Iowa State Opioid Response (SOR)

Community Assessment Workbook

Iowa Department of Public Health, Division of Behavioral Health

June 1, 2019

Products and Due Dates

Table: Deadlines for Activities and Workbook Completion

Product	Due Date	Date Completed
Reconvene group and identify additional stakeholders to include to assist with data collection, interpretation and completion of Community Assessment Workbook.		
Identify needed data and determine if data is currently available or will need to be collected.		
Collect data from existing sources, including law enforcement and stakeholder interviews, county meetings and focus groups, as appropriate.		
Convene coalition, collaborative council or evaluation subcommittee to assist in review and completion of CAW.		
Community Assessment Workbook submitted to IDPH	June 1, 2019	

By **June 1, 2019**, a final copy of the SOR Community Assessment Workbook (starting at page 9 of the workbook) should be submitted electronically to Iowagrants.gov and:

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Introduction

The State Opioid Response (SOR) project in Iowa will continue the expansion of capacity among the Integrated Provider Network with a focus on accessible opioid treatment. Key steps to expand capacity will include a thorough assessment and strategic action plan involving local stakeholders. Funding will support planning and implementation of evidence-based practices for prevention, treatment and recovery, including medication assisted treatment (MAT) for opioids.

The focus of this project is to assist communities across the state to build capacity for a successful community response to the opioid crisis. Plans will include prevention-focused media, promotion of the Iowa Prescription Monitoring Program (PMP), expanded treatment options, and naloxone distribution. The SOR project will leverage the service improvements gained through other opioid-focused efforts, making evidence-based practices more accessible to Iowans affected by opioid use disorder across the state.

The SOR funding is part of the strategic effort to address the crisis related to opioid use disorders and their negative consequences. The grant is focusing efforts on Iowans aged 18-44, as data analysis of opioid-related deaths, opioid treatment admissions, and hospitalizations for drug overdose indicated this group to be most affected.

The STR grant is utilizing the steps of the Strategic Prevention Framework (SPF) to assure that Iowa's treatment catchment areas become Opioid Informed Communities, ready to respond to this crisis, as it manifests on the local level. The SPF is a five-step, data driven process used to 1) assess needs; 2) build capacity; 3) engage in a strategic planning process; 4) implement a strategic plan and 5) evaluate processes and outcomes. Cultural competency and sustainability are a focus across all five SPF steps.

An Opioid Informed Community is one whose stakeholders:

- *Are aware of current opioid-related risks and problems in their communities,*
- *Prioritize education, prevention, treatment (including MAT), and recovery from opioid use disorders, and*
- *Agree to implement a plan of action to address both the current opioid crisis and underlying factors that may contribute to the crisis.*

Figure 1: Five Steps of the Strategic Prevention Framework Process

The first phase of the SPF model is Assessment, which involves the gathering and examination of data related to substance use and related consequences, community climate, environment, and infrastructure/resources.

Just like when building a house, having a strong foundation is essential. Investing time in a thorough assessment will increase the likelihood that your efforts will achieve the desired change that you are seeking. While many communities across the country are struggling with the devastating effects of opioids, the specific variables and conditions that create an environment in which this occurs can be different from one community to another. Identifying the scope of the problem (by looking at the consequences and consumption trends for opioids in your county) and the specific variables and conditions that are contributing to opioid use disorder, you will be better able to focus your resources on the specific things that need to be changed. By design, this Community Needs Assessment Workbook is intended to walk you through the assessment process in a step-by-step manner to assess your local treatment and recovery needs.

Workbook Organization

The workbook is organized into sections to assist you in conducting a community assessment that will result in identifying and prioritizing the specific intervening variables and underlying conditions contributing to opioid-related problems in your community. The specific steps will include:

- Identifying consumption and consequence patterns with existing and original data
- Identifying the intervening variables that are contributing to the problem
- Setting priorities
- Identifying underlying conditions
- Determining which intervening variables and underlying conditions you will address

After completion of this workbook, the next step will include determining your community's capacity to address the priority issue.

Data Collection and Stakeholder list:
To be effective, you *should not complete this workbook alone*. Instead, an assessment committee, or similar body should be formed to complete this task. The assessment committee must include networks of people and organizations that bring substance abuse and mental health data, analytical thinking, and epidemiological capacity to planning and decision-making in your community. You also want to be sure to include members of the priority populations, such as those impacted by opioid use disorder (OUD) and their families. Consider involving key stakeholders, such as pharmacists, local healthcare providers and law enforcement early in the process. Their engagement will be important as you move through the processes of assessment, planning and implementation.

Required stakeholders include representatives from all of the following in the catchment area:

1. Treatment agencies
2. SUD Prevention
3. Opioid Treatment Programs (methadone clinics)
4. First responders/EMS/Law enforcement/Fire department
5. Healthcare providers (prescribers, pharmacists)
6. People in treatment or recovery (or family members of persons with OUD)

Recommended additional stakeholders relevant to your community:

1. Colleges/University
2. Correctional facilities/re-entry services
3. Court systems
4. Faith communities
5. Government/elected officials
6. Harm reduction/syringe services programs
7. Employers/business leaders
8. Veterinarians

You may also need to periodically convene a larger community coalition or Advisory Council to assist in identifying possible sources of data, solicit volunteers for data collection and

interpretation, and to assist in setting priorities and deciding which intervening variables your area will focus on.

Much of the data needed to complete this workbook may be publicly available or provided to you. In some cases, where local level data is not available to IDPH, you will be responsible for finding the information. Proportions or rates are used for simplicity, and it is acknowledged that they may vary according to their margin of error. In addition to the existing data sources that are specifically outlined in this workbook, local surveys or other data sources are encouraged to be used as sources of auxiliary information to aid in the decision making process. Your community may have already gathered survey results from businesses or from local law enforcement that may help in the needs assessment.

Keep in mind that this document is designed to be shared with stakeholders and community members as a way to increase understanding, engagement and collaboration. When discussing the scope of the problem and contributing factors in your community, avoid language that is blaming or shaming. Please identify data, challenges and barriers that exist in a way that invites understanding, collaboration and a sense of shared outcomes.

Existing Data

You may be surprised at how much data already exists at your local or county level. Some of these data will be provided directly to you by IDPH. Other sources of data may come from your local law enforcement agencies, or city and county public health departments. Some examples include data gathered by local public health agencies as part of their Community Health Needs Assessment (CHNA) and Health Improvement Planning (HIP) or information from first responders regarding the number of opioid-related emergencies. A key to successful assessment is to identify who is already collecting local data and work collaboratively to access, analyze, and interpret such data.

Original Data

In addition to existing data, you will also need to gather original (new) information. The purpose of this data collection is to gather information directly from your area by observation or research. This will enable you to fill in gaps where existing data may not exist, or be incomplete. Examples of this will include community readiness interviews with key partners and stakeholders, and/or conducting focus groups and town hall meetings.

