuring the quality and outcomes of a coalitions work', sustaining what works, replacing what fails.

Although the SPF steps are numbered, they are not linear and several may take place simultaneously. Incorporated throughout each step, serving as keystone for the SPF, are concepts of cultural competence and sustainability.

Bullets within each cell of the Coalition Functions Matrix represent coalition **capacities**, defined as "the actual knowledge, skill sets, participation, leadership and resources required by community groups to effectively address local issues and concerns."[3] The bullets provide an illustrative (not exhaustive) list of the many capacities necessary for a coalition to move competently through the SPF steps for each coalition function.

The Coalition Functions Matrix will be used as a reference throughout chapters three through six. Each chapter takes a more detailed look at one coalition function, describes related capacities, examines selective illustrative research evidence and provides exemplary stories from our eight study coalitions.

The Coalition Functions Matrix on pages 10 and 11 presents a basic framework for helping coalitions clarify both purposes and capacities. A pull-out version of this matrix is included at the front of this booklet to make it easier to use the framework.

What Coalitions Can Do: Foundations and Fundamentals

3

The exact "form" a coalition takes evolves as members come together, marshal human and material resources, reach consensus on coalition purposes/plans and establish an organizational structure with operating procedures. Coalition development functions address these foundations and fundamentals. Illustrative capacities for coalition development and maintenance functions are shown as bullets in Table 1. This chapter describes some details of this essential work and provides illustrations/exemplars from our eight study coalitions.

When profiling needs, resources and readiness (Step #1) specifically for the coalition development and maintenance function, coalitions consider several questions including who they want to participate, how and why. Coalitions need certain skills and resources to address any particular community issue and by definition seek to engage representation from a broad spectrum of key community sectors. This is why coalition conveners often find themselves asking, "Who else needs to be at the table?". This is also why so many pages of "How to" materials for coalitions are devoted to advice on who and how to recruit. As can be readily seen from figures 1 and 2 on the next two pages the study coalitions generated an extraordinary range of participation among a wide diversity of constituencies.

Mobilizing existing and building new capacities to address needs has recently received increased emphasis as an integral part of prevention planning (Step #2). Lessons have been learned that coalition action is optimally undertaken when adequate capacities are in place to make success more probable. Capacity for action can be built by changing members' knowledge, attitudes and skills. Some knowledge and skills relate to participation skills, whether how to chair a subcommittee or how to present coalition positions concisely to community constituencies.

Using data from 35 municipal coalitions, one study found coalitions that had done a better job building capacities (e.g., increasing their members' perceived skills and making more extensive linkages with community organizations) were more likely to be rated by community leaders as creating effects one year later (e.g., increasing resources devoted to prevention, changing community attitudes and promoting prevention policies).[4]

Figure 1: Participation Chart for Healthy Androscoggin (Traditional Coalition)

Business Community	▶ Hartford Agency	▶ Hannaford	▶ Tambrans-Proctor & Gamble	Androscoggin Valley Chamber of Commerce	✱ Career Center		
Civic Groups & Grassroots Community Organizations	▶ Lewiston Auburn Trails	United Somali Women of ME	Androscoggin Land Trust				
Religious Organizations	▶ Rabbi of Local Synagogue	Interfaith Clergy Council					
Youth Services Organizations	✱ New Beginnings	▶ YMCA	▶ YWCA	✱ Head Start			
Community-based Health, Social Services & Prevention Providers	✱ WIC, Site Supervisor	▶ Amer. Cancer Society Exec.	▶ Auburn Housing	▶ Lewiston Housing	Advocates for Children	Common Ties	Cooperative Extension
	Horizons 55	Senior Plus	United Way of Androscoggin				
Prevention & Health Promotion Coalitions	▶ Healthy ME Partnerships (HMP)	▶ One ME	ME Coalition On Smoking Or Health	ME Assoc. of Prevention Providers	ME Tobacco Free College Network	Smoke-free Housing for ME Committee	
Hospital & Medical Care Sector	✱ St. Mary's Hospital	✱ Central ME Medical Center	✱ Fam. Practice Physician	Sister's of Charity Health System			
Law Enforcement	✱ Auburn Police Dept.	▶ Lewiston Police Dept.	▶ Lisbon Police Dept.	▶ School Resource Officers	Androscoggin County Sheriff Dept.	JCCO (Juvenile) Co. Corrections Officers	▶ Asst. District Attorney
Local Government	Androscoggin Valley Council of Governments	City of Auburn	City of Lewiston				
Local Media	▶ Turner Publishing	▶ Gleason Media	▶ Uncle Andy's Digest	▶ Lewiston Sun Journal	Great Falls TV	Local Public Access TV	
Schools	✱ Central ME Community College Rep	✱ Lewiston Schl Substance Abuse Coord.	▶ Bates College HR Rep.	▶ Lewiston School Health Coordinator	▶ School Nurse in local school districts	▶ Safe & Drug Free Schools Comm. Rep.	
Parents	✱ Ch. Lewiston Schl. Bd. Parent of Teen	✱ Parent of Turner Teen	▶ Parent of Leeds Teen	▶ Parent of Lewiston Teen	Lisbon SADD		
Youth	▶ Leavitt HS Youth 2 Youth	▶ Lisbon MS. & H.S. Y 2 Y	▶ Lewiston M.S. & H.S.Y2Y	▶ Poland Maine Youth Voices	▶ Auburn M.S. & H.S. Y2Y		
Other	✱ Local Rep. ME House	✱ USM Muskie School Faculty Member					

✱ = Board Member
▶ = Member
Others are Partnering Organizations

Figure 2: Participation Chart for Healthy Hancock (Federation of Coalitions)

Business Community	**Secondary connections through participating coalitions (See organizations outlined in red below)**					
Civic Groups & Grassroots Community Organizations	**Secondary connections through participating coalitions**					
Religious Organizations	**Secondary connections through participating coalitions**					
Youth Services Organizations	**Secondary connections through participating coalitions**					
Community-based Health, Social Services & Prevention Providers	Extension of Hancock	Downeast Health Services	**Secondary connections through participating coalitions**			
Prevention & Health Promotion Coalitions	▶ Union River Healthy Com-munities (HC)	▶ Bucksport Bay HC	▶ Healthy Island Coalition	▶ Healthy Acadia (HC & HMP)	▶ Healthy Peninsula (HC & HMP)	▶ Coastal Hancock (HC & HMP)
Hospital & Medical Care Sector	Maine Coast Mem. Hospital	MDI Hospital	Blue Hill Mem. Hospital			
Law Enforcement	**Secondary connections through participating coalitions**					
Local Government	▶ Hancock Plng Commission	Town of Bucksport	**Secondary connections through participating coalitions**			
Local Media	**Secondary connections through participating coalitions**					
Schools	Ellsworth Schl. Department	Bucksport Schl. Department	School Union 98	School AU 76		
Parents	**Secondary connections through participating coalitions**					
Youth	**Secondary connections through participating coalitions**					
Other	**Secondary connections through participating coalitions**					

▶ = Voting Member HH is not a 501(c) (3)
Co-chairmanship circulates yearly
Each coalition represented (see red outline) has a structure similar to Figure 1 above.

Using Diagrams to Show Similarities and Differences in Coalition Structure

How to Read Figures 1 & 2:

The format of both figures draws on the idea of the "community wheel," the spokes of which are often used to depict the different sectors of the community that participate in a coalition. Here, however, community sectors are listed vertically in the far left column. Specific participating organizations that come from each sector are listed horizontally across the columns. This allows the viewer to see both the extent to which the community sectors are represented in their coalition and the strength of representation, as measured by the number of organizations in each sector.

Figures 1 and 2 were selected to show the greatest contrast between types of coalitions. Figure 1 represents Healthy Androscoggin, a traditional coalition – the kind that most of the literature on coalitions describes. Figure 2 is Healthy Hancock, a "federation of coalitions," which represents an organization specifically developed with community capacity building in mind. Coalitions look very different, depending on the particular community organizations they engage as participants. The total number of organizations and the way they were arrayed across the sectors varied greatly across the study coalitions. The patterns were rooted in the nature of the community and the origins of the coalition.

The relative influence or degree of participation of individual organizations within the array also varies greatly. Figures 1 and 2 are called participation diagrams rather than member diagrams because they encompass several degrees of involvement. In these diagrams, board or steering committee members are marked with an "✱" and coalition members are marked with an "▶." All the other participants are partnering organizations, which may not attend coalition meetings on a regular basis, but play roles that are significant to the progress and activities of the coalition. Just as sector representation varies, the number of board members, coalition members and partnering organizations and the relative influence they represent varies greatly from coalition to coalition.

Form (structure) follows function. When participation diagrams for the study coalitions were compared, a visible difference emerged between coalitions whose major purpose was to run programs and/or implement environmental strategies and coalitions that focused more on community capacity building. Healthy Hancock provides an example. In contrast to Figure 1, Figure 2 shows relatively few directly participating organizations. Healthy Hancock was created to support other organizations – its participating coalitions – and it provides support functions: networking and communication; collaborative policy and advocacy work; county-wide research/evaluation; coordinated planning; joint leveraging of resources; and collaborative initiatives. The diagram shows the participating coalitions themselves (the row outlined in red), along with a few other partnering organizations, such as the county planning agency, hospitals and school districts with multi-town or county-wide scope. For a coalition like Healthy Hancock, most of the community organizations represented by the sectors of the community wheel are represented indirectly, through the other organizations. The core of Healthy Hancock represents fewer community sectors, while the total number of organizations in sectors represented indirectly, through secondary connections is large, being duplicated five times, once for each participating coalition.

