Collaboration to Prevent Alcohol-Related Harms

A Literature Review of Three Approaches

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Executive Summary

The use of alcohol can result in a wide variety of physical, cognitive, psychological, and social harms. Alcohol consumption makes a significant contribution to global deaths and disability-adjusted life years, an estimate of the total years lost due to poor health, disability, or early death. Alcohol-related harms can occur from varying levels of use, depending on the harm; some harms are associated more with heavy use (binge drinking), some with alcohol abuse/dependence, and some with use of alcohol in general. Alcohol-related harms do not occur in a vacuum and are intertwined with other risk factors and adverse circumstances.

There is increasing recognition that collaboration between professionals is important in efforts to address alcohol-related harm. Collaboration can mean many different things but involves different individuals and organizations (often from different sectors, such as health, social services, community, justice, and education) engaging in joint actions with a shared goal. Since alcohol-related risks and protective factors, as well as harms, are relevant to many sectors, such collaboration is important for effective prevention efforts. The goal of this review was to examine literature on collaborative initiatives and practices to prevent alcohol-related harm, with a primary focus on multi-sectoral collaboration that includes health care and service providers.

Three categories of collaborative prevention efforts were identified in the literature and described in this review, although elements from each may overlap. The first category is the collaborative prevention of alcohol-related harm through assessment of individuals at risk and intervention/referral. Collaborative prevention efforts within this category involve the identification of individuals who are at risk of harm (either by screening in broad populations or identifying individuals based on their interactions with existing services), and engaging in intervention efforts aimed at preventing harm and linking individuals to appropriate support and services. This category includes Screening, Brief Intervention, and Referral to Treatment (SBIRT) models, as well as the Hub/Situation Table Model of intervention. In the case of screening models, collaboration occurs through partnerships between sectors to achieve screening and brief intervention, as well as through referral networks for individuals who require more support or intervention. In the Hub/Situation Table Model, collaboration occurs through multidisciplinary team-based intervention planning for at risk individuals, and referrals to appropriate services.

The second category is the prevention of alcohol-related harms through collaborative inter-professional care and programming. Collaborative prevention efforts within this category involve multidisciplinary care teams and wrap-around programming, in which professionals from different relevant sectors work together to provide appropriate support and services for individuals at risk of alcohol-related harm. Collaboration in this type of prevention focuses on multidisciplinary team-based service provision and intervention, as well as strong partnerships and referral networks that can be drawn upon for additional resources and referral.

The third category is the prevention of alcohol-related harms through collaborative community-based prevention models. Collaborative prevention efforts within this category involve community-based and community-level prevention (aimed at the whole community or a whole sub-population within a community) that is based on prevention needs, risks and protective factors, and existing resources within that community. Members of the community are key partners in these types of

prevention efforts, and change is often driven through community coalitions that include stakeholders from many different sectors. Prevention efforts within these types of models tend to be broad and aimed at addressing several risks/protective factors/harms within the community. These efforts can be achieved using prevention frameworks that guide community efforts towards change.

The literature included in this review demonstrates that collaboration efforts to prevent alcohol-related harm can occur in many different forms, including: interprofessional information sharing; joint meetings; structured multidisciplinary teams and programs; the formation of community coalitions and advisory boards; cross-sector education; intervention planning, and evaluation; and referral/partnership networks. Collaboration to prevent alcohol-related harms may involve individuals and organizations across multiple sectors, depending on the focus of prevention efforts. The literature reviewed below illustrates how collaborative prevention efforts can reduce use of alcohol and prevent alcohol-related harms for those who are within “target populations” but also suggests that collaboration has additional benefits for service providers and other professionals. The prevention efforts described in this review offer ideas and frameworks for how service providers can engage in collaborative efforts to reduce alcohol-related harm.

1. Introduction

The use and abuse of alcohol can result in a wide variety of physical, cognitive, psychological, and social harms. These include direct causation and increased risk of many non-communicable diseases, including cancers (Connor, 2016; Jun et al., 2023; Iranpour & Nakhaee, 2019; Rehm et al., 2019), increased risk of transmission of some infectious and sexually transmitted diseases (Morojele et al., 2021; Rehm et al., 2017; Scott-Sheldon et al., 2016); alcohol use disorders and mental health issues including major depressive disorders and psychosis (Jordaan & Emsley, 2014; Rehm et al., 2017; Shield, Parry, & Rehm, 2014), suicide attempts (Borges et al., 2016; Chikritzhs & Livingston, 2021; Iranpour & Nakhaee, 2019; Rehm et al., 2017), alcohol poisoning/overdose (Egerton-Warbuton, Gosbell et al., 2017; Rehm et al., 2017), interpersonal conflicts and violence (Beynon et al., 2019; Chikritzhs & Livingston, 2021; Egerton-Warbuton et al., 2017; Karriker-Jaffe, Greenfield, & Kaplan, 2017; Iranpour & Nakhaee, 2019; Rehm et al., 2017), motor vehicle accidents (Chikritzhs & Livingston, 2021; Iranpour & Nakhaee, 2019; Rehm et al., 2017), and other accidental and intentional injuries to self and others (Beynon et al., 2019; Chikritzhs & Livingston, 2021; Egerton-Warbuton et al., 2017; Rehm et al., 2017; World Health Organization, 2024). Consumption of alcohol by pregnant individuals may also have adverse effects on the fetus and result in adverse outcomes such as increased risk of spontaneous abortion and stillbirth, preterm birth, and fetal alcohol spectrum disorders (FASD) (Addila et al., 2021; Bailey & Sokol, 2011; Popova et al., 2023; Rehm et al., 2017). The World Health Organization (2024) estimated that alcohol consumption resulted in 2.6 million deaths (4.7% of all deaths) and 115.9 million disability-adjusted life years (4.6% of all DALYs) in 2019, largely due to non-communicable diseases (e.g., cardiovascular, digestive, cancers), injuries (both unintentional and intentional), and mental health conditions.