Stakeholder Interviews

As part of this needs assessment, you may conduct interviews with law enforcement officers. Consider who will be the best respondents to gather the information you are seeking. It may be someone who has decision making and fiscal authority, such as the Sheriff or Chief of Police, or someone who works more closely day to day in your community, such as a deputy sheriff, patrol officer, or school resource officer. Your assessment committee and coalition/collaborative council should consider what interviews would be the most appropriate and informative for your area.

You are also encouraged to conduct focus groups or one-on-one interviews with healthcare providers and pharmacists in your area as part of the assessment process. Many strategies connected with this project will require their participation and it is essential to involve them in the project as collaborative partners as early as possible.

As part of your data collection, you may also want to consider interviews with emergency room staff, school officials, or other service providers about their interactions with the opioid-related issues.

A sample protocol for the law enforcement interviews and ideas on how to gather and analyze qualitative data from these interviews can be found in Appendix A.

Town Hall Meeting

You may also need to hold a town hall meeting. Town hall meetings are a good way to gather original data from a large group at one time. A sample protocol for the town hall meeting and ideas on how to gather and analyze qualitative data from this meeting can be found in Appendix B.

Community Readiness Surveys

According to the Community Tool Box from the University of Kansas, "Community readiness is the degree to which a community is ready to take action on an issue." Figuring out where your community is, in terms of readiness, can also be a key component in deciding what interventions and approaches are likely to work best. As part of the assessment step you will be given additional information on how to conduct community readiness surveys for opioid-related problems. This will also be key information as you determine your capacity and update the strategic plan for your project.

Consider the data you have collected through these surveys as you add additional local data for each section, and as you answer the summary questions throughout the document. See appendix A.

In addition to the training that will be provided by IDPH, for more information on Community Readiness you can visit:

From the University of Kansas
http://ctb.dept.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/community-readiness/main

Community Toolbox: Assessing Needs and Resources http://ctb.ku.edu/en/assessing-community-needs-and-resources

SAMHSA *Stages of Community Readiness*
https://www.samhsa.gov/capt/tools-learning-resources/stages-community-readiness

Additional, Original Data

At the heart of the SPF is the idea that communities are best positioned to solve local problems. You will need to work with your coalition, advisory Council, and other key partners to determine what kind of data will best assist you in making a determination of why your community is impacted by opioids so that you can then figure out the best way to intervene. When collecting original data consider who may already have access to the data you are looking for, or who can

best inform you about the issue and culture in your community. Consider also who you will need as potential partners as your project moves forward such as treatment providers, those in recovery, local public health, elected officials, business leaders, and others. Involving them now during the assessment phase is a great way to build project capacity early on.

Cultural Competence
In the model of the SPF, you will see that cultural competence is located in the middle. This is because it should be considered throughout every step of the process, starting with assessment. When establishing your assessment committee, collecting, interpreting and sharing your data, you should do so with the cultural makeup of your community in mind.

You can consult the following resources for additional information:

SAMHSA's Tools from the CAPT
Increasing Cultural Competence to Reduce Behavioral Health Disparities
https://www.samhsa.gov/capt/sites/default/files/resources/increasing-cultural-competence-reduce-behavioral-hd.pdf

{Insert IPN Area Here} Community Assessment Workbook

State Opioid Response (SOR)

{June 1, 2019}

(AGENCY NAME HERE)

Community Needs Assessment Workbook Contributors

List the names of people in your community, the organizations/sectors they represent, and the contributions they made to complete this workbook in Table 2 below. Please do not include the names here of anyone whose contributions or responses should be kept confidential or anonymous, such as the names of focus group attendees.

As with all tables in this document, please add additional rows as needed.

Table: Workbook Contributors

Name	Organization/Sector (see required stakeholders pg. 5)	Contribution

State & Local Data Sources

The Table below provides a list of the data sources used in this workbook as well as a description of the data, and where it came from. Data that has been provided in the workbook are listed. Please add rows at the end of the table to describe each additional source from which data was collected.

Table: Data Sources

Data Source	Data Description	Data Location
Combined data from CDC, Census, Bureau of Labor	The Opioid Misuse Community Assessment Tool created by NORC at the Univ. of Chicago for the USDA Rural Development	https://opioidmisusetool.norc.org/#
Iowa Youth Survey (IYS)	Statewide school survey of 6th, 8th, and 11th graders (2002-2018). Consumption variables & Youth Perception of Risk	http://www.iowayouthsurvey.iowa.gov/
Justice Data Warehouse (JDW)	JDW is a central repository of key criminal and juvenile justice information from the Iowa Court Information System (ICIS), maintained by Criminal and Juvenile Justice Planning (CJJP)	https://humanrights.iowa.gov/cjjp/justice-data-warehouse
Treatment Episode Data Set (TEDS)	A web-based source of substance abuse treatment data.	https://wwwdasis.samhsa.gov/webt/newmapv1.htm
American Community Survey	The American Community Survey is a survey conducted by the U.S. Census Bureau every year from a random sample of people in every state.	https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml
Medicare Part D Opioid Prescription Claims	National Medicare Part D prescription drug claims prescribed by health care providers through 2016 is collected by the Centers for Medicare & Medicaid Services and the U.S. Department of Health and Human Services (HHS)	https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/OpioidMap.html
Centers for Disease Control and Prevention (CDC), Overdose Death	National Drug-Poisoning deaths identified through the International Classification of Diseases, Tenth Revision (ICD-10) for each state.	https://www.cdc.gov/drugoverdose/data/index.html
Iowa Board of Pharmacy Verifications	On-line Directory of all pharmacies and other Board licensees in Iowa	https://pharmacy.iowa.gov/miscellaneous/verifications

Behavioral Risk Factor Surveillance System (BRFSS)	An annual national health-related telephone survey that collects state data about US residents regarding their health-related risk behaviors, chronic health conditions, and use of preventative services	http://idph.iowa.gov/brfss
Iowa Department of Education – Graduation Rates	Four- year graduation rates for Iowa students in a given cohort year (class)	https://www.educateiowa.gov/education-statistics#Student_Performance
Substance Abuse and Mental Health Services Administration (SAMHSA)	Buprenorphine Treatment Provider- find physicians authorized to treat opioid dependency by buprenorphine in each state	https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator?field_bup_physician_us_state_value=IA
Substance Abuse Treatment Providers in Iowa	Iowa Department of Public Health maintains a list of licensed treatment providers in each county in Iowa	http://idph.iowa.gov/substance-abuse/program-licensure
U.S. Department of Labor: Bureau of Labor Statistics	Federally calculated unemployment rates by state, seasonally adjusted percentage of labor force seeking work	https://www.bls.gov/web/laus/laumstrk.htm
Iowa Food Assistance Program	Iowa State Data Center provides information on the average food assistance program (formerly food stamps) benefits per month per recipient	http://www.iowadatacenter.org/data/dhs/food
Iowa Medicaid (Title XIX) Recipients and Benefits	Iowa State Data Center provides information on the average Medicaid benefits per month per recipient	http://www.iowadatacenter.org/data/dhs/medicaid
Iowa Department of Public Safety	Federal Bureau of Investigation (FBI): Uniform Crime Reporting (UCR) Reporting - provides drug arrest data (Drug/Narcotic Violations and Drug Equipment Violations) by county.	http://www.dps.state.ia.us/commis/ucr/

Community Description

{INSERT A CATCHMENT AREA MAP HERE}

Description of Your Community

Use this section of the workbook to gather and interpret data specific to the demographics and make-up of your community. You may use county data or combine counties to represent your community. Please specify in each table what area you are reporting information.