Healthy Hancock was only one of the study coalitions that focused on community capacity building. Healthy Hancock was chosen for Figure 2 because its structure lends itself to illustration. However, York's Community Wellness Coalition and Waterville PATCH also focus most of their efforts on community capacity building and all the other UGS coalitions provide varying degrees of community support along with their primary focus on programs or strategies or a combination of the two.

While Healthy Hancock is a federation of coalitions that do not overlap geographically, the other coalitions in Maine that provide substantial community capacity building function in contexts where there are a great many community coalitions and local organizations that have overlapping boundaries and missions, which pose their own set of challenges. Each coalition is inventing this function as it evolves and each can provide insights into what might work in Maine. Chapter 6 contains more on the community capacity building function.

Mission Statements from the UGS Study Coalitions

Community Wellness Coalition: "To develop and support collaborative projects which lead to individual, family and community well-being in the Kittery, Eliot, York and South Berwick (KEYS) Region of southern York County Maine."

Greater Waterville Planned Approach to Community Health (PATCH): "PATCH's goal is to continually maintain a process to assess and address community health needs of the Greater Waterville Region."

Healthy Androscoggin: "Healthy Androscoggin is a community coalition dedicated to improving the health of Androscoggin County citizens through colaborative planning, community action, eduction, and prevention."

Healthy Community Coalition: "To measurably improve the health and well-being of all people of Franklin County and neighboring towns using a coordinated approach of education, health promotion and outreach."

Healthy Hancock: "Healthy Hancock is a collaborative of community-based coalitions, allied organizations and schools committed to working together to improve health in Hancock County."

One ME One Portland Coalition: "To reduce illegal tobacco and alcohol use among 12 to 17 year old individuals in Portland by providing clear, consistent and effective messages and resources to Portland's children, teenagers, parents and families."

River Valley Healthy Communities Coalition: "Measurable improvement in the quality of life in the River Valley towns of Northern Oxford County through coordinated, ongoing community health promotion."

Youth Promise: "To mobilize people from our communities to build the character of our youth by promoting a healthy start, caring environments, productive activities in safe places, and opportunities for young people and adults to serve others."

Researchers found that the degree of cohesion and communication among coalition members was related to implementation success in tobacco control coalitions.[5]

Cohesion doesn't mean avoidance of conflict. In fact, one national study examining hundreds of coalitions found that the ability to identify and confront conflict and "transform" it into new solutions was most related to the coalition attaining their goals.[6]

Other knowledge and skills relate to prevention and health promotion content areas. Establishing regular linkages with a variety of community organizations is also a coalition capacity. This is because most contact between a coalition and different community sectors comes through members existing connections. Where these don't exist the coalition is well advised to establish some mechanism of developing and regularly maintaining such linkages.

Coalitions often generate significant energy and discussion as they **forge consensus around their purpose, mission and goals** (Step #3). Opinions about purpose, mission and goals deserve robust discussion because they create the coalition's initial identity and collective commitment among members. As we saw in Chapter one, community conditions at the time of a coalition's emergence often determine a coalition's initial focus and breadth. The mission statements of our eight study coalitions are shown in the box on this page.

Of course, as indicated in Table 1, planning for coalition development extends beyond consensus on a mission. Plans must be developed for several coalition functions ranging from establishing how communication among members will be handled between meetings (e.g., how minutes will be distributed, agendas formulated) to determining how to monitor and evaluate how satisfied members are with the coalitions internal operations.

The coalition also **establishes an organizational structure and operating procedures.** Here (Step #4) the coalition will answer questions such as "How many officers and committees will we have?" "Will decisions be made at the top or only with the involvement of many members?" Structure refers to the way an organization arranges its human resources for goal-directed activities. Struc-

ture includes such aspects as the number of formal officer roles for members to take part in within the organization, specialization (the degree to which activities are divided into specialized committees within the organization), and formalization (the degree to which rules and procedures are written and precisely defined). The structure and processes developed by a coalition create an organizational climate within the coalition that influences the degree to which the members are satisfied and committed to the coalition and devote their time and energy to participation in the coalition.

Evaluating member satisfaction and commitment is one aspect of monitoring evaluating and improving coalition development and maintenance (Step #5). Because voluntary members are free to withdraw their energy at any time, monitoring whether members feel engaged, their voices heard and their existing skills utilized can be very valuable for a coalition. Evaluation of such internal aspects can be as simple as informally gathering feedback after each meeting or developing and administering yearly surveys of members. Like any organization, coalitions are well advised to gather data about their own internal functioning and then use the data to recommend quality improvements. Since these recommendations often advocate changes in previous steps such as adding new training or changing coalition procedures, this is an example of "cycling" and how, although presented sequentially, the steps actually interact dynamically over time. In the next chapter we begin to examine the kinds of functions coalitions perform externally in their communities.

Another perspective on the structure of coalitions: When study participants were asked to describe what a coalition was, they came up with the image of a tree. Figure 3 depicts just those parts of the tree that this foundations chapter deals with – the structure of the coalition itself, including the resource base, the coalition board, the community sectors, and a sampling of participating organizations. Chapters 4 and 5 will add programs and services, strategies, and outcomes.

Cycling

The steps in the Coalition Functions Matrix interact dynamically over time and need to be revisited periodically or when a change in conditions warrants rethinking.

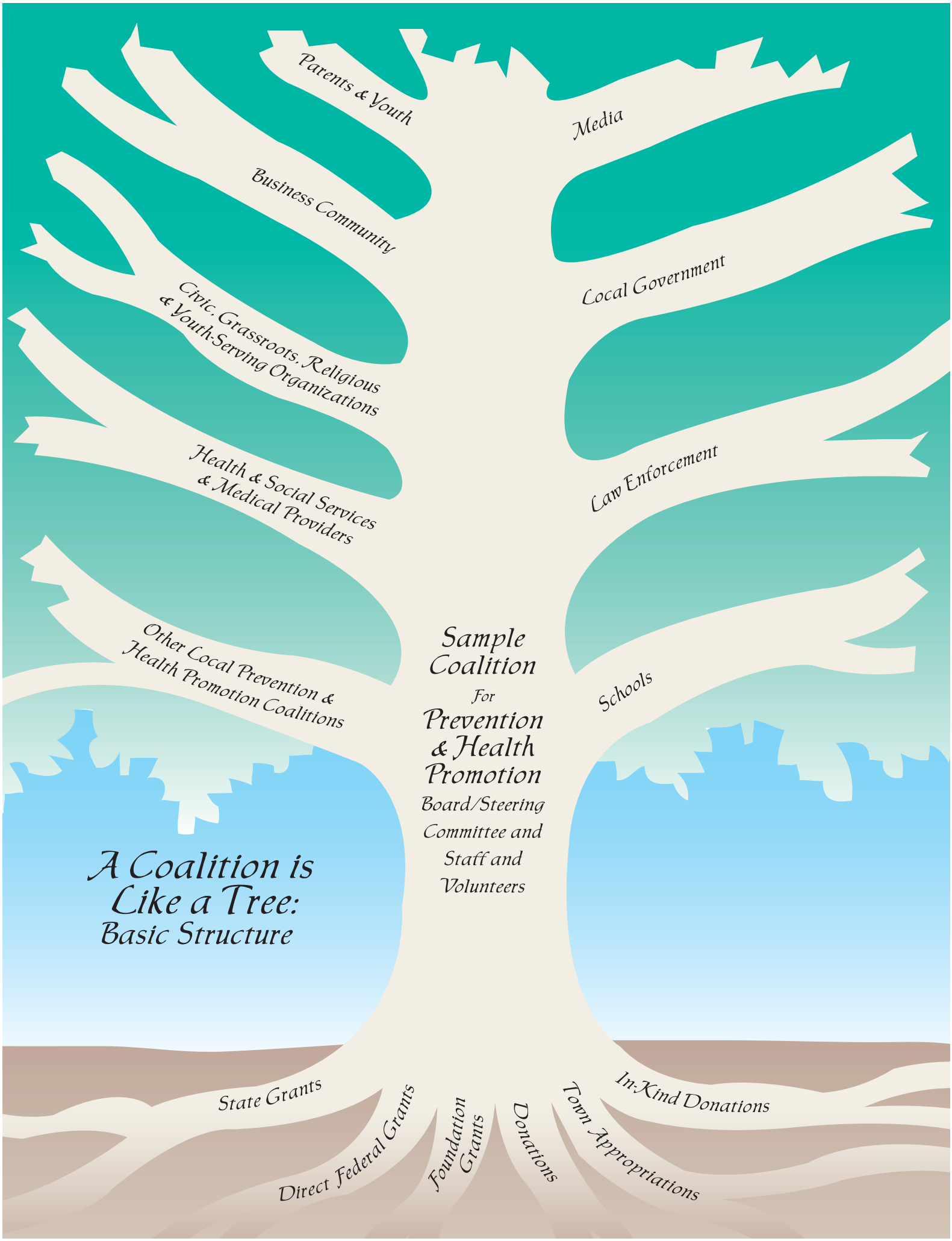
A Coalition is Like a Tree *The roots are the resources that give it life; the trunk is the board or steering committee; the large limbs are the community sectors represented and the smaller branches the specific organizations in each of the sectors that are members or partnering organizations. The leaves are the programs and strategies that come about because the coalition has determined the need for them, developed resources for them and enlisted champions to implement them. The fruits of the tree are the outcomes of all its efforts.*

Cycling - Restructuring One ME One Portland: "Sometimes you have to get small to get big." Those words were said to me (Ronni Katz) by a member of one of the coalitions I coordinate for the City of Portland Public Health Division. At the time, they seemed to apply only to a particular group but that simple phrase became a prophetic guideline for the One Maine One Portland Coalition (OMOP).