The presence and severity of many alcohol-related harms may be associated with specific amounts of alcohol consumed or patterns of alcohol use (Rehm et al., 2017). The World Health Organization (2024) identified the need to consider substance-use prevention/intervention efforts in relation to four categories: 1) *Hazardous substance use*, where the pattern of use increases risks of harmful consequences to the themselves or others and warrants attention, but overt harms are not yet occurring; 2) *Episode of harmful use*, where there may or may not be patterns of use causing harm but clinically significant harms occur to the user or use results in their behaviours causing harm to others; 3) *Harmful pattern of substance use*, where a sustained pattern of use causes clinically significant damage to the user or this pattern of use results in harms to others; and 4) *Substance dependence*, where there is evidence of impaired control over use, increasing precedence of use over other aspects of life, and evidence suggesting neuroadaptation to the substance. The risks and harm targeted by prevention efforts may be related to one or more of these categories of use. These categories are not mutually exclusive, and substance use exists on a continuum of severity, both across and within categories. Substance use disorders are reflected mainly in categories 3 and 4 and can be diagnosed using ICD-11 or DSM-V criteria when an individual's pattern of substance use is causing damage to their physical or mental health or is leading to clinically significant functional impairment (American Psychiatric Association, 2013; World Health Organization, 2021; Volkow & Blanco, 2023).

An important consideration for prevention/intervention efforts is that the harmful use of alcohol is associated with other risk factors and adverse circumstances, which may contribute to alcohol use and increase the risks of alcohol-related harms. For example, Ozechowski and Wilson (2022) found that adolescents who screened positive for risk of substance use disorder using the CRAFFT tool[1] were at significantly higher risk for depression, more likely to have a history of self-harm and suicidal behaviour, more likely to report conflict in their home environment, and reported more problems at school with their grades and attendance when compared to those with a negative CRAFFT screen. Compared to other adolescents, those who were at risk for substance use disorder also reported less engagement in healthy behaviours (e.g., good nutrition, physical activity, and adequate sleep) and were more than twice as likely to report they had no one they were able to talk to (Ozechowski & Wilson, 2022). Rutman and Hubberstey (2019) reported that problematic substance use among women accessing multi-service programs was strongly intertwined with other issues such as inadequate housing, violent relationships, mental health issues, material-child separations, and isolation.

Reviews have suggested that alcohol misuse is associated with other psychopathologies including but not limited to post-traumatic stress disorder, other substance use disorders, eating disorders, depression, and anxiety disorders (Debell et al., 2014; Castillo-Carniglia et al., 2019; de Aguiar & Bloc, 2024). These associations with other risk factors/adverse circumstances suggest that it may be useful to consider individuals' broader needs and risk factors in prevention efforts targeted at harms associated with the problematic use of alcohol. It is also important to consider how professionals from different sectors (e.g., health, social services, education, justice) can work together in these prevention efforts.

There is increasing recognition of the importance of collaboration between professionals to address alcohol-related harms. Collaboration may involve different professionals working together within the same setting to provide more holistic care/services to patients or clients, such as multidisciplinary care teams/programs and health centres where health and social service professional are co-located (e.g., Kousgaard, Scheele, & Vrangbaek, 2019; Mellinger et al., 2021). It may also involve cross-sector collaboration, which entails partnerships between different sectors such as government, health, non-profit, academia, communities, policymakers, and multi-organizational stakeholders (Chircop, Bassett, & Taylor, 2015). Bryson, Crosby, and Stone (p. 4, 2006) defined cross-sector collaboration as "the linking or sharing of information, resources, activities, and capabilities by organizations in two or more sectors to achieve jointly an outcome that could not be achieved by organizations in one sector separately".