Table: Community Facts

Source: American Community Survey (from American Fact Finder) and State Data Center of Iowa

County Demographics	Description	Area/ County (N)	Area/ County Rate (%)	State (N)	State Rate (%)
2015 Population Estimate	Total Population Estimate		N/A	3,093,526	N/A
2015 Population by Gender	Male			1,534,595	49.6%
	Female			1,558,931	50.4%
2015 Population by Age	<5			196,570	6.4%
	5 to 14			407,996	13.2%
	15 to 24			439,616	14.2%
	25 to 34			389,904	12.6%
	35 to 44			363,791	11.8%
	45 to 54			414,940	13.4%
	55 to 64			400,941	13.0%
	65 to 74			249,287	8.1%
	75 to 84			153,362	5.0%

	85 and over			77,119	2.5%
2015 Race	White			2,820,046	91.2%
	Black or African American			97,788	3.2%
	American Indian and Alaska Native			9,977	0.3%
	Asian			62,997	2.0%
	Native Hawaiian and Other Pacific Islander			1,882	0.1%
	Other Race			39,872	1.3%
	Multi-racial			60,964	2.0%
2015 Ethnicity	Hispanic or Latino			168,230	5.4%
	Not Hispanic/Latino			2,925,296	94.6%
Income (2011-2015)	Median Household Income		N/A	$53,183	N/A
Economic Insecurity (Jan. 2017)*	Current Unemployment Rate	N/A		N/A	3.3%
Educational Attainment (2011-2015)	High School Graduate or Higher			2,830,576	91.5%
	Less than High School			262,950	8.5%
Economic Characteristics (2011-2015)	Below Poverty for All Ages			373,883	12.1%
	Under 18 years			112,740	3.6%
	18 to 64 years			227,282	7.3%
	65 years and over			33,861	1.1%
Government Assistance (2016)**	Food Assistance Benefits (Average Monthly Households)		N/A	178,013	N/A
	Food Assistance Benefits (Total Annual Benefits)		N/A	$504,937,952	N/A
	Medicaid Benefits (Average Monthly Recipients Eligible)		N/A	599,295	N/A
	Medicaid Benefits (Total Annual		N/A	$2,733,110,585	N/A

	Benefits)				

NOTE: Percent = (N ÷ Total Population Estimate) × 100%
* Source (Unemployment): U.S. Department of Labor, Bureau of Labor Statistics
**Source (Govt. Assistance): Iowa State Data Center: Food Assistance Program and Medicaid (Title XIX) Recipients and Benefits

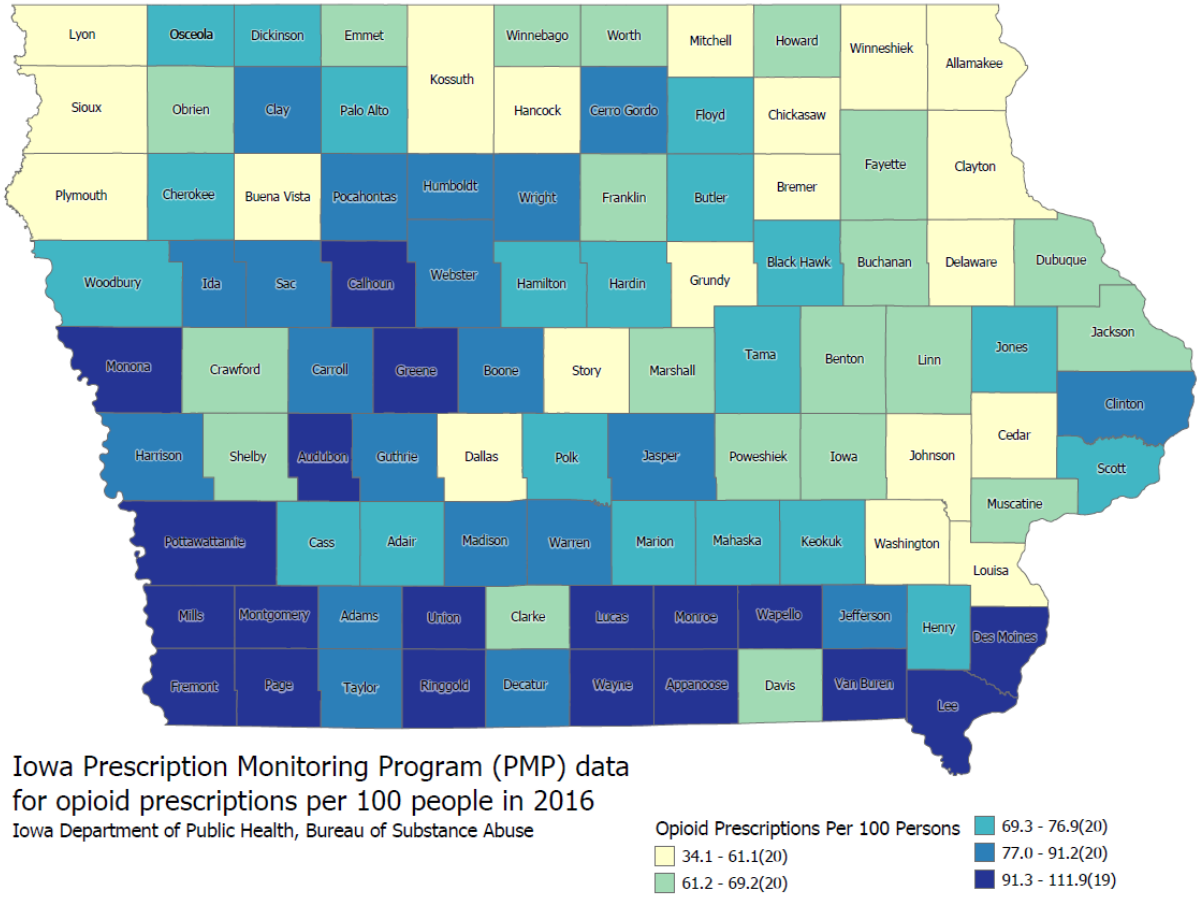
Other Data Sources
(List any other data here that would be helpful in describing your community. This may include additional demographics; a description of the geography; how your area is similar or different than surrounding counties or other areas in the state; information about specific cultural groups in your community; and any other information that you feel will be helpful in painting a picture of the geographical and cultural landscape of your community.)

Community Description

Utilizing the information above, provide a an updated brief description of your catchment area. Include the assessment committee's definition of "community" (which counties/areas are included or not) and the rationale for your definition of "community". What about the geographic and cultural makeup of your community has changed since the first opioid CAW? What will be an asset in implementing the State Opioid Response in your community? What may make it challenging?