OMOP's original conception involved creating a "Super Coalition," comprised of five established Portland coalitions with experience in youth substance abuse prevention. Representatives from each coalition were invited to form an Interim Steering Committee of 21 people and with One ME funding they were "off and running."

All too often, even the best laid plans encounter detours when the "rubber meets the road" and implementation begins. Seven months into the project, after a period of tension, I was hired as a replacement coordinator. At that point, many of the original members had stopped participating and the structure was beginning to unravel. It was time to recycle back to the original plan to focus on the mission that had brought people together in the first place. After reviewing the situation and speaking with members, it became clear that my most immediate goal was to restore relationships.

The multi-layered infrastructure that been created was put on hold and we developed a loose structure that consisted of a core steering committee that met monthly and followed Robert's Rules for decision making. Within a year, OMOP was implementing three model programs and one non-model program. Many of the faces on the steering committee have changed and we have revisited our original mission. We are now changing it to reflect a more holistic prevention approach. Staff has been hired to work with OMOP on evaluation and program development and to serve as a salaried member of the CMCA Action Team. We are in the process of redefining our role as a coalition to reflect our success in fostering partnerships, building capacity and conducting assessments. We are working with partner agencies to create a community prevention plan for Portland, which emphasizes many of the original concepts we came together to promote. As the old adage goes, "Everything old is new again."


Parents & Youth
Media
Business Community
Local Government
Civic, Grassroots, Religious & Youth-Serving Organizations
Law Enforcement
Health & Social Services & Medical Providers
Schools
Other Local Prevention & Health Promotion Coalitions
Sample Coalition For Prevention & Health Promotion Board/Steering Committee and Staff and Volunteers
A Coalition is Like a Tree: Basic Structure
State Grants
Direct Federal Grants
Foundation Grants
Donations
Town Appropriations
In-Kind Donations

What Coalitions Can Do: Programs and Services

The vast majority of prevention and health promotion activities are program and service interventions located in communities, usually in schools, youth agencies or health centers. They are designed to change knowledge, attitudes and behaviors among a specific group (e.g. social learning skills for junior high school students; parenting for single parents of elementary school children). All eight of the UGS study coalitions implemented at least one or two programs and services, whether or not this function represented their primary focus. Historically, providing programs and services has been the focus of most community coalitions.

Coalitions are well positioned to implement programs and services because they can reach significant portions of community populations and work with a variety of community organizations to plan an array of effective and integrated programs. This chapter describes such work. It is organized around the illustrative capacities for program and service development that are shown as bullets in Table 1.

When a coalition **profiles population needs, resources and readiness** (step #1), it begins with compiling and analyzing community data. Here a coalition asks "What does the problem look like and what resources do we need to solve it?" Coalitions use data about consequences (What happens as a result of alcohol or drug use?) and related consumption patterns (What substance is being used, by whom, with what frequency and severity?). This information allows a coalition to prioritize needs according to health burden, taking into account the magnitude of problems and their severity. Coalitions are also in an ideal position to use knowledge of their own particular community context to consider additional criteria: Which problems seem most changeable?; What resources already exist? All in all, both numbers (quantitative data) and local knowledge (qualitative data) are used to identify community priorities.

Coalitions are well positioned to implement programs and services because they can reach significant portions of community populations and work with a variety of community organizations to plan an array of effective and integrated programs.

Building capacity for evidence-based programs (step #2) has become much easier over the last decade. This is because several federal agencies have articulated standards for evidence-based programs and systematically compiled lists of such programs. Federal agencies such as the Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC) have developed compendiums of model[iv] programs and are increasingly requiring that communities choose among such programs to assure that scare resources will be spent on proven programming. Model programs are a great resource for local prevention providers who can contract with developers for training and receive "certification" to deliver programs locally. In addition, CSAP has established regional Centers for the Application of Prevention Technology (CAPTs) whose primary role is to "bring science to service" by providing states and coalitions with a variety of training and technical assistance services.

Planning for evidence-based programs and services (Step #3) has also never been easier. The National Registry of Evidence-based Programs and Practices (NREPP) established by CSAP currently contains 66 model programs and services. These programs range from prevention curricula for youth populations (e.g. middle school youth) and families to specific services such as model family therapy services for youth showing early warning signs (e.g. youth referred to high school student assistant counselors).[v] One important part of a coalition's planning for programs and services is to insure that any evidence-based program chosen is a good "fit" for the local target population (e.g., age, culture, language, gender). Another important part of the coalition's planning is to be aware of the number and scope of all prevention programs going on in the community. When there are several programs, the coalition can work to avoid duplication and increase the probability that the programs are integrated.

Implementing evidence-based programs and services (Step #4) is, in the words of one leading researcher a question of "finding the balance."[9] The "balance" in question is that between "fidelity" or the rigorous adoption of an evidence-based program, changing as little as possible, and "adaptation" or the modification of a program in response to local community conditions, including cultural norms, values and social patterns / institutions. Many adaptations are possible, from changing the number or length of sessions to changing the target population or setting. Once adaptations are decided upon, plans are drawn up that provide a roadmap for the systematic implementation of the program, specifying number of sessions, expected duration, number and kind of participants and so on. Better implementation leads to better outcomes and implementation plans are also very useful in program evaluation, discussed next.

Figure 4 presents the tree diagram of coalition structure from Chapter 3 with sample programs and services (leaves) added. These are listed next to some of the community sectors. Generally, one or two organizations take the lead in implementing programs and services, though it is the whole coalition that determines need, plans and supports the program efforts. The expected outcomes for these programs and services are represented by the fruit.

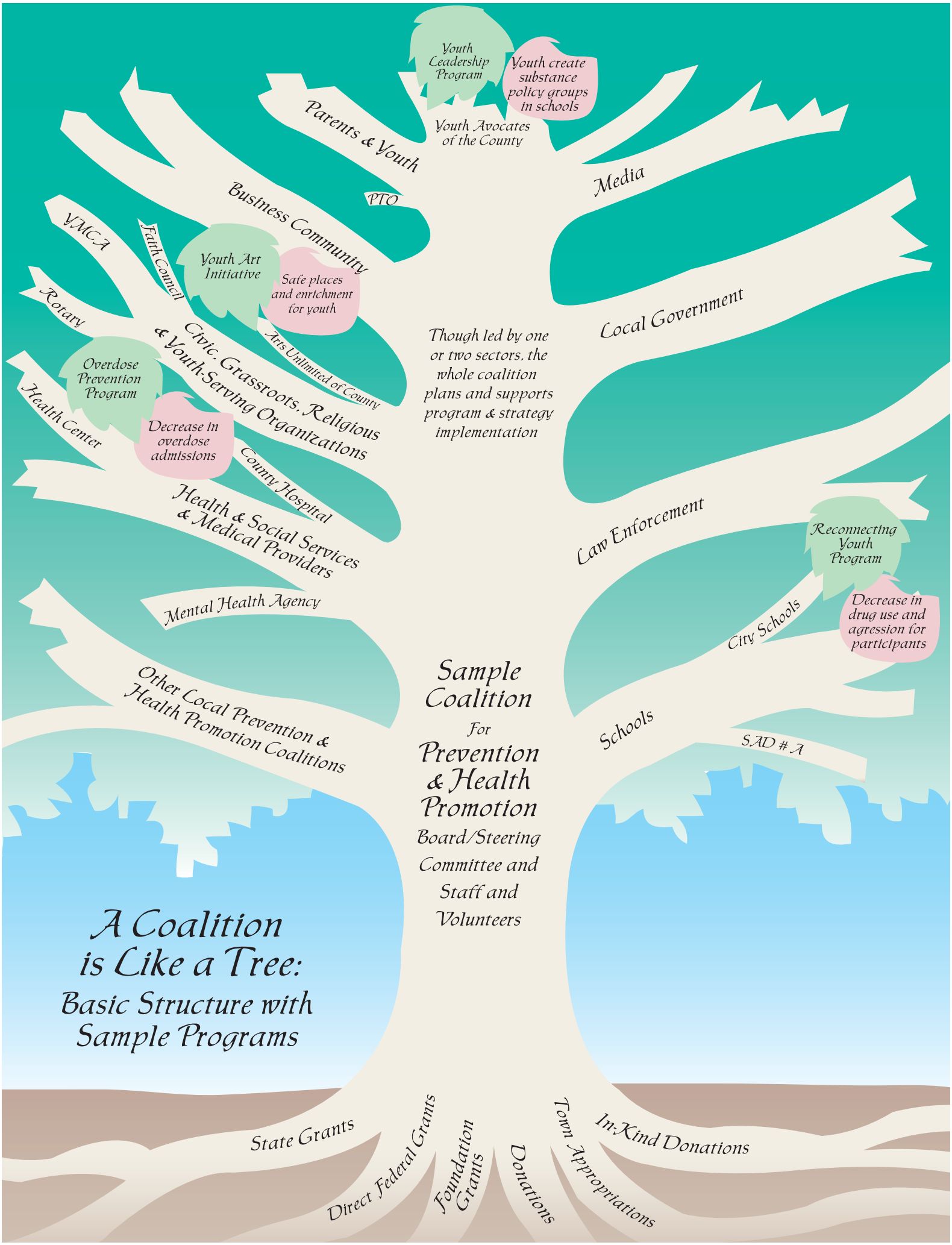
A Sampling of Model Programs and Research Results

Project Northland consists of school-based curricula in sixth through eighth grades, parental involvement and educational activities. Twenty-four school districts and surrounding communities were randomly assigned to intervention and delayed program conditions. At the end of eighth grade, students in intervention communities significantly reduced alcohol use, and baseline nondrinkers (about two-thirds of the sample) also reported significant reductions in smoking and marijuana use.[7]

The Strengthening Families Program for Parents and Youth 10 – 14, is a seven session intervention delivered within parent, youth and family sessions using narrated videos that portray typical youth and parent situations. Sessions are highly interactive and include role-playing, discussion and projects designed to improve parenting skills, build life skills in youth and strengthen family bonds. A rigorous longitudinal analysis has shown that for every nine youth who received the program, one fewer (than usual) reported ever using alcohol four years later.[8]

[iv] CSAP's lists of evidence-based programs, include categories of promising, effective and model programs. Note that, in order to be considered a "model" program, developers must agree to provide quality materials, training, and technical assistance for nationwide implementation.