Given the wide variety of alcohol-related harms and intertwined risk factors for the problematic use of alcohol, such collaboration is important for effective prevention efforts. The goal of this literature review is to examine literature on collaborative initiatives and practices to prevent alcohol-related harms, with a primary focus on collaborative efforts that include health care and service providers and are multi-sectoral. Three categories of prevention efforts were identified: 1) the collaborative prevention of alcohol-related harms through assessment of individuals at risk and

[1] The CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble; Knight et al., 1999) is a tool developed to screen for potential substance use, substance-related riding/driving risk, and substance use disorder among adolescents (aged 12-21 years).

intervention/referral; 2) the prevention of alcohol-related harm through collaborative inter-professional care and programming; and 3) prevention of alcohol-related harm through collaborative community-based prevention models. Each of these categories is described in the sections below.

2. Collaborative Prevention of Alcohol-Related Harms Through Assessment of Individuals at Risk and Intervention/Referral

2.1 Screening, brief intervention, and referral to treatment of individuals at-risk

Individuals and service providers can collaborate to reduce harms through the use of the Screening, Brief Intervention, and Referral to Treatment approach (SBIRT). SBIRT is an evidence based, public health approach to the early intervention and provision of treatment services for Individuals engaging in risky or potentially risky behaviours. Each of these service components is outlined by Del Boca and colleagues (2017), as part of their program matrix intended to help researchers and evaluators assess variation/similarities across programs, and factors that are associated with successful SBIRT initiatives. The components of SBIRT are described briefly below in Table 2.

Table 2. Components of SBIRT (from Del Boca et al., 2017, p. 14-16)

Screening	May include a “pre-screening” stage, where people are asked a small number of questions about alcohol and drug use; those who answer affirmatively are assessed using a full screening tool for patterns of use/related problems. Screening uses validated tools to assess the likelihood that someone has a substance use disorder or is at risk for substance-related harms.
Brief Intervention	Brief intervention (often incorporating the principles of Motivational Interviewing) is a quick effort to provide information/advice about alcohol or other drug use, increase motivation to avoid or reduce use, and teach behavioural change skills. The goal of brief intervention is to reduce consumption and associated harms.
Brief Treatment	Brief treatment may be an additional component of SBIRT initiatives, where higher risk individuals are offered a limited number of structured treatment sessions designed to elicit behaviour change.
Referral to Treatment	Referral to Treatment is provided to individuals whose screening results indicate they have a probable substance use disorder. Often includes case management to facilitate referrals to different types of resources, including specialty treatment services.

SBIRT can be used to screen for and address several risks, but its most frequent implementation is to screen for and prevent/reduce alcohol-related harms (Del Boca et al., 2017). SBIRT can be used to identify and intervene with individuals across the substance use continuum, including those who identify they use substances but do not meet screening criteria, those who meet screening criteria for being at risk of substance-associated harm, and those who meet screening criteria for having an alcohol or substance-use disorder (Wamsley et al., 2018). Since individuals who use one substance often use others, and there are also relationships between substance use and mental health issues (as well as other issues such as domestic violence), there may be benefits from the implementation of SBIRT to target multiple risk factors (Del Boca et al., 2017).

Some multi-factor tools have been developed to screen for multiple risks at the same time. An interesting example is the StartSmart tool, which was developed in consultation with prenatal providers and patients to screen pregnant individuals for several risks and protective factors including mental health, intimate partner violence, alcohol use, tobacco use, use of other drugs, weight, immunization completion, prenatal vitamin use, physical activity levels, sleep quality, and nurse-family partnership (Gance-Cleveland et al., 2019). Patients' protective behaviours are then reinforced, and brief intervention and referrals are implemented for the specific risks identified depending on the factor and level of risk (Gance-Cleveland et al., 2019). Although SBIRT is often implemented in primary care (including prenatal care), it has been used in a number of settings including pediatric care, emergency departments, schools and school-based health centres, community-based organizations, community behavioural health organizations, mental health clinics, and juvenile justice programs (Barata et al., 2017; Hostage et al., 2020; Hunt et al., 2022; Karno et al., 2020; Mitchell et al., 2013).

There is a significant amount of evidence that SBIRT can be effective to reduce use and problematic use of alcohol and other substances among both adolescents and adults (e.g., Aldridge, Linford, & Bray, 2017; Barata et al., 2017; Karno et al., 2020; O'Donnell et al., 2014). The Substance Abuse and Mental Health Services Administration (SAHMSA) established a wide-scale grant program to promote the use of SBIRT in a variety of medical settings across the United States. Analysis of outcomes across these SBIRT initiatives (which screened over 750,000 adult patients) demonstrated significant decreases from pre- to post-SBIRT for almost all measures of substance use (Aldridge, Linford, & Bray, 2017). Six months post-SBIRT, the prevalence of alcohol use was lower by 35%, and the prevalence of heavy drinking (defined as drinking until intoxication) was lower by 43.4%. When outcomes were compared across the different SBIRT services (brief intervention only vs. brief intervention and treatment vs. brief intervention and referral to treatment), brief intervention appeared to yield the weakest outcomes (Aldridge et al., 2017). It is important to note however that across the large base of literature on SBIRT research findings on effectiveness are mixed, and there is significant variability across outcomes used to assess efficacy which does make it challenging to compare or analyze findings across studies (Shorter et al., 2019).