Consumption Data

This section looks at consumption data. This will help you identify who specifically is misusing opioids in your community, and help you begin to identify any subgroups of the target population, patterns or trends that you will want to address.



Iowa Prescription Monitoring Program (PMP) data for opioid prescriptions per 100 people in 2016
Iowa Department of Public Health, Bureau of Substance Abuse

Table: Percentage of Students Who Reported Misusing Prescriptions
Source IYS

Indicators	Area	Grade	2012	2014	2016
Students Who Used Prescriptions Not Prescribed by a Doctor in the past 30 Days – *2012*-B43, *2014*-B44, *2016-B45*	{Insert Community Name Here}				
		11th			
	Iowa				
		11th	6%	5%	5%
Students Who Used Prescriptions Differently	{Insert Communi				
		11th	N/A		

than Directed in the past 30 Days –*2014*-B45, *2016-B46*	ty Name Here}				
	Iowa				
		11th	N/A	4%	4%

Other Data Sources

Consider analyzing other data sources that will help identify and detail problems around opioids, including local information that may be available, or that you can collect through focus groups, surveys or one on one interviews. For example, you may include a focus group with young adults; a school survey given to college students, including those in alternative education settings; and information from other local treatment providers. Information regarding consumption, including where, how often and when members of the target population are consuming, can assist you in figuring out where to target your efforts.

Analyzing Consumption Data

Are there specific groups whose consumption stands out? Has this changed since the first opioid CAW?

How does consumption in your county compare to state rates? Are there specific groups whose rates differ from others across the state?

Which groups in your community have consumption rates or patterns that are most concerning to you?

Consequence Data

This section looks at consequence data and will help you identify which opioid consequences are of greatest concern in your community. You will look at consequences such as involvement with the legal system and health-related consequences such as excess use and use disorders, emergency room visits, and overdose related fatalities. You will also include any additional local data that will assist you in looking at the consequences related to opioids and which populations

are experiencing them.

Opioid Use Disorder

The table (below) shows the rate, by county, of residence for treatment admissions due to heroin or other opioids as the primary drug. The Iowa rate has been included in the table to provide a comparison. The year-specific estimated census data were used for that purpose.

Table: Number and Percent of Treatment Admissions for Primary Drug of Choice of Heroin or Other Opioids
Source: Iowa CDR

Treatment Admissions	{Insert Area Name Here}						Iowa					
	2014		2015		2016		2014		2015		2016	
	N	%	N	%	N	%	N	%	N	%	N	%
Total Admissions		N/A		N/A							2,274	
Heroin												
Other Opioids												

Opioid-Related Crimes

Table: Number of Offenders with Opioid-Related Offenses by Age Group at Time of Offense
Source: ICIS, JDW-CJJP

Age Group	Area	FFY2014	FFY2015
Age 21+ Offenders	Enter County Name Here}		
	Iowa		

Note: IDPH will provide this data for counties. JDW is continuously being updated; so there may be slight change in the numbers over time. This table counts unique offenders in the adult and juvenile court systems for prescription drug offenses in FFY14 or FFY15, regardless of whether the offense resulted in conviction. The unit of measure is offenders rather than offenses in an effort to reduce over counting in adult and juvenile courts. Unique offenders were identified through a match on FN, LN, and DOB.

Table: Number of Charges and Convictions for Prescription Drug-Related Offenses in Adult Court System
Source: ICIS, JDW-CJJP

Adult Court	Area	FFY2015	FFY2016	FFY2017

RX Disposed Charges	{Enter County Name Here}			
	Iowa	1,797		
RX Convictions	Enter County Name Here}			
	Iowa	591		

Note: IDPH will provide this data for counties. JDW is continuously being updated; so there may be slight change in the numbers over time. This table is a count of charges disposed in adult court in FFY15- FFY17 for prescription drug offenses (where charges were filed), and the number of convictions (guilty and deferred). Please note that an offender could receive multiple charges for the same offense.

Opioid-Related Deaths

The source of statewide and county-level information for opioid-related deaths (which includes overdose fatalities) was the Iowa Department of Public Health. Numbers and rates in some categories may not be available in your county, if there are so few people that it would pose a risk to confidentiality to release the information. If this is one of your counties, gather this information from other knowledgeable sources who may be able to provide a general impression of the extent of drug-related poisoning deaths in your county.

Table: Number and Rates of Opioid-Related Deaths
Source: IDPH Vital Records

Deaths	{Insert County Name Here}				Iowa			
	2016		2015-2017		2016		2015-2017	
	N	Rate	N	Rate	N	Rate	N	Rate
All Opioid-related								

Note: Rate per 100,000 population

Drug Overdose- Emergency Room Visits

Table: Number and Percent of Emergency Room Visits due to Drug Poisonings
Source: IDPH

Calls	{Insert County Name Here}				Iowa			
	2016		2017		2016		2017	
	N	%	N	%	N	%	N	%
Opioid-Related Emergency								

Room Visits								

Calls to Iowa Poison Control Center

Table: Number of Calls Due to Drug Exposures
Source: Iowa Poison Control Center

Calls	{Insert County Name Here}				Iowa			
	2015		2016		2015		2016	
	N	%	N	%	N	%	N	%
Total Calls (All Substances)		N/A		N/A	26,249	N/A	26,741	N/A
Synthetic Opioid	N/A	N/A			N/A	N/A	3	0.0%
Prescription Opioid					893	3.4%	850	3.2%
Heroin					27	0.1%	32	0.1%

Note: The table only provides counts for human "exposures," excluding calls for animal exposures and information-related calls. Iowa Poison Control Center (IPCC) data likely underestimates the total number of drug-related poisonings in Iowa. It would not capture cases in which IPCC was not called, such as overdoses treated by physicians who do not feel the need to seek additional assistance in managing the case. Synthetic Opioids include acetyl fentanyl, carfentanyl, and U-47700. This category is only available for 2016. Prescription Opioids include Buprenorphine, Fentanyl, Hydrocodone, Hydromorphone, Methadone, Morphine, Oxycodone, Oxymorphone, Tapentadol, and Tramadol.

Other Data Sources

This is an important part of the community assessment since it relates to area specific data not available at the state level. You may gather data from other sources in your community or area that already exists or you may utilize data gathered specifically for this project such as data from town hall meetings, focus groups or one-on-one interviews. Keep in mind the purpose of this section is to identify the consequences of opioids in your community and which segments of the population are experiencing them. This will help you to know where to focus your resources and efforts. For example: data from law enforcement regarding impaired driving incidents; surveys or key information interviews regarding local emergency room data; or focus group results from your local recovery community. Share that information here:

Consider finding the number of Non-fatal overdoses? Any opioid-specific recovery services?

Analyzing Local Consequences

What consequence data stands out the most to you? What consequences are of the most concern to your coalition?

How do opioid consequences in your community compare to the state? Is your problem bigger, smaller or about the same? Discuss the differences.

What segments of your community population appear to be most impacted by the consequences you have identified?

When you consider measures such as prevalence, severity, state ranking and trends, what consequences do you think will be the most important to focus on reducing in your community?