[v] All model programs listed in NREPP are web-accessible and this registry is searchable by age groups and / or particular types of interventions.


Youth Leadership Program
Youth create substance policy groups in schools
Youth Avocates of the County
Parents & Youth
PTO
Business Community
YMCA
Faith Council
Youth Art Initiative
Safe places and enrichment for youth
Rotary
Civic, Grassroots, Religious & Youth-Serving Organizations
Arts Unlimited of County
Overdose Prevention Program
Health Center
Decrease in overdose admissions
County Hospital
Health & Social Services & Medical Providers
Mental Health Agency
Other Local Prevention & Health Promotion Coalitions
Though led by one or two sectors, the whole coalition plans and supports program & strategy implementation
Sample Coalition For Prevention & Health Promotion Board/Steering Committee and Staff and Volunteers
Media
Local Government
Law Enforcement
Reconnecting Youth Program
Decrease in drug use and agression for participants
City Schools
Schools
SAD # A
A Coalition is Like a Tree:
Basic Structure with Sample Programs
State Grants
Direct Federal Grants
Foundation Grants
Donations
Town Appropriations
In-Kind Donations

Sustainability for Coalition-developed Programs: The River Valley Healthy Communities Coalition (RVHCC) coordinated a free day camp as part of their Communities for Children initiative. Beginning in 1999 RVHCC ran a summer day camp program for children ages 5-12 at the Town of Mexico Recreational Park. No camper fees were charged; and modest grants and community donations covered the costs of a part-time camp director, materials, and refreshments. Adult volunteers assisted the director and older children were encouraged to volunteer as assistant counselors.

At the same time another day camp program, sponsored through the Greater Rumford Community Center (GRCC), had been in operation since 1978. The GRCC day camp used the ski lodge for indoor activities on rainy days and through a cooperative agreement with School District #43, it provided bus transportation for its campers. Swimming instruction and recreation swimming were available to campers in Black Mountain's swimming pool. Even with all of these features, at $60 per week, the camp had steadily lost campers. In 2002 it enrolled only 45 children.

In contrast, although the Mexico Recreation Park day camp was centrally located and had ball fields, tennis courts, playground equipment, picnic tables, restrooms and a large covered stage, it was short on resources: no transportation, nor swimming pool, no shelter for rainy days. Nonetheless, by the summer of 2002, the RVHCC day camp served nearly 100 children.

In a series of planning and evaluation meetings that began in the fall of 2002, RVHCC and GRCC staffs came to recognize the mutual benefits of their bringing the two day camp programs together: heightened profile in the community, more efficient management, and, even more important, greater benefits to the children of the River Valley region. In early March of 2003, the boards of the two organizations approved the merger and preliminary work plan for the Summer Day Camp 2003.

The merger was expected to increase the number of area children participating in summer day camp, enhance the camping experience for all, but especially for those previously served by the RVHCC camp. The role of the Coalition would be to provide technical assistance to a day camp program fully "owned and operated" by the Community Center. In addition, the RVHCC would seek funding from grants and community support to provide "Camperships" to those children whose families could not afford the weekly fee.

The joint plan produced a well-structured day camp program. Together the Coalition and the Rumford Community Center created a sustainable summer alternative that is still operating in 2006.

Sampling, continued

Brief Strategic Family Therapy (BSFT) is a short-term, problem focused therapeutic intervention targeting children and adolescents 6 to 17 years old. Delivered in 8 to 12 weekly 1 to 1.5 hour session by a trained therapist, BSFT changes family members' behaviors that are linked to both risk and protective factors related to substance abuse. BSFT has demonstrated decreases in substance use (75% reduction in marijuana use) as well as reductions in negative behaviors (58% reduction in association with antisocial peers; 42% reduction in conduct problems.[10]

The prevention programs a coalition can provide are limited only by the way a coalition balances needs, existing capacity, available champions or sponsors and the resources (funding) that can be obtained. The programs and services provided by the UGS Study coalitions covered the spectrum from health and education to the physical environment and substance abuse prevention. Because the programs were coalition efforts and based on comprehensive needs assessments, many served multiple functions, with expected outcomes in several program areas. A description of a program conducted by Youth Promise of Lincoln County appears on the next page.

Evaluating sponsored programs and services (Step #5) has also taken on more importance over the past decade. Pressure to evaluate has come from many quarters. Externally, accountability demands from funding sources have increased as they seek credible evidence to document the impacts of the dollars they spend. Internally, a desire by coalitions for formative feedback to improve program quality can lead to more emphasis on evaluation, as can an understandable wish to document outcomes that help acquire further funding.

As mentioned previously, the steps in the SPF, although listed sequentially, are anything but linear. An evaluation provides the most useful and usable information when the evaluator works with program developers from the beginning. Together they describe the program "logic" that links program components to measurable objectives and formulate the questions the evaluation is to answer.

Adapting a Model - Youth Promise's Mentor Assisted Community Service Program: Youth Promise of Lincoln County began The Mentor Assisted Community Service (MACS) Program in 1997 to fill a need for alternatives to sentencing in the juvenile justice system. Based on the very successful Blue Print program, Big Brothers/Big Sisters, the MACS Program provides juvenile offenders and their families with a timely, structured and meaningful community service experience.

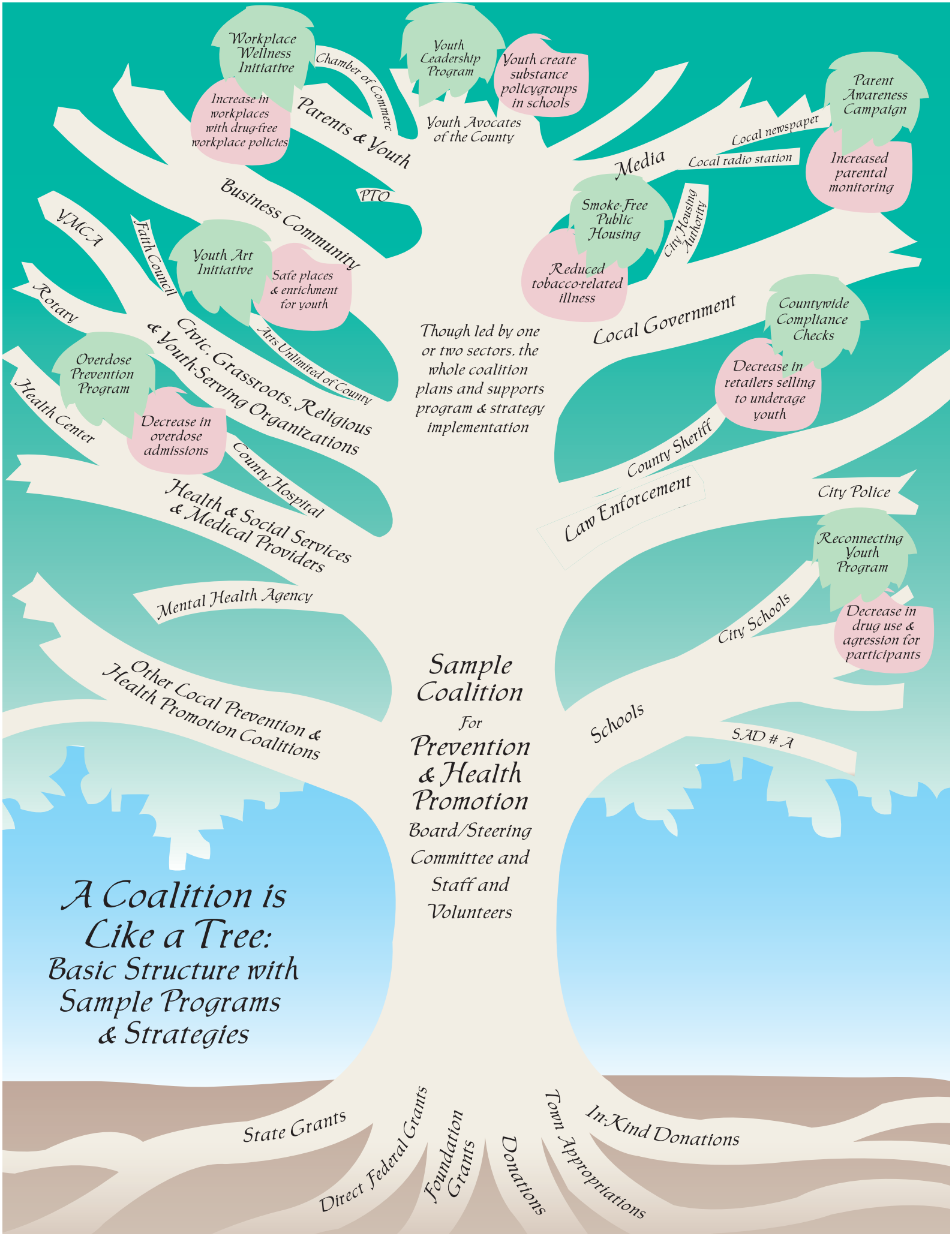
Mentored work sites include Miles Hospital, the Alna Town Office, the Boothbay Railroad Museum, the Nobleboro and Waldoboro Transfer stations, Safe Haven Farm, the local police departments, St. Andrews Village(assisted living) and others. The mentors are employees from the sites who volunteer and are trained to work with the youth. They are mostly parents and grandparents who care about youth and, though they are kind and accepting, they hold youth accountable for their tasks. The mentors work with the youth during their assigned hours. In addition to providing supervision, mentors model appropriate behaviors and help to change perceptions and improve attitudes, life and work skills.