There are multiple ways that interprofessional and intersectoral collaboration can enhance SBIRT efforts. Collaboration may be part of initial efforts to establish an SBIRT process; for example, in designing a tailored screening tool (Hostage et al., 2020), determining intervention priorities and community resources (Maslowsky et al., 2017), and incorporating the screening process into existing workflows and records (Hostage et al., 2020). Collaboration can also occur at the brief

intervention stage. Resource constraints may impact the ability of professionals in a specific context to complete training/education on SBIRT and conduct screening/interventions, which necessitates strong interprofessional and even intersectoral partnerships to implement SBIRT in that context (Barata et al., 2017; Maslowsky et al., 2017). In their systematic review of the use of SBIRT for alcohol use disorders in an emergency department context, Barata and colleagues (2017) found that brief interventions were performed by a variety of different professionals and staff members including physicians, medical students, nurses, social workers, psychologists, community outreach workers, and health promotion advocates. Pannella Winn and colleagues (2019) found initial positive outcomes from their school-based SBIRT model where the brief intervention was done by peers (young adults with lived experience of substance use recovery). These peer-led intervention sessions, which were positively received by both mentors and participants, focused on multiple protective and risk factors, including goal setting, wellness, social supports and influences, risks of alcohol and other drugs, and engagement in community activities (Pannella Winn et al., 2019). Finally, SBIRT depends on successful partnerships/ referral networks with external organizations, including specialty treatment providers (Del Boca et al., 2017). It is important that strong referral networks are developed so that professionals are confident managing individuals who screen positive for being at higher risk of harms; access to appropriate resources needs to be available (Del Boca et al., 2017; Hostage et al., 2020).

An example of how collaboration can happen at different levels of SBIRT is the implementation of SBIRT across ten Wisconsin high schools described by Maslowsky et al. (2017). This initiative arose from a partnership between the University of Wisconsin-Madison and a community-based non-profit organization: IMPACT Alcohol and Other Drug Abuse Service, Inc. The project team engaged with community coalitions and local schools to develop the model of SBIRT that would be used, as well as an implementation and evaluation model for the initiative. Screening consisted of all ninth and tenth grade students answering questions about use of alcohol and other drugs within the past year, as well as follow-up questions to help tailor the brief intervention. Students who reported alcohol or drug use were also given the CRAFFT tool to identify problematic substance use. Screening was done within schools by trained health educators (social work students), to address the lack of time and resources reported by school staff. Immediately after screening, the health educator reviewed students' responses, asked them open-ended questions about their substance use/abstinence, and provided feedback on students' level of risk related to their substance use. The brief intervention was based on Motivational Interviewing and focused on provision of education on potential negative consequences of their substance use to students who wanted to receive it, encouraging reduction/continued abstinence, and helping students who wanted to make changes develop a plan to do so.

Students whose CRAFFT score suggested a substance use disorder were educated on the risks suggested by their score on the screening tool and provided with contact information for local referral agencies. The health educator also asked the student's permission to involve their parent or the school guidance counselor in the referral process. Appropriate referral resources had been identified by the substance use coalitions and included private and non-profit substance abuse treatment organizations. Evaluation results suggest that the model was acceptable to students, who felt comfortable discussing their substance use/abstinence with the health educators. Over 80% of non-substance using students reported they intended to remain abstinent after the SBIRT

session, and a substantial number of students who currently used substances reported that they intended to reduce their use (e.g., 57% “strongly agreed” they wanted to reduce their alcohol use) after the session. Importantly, reported intentions to avoid substance use were high among students who reported pre-SBIRT that they were “not sure”, “likely”, or “very likely” to start using substances in the next year (Maslowsky et al., 2017). The implementation of SBIRT described by Maslowsky et al. illustrates the importance of collaboration between different stakeholders to ensure that prevention activities are appropriate for the target population, meet community needs, address gaps in prevention resources, and draw upon existing resources and partnerships. It is also an interesting application of SBIRT because brief intervention was done with all students, with the intent of preventing onset of substance use among students in addition to the reduction or prevention of harms among those already using substances.

2.2 Collaborative risk-driven intervention: the Hub model

Assessment of individual risk can also lead to intervention that is collaboratively developed rather than driven by referrals to individual professionals. The Hub model, also referred to as the Situation Table Model was inspired by a risk-driven intervention model in Scotland. The first Canadian Hub was implemented in Prince Albert in 2011 (Bhayani & Thompson, 2016). There are now 15 Hubs operating throughout Saskatchewan, including one in Saskatoon (Saskatoon Police Service, 2025). The Hub model is a collaborative, multi-sectoral intervention model that involves the identification of individuals/families with multiple risk factors for imminent harm, and the planning of an intervention to manage risks and prevent harm (Nilson, 2014; Nilson, 2016). Importantly, this model is effective for addressing both harms that are anticipated to occur and those that are actively occurring (Nilson, 2014). As illustrated by Bhayani and Thompson (2016), the model is flexible, and the development of each Hub is grounded in community issues, needs, and capacity for provision of services.