Looking at Consumption and Consequences Together

Are there groups in your community who stood out in both your consumption and consequence data?

Considering both consumption and consequence data, which groups will be important to target with your efforts through this project (again consider factors such as severity, prevalence and trends)?

Intervening Variables

These are the variables in your community that answer the "Why here?" They can assist your coalition/advisory council in identifying why opioid-related problems are specifically happening in your community so that you can chose the most effective strategies to address those specific reasons. In addition to considering what you have already noted in the workbook thus far, the following factors are important to add as you prioritize how to address the opioid-related issues in your community.

1. Prescribing practices

Overprescribing of opioids can lead to OUD throughout a community.

Table: Number of Licensed Pharmacies and their Engagement in Preventing Prescription Misuse

Source: Iowa Board of Pharmacy

Pharmacies	**Area**	**2016**	**2017**
		N	**N**
Total Active Pharmacies	{Insert Area Name Here}		
	Iowa	N/A	911
Pharmacies with	{Insert		

Drug Drop Boxes that are for Controlled & Non-Controlled Substances	Area Name Here}		
	Iowa	30	45
Pharmacies participating in Naloxone Standing Order	{Insert Area Name Here}		
	Iowa	52	295

Table: Number of Medicare Prescribers and Average Opioid Prescribing Rate from Claims for over 65 Medicare Beneficiaries
Source: CMS Medicare Part D

Medicare Prescribers	**Area**	**2013**		**2014**	
		N Prescribers	**Average Opioid RX Rate**	**N Prescribers**	**Average Opioid RX Rate**
Total Prescribers	{Insert Area Name Here}				
	Iowa	9,767	4.9%	10,064	4.8%
Prescribed Opioids at least once	{Insert Area Name Here}				
	Iowa	4,881	5.7%	4,941	5.7%
Specialty in Pain Management [1]	{Insert Area Name Here}				
	Iowa	22	56.7%	24	55.0%
Specialty in any type of Surgery[2]	{Insert Area Name Here}				
	Iowa	713	31.3%	703	31.1%
Specialty in any type of Oncology[3]	{Insert County				

	Name Here}				
	Iowa	146	11.2%	157	10.7%
Physical Therapists, Massage Therapists, and Chiropractors[4]	{Insert County Name Here}				
	Iowa	9	0.0%	3	0.0%
Family Medicine, General Practice, Internal Medicine, Nurse Practitioners, and Physician Assistants [6]	{Insert County Name Here}				
	Iowa	4,499	4.8%	4,728	4.8%
Dentists[7]	{Insert County Name Here}				
	Iowa	1,251	6.5%	1,275	6.3%

Note: The data are limited to Number of Medicare Part D claims by provider. This is not intended to estimate the total number of prescribers in Iowa or the opioid prescription rate for non-Medicare beneficiaries, such as patients under the age of 65. Other information will be released through the Prescription Monitoring Program as it becomes available.

[1] Pain Management, Intervention Pain Management [2] Cardiac Surgery, Colon & Rectal Surgery, Colorectal Surgery, General Surgery, Hand Surgery, Maxillofacial Surgery, Neurological Surgery, Neurosurgery, Oral and Maxillofacial Surgery, Oral Surgery (dentists), Orthopaedic Surgery, Orthopedic Surgery, Plastic and Reconstructive Surgery, Plastic Surgery, Surgery, Thoracic Surgery, Vascular Surgery [3] Gynecological Oncology, Hematology Oncology, Medical Oncology, Radiation Oncology, Surgical Oncology [4] Chiropractic, Massage Therapist, Physical Therapist [5] Behavioral Analyst, Clinical Psychologist, Counselor, Licensed Clinical Social Worker, Marriage and Family Therapist, Neuropsychiatry, Psychiatry, Psychiatry & Neurology, Psychologist (independent), Social Worker [6] Family Medicine, Family Practice, General Practice, Internal Medicine, Nurse Practitioner, and Physician Assistant [7] Dentists

Other Data Sources

List any additional local data related to overprescribing here.

2. First Responders

Table: First Responder Engagement in Preventing Overdoses by Location

Source: Local Communities EMS, Fire Departments, Law enforcement, other

First Responders	Location	Agency Name	N
Naloxone Access and	{Insert Area Name Here}		

training			
Law Enforcement Locations with Drug Drop Boxes	{Insert Area Name Here}		
	Iowa	State	120

Table: First Responder Opioid-related Emergencies
Source: Local Communities EMS, Fire Departments, Law enforcement, other

First Responders	Location	Agency Name	# people	# of incidents	# doses of naloxone used
Opioid-related 911 calls	{Insert Area Name Here}				
Naloxone deployments	{Insert Area Name Here}				

Other Data Sources

List any additional local data related to law enforcement here. You may want to consider including any information about local ordinances or policies related to opioids and how these are enforced.

3. Available Resources and Services

The availability and access to resources which lead to and support recovery have a dramatic impact on individuals' success.

Table 1: Number of Iowa Substance Treatment Programs and Providers
Source: SAMHSA and IDPH

Treatment Providers	Area	N
Licensed Substance Abuse Treatment Providers (IDPH 2017)	{Insert Area Name Here}	
	Iowa	117
Licensed Opioid Treatment (methadone) Provider Locations (IDPH 2017)	{Insert Area Name Here}	
	Iowa	9
Physicians with Buprenorphine Waiver (SAMHSA)	{Insert Area Name Here}	
	Iowa	51

Table: Recovery Support Programs in the Community by Location and Number of Meetings Held
Source: Local communities

Recovery Programs in the Community	Location (city/town)	# of meetings or distributions (average per location each month)	Names of Organization or Group (if applicable)
12-Step Groups			
Alternative Support Groups for Substance use disorders			
Recovery Community Centers			

Other Data Sources

List any additional local data related to individual factors here.

Prioritizing

Based on the data you have collected, how much of an impact do you think each intervening variable has on the issue of opioids? Rate each intervening variable on scale of 1-10 and

include the reason (based on data) for your score.

Intervening Variable	Score
Prescribing practices	**1 2 3 4 5 6 7 8 9 10**
Supporting Data:	

Intervening Variable	Score
First Responders	**1 2 3 4 5 6 7 8 9 10**
Supporting Data:	

Intervening Variable	Score
Available Resources & Services	**1 2 3 4 5 6 7 8 9 10**
Supporting Data:	

Intervening Variable	Score
Other	**1 2 3 4 5 6 7 8 9 10**
Supporting Data:	

After you have given each intervening variable a score, list them in order (highest score to lowest score) in the chart below.

Intervening Variables (highest to lowest)

Underlying Conditions

Underlying conditions drill down the factors and conditions contributing to the problem even further. They answer even more specifically what is coming together to cause this to happen in your community. For example, a community has determined that youth are telling them it is very easy to get access to someone else's prescriptions and use them to get high (social availability). This alone does not tell you where they are getting them. They may be getting them from older peers or they could be taking them from an unknowing grandparent. The "but why here?" is important because a media campaign aimed at 20 to 25 year olds on the consequences of sharing their prescriptions with others would have no impact if the source was a grandparent's medicine cabinet. In that case a strategy aimed at older adults making them aware of the issue and encouraging them to dispose of unused medications may be the best fit.