Having a variety of sites allows the director of the program to carefully match each youth with a site that can facilitate his or her experience of giving back and reconnecting to the community. In 2005, 77 youth performed 2,991 hours of community service, along with 6,407 mentor hours and indirect service hours, for a total dollar value of $69,368 to communities. Today, the MACS Program has seventy-five mentored community work sites where youth do their community service. Some youth have been hired at their work sites over the years. For example, this past year Waldoboro hired one of the MACS youth to work at the Transfer station. Fifteen youth will be placed at the week-long Miles Rummage Sale this year. Last year all the youth completed their service mid-week and finished the week as volunteers.

In 2005, 90% of the MACS youth increased their scores on the Nowicki, a social skills survey instrument, and decreased their scores on the Beck Depression Scale. The average recidivism rate for youthful offenders in Maine is 34%; MACS program participants re-offend at a rate of 4%. This program works.

Several years after MACS was up and running, Youth Promise initiated an offshoot of the program. The new program works with youth who have been suspended or are at risk of expulsion from school. Students are offered the chance to come back to their classes when they have completed half their suspension hours and make up the time missed by becoming part of the MACS-SAYS (Mentor Assisted Community Service-School Alternative to Youth Suspension) Program, which operates after school and offers one hour of study time, 2.5 hours of community service in the school, and a half hour of rap time to talk about issues and needs. The school is noticing distinct differences in how the students in the program act around the school after completing the program.

Most evaluation questions fall into two fundamental categories, process and outcome. Process evaluation addresses the general question "What is the extent to which we have implemented the program as intended?" This includes determining if the number of sessions and their duration matched the plan, if the curriculum was followed with fidelity and if the intended number and type of participants were reached. Outcome evaluation addresses the general question "Did the program produce the changes it was designed to produce in the participants"? This may include changes in risk and protective factors (e.g., Did perception of the risk of using marijuana increase? Did school bonding increase?), as well as targeted longer term behavior change (e.g., Did the actual use of marijuana decrease?). Once answered with the appropriate design and data analyses, these questions lead to further decisions about whether a program should be retained and refined or eliminated? And thus the cycle of program and service development and integration moves on to another turn.


Workplace Wellness Initiative
Chamber of Commerce
Increase in workplaces with drug-free workplace policies
Parents & Youth
Youth Leadership Program
Youth create substance policygroups in schools
Youth Avocates of the County
Business Community
PTO
YMCA
Faith Council
Rotary
Youth Art Initiative
Safe places & enrichment for youth
Arts Unlimited of County
Civic, Grassroots, Religious & Youth-Serving Organizations
Overdose Prevention Program
Health Center
Decrease in overdose admissions
County Hospital
Health & Social Services & Medical Providers
Mental Health Agency
Other Local Prevention & Health Promotion Coalitions
Media
Local newspaper
Local radio station
Parent Awareness Campaign
Increased parental monitoring
Smoke-Free Public Housing
City Housing Authority
Reduced tobacco-related illness
Though led by one or two sectors, the whole coalition plans and supports program & strategy implementation
Local Government
Countywide Compliance Checks
Decrease in retailers selling to underage youth
County Sheriff
Law Enforcement
City Police
Reconnecting Youth Program
City Schools
Decrease in drug use & agression for participants
Schools
SAD # A
Sample Coalition For Prevention & Health Promotion Board/Steering Committee and Staff and Volunteers
A Coalition is Like a Tree: Basic Structure with Sample Programs & Strategies
State Grants
Direct Federal Grants
Foundation Grants
Donations
Town Appropriations
In-Kind Donations

What Coalitions Can Do: Community-level/ environmental Strategies

5

Figure 5 shows the complete coalition tree with a sampling of community-level/ environmental strategies, and expected outcomes, added to the programs shown in Figure 4.

Comprehensive community interventions combine individual and environmental change strategies across multiple settings. For example, an intervention for tobacco control might combine a school curriculum for youth to prevent initiation of smoking and a media campaign aimed at reducing parental smoking in the presence of youth (individual change strategies) with policy change efforts advocating a municipal smoking ban for restaurants and increased enforcement of ordinances prohibiting youth access to tobacco (environmental strategies).[11]

Community-level or environmental strategies represent a new theoretical perspective on prevention and health promotion. This perspective sees behavior as embedded within and influenced by the context and conditions of the community. Individuals are seen as being influenced by factors in their environment such as the rules established by the social institutions that they are part of, media messages they are exposed to and the cost and availability of alcohol, tobacco or other drugs. Community-level strategies thus seek to directly change these aspects of the community environment which will then impact the community population. Coalitions, as representative and authoritative bodies, are often the most appropriate vehicle to sponsor community-level strategies. Whether used alone or in combination with programs to form a "comprehensive community initiative", community-level strategies have been accumulating evidence and gaining prominence. This chapter uses the illustrative capacities for community-level strategies shown as bullets in Table 1 to describe this flourishing new branch of community prevention and health promotion.

Profiling needs, resources and readiness (Step #1) for community-level interventions involves a coalition taking a careful look at the community environment. Coalitions may gather data about availability (e.g., How easily can our young people get alcohol?), norms (e.g., How tolerant is the community of intoxication?) policy (e.g., Is alcohol server training mandated by law?) and enforcement (e.g., How likely is it that drunk drivers get caught?). Methods range from the formal and quantitative (e.g., "compliance checks" by police to see if retail outlets sell alcohol to underage patrons), to the informal and qualitative (e.g., observing and mapping drug sale "hot spots" in a neighborhood). As with programs and services, data are used to prioritize targets. As might be expected, assessing

Communities Mobilizing for Change on Alcohol (CMCA) is a community-organizing program designed to reduce adolescent access to alcohol. It employs a range of media, policy and enforcement strategies to reduce illegal alcohol sales to youth and by obstructing the provision of alcohol to youth by adults. In a randomized control trial of 15 communities, intervention communities experienced a 17 percent increase in the proportion of bars and restaurants checking age identification and a 24 percent decrease in the proportion selling to buyers who appear underage. Youth aged 18 to 20 in intervention communities reported they were less likely to try to buy alcohol, drink in a bar, or consume alcohol, and there was a 17 percent decline in the practice of providing alcohol to younger teenagers.[12]

Prevention of Alcohol Trauma: A Community Trial was implemented over five years in two communities in California and one in South Carolina, each with a matched comparison community. The intervention had multiple components: community mobilization, training bar staff, increasing responsible beverage service practices and increasing enforcement of local Driving While Intoxicated laws. There was a significant reduction in alcohol sales to minors in experimental communities (off-premise outlets in these communities were half as likely to sell alcohol to minors as in comparison communities) and significant reductions in alcohol-involved traffic crashes. [13]

norms and political will is extraordinarily important in promoting community level change (e.g., How will the hospitality industry in our town respond to an attempt to prohibit "happy hours"?)

Building capacity for community-level strategies (Step #2) is both exciting and challenging. While community-level strategies are scientifically sound, they haven't been developed into standardized products to the degree that school curricula have. Additionally, while many prevention practitioners have training relevant to programs and services, far fewer have skill sets such as social marketing or strategic policy planning. This means that considerable training and technical assistance is called for in developing a common knowledge and skill base among coalition members for these initiatives. Fortunately, a variety of training and technical assistance opportunities incorporating community-level/environmental strategies have recently been developed by governmental and non-profit organizations alike (see resource page at the end of this booklet).

Planning for community-level interventions (Step #3) has advanced significantly in the past several years. Several exemplars of planning processes for community-level strategies now exist, especially in content areas such as Tobacco Control efforts sponsored by the Centers for Disease Control and Prevention (CDC), the Enforcing the Underage Drinking Laws Program (EUDL) of the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the Drug Free Communities (DFC) program of the Office of National Drug Control Policy (ONDCP). These initiatives have devoted considerable resources to assist coalitions in carefully planning and implementing community-level strategies. For example, CDC has published Best Practices for Comprehensive To bacco Control, which contains planning instructions for initiatives such as a smoke-free ordinance campaign.

Implementation of community-level strategies (Step #4) is often more complex and fluid than the implementation of a curriculum. When promoting a policy change the coalition must be nimble. A planned sequence of actions to promote a policy change might need to be rethought due to dynamic changes in community conditions or events. A coalition may also play different roles in different initiatives. One case study of coalition roles in policy change[14] described a developer role, a facilitator role and an arbitrator role. When in the developer role the coalition generates the idea for a policy change and advocates for it with the community and decision makers (e.g., the coalition sponsors a ban on alcohol in county parks as a new policy, advocates and convinces the town council to adopt the policy and works with the recreation department on implementation).