Hubs can involve professionals from numerous different sectors, including police, probation, health, education, addictions, social work, mental health, outreach, and community Elders (Nilson, 2016), with police agencies often playing a significant role in their development and implementation (Bhayani & Thompson, 2016). Since many risk factors are intertwined and have cumulative effects on outcomes, the multidisciplinary approach of the Hub model is important for the prevention of harms (Nilson, 2016). Hub representatives meet regularly (e.g., once a week) to discuss situations of elevated risk. Although mechanisms for identifying situations for discussion vary between Hubs (for example, the Saskatoon Hub will consider cases identified by any member of the public), individuals/families in need of multi-sector intervention are often identified through service providers working at agencies who are part of the Hub. As described by Nilson (2014; 2016), Hub members will consider whether the nominating agency has exhausted all options available to meet the individual/family’s needs (i.e., is there truly a need for collaborative intervention), and whether the situation meets the Hub’s criteria for being a situation of acutely-elevated risk (factors such as the probability of harm occurring, intensity or severity of potential harms, previous efforts to mitigate risks, and multidisciplinary nature of risks). If the situation is deemed appropriate for the Hub, basic information about the individual/family is shared to determine which agencies should be involved in the discussion, followed by a discussion among the appropriate agencies to share additional information and plan the intervention.

The intervention depends on risk factors and context. Typically, an agency representative will connect with the individual and family- in some cases after consulting their relatives and other service provider - to discuss the situation and provide immediate support to reduce the risk of harm. (Nilson, 2014; 2016). Safety planning and Motivational Interviewing are used when appropriate. Safety planning helps individuals to identify risks and create strategies to stay safe. Motivational Interviewing encourages motivation for change through guided conversations.

The Samson Cree Nation Hub will often ask the family if they would like to participate in an intervention circle, to plan intervention support with the individual/family, a familiar Elder, and appropriate agency representatives (Nilson, 2016). Following an intervention, the team reports on the results of the intervention at the next Hub meeting, and either closes the discussion (if sufficient support/services have been put in place) or plans another intervention (Nilson, 2014). A wide variety of health and social services can be mobilized through Hub intervention, as the goal is to quickly connect people to support and resources that will reduce the elevated risks of harm.

While the Hub model is not specific to the prevention of alcohol-related harms, alcohol use may be a predominant risk factor for harm in many situations that are discussed in Hubs. Although Brown and Newberry (2015) reported that alcohol use was a risk factor in less than 20% of the situation table discussions in a Waterloo-region Hub, it was the most prevalent risk factor in Prince Albert Hub discussions (Nilson 2014). Other risk factors in situations discussed by Hubs include (but are not limited to): mental health issues, use of other substances, physical and emotional violence, criminal involvement, crime victimization, poor physical health or self-care, self-harm, missing/runaway, suicide, negative peer involvement, gang involvement, lack of social and/or family support, need for parenting support, parent-child conflict, frequent school truancy, antisocial/negative behaviours, inadequate housing, poverty, unemployment, and radicalization to violence (Bhayani & Thompson, 2016; Brown & Newberry 2015; Nilson, 2014; Nilson, 2016; Thompson & Leroux, 2023).

Evaluation results of Hub models have suggested that they are very successful in quickly connecting individuals/families to services that lower the risks of harm, some of which were not previously accessible to them (Bhayani & Thompson, 2016; Brown & Newberry, 2015; Nilson, 2014; Nilson, 2016). Most clients also respond quite positively to the collaborative interventions, and the model has been successful in increasing trust between at-risk individuals/families and service providers (Brown & Newberry, 2015; Nilson, 2014; Nilson, 2016). The Hub model also appears successful in preventing crisis situations, with reductions in demand for emergency responses and police services after implementation (Bhayani & Thompson, 206; Brown & Newberry, 2015; Nilson, 2016).

Professionals who are involved in Hubs have also reported a number of benefits, including reduced silos in service delivery, reduced feelings of needing to solve complex problems alone, increased ability to provide a tailored response to clients' needs (which are often complex), increased collaboration, trust, and respect among diverse community partners, and increased knowledge of available services within the community (Bhayani & Thompson, 2016; Brown & Newberry, 2015; Nilson, 2014; Nilson, 2016). Addictions professionals participating in the Prince Albert Hub have reported that the Hub is crucial for addressing multiple risks affecting individuals/their families and offering support services prior to a crisis. These service providers

stated that a lot of time was previously spent trying to find out the whole scope of their client's issues and what other services they are involved with, often with limited success. Hub offers the ability to quickly share information and develop a more holistic and immediate response, which addictions professionals saw as incredibly beneficial (Nilson, 2014). It is important to note also that professionals report the benefits of this model extending beyond the Hub discussions/interventions themselves. Benefits such as a more holistic understanding of risks, increased knowledge of services within the community, and relationships with other agencies facilitate better collaboration and service provision to other clients beyond the Hub (Brown & Newberry, 2015; Nilson, 2014; Nilson, 2016). Professionals working in the Samson Cree Nation Hub also noted that the data obtained through Hub discussions has helped their First Nation to identify key needs within their community, which has resulted in the development of new programming to meet those needs (Nilson, 2016).