Go back through the data you have gathered so far, and collect new data if needed, to list at least one underlying condition for each intervening variable, and the data that supports it.

Intervening Variables (highest to lowest)	Underlying Conditions	Supporting Data

Final Conclusions

Summarize your final conclusions here. What data stood out most to you? What intervening variables and underlying conditions will be most important to consider as you move forward? Is there any information or data that you feel may still be missing and how will you address those gaps?

Appendices

Appendix A. Community Readiness

The full handbook is here: http://triethniccenter.colostate.edu/docs/CR_Handbook_8-3-15.pdf
The survey questions are:

Appendix A

Community Readiness Interview Questions

1. **For the following question, please answer keeping in mind your perspective of what community members believe and not what you personally believe.**

   On a scale from 1-10, how much of a concern is *(issue)* **to members of** *(community)*, **with 1 being "not a concern at all" and 10 being "a very great concern"?** *(Scorer note: Community Climate)*

Can you tell me why you think it's at that level?

Interviewer: Please ensure that the respondent answers this question in regards to ***community members*** *not in regards to themselves or what they think it should be.*

COMMUNITY KNOWLEDGE OF EFFORTS

I'm going to ask you about current community efforts to address *(issue)*. By efforts, I mean any programs, activities, or services in your community that address *(issue)*.

2. Are there efforts in (*community)* **that address** (*issue*)**?**

If ***Yes****, continue to question 3; if* ***No****, skip to question 16.*

3. Can you briefly describe each of these?

Interviewer: Write down names of efforts so that you can refer to them in #4-5 below.

4. How long have each of these efforts been going on? *Probe for each program/activity.*

5. Who do each of these efforts serve (e.g., a certain age group, ethnicity, etc.)?

6. About how many community members are aware of each of the following aspects of the efforts - none, a few, some, many, or most?

- **Have heard of efforts?**
- **Can name efforts?**
- **Know the purpose of the efforts?**
- **Know who the efforts are for?**
- **Know how the efforts work (e.g. activities or how they're implemented)?**
- **Know the effectiveness of the efforts?**

7. Thinking back to your answers, why do you think members of your community have this amount of knowledge?

8. Are there misconceptions or incorrect information among community members about the current efforts? *If yes:* What are these?

9. How do community members learn about the current efforts?

10. Do community members view current efforts as successful?

Probe: What do community members like about these programs?
What don't they like?

11. What are the obstacles to individuals participating in these efforts?

12. What are the strengths of these efforts?

13. What are the weaknesses of these efforts?

14. Are the evaluation results being used to make changes in efforts or to start new ones?

15. What planning for additional efforts to address (*issue*) is going on in (*community)*?

Only ask #16 if the respondent answered "No" to #2 or was unsure.

16. Is anyone in (*community)* **trying to get something started to address** (*issue*)? **Can you tell me about that?**

LEADERSHIP

I'm going to ask you how the leadership in *(community)* perceives *(issue)*. By leadership, we are referring to those who could affect the outcome of this issue and those who have influence in the community and/or who lead the community in helping it achieve its goals.

17. Using a scale from 1-10, how much of a concern is (*issue*) **to the leadership of** (*community)***, with 1 being "not a concern at all" and 10 being "a very great concern"?**

Can you tell me why you say it's a_____?

17a. How much of a priority is addressing this (*issue*) **to leadership?**

Can you explain why you say this?

18. I'm going to read a list of ways that leadership might show its support or lack of support for efforts to address (*issue*)**.**

Can you please tell me whether none, a few, some, many or most leaders would or do show support in this way? Also, feel free to explain your responses as we move through the list.

How many leaders…

- **At least passively support efforts without necessarily being active in that support?**

- **Participate in developing, improving or implementing efforts, for example by being a member of a group that is working toward these efforts?**
- **Support allocating resources to fund community efforts?**
- **Play a key role as a leader or driving force in planning, developing or implementing efforts? (prompt: How do they do that?)**
- **Play a key role in ensuring the long-term viability of community efforts, for example by allocating long-term funding?**

19. Does the leadership support <u>expanded</u> efforts in the community to address <u>(*issue*)</u>?

If yes: **How do they show this support? For example, by passively supporting, by being involved in developing the efforts, or by being a driving force or key player in achieving these expanded efforts?**

20. Who are leaders that are supportive of addressing this issue in your community?

21. Are there leaders who might oppose addressing <u>(*issue*)</u>? How do they show their opposition?

<u>COMMUNITY CLIMATE</u>

For the following questions, again please answer keeping in mind your perspective of what community members believe and not what you personally believe.

22. How much of a priority is addressing this issue to community members?

Can you explain your answer?

23. I'm going to read a list of ways that community members might show their support or their lack of support for community efforts to address <u>(*issue*)</u>.

Can you please tell me whether none, a few, some, many or most community members would or do show their support in this way? Also, feel free to explain your responses as we move through the list.

How many community members…

- **At least passively support community efforts without being active in that support?**
- **Participate in developing, improving or implementing efforts, for example by attending group meetings that are working toward these efforts?**
- **Play a key role as a leader or driving force in planning, developing or implementing efforts? (prompt: How do they do that?)**
- **Are willing to pay more (for example, in taxes) to help fund community efforts?**

24. About how many community members would support <u>expanding</u> efforts in the community to address <u>(*issue*)</u>? Would you say none, a few, some, many or most?

If more than none: **How might they show this support? For example, by passively supporting or by being actively involved in developing the efforts?**

25. Are there community members who oppose or might oppose addressing (*issue*)? How do or will they show their opposition?

26. Are there ever any circumstances in which members of (*community)* might think that this issue should be tolerated? Please explain.

27. Describe (*community*).

KNOWLEDGE ABOUT THE ISSUE

1. On a scale of 1 to 10 where a 1 is no knowledge and a 10 is detailed knowledge, how much do community members know about (*issue*)?

Why do you say it's a_____?

2. **Would you say that community members know nothing, a little, some or a lot about each of the following as they pertain to** (*issue*)? (*After each item, have them answer.)*

- **(*issue*), in general *(Prompt as needed with "nothing, a little, some or a lot".)***
- **the signs and symptoms**
- **the causes**
- **the consequences**
- **how much (*issue*) occurs locally (or the number of people living with (*issue*) in your community)**
- **what can be done to prevent or treat (*issue*)**
- **the effects of (*issue*) on family and friends?**

3. What are the misconceptions among community members about (*issue*)**, e.g., why it occurs, how much it occurs locally, or what the consequences are?**

4. What type of information is available in (*community)* about (*issue*) (e.g. newspaper articles, brochures, posters)?

If they list information, ask: Do community members access and/or use this information?

RESOURCES FOR EFFORTS *(time, money, people, space, etc.)*

If there are efforts to address the issue locally, begin with question 33. If there are no efforts, go to question 33.