In a facilitator role, the coalition responds to a community member's request (e.g., the coalition mobilizes support for a "Boating Under the Influence" ordinance at the request of parents who lost a child in a related tragedy). Here the coalition has authority to act because of its standing as the community "voice" for alcohol and drug issues. In fact being perceived as apolitical can occasionally put the coalition in the third kind of role, that of arbitrator between two conflicting community interests (e.g., local merchants and residents disagree on the appropriate scope of alcohol advertising and sales at community celebrations and seek the expertise of the coalition in formulating a compromise).

Of course the implementation work of a coalition isn't complete once a policy has been adopted. Enforcement of new or existing policies is an important component in the effectiveness of regulations or other policies. Therefore a coalition often finds itself advocating for increased enforcement strategies such as underage compliance checks in retail outlets. Such monitoring has the dual aim of increasing vendor compliance with appropriate identification checking procedures as well as deterring underage attempts to purchase alcohol or tobacco.

Finally, if community-level strategies themselves are a developing area in prevention and health promotion, then **evaluation** of such efforts (Step #5) can at best be called emerging. In fact, a publication released in October 2005 by the California Endowment entitled The Challenge of Assessing Policy and Advocacy Activities states that…"this is the first report to attempt to think comprehensively about the steps needed in an approach to prospective policy change evaluation[15]". The authors cogently describe how evaluation of community-level/environmental strategies differs from traditional evaluation models. Primarily these differences revolve around the fluid and dynamic nature of these efforts. The authors note that evaluation designs of these initiatives must be based on an articulated "theory of change" that is flexible enough to accommodate the changing nature of the interaction among community environment and coalition strategies. Stressed also is the necessity for documenting changes in "the policy environment" (e.g., increased awareness of an issue among residents, increased coverage in local newspapers) as milestones along the way to actual policy change.

Three "stories" from the UGS study coalitions provide examples of implementing community-level or environmental strategies in Maine.

In a research study that directly tested the effects of adding a community level intervention to a school based program, eight matched pairs of small Oregon communities were randomly assigned to receive either a school based prevention program alone or a school based program plus a community program. The community program included components of a) media advocacy for publicizing the tobacco problem; b) youth anti-tobacco activities; c) a family communication module designed to promote no use messages from parents and d) activities to reduce youth access to tobacco. Smoking prevalence in communities with the comprehensive program was significantly lower than comparison communities after one year of intervention and one year after the intervention had ended. [15]

Strategies for Preventing Youth Substance Abuse: In 2002, **Healthy Androscoggin** identified youth substance use as a growing concern in our communities and, with grant funding from the One ME Project, adopted the evidence-based Communities for Mobilizing for Change on Alcohol (CMCA) program. We invited community partners (including schools, parents, health care providers, substance abuse treatment providers, businesses, and law enforcement) to engage in a planning process, identify risks and protective factors for youth substance use, and develop strategies to address them. We organized a first-time offender diversion program that focuses on alcohol, tobacco, and marijuana. The program provides a positive opportunity for youth to rethink their decision to use substances and reinforce the risk of use in lieu of suspension from school and/or a court hearing. Healthy Androscoggin also organized merchant education and server/seller trainings and conducted a number of media awareness campaigns about substance use, including a social marketing campaign designed to increase awareness of the consequences of providing alcohol to minors or a place for them to use. The first lady of Maine, Mrs. Karen Baldacci, is our spokesperson for this campaign. Healthy Androscoggin also brought three local police departments together and, for the first time ever, created an Alcohol Enforcement Team. The team follows up leads on teen parties and provides surveillance of common places that teens gather (e.g., sand pits). Team patrols began in November 2004 and our law enforcement liaisons feel that they have had a positive impact on our youths' perception of getting caught by police if they drink alcohol. This work has also led to the first documented agreement of mutual aid for party dispersal between the three police departments.

Smoke-Free Housing Policies in Androscoggin County, ME: **Healthy Androscoggin** started receiving phone calls from public and private housing tenants, as well as landlords, in 2001. The messages were similar: "I or my family members have asthma, COPD, emphysema, etc.; my neighbor smokes and it is exacerbating my disease." We did not have any answers. So we did our research, contacting partners around the state, and discovered that no one in Maine was addressing the issue of secondhand smoke exposure in multi-unit housing. We took this to our policy committee and decided to approach our two local housing authorities and ask them about their perspectives on the issue. Both Lewiston and Auburn Housing Authorities said they had received numerous complaints but were not sure how to proceed. So in January 2002, we conducted a survey of 850 housing authority tenants in Lewiston and Auburn. Almost half the surveys were returned and, though 17.6 percent of respondents lived with smokers, 76.4 percent of tenants said they would choose to live in a smoke-free complex, 48.2 percent said cigarette smoke from other units bothered them, and nearly half wanted information on smoke-free environments. Given these staggering results, that over three-quarters of tenants would choose to live in a smoke-free complex and that a majority of landlords did not know that smoke-free policies are legal, we identified a large gap. Through a multi-step process, which includes grandfathering in existing tenants who smoke, the Auburn Public Housing Authority has developed a policy that will eventually allow all tenants to live free of second-hand smoke, thereby becoming the third housing authority in the nation to become smoke-free. In 2006, Lewiston Housing Authority also adopted a policy to become tobacco free.

Creating Community-wide strategies – Tobacco Free Franklin Families: The **Healthy Community Coalition (HCC)** in Farmington has a history of fighting tobacco use in the community, with impressive results. Franklin County has the lowest adult smoking rate in the state, despite one of the lowest median incomes, and boasts numerous "firsts" in policies restricting tobacco. Despite successes, in the late 1990s HCC became alarmed by data suggesting the prevalence of tobacco use by pregnant women was nearly twice that of the larger adult population. Some rushed to condemn these women for their unhealthy behaviors, but HCC as a whole took another approach: explore the problem to understand better why it was happening and what we could do if we worked together. Focus groups and further research made clear that tobacco use during pregnancy was strongly correlated to poverty; more than 95% of the women who reported smoking throughout their pregnancy were MaineCare recipients. Tobacco use is generally linked to income level but the correlation for pregnant women was far more dramatic. Evidence suggests that poverty compounds stressors and tobacco superficially alleviates them. No matter how much she knows about the importance of a tobacco-free pregnancy, a woman who cannot pay her rent or buy groceries has difficulty finding the will to focus on tobacco cessation.

Recognizing that condemning pregnant women only contributes to stress and further isolates women without influencing their willingness to quit, HCC launched the Tobacco Free Franklin Families (TFFF) initiative to support low income pregnant women and parents of children aged 0-5 in addressing the challenges of new parenthood and becoming tobacco free. HCC identified the many organizations, individuals, and agencies that touched the lives of these women – from obstetrics physicians to Head Start to day cares – and recruited the organizations to become a part of TFFF. With funding from the American Legacy Foundation, HCC trained organizations on techniques for talking with women about tobacco use. TFFF also offered stress management workshops and trained community members to conduct them. An epidemiologist studied TFFF impact by interviewing all parents of children age 3-6 months during the spring of 2004 and again in the spring of 2005. Parents reported an average of three separate encounters with agency representatives discussing tobacco use, and overall there was a 20% decline in tobacco use over the one year period.

What Coalitions Can Do: Community Capacity Building

Community capacity building is the most inclusive of coalition functions. Community capacity building initiatives are intended to convene, mobilize and coordinate a community's overall ability to take collective action around a wider swath of community life (e.g., health, housing, job training). Many of our study coalitions, for example, were "healthy community coalitions" that work to build community capacity as an outcome itself. This outcome, increased community capacity, enables a robust response to multiple strategic health priorities that arise over time. This chapter reviews actions for community capacity building (bullets in Table 1) and illustrates them with exemplars from our study coalitions.

Profiling needs, resources and readiness (Step #1) for community capacity building may take place across three levels of social agency within the community: individuals, organizations and organizational networks. Assessment of needs, resources and readiness may be done from either a "consumer" or from a "diagnostic" approach. In a consumer approach, participants are directly asked what they need (e.g., What kind of leadership training seminars would you most like to see?"). In a diagnostic approach, data from a developed instrument is used to identify where capacity building is most needed. For example, the degree of collaboration in a community's organizational network can be measured through network surveys of key respondents in community organizations. Data from consumer and diagnostic methods are used to prioritize targets for community capacity building.

Building capacity for community capacity building (Step #2) is similar to the concept of "training of trainers" in curricular programs. That is, many of the strategies for community capacity building involve training and technical assistance interventions. For example, a coalition may develop or compile a set of data indicators about community health, but the data becomes more helpful to

Examples from Other States

A County Perspective (CLCP) is a statewide training program of the Georgia cooperative extension service that trains local community leaders. It is a 72-hour, 12 week program divided into three units: individual values and leadership overview, participatory leadership skills, such as group management and problem-solving skills, and applied leadership skills, where the community development process is used to address a problem in the participants' community. Pretest and posttest data was gathered in 8 participating counties randomly chosen from a group of 15 counties who had applied for the program. The training significantly increased participants (N=281) confidence in the areas of promoting causes, motivating people, making informed decisions on local issues and working with local leaders, while the control group made no such gains.[17]

The Urban Institute's National Neighborhood Indicators Partnership (NNIP) includes 12 municipal partner sites around the country. The municipal partners have each built information systems on neighborhood conditions in their cities. The partners facilitate the "direct and practical" use of data by city and community leaders for community capacity building. Stories have been gathered from around the country illustrating applications of neighborhood indicators. The applications ranged from launching new initiatives based upon indicators (e.g., starting a comprehensive teen parenting program in Oakland, CA) to developing new approaches to existing issues (e.g., reforming the handling of tax-delinquent properties in Providence, RI). Overall, these stories weave a rich tapestry of the myriad uses of this new information resource to train emerging community leaders and develop initiatives for policy change. [18]

consumers with training and technical assistance provided by the coalition on how to best use it.