The Hub model is therefore a promising community model for collaborative, intersectoral prevention of harms, including those where alcohol use/misuse is a contributing factor. Moreover, it is a model that offers broader collaborative benefits and increased cohesion among different agencies. Education/training resources have been created to help communities develop Hubs[2]. Agencies who have not previously been involved within a Hub in their community may also be able to become involved, if the care/services they provide are relevant to the situations that are discussed by that Hub. Given the Hub model's flexibility (e.g., in focus, types of situations discussed, agencies/sectors involved), there is a lot of potential for adaptation. For example, the model has been adapted and evaluated in two Canadian jurisdictions to focus specifically on the prevention of violent extremism (Thompson & Leroux, 2023). It is easy to imagine how a modified version of the Hub model could be implemented to focus more narrowly on alcohol use and the prevention of alcohol-related harms.

2.3 Barriers and facilitators to assessment and intervention for individuals at risk

Several barriers, as well as recommendations, have been identified as important to consider for both SBIRT and the Hub model. Time and human resource constraints are notable barriers to successful implementation of these models (Hunt et al., 2022; Monico et al., 2021; Nilson, 2014; Nilson, 2016; Wouldes et al., 2021).

In primary care settings, even when primary care providers feel it is important for them to be the ones implementing screening processes with their patients, the time constraints (especially when patients are there for acute care) make successful implementation challenging (Monico et al., 2021). In their review of the literature on SBIRT with adolescents, Mitchell et al. (2013) noted that time constraints may vary widely between settings, with the possibility of fewer time constraints for screening/brief intervention in settings such as schools. Another barrier to SBIRT is a lack of well-integrated hand-off/referral processes. Referrals may be underutilized due to limited provider knowledge or limited availability of available and accessible resources (Monico et al., 2021; Hostage et al., 2020; Hunt et al., 2022; Wouldes et al., 2021). In relation to the Hub model, effectiveness is hampered when there is turnover of Hub members, lack of representation from

[2] Examples of such resources are: E-Learning Products | The Global Network for Community Safety & Well Being and 0001 Situation Table Training | Laurier Continuing Education.

relevant agencies, and time constraints for members that lead to limited or inconsistent engagement in discussions and intervention (Nilson, 2014; Nilson, 2016). Other barriers to the success of both these models include client/patient refusal of services or treatment and limited leverage over clients to facilitate good outcomes, and challenges with managing or adjusting to workflows (Nilson, 2014; Nilson, 2016; Hunt et al., 2022).

While the above are common barriers, other barriers may also be pronounced within or specific to contexts. For example, in the implementation of SBIRT in prenatal settings, major barriers to the success of SBIRT are provider misperceptions that the vast majority of pregnant individuals abstain from alcohol and harmful drug use, concerns about damaging rapport with the patient by inquiring about their use of alcohol and drugs, and perceptions that screening is ineffective because individuals will under-report their substance use due to stigma (Wouldes et al., 2021). Important considerations for implementing Hubs are how privacy and consent can be managed, given the extent of the information that needs to be shared about individuals and families for effective collaborative intervention. Nilson (2014) described how these barriers were overcome by working closely with a multi-sector task force of legal and policy experts on privacy, to develop Hub processes in ways that best protect the privacy and autonomy but also the safety of Hub clients. Key to these discussions were understanding how the *Health Information Protection Act* and other forms of legislation and regulation are tools not only to protect individuals' privacy, but also to protect individuals from harm. Because Hubs work with situations of acutely elevated risk, there are opportunities to share information between professionals and intervene without explicit prior informed consent from Hub clients (Nilson, 2014).

Some potential facilitators and recommendations for implementing both Hub and SBIRT models have been identified as well, which can help address the barriers above. Having community and individual organization buy-in and the development of trust and cooperation between participating organizations/members are important facilitators of success for Hubs (Nilson, 2014; Nilson, 2016). Recommendations include: ensuring that both relevant agencies and suitable individuals from those agencies (those who are team players, open-minded, non-judgmental, and problem solvers) are involved; working on ways to ensure that Hub members can successfully balance Hub work with their primary organization duties (i.e., via additional agency staff and/or reallocation of work); developing close relationships between participating organizations as a whole rather than just individuals who are Hub representatives; and developing a follow-up mechanism to ensure that Hub clients are not just connected to services but are successfully engaging with them (Nilson, 2014; Nilson, 2016).