5. **How are current efforts funded? Is this funding likely to continue into the future?**

6. **I'm now going to read you a list of resources that could be used to address** (*issue*) **in your community. For each of these, please indicate whether there is none, a little, some or a lot of that resource available in your community that could be used to address** (*issue*)**?**

    - **Volunteers?**
    - **Financial donations from organizations and/or businesses?**
    - **Grant funding?**
    - **Experts?**
    - **Space?**

7. **Would community members and leadership support using these resources to address** (*issue*)**? Please explain.**

8. **On a scale of 1 to 5, where 1 is no effort and 5 is a great effort, how much effort are community members and/or leadership putting into doing each of the following things to increase the resources going toward addressing** (*issue*) **in your community?**

    - **Seeking volunteers for current or future efforts to address** (*issue*) **in the community.**
    - **Soliciting donations from businesses or other organizations to fund current or expanded community efforts.**
    - **Writing grant proposals to obtain funding to address** (*issue*) **in the community.**
    - **Training community members to become experts.**
    - **Recruiting experts to the community.**

9. **Are you aware of any proposals or action plans that have been submitted for funding to address** (*issue*) **in** (*community)***?**

If Yes: **Please explain.**

Additional policy-related questions:

10. What formal or informal policies, practices and laws related to this issue are in place in your community? (*Prompt*: An example of ―formal‖ would be established policies of schools, police, or courts. An example of ―informal‖ would be similar to the police not responding to calls from a particular part of town.)

11. Are there segments of the community for which these policies, practices and laws may not apply, for example, due to socioeconomic status, ethnicity, age?

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

13. How does the community view these policies, practices and laws?

Demographics of respondent (optional)

1. Gender:
2. What is your work title? _____
3. What is your race or ethnicity?

   ___Anglo ___African American

   ___Hispanic/Latino/Chicano ___American Indian/Alaska Native

   ___Asian/Pacific Islander ___Other_____
4. What is your age range?

   ___19-24 ___25-34

   ___35-44 ___45-54

   ___55-64 ___65 and above
5. Do you live in (community)? YES NO If no: What community? _____
6. How long have you lived in your community? _____
7. Do you work in (community)? YES NO If no: What community? _____
5. Do you live in (community)? YES NO If no: What community? _____

Appendix B. Law Enforcement Interviews

One method for obtaining data is the face-to-face interview. With this method, you talk to each participant directly. This can be done in the participant's workplace, in your office, or any other suitable place. We recommend that you use a semi-structured interview format. This means that you will ask a set of questions prepared in advance. Clarification to follow-up questions may still be used. By asking general questions and having your participants provide answers in their own words, you may gain more complete information. The interview should be structured, but not so structured that it does not allow participants to discuss prescription misuse in the county freely.

Although face-to-face interviews are a valuable way to collect data, they are not without drawbacks. The appearance and demeanor of the interviewer may affect the responses of the participants. Subtle changes in the way an interviewer asks a question may elicit different answers. Also, be aware that the interviewer may not respond similarly to all participants. For example, an interviewer may respond differently to a participant they know versus a participant they have never met before.

The Interviewer

Fundamental to the interview is an interviewer who leads the discussion. This person should feel at ease speaking in a one-on-one conversation. The interviewer's goal is to make the participant feel comfortable in expressing themselves openly while remaining unbiased and keeping the discussion on track. It is recommended that you use someone who has conducted face-to-face interviews before. The interviewer should be able to ask the questions the same way for each participant and be able to read the questions in a neutral manner. The interviewer should also be practiced in active listening techniques that encourage participants to honestly and openly respond to the interview questions.

Choosing the Participants

As part of this needs assessment, you will need to conduct interviews of key law enforcement officers, such as the Chief of Police and the County Sheriff. You should consider what other interviews would be most appropriate and informative for your county. In addition to the law enforcement interviews, you may want to interview emergency room staff, drug treatment providers, or county leaders. One thing to consider when choosing your participants may include the length of time they have held their current position. Be careful not to choose someone who is too new to be able to accurately answer your questions. The interviewer should keep in mind the questions they are trying to answer, and they should feel creative in how they choose participants.

Conducting the Interview

The interview should last about 30 minutes and follow a semi-structured format. Only the interviewer and the participant should be present during the interview, and the interviewer

should make sure the interview is being conducted in a private location where others cannot hear the conversation. The interviewer should ask the questions and let the participant respond without interrupting. The interviewer should allow the participant to talk freely but not ramble about unrelated issues. The interviewer should make every attempt to find a balance between keeping the conversation on track and allowing it to flow naturally. To accomplish this, a "funnel" structure is often used. This approach is best outlined as a series of questions that move from general to specific.

Introductory Questions

These are questions that introduce the topic for discussion. They should make the participant feel at ease with the interviewer. Usually they are not critical to the research; rather, they are intended to foster conversation and get the participant to start thinking about the topic.

Key Questions

These are questions that drive the research. Their answers provide the best data for later analysis. They should be focused on the topic of interest and open-ended. The interviewer's goal with these questions is to illicit open responses from the participant. You should avoid both questions that allow for short answers and questions that can be answered with a "yes" or "no."

Ending Questions

These questions bring closure to the discussion and enable the participant to look back upon previous comments. The participant should be asked to summarize their thoughts in some way.

Sample Questions You May Choose to Use for Your Interviews

Introductory Questions

What prescription drug problems do you see in our county?

What factors do you believe are causing these problems?

Key Questions

Do you think opioid/non-medical use of prescription drugs is under reported? Do you think it has increase/decreased/stayed about the same over the past 3 years?

Are any officers assigned specifically to opioids or non-medical use of prescription offenses in our county?

Are there any Drug Recognition Experts in the community? Would they be beneficial in helping with the opioid/non-medical use of prescription drugs?

Can officers identify the signs of people under the influence of opioids? Have they had

special training?

What else are law enforcement officers doing around the non-medical use of prescriptions in our county?

What more could be done? How could law enforcement better address this issue?

What do you think about the community's readiness to deal with opioid users? For example, are there other resources besides jail to take people who are under the influence?

Do you think treatment is adequate?

Has law enforcement and the treatment community engaged in dialogue on related issues?

Does your department use the opioid overdose reversal drug naloxone? Do officers/first responders carry naloxone?

Does law enforcement refer people directly to treatment via a diversion program?

Does law enforcement have a good relationship and/or exchange information with hospitals or health care professionals?

Ending Questions

How do you think the criminal justice system is helping reduce the prescription drug problems in our county?

Would a "Good Samaritan" law help save lives in our community by encouraging 911 calls when people overdose on opioids?

Has your agency used Iowa's Prescription Monitoring Program when conducting prescription drug diversion investigations?

Our goal is to find out what the driving factor is that is causing the non-medical use of prescription drugs in our county. Is there anything you would like to add or do you have any final comments?

Thank you for your time and input.

Recording and Using the Information

In addition to taking notes, every effort should be made to record the law enforcement interview, but first seek permission from your participant. The use of recording equipment is important because it will allow revisiting the conversation and pulling direct quotes made by the participant. This discussion can also be transcribed or at least listened to for quotes and general ideas. We suggest using a data matrix like the one found on the next page to keep track of major themes and quotes from the discussion.