Designing, developing and delivering quality training and technical assistance requires a complex set of skills that involves more than content knowledge, as anyone who has ever experienced an "expert" who is a poor teacher knows. Thus a coalition engaged in community capacity building must identify a cadre of personnel with such skills among their members or within the community and engage their services. Alternatively, a coalition can broker a relationship between external consultants or provider organizations.

Planning for community capacity building (Step #3) has been enhanced by the availability of national, state and regional training and technical assistance devoted to community capacity building which provide models and frameworks. For example, for the last twenty years, the "healthy communities" movement has been disseminated to hundreds of communities across the country who address community-based health and quality of life initiatives targeted to local foci identified by local coalitions. In fact, there is a Maine Network of Healthy Communities that connects Maine communities with coalitions based upon the notion that "…well-informed people, working together in an effective process, can make a profound difference in the health and quality of people's lives."

Internet technology has also been a boon to providing capacity building guidance. For example, the Community Toolbox established by the Work Group on Health Promotion and Community Development at the University of Kansas provides "one stop shopping" for community-building guidance and assistance.. The Community Toolbox provides over 6,000 pages of skill-building resources that can be accessed through several inter-related gateways such as "learn a skill", "plan the work", "solve a problem", "explore best processes and practices" and "connect with others".

Implementation of community capacity building (Step #4) is organized around putting some combination of strategies into place for the community. These capacity building strategies include: i) expanding the community information base: the systematic provision of data and information for use by community organizations; ii) cultivating leadership: programs to enhance the knowledge and skills of community residents that will enable them to take leadership roles in community initiatives; iii) organizational development: the provision of systematic training and technical assistance to enhance organizational competence and effectiveness; iv) strengthening inter-organizational linkages: creating networks that will allow a community to respond in a more effective and efficient manner and v) facilitating the community becoming a "learning organization": promoting the continuous assessment of conditions and refinement of practice through data-based decision making and strategic planning processes.

Evaluating community capacity building strategies (Step #5) distinguishes among three kinds of evaluation, each with different foci. Some evaluations focus on leadership skills acquired, organizational capacities built, networks established and processes adopted (capacity assessment). Some evaluations measure organizational or community level of activity pre and post capacity build-

ing (performance measurement). Still other evaluations link performance to consequences for the people and the institutions of the community (outcome evaluation).

In Chapter 3 we saw that coalitions that emphasized community capacity building were often structured differently from those that emphasized other functions. The major difference was that these coalitions have more indirect or secondary relationships with at least some of the community sectors in the community wheel. They are often smaller groups because they can depend on their members (often coalitions or large community organizations) to bring the needs and interests of their own constituencies to the table.

It is important to note that coalitions that are comprised of other coalitions cannot substitute for their participating coalitions any more than the United Way can replace United Way agencies. To avoid duplication, then, these coalitions must find and perform just those functions that can benefit their participants and explicitly focus on removing rather than adding duplicative layers.

Whether community capacity building coalitions are federations of coalitions with similar missions and non-overlapping territories or collaboratives composed of coalitions and organizations with overlapping missions and boundaries, the capacities they need are fundamentally the same. And the overarching capacity required is flexibility.

Three of the following descriptions of community capacity building – PATCH, Community Wellness Coalition (CWC) and Healthy Hancock – come from the UGS study coalitions. The fourth description comes from a collaborative that was not studied but which emerged during the time the study was in progress. It is included here because it is a county-level entity in a complex urban/suburban context and because CWC is one of its members.

The Nebraska Department of Economic Development (DED) and the University of Nebraska at Omaha's (UNO) Center for Applied Urban Research provide an exemplar of community strategic planning. The program, Strategic Training and Resources Targeting (S.T.A.R.T.) was designed primarily for communities with populations between 2,500 and 10,000 wishing to engage in economic development, but was later altered to include large communities. Over the course of nearly ten years, the organizations jointly changed what started as a consultative-based approach into a largely self-help approach. Through the use of technological innovations (e.g., an introductory videotape to help assess community readiness; a software program containing the beginnings of a local data base) and a social innovation (e.g., the Governor unveils the finalized action plan at a formal town hall meeting), the program has increased the number of communities served, enhanced the self-help structure of the program and fostered community ownership. [19]

Greater Waterville PATCH - a Process for Building Community Capacity: In 1987 a core group of volunteers, with the sponsorship of the Maine Bureau of Health (now the Maine CDC) and guided by a Centers for Disease Control process called Planned Approach to Community Health (PATCH), convened in Waterville. After 18 months of assessment and planning the Greater Waterville PATCH Community Health Board emerged with a set of community health priorities. Greater Waterville PATCH was incorporated as a non-profit (501c3) entity two years later, in 1989.

The Board of Directors of PATCH is compromised of volunteer representatives from area healthcare organizations, social services organizations, churches, civic organizations, schools, businesses and individuals with a common interest in community, physical, mental and spiritual health. PATCH completes an annual health and human needs assessment. At the annual retreat, attended by Board members and other interested parties, the assessment information is analyzed to identify priority health issues that will be addressed in the coming year. Coalitions or workgroups are formed in the community to address these priority health issues.

PATCH has never been seen as just a program, an agency, or a coalition. It has instead created "space" in a community for people to come together and examine collectively what's good, and what more needs to be done to improve the health of the community. PATCH has always discussed openly the importance of avoiding duplication of effort; rather than engaging in program or service delivery, PATCH identifies the community organizations and individuals who are best suited to address identified needs directly, while it continues to be a fiscal sponsor for grants that are designed to meet the identified priorities.

The accomplishments of PATCH are due to the combined efforts of the many individuals that have made a commitment to the PATCH process. To quote one Board member; "Our product is collaboration." With this philosophy, PATCH has become a community group that provides capacity building. The needs of the community are the priority, and the members of PATCH and their respective organizations strive to best meet those needs.

Supporting Community Solutions - Community Wellness Coalition: The Community Wellness Coalition (CWC) began in the mid-nineties. Three women put their heads together when they couldn't find the resources they needed for positive child, youth and family and community development in Southern York County. It became clear to them that a community coalition could help achieve collaborative solutions and then CWC evolved.

Community support organizations like CWC tend to have two primary functions:

1. visioning, planning, and measuring progress through the use of community outcomes and indicators (not program performance measures);
2. responding to community needs and opportunities as they arise, brokering responses to the appropriate community sectors (singly or collaboratively), and creatively addressing any issues for which there is not an appropriate organization or topical coalition "home." If a CSO starts a project, it doesn't hold onto that project, but tries to set it up as an independent entity or find an appropriate community organization to adopt it.

These functions are illustrated by CWC's early community organizing work. In May 1997, CWC convened its Steering Committee members (individuals and organizational representatives) and other community leaders and concerned citizens to meet with an organizational development professional and explore holding a three-day Future Search Conference. The Future Search was held in October 1997, with 62 community leaders (ranging from high school students to town managers, from church members to the hospital president) participating. The focus was "the well-being of the people of the KEYS region (Kittery, Eliot, York and South Berwick)" and the purpose was to vision and plan. At the conference, 10 workgroups self-organized. CWC followed up and supported the energy of the workgroups, writing grants to provide resources for the work and managing grants for the workgroups when necessary. Those work groups have produced most of the accomplishments of CWC, including an Arts & Heritage directory, the Senior Leadership Coalition, the Mental Health Task Force, the Landmark Hill Community Resource Center (10 co-located health and human service organizations), the Family Resource Center at Landmark Hill, and two community needs and resources assessments. Even CWC's work of starting the area's four Communities for Children & Youth Councils, the Healthy Community Coalition projects, the Healthy Maine Partnership, and the One ME Coalition came from that broad community visioning, because those state-funded initiatives were built on the foundation laid by the Future Search work groups.

An Emerging Organization - the York County Prevention Collaborative: Although not part of the UGS study, another relatively new organization in York County illustrates both goals of a county-level community capacity building organization in an area that contains many overlapping organizations, and collaboration methods that can reduce duplication and extend scare resources.

The York County Prevention Collaborative (YCPC) is a council of 17 organizations that have worked together since 2002. Its mission is to connect and support initiatives that focus on the prevention of violence and abuse and the promotion of health and well-being. YCPC includes three hospitals/primary and emergency care facilities, two universities, the Department of Corrections and United Way of York County, as well as a variety of prevention, social services, abuse prevention and other community organizations, including the Community Wellness Coalition, which focuses on southern York County. Member organizations have strong relationships with local school districts and law enforcement as well as the health and social services sectors.

YCPC's goals include becoming a forum for all the county's coalitions that serve children and families and including all sectors and all parts of the county, creating new ways to work together and assist member coalitions by helping them increase their efficiency and effectiveness. In addition, YCPC is working on developing methods for pooling resources (sharing needs assessment and results data and other information; sharing grant writers, work and meeting space and equipment; and possibly pooling funding) for participants. The YCPC Coordinating Council meets monthly and has developed working subcommittees focused on three areas: data collection; building internal and external communication systems; and developing the infrastructure of the YCPC. In 2006 YCPC received an SPF-SIG strategic planning grant, for which it selected a member organization, Day One, Inc., as fiscal agent. The grant will allow YCPC to continue building its capacity to provide community support while it creates a unified substance abuse strategic plan.