Some general potential facilitators and solutions to barriers have also been identified for SBIRT models. To address time and resource constraints, the question of who is doing screening and brief intervention should be carefully considered. If screening is happening in a primary care context, there may be opportunity for someone other than primary care physicians (such as intake staff, social workers, or behavioural health providers) to complete the screening; use of electronic screening tools may address the barrier of time constraints reported by primary care providers (Hunt et al., 2022). Collaborative partnerships may also support the conduct of brief interventions by specialized interventionists, which can also help reduce time constraints on providers in the setting where initial screening occurs (Mitchell et al., 2013; Vendetti et al., 2017). Leveraging support from interprofessional team members like social workers and clinical

educators was identified by nurse site coordinators as a key facilitator of implementing SBIRT processes within acute care settings (Keen et at., 2021). Other facilitators include: comprehensive provider education and training prior to implementation; tailoring implementation strategies to the barriers and strengths of the implementation site/s; strong and committed leadership, champions, and buy in from staff; early involvement of the electronic health records team to incorporate SBIRT into existing workflows; the development of strong inter-organizational communication, collaboration, and referral pathways; offering co-located services or remotely delivered intervention to enhance referral success; and ongoing monitoring/feedback on SBIRT processes (Hostage et al., 2020; Keen et al., 2021; Vendetti et al., 2017).

3. Prevention of Alcohol-Related Harms Through Collaborative Interprofessional Care and Programming

3.1 Interprofessional care teams

One type of interprofessional collaboration is referred to as “integrated care”. Although there is significant variation in how this term is used, integrated care in the context of individuals with alcohol use disorder (AUD) may refer to coordination between AUD-specific services (e.g., detoxification, residential rehabilitation, treatment) as well as coordination between AUD-specific services and non-AUD specific services like housing, mental health and parenting support (Savic et al., 2017). In their review of approaches to facilitate integrated care, Savic et al. (2017) found that case management was the most identified approach that is useful for facilitating integrated care for individuals with multiple and complex needs, while referral was useful as a simple integrated working strategy when an individual’s needs cannot be met in one location/by one agency. Integrated care may occur on a spectrum, with co-located multidisciplinary care being the most integrated form (Haque & Leggio, 2014).

As a form of integrated care, interprofessional team models are increasingly being implemented within the health system context to integrate care for individuals with problematic alcohol use who are experiencing alcohol-related harms. These are collaborative, multidisciplinary efforts by professionals such as hepatologists, gastroenterologists, psychiatrists, psychologists, nurses (including psychiatric nurses), general practitioners, social workers, support workers, and addictions or alcohol specialists, to reduce alcohol use and prevent further alcohol-related harms (Haque & Leggio, 2014; Holbeck, DeVries, & Singal, 2023; Hughes et al., 2013; Kools, et al., 2022; Mellinger et al., 2021; Moriarty, 2020). Many of these collaborative care models are specifically for individuals who have alcohol-associated liver disease (ALD) to help redress the high proportion of individuals in this population who do not receive support and treatment for alcohol use disorder (Haque & Leggio, 2014).

An example of an interprofessional care team is the Michigan Alcohol Improvement Network (MAIN) ALD clinic described by Mellinger et al. (2021). This is a clinic-based model where a hepatologist, psychologist, psychiatrist, nurse, and social worker convene for a half-day clinic two to three times a month, at which two or three patients with alcohol-associated liver disease are thoroughly evaluated (social, past medical, psychiatric, and substance use histories; physical and mental status examinations; laboratory tests; and baseline assessments of mood, anxiety, sleep, alcohol, and drug use). The care team meets at the end of the clinic session to review the patients

seen, and treatment planning is personalized (based on evaluations, patient readiness for change, and AUD treatment preferences). The team also meets regularly to assess interval patient data and strategize on next steps for each patient. The care team may refer patients to additional resources as needed and use telemedicine visits to reach patients with limited access to local care. This multidisciplinary team model showed promising early outcomes in encouraging one-on-one alcohol use disorder treatment and use of relapse prevention medications. Emergency department utilization and inpatient hospitalizations decreased by over 50% during the six months following individuals' initial clinic visit, and their scores on a measure of liver disease severity significantly improved (Mellinger et al., 2021).

Other research has shown similarly positive outcomes for multidisciplinary care teams, suggesting they reduce use of alcohol and associated harms. A systematic review of integrated care for liver disease patients suggested that an integrated care model reduces the risk of alcohol relapse and leads to an 81% reduction in patient mortality on long-term follow up (Elfeki et al., 2023). Results from a randomized controlled trial of another collaborative, multidisciplinary care team model in primary care that focused on care management and outreach for individuals with opioid and alcohol use disorders also showed positive outcomes (Watkins et al., 2017). Patients in the collaborative care group were significantly more likely to report substance abstinence from alcohol and other drugs at six months compared to those getting usual care, and were also more likely to have initiated and engaged in treatment and be receiving psychotherapy.