The information gathered from these interviews should be used to complement other quantitative work by the use of participant quotes and the grouping of ideas. The grouping of ideas refers to categorizing the participant attitudes, feelings, or beliefs toward the topic. This may simply involve discussions revolving around a single question. In other cases, this may involve outlining the major topics brought up during the interview.

Notes for Law Enforcement Interview

Date:_____ Location:_____ Participant's Title:_____ Interviewer:_____

Section	Major Ideas of Themes	Quotes
Question 1		
Question 2		
Question 3		
Other thoughts, ideas, comments, or themes that arose during the interview:		

Appendix C. County Meeting or Focus Groups Protocol

Holding a town hall meeting is an efficient way to gather qualitative data through the use of a focus group methods. The reward for this work is dynamic information not just about what people feel, but about *why* people feel the way they do about a particular subject or idea. Group discussions have the potential to provide data with both accuracy and depth. The town hall meeting is intended as a complement to the rest of the needs assessment.

What follows is a discussion of the general system for running a town hall meeting successfully.

The Moderator

Fundamental to the town hall meeting is a moderator who facilitates the discussion. This person should feel at ease speaking in front of the group, but he or she is not a teacher. The moderator's goal is to make the participants feel comfortable in expressing themselves openly while keeping the discussion on track.

Becoming a talented moderator takes practice. For most novices the best strategy is to play the role of a *seeker of wisdom*. This role assumes that the participants have the wisdom you need and will share it if asked the right questions.

Most importantly, moderators must learn to listen and not talk.

Choosing the Participants

You can do one town hall meeting or a series of meetings. These meetings should consist of at least 10 people who either volunteered to come or who were chosen specifically. Most meetings are made up of a homogeneous group of strangers, but don't be afraid to invite specific individuals to attend the meeting. Key participants may include county members, police officers, parents, adolescents, someone from your advisory council, bar owner, and any other individuals who may have insight on the topic. The State Epidemiological Workgroup strongly recommends the inclusion of individuals that represent the diversity of the county or the minority groups. It is helpful to keep contact information for the participants as they may be involved in other parts of the project.

Setting the Rules

Prior to starting the discussion, the moderator should lay down a few ground rules. Generally, these include, only one person talking at a time; no side discussions among participants; no members should be put down because of their opinions; all thoughts and ideas are valued; and there are no wrong or right answers. Like with selection of group members, care and creativity should be used when setting rules.

Conducting the Discussion

The discussion itself should last between 1 and 2 hours and follow a structured format. The moderator should make every attempt to find a balance between keeping the group discussion on track and allowing it to flow naturally. In order to accomplish this, a “funnel” structure is often used. This approach is best outlined as a series of questions that move from general to specific.

Opening Question

This is a “round robin” question that everyone answers at the beginning of the meeting. It is designed to be answered quickly and to identify those characteristics that participants have in common. It should make everyone in the group feel more at ease.

Introductory Questions

These are questions that introduce the topic for discussion. Usually they are not critical to the research; rather, they are intended to foster conversation and interaction among the participants.

Key Questions

These are questions that drive the research. Their answers provide the best data for later analysis. They should be focused on the topic of interest and open-ended. The moderator’s goal with these questions is to illicit discussion among the participants. You should avoid both questions that allow for short answers and questions that can be answered with a “yes” or “no.”

Ending Questions

These questions bring closure to the discussion and enable participants to look back upon previous comments. Once again a “round robin” approach is best, and participants should be asked to summarize their thoughts in some way.

Sample Protocol You May Use for Your County Meeting(s) or Focus groups

Opening Question

Tell us your name and what brought you here today. (Round Table)

Introductory Questions

What do you see as the problems related to prescription drug use in our community?

What prescription drugs do you think are most abused in our community?

What factors are causing these problems?

A number of concerns and possible causes for those concerns have been mentioned. Let’s think about three possible causes of prescription drug abuse in particular. For the remainder of this discussion, let’s think about overprescribing, law enforcement, social availability and

individual factors.

Key Questions

Let's talk first about overprescribing (in greater amounts or on more occasions than necessary).

To what extent do you think overprescribing may be an issue in our community?

How easy or difficult do you think it is to get a prescription for opioids in our community?

Are you aware of any programs or policies that make it more difficult to get opioid prescriptions or to "doctor shop" in our community?

What do you think could be done to prevent overprescribing in our community?

Let's talk now about law enforcement.

What is law enforcement already doing to address prescription drug abuse in our community?

What barriers get in the way of law enforcement being able to address the problem of prescription drug abuse in our community?

How could those barriers be overcome?

Let's look at social availability. Social availability refers to the procurement of prescription drugs through social sources such as friends and family.

Where are the youth in our county getting them? Give examples.

Where are high school aged youth and younger getting them?

Where are minors out of high school getting them?

Where do youth consume them?

What are your experiences with prescription drugs at parties where youth are using

To what extent do you think *social availability* really contributes to this problem? (Round Robin).

Lastly, let's think about individual factors. Individual factors could be biological, socio-economic, or individual attitudes, such as whether youth are at risk or harm in using prescription drugs in a way other than they are prescribed or intended, or how socially acceptable they think it is to use them.

What makes the people in our county different and unique?

What individual characteristics do you think contribute to this problem in our community? Do you think youth or adults see non-medical use of prescription drugs as harmful?

Based on the things we've just talked about to what degree do you think the *individual characteristics* of the people in our county are a cause of non-medical use of prescription drugs in our community? (Round Robin)

Ending Question

Considering the causes that we've talked about today, overprescribing, law enforcement, social availability, and individual factors, which one do you think is the leading cause of the non-medical use of prescription drugs in our county? (Round Robin)

Our goal is to find out what is contributing to the non-medical use of prescription drugs in our county. Have we missed anything? Do you have any final comments?

Thank the participants for coming.

Recording and Using the Information

Every effort should be made to record the town hall meeting by having a colleague take notes and through the use of a tape or video recorder. The use of recording equipment allows the meeting to be revisited when needed. Consider soliciting the audience and parental consent (if youth are involved) before starting videotaping the event. This discussion can also be transcribed or at least listened to for quotes and general ideas. We suggest using a data matrix like the one found on the next page to keep track of major themes and quotes from the discussion. Feel free to expand the table as needed.

The information gathered from this meeting should be used to complement other quantitative work by the use of participant quotes and the grouping of ideas. The grouping of ideas refers to the categorizing of attitudes, feelings, or beliefs of the group toward the topic. This may simply involve discussions revolving around a single question. In other cases this may involve outlining the major topics brought up by the group.

Notes for Town Hall Meeting

Date:_____ Location:_____

Number of People in Attendance:_____ Note Taker:_____

Section	Major Ideas of Themes	Quotes	Consensus or Disagreement?
Question 1			
Question 2			
Question 3			
Other thoughts, ideas, comments, or themes that arose during the town hall meeting:			