A Federation of Coalitions - Healthy Hancock: Healthy Hancock began when PATCH programs at several Hancock County hospitals began collaborating on health-promotion activities. The partnering organizations knew that by working together they could expand the reach and impact of programs, while bringing a broader range of expertise and resources to bear on initiatives in their local service area communities. By the late '90s several other groups had joined the county-wide collaborative, including two healthy community coalitions representing separate parts of the county and the regional planning commission.

When the Healthy Maine Partnerships RFP was issued, the partnering organizations and coalitions knew that by working together they could accomplish more. They incorporated language formalizing the "Hancock County Coalition for Community Health" (Healthy Hancock) into their applications. Their powerful vision provided a foundation for the next six years of collaborative public health planning, research, advocacy and programming. By 2001, three HMP grants had been awarded, and the partnership directors and school health coordinators joined the Healthy Hancock team.

Healthy Hancock is a federation of coalitions and other organizations, representing all of geographic regions of Hancock County and integrating expertise and focus on different public health-related functions such as planning and community health education. Members meet bi-monthly, communicate regularly, and often join forces on projects that will benefit and enhance local efforts. One partner organization agrees to serve as the lead agency for a project, but funds are shared among the coalitions and organizations that will implement the project in their local service areas.

Other Healthy Hancock efforts include the Hancock County Food Pantry Network, a forum for directors and volunteers at the 10 food pantries across the county. In the nearly three years since Healthy Hancock convened the HCFP Network, member have: advocated for and secured an additional 40,000 lbs of food for Hancock County's emergency food system; collaborated to improve local food distribution systems; and worked together to educate themselves on a range of issues. Healthy Hancock not only convenes the network, but also helps the member pantries conduct assessments and implement countywide programs such as "Plant-A-Row for the Hungry."

Healthy Hancock would not exist without the grassroots, community-based coalitions and organizations that form its core. These local coalitions undertake numerous initiatives that are unique to their service areas. Whenever broader collaboration will enhance local efforts, Healthy Hancock offers an ongoing venue for coalitions and organizations to network, share information and expertise, leverage resources, and collaborate on a broad range of efforts.

Learnings and Implications

7

Maine's prevention system is currently undergoing substantial change. The findings of the Unified Governance Structure (UGS) study can help to guide the response of local coalitions and their state sponsors in a variety of ways as they work to transform the way Maine undertakes prevention and health promotion. This chapter presents the major lessons learned from the study and draws implications for both local coalitions and state level programs.

Lessons Learned:

- Coalition capacities can be classified according to their general functions or purposes. The Coalition Functions Matrix (Table 1) describes these functions:
  - Coalition maintenance
  - Program and service development and integration
  - Community-level/environmental strategies
  - Community capacity building
- Depending on what function a coalition is implementing, there are different capacities necessary at each stage of the Strategic Prevention Framework (or any strategic planning steps that are similar to this relatively generic framework).
- While much of the existing literature on coalitions focuses on coalition maintenance, many funders have begun to describe coalition work in terms of expected outcomes related to the other three coalition functions. Research literature is currently accumulating around such functions as program development, implementation of community-level/environmental strategies and community capacity building.
- The coalitions that participated in the UGS study all carry out all of the coalition functions but with different degrees of emphasis, ranging from a predominant focus on programs to a predominant focus on community capacity building.
- Form follows function. That is, coalition structure (who participates and how they are organized) is related to the functions emphasized.
- Context is a vital ingredient:
  - The functions that coalitions emphasize are a result of local context, including their histories and the configuration of other organizations in their communities. The study coalitions confirmed this.

- The geographic and economic characteristics of a coalition catchment area are also an important element of its context.

- Funders' priorities influence local structure, according to all the UGS study coalitions. Having multiple funding streams can help coalitions to balance the needs of external funders with local needs, identified through local needs and resources assessment.
- When coalitions move to the stage of working with multiple funding streams, however, the business aspects of managing their activities (budget management; reporting; personnel management; etc) take an increasing amount of time. Study coalitions estimated these activities took 25% of coalition leader time. This aspect of coalition maintenance grows with coalition growth; however, the necessity to continue to work on all the other aspects of coalition maintenance (participation; training; networking, etc.) does not go away. Finding resources and skills for business/management is one of the most difficult issues coalitions face.
- It is not necessary for a single coalition to place equal emphasis or even perform all the functions in the Coalition Functions Matrix, although coalition maintenance is needed for all. Multiple coalitions operating in the same general area can share the load and focus on different functions. What is important is that all the functions are covered, either through coalition work or through other community-based organizations, in any given geographic area and that they are coordinated.
- There are two kinds of sustainability.
    - Sustaining the coalition, so that it can continue its efforts (part of the coalition maintenance function, an internal function)
    - Sustaining the programs, services and strategies (the external functions). This often in volves finding partners in the community to adopt and institutionalize programs and strategies
    - Each type of sustainability requires different capacities and different partners.
- Coalitions with a major focus on community capacity building (supporting citizens and organizations within the community) tend to be structured differently. For them, many community sectors may be represented indirectly, through other organizations, often through other participating coalitions. For example, a coalition that has extensive participation from local schools may participate as a member of a local capacity building coalition, thus bringing the school sector to the table indirectly.
- There is no substitute, however, for representation of the community organizations in the community wheel. A coalition that is comprised of other coalitions or organizations is building on the grassroots efforts of its participating organizations and individuals and cannot act as a substitute for them.
- The structure of coalitions that focus on community capacity building is also influenced by the geographic configuration and purposes of the organizations they support. An organization like Healthy Hancock is a federation of independent coalitions with non-overlapping boundaries. An organization like the Community Wellness Coalition or the York County Prevention Collaborative provides capacity building in a very different context, in places where there are many organizations and community coalitions with overlapping boundaries and missions. The need for coordination and community-wide visioning/planning increases as the complexity of the context increases. This is particularly true for areas with concentrations of population that are relatively rich in educational and social service resources.
- It appeared from the study coalitions that, while all the coalitions provided some community support (capacity building), when community capacity building was a major focus it was less likely that coalition would create programs and/or environmental strategies that they would own and more likely that they would play the role of incubator. This is because these functions are often maintained by member organizations or "spin off" organizations. This also suggests that the capacity building function may require a different kind of coalition than coalitions that perform direct programs/services/strategies functions. More research is needed on this.
- Research on the concept of community capacity building and community support organizations is in its infancy. The coalitions in the study that emphasized this function approached it in different ways and considered the study itself one way to learn from each other about new ways of carrying out this function. They asked that their network continue via a listserv.

Study Implications for Local Coalitions:

- Clearly delineating and differentiating the functions they perform and recognizing that there are different strategic planning steps to carry out each function can help coalitions clarify their purposes and use their time, funds and connections wisely.
- Distinguishing coalition maintenance functions from the other functions can help coalitions to strike a balance between acting to solve problems and sustaining their capacity to do so. The Coalition Functions Matrix can help coalitions to be proactive – to keep asking, "What is our coalition doing?"
- The Coalition Functions Matrix can also help coalitions to choose the functions that best reflect community needs, recruit partners and resources to match functions, and structure their processes to match what they intend to accomplish.
- The concepts behind the coalition functions and strategic planning steps are not limited to any one funding source or type of prevention/health promotion. Thus, the general framework can be used for cross-program collaboration at the local level.

Study Implications for State Level Programs

- Supporting coalitions can be based on supporting those local entities that have the most capacity to carry out a particular function. While all coalitions need to perform coalition maintenance functions, different coalitions may focus on providing programs, implementing community-level/environmental strategies or community capacity building. State level programs can target resources based on the particular functions they wish to support with a particular funding source.
- Because different functions require different participation patterns and structures it may not be helpful to try to force communities to develop a single coalition that performs all the functions in the Coalition Functions Matrix. Multiple coalitions can operate in the same general with each contributing a different function or set of functions. It is important is that all the functions are covered in any given area and that they are coordinated. If a single coalition does represent all the functions it will need to very large and complex. While many existing coalitions that are located in the same geographic area already share the same fiscal agent or are set up as committees/subcommittees within the same coalition structure, where separate but overlapping coalitions duplicate functions, one of the roles of a community capacity building organization would be to address this issue.
- While community capacity building is the least understood of the coalition functions, the examples provided by study coalitions suggest that continued assistance on the part of state level program sponsors can serve to strengthen local capacity building. Providing networking opportunities for organizations that identify community capacity building as a major focus to help them learn from coalitions that are already working on this function would strengthen the entire Maine system.
- The Coalition Functions Matrix can be used to assist with the development of resource allocation plans and training and technical assistance. If the first question is "What do we want to fund coalitions to do," then using the matrix at each step in the strategic planning process to focus in on specifics can better target scarce resources.
- It is not necessary for every coalition to have the capacity to support all functions or have expertise in every activity. It is necessary, however, for the capacity to exist within the broader prevention system. For example, not every coalition will be able to carry out evaluations, but evaluation capacity needs to exist within the system (perhaps sponsored by a state sponsor) and made available to the coalition. If specific functions and capacities are delineated, it becomes easier to pinpoint exactly where development of supports will be most appropriate and how different levels of the system can work together.
- Because the framework for the UGS study is generic – in terms of functions and in terms of the capacities needed for strategic planning steps, it can be used to facilitate state level cross-program planning

The work of the Unified Governance Structure Study provides a method for Maine's community-based coalitions and their state-level sponsors to ask and answer more sophisticated questions about what they aim to accomplish and the specific capacities that are needed to accomplish the functions they choose to perform.

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