Hughes and colleagues (2013) described the alcohol assertive outreach team, which is an intensive case management model developed for patients with ALD who have at least two hospital admissions solely attributable to alcohol as well as the patients with the highest number of alcohol-related admissions. Multi-sector team members developed a case file on each patient and individual plans were implemented based on their needs; these included fast access to alcohol detox, referral and support getting to outpatient specialist services, alcohol and psychological support, and assistance with housing. Patients were intensively managed for six months, which included the use of assertive outreach strategies like repeat phone calls, letters, and home visits. The alcohol assertive outreach team model significantly reduced both emergency department visits and hospital admissions (Hughes et al., 2013).

Interprofessional care models have also been developed for individuals who are pregnant or new parents and use substances. Collaboration between multiple professionals can reduce harms by addressing not only substance use during pregnancy but also many of the factors that contribute to or are associated with it (e.g., homelessness, poverty, gender violence, mental illness, inadequate health care, stress, and medical conditions like HIV, liver disease, and hepatitis; as cited in Gulbransen et al., 2024). In their recent scoping review, Gulbransen and colleagues (2024) identified eleven articles describing interprofessional care teams that provided care to individuals using substances through the periods of pregnancy, birth, and postpartum. All the care teams included an obstetrician, and other team member roles included a midwife, nurse practitioner, patient navigator, pharmacist, nutritionist, childcare provider, dental hygienist, cultural liaison, art therapist, music therapist, and spiritual care provider. Having choice regarding which professionals they desire interaction appears to enhance client experience and foster their autonomy. These interprofessional care models emphasized collaboration among care providers (including the importance of multidisciplinary team meetings). Co-location of as many services as

possible was helpful to reduce client access barriers and facilitate communication and care planning among professionals. These programs also relied on strong partnerships with external community organizations.

Central to this model of care is the incorporation of trauma-informed and harm reduction principles. The reviewed programs also reported themselves as emphasizing approaches that were non-judgmental, respectful, positive, relational, and focused on trust and shared decision-making, although there was often limited description of how these principles were actioned. Key findings from the studies in this review included decreased substance use, as well as initiation and maintenance of substance use disorder treatment, increased engagement in prenatal care, improved neonatal outcomes such as decreased preterm deliveries and neonatal intensive care unit admissions, and increased client/baby togetherness and custody (Gulbransen et al., 2024). Although this review did not focus on program challenges and facilitators, tension between billable service guidelines and the need for frequent, supportive client interactions and addressing dual needs (newborn and parents) when substance use is continued were noted by program leaders as barriers. Interprofessional care can also remain siloed despite collaborative efforts, but program champions are important to the success of interprofessional care models.

3.2. Wraparound services for individuals who are pregnant or parenting

Collaborative interprofessional services that address the prevention of alcohol-related harms may not always have substance use as their primary focus. Interprofessional, multi-service "wraparound" programming (where health and social services and supports are "wrapped around an individual" at a single location) for individuals who are pregnant or parenting are also a way to prevent alcohol-related harms including FASD, although they may not represent themselves specifically as FASD prevention programs due to stigma (Rutman & Hubberstey, 2019). Similarly, pregnant and parenting individuals may access this type of programming for multiple reasons (help addressing substance use in addition to help with other issues) or have other motivations, such as desire for help with child welfare/parent-child connection, support with housing, or help with support/information/services related to pregnancy, prenatal care, or health care (Hubberstey et al., 2019). Some clients reported being initially drawn to programs for meals and support with other basic needs, then remained to access a broader scope of services (Rutman et al., 2020). Programs addressing the use of alcohol and other substances that incorporate practical and integrated wraparound supports are valued highly by clients, as they help to address issues that may perpetuate substance use or create barriers to addressing it (Krakouer et al., 2022; Rutman et al., 2020).

The Co-Creating Evidence: National Evaluation of Multi-Service Programmes Reaching Women at Risk (CCE) project was a three-year evaluation of eight interprofessional, multi-service programs in Canada that were designed to holistically address a variety of needs of individuals at risk of having an infant with prenatal substance exposure (Hubberstey et al., 2021). The details of these programs can be viewed in Hubberstey et al. (2021), but all involved a range of professionals and facilitated a range of health, wellness, cultural, social, and practical supports for clients through core program services, co-located services, and contracted services/collaborative partnerships with external organizations. Both formal and informal partnerships were crucial for ensuring that clients' needs could be met, including primary and specialized health, prenatal and addictions

care, Indigenous cultural support, housing and income assistance, and assistance with child welfare issues (Hubberstey et al., 2021). Important aspects of partnerships included participation in case meetings or joint planning meetings, information sharing agreements, secondment of staff to work on-site, staff-sharing, mutual referrals, access to resources, attending or offering training, and provision of regular on-site services. Service providers and program staff identified a number of additional benefits to these partnerships, including: improved access to services; increased ability to address social determinants of health challenges that pose barriers to service access; increased understanding across partners of addictions and interconnected issues, including the impacts of trauma; a shift towards less judgmental attitudes and an increased use of trauma-informed approaches to services; increased support for Indigenous cultural connection; and increased cross-sectoral understanding (of programs, services, partners' roles, and clients) and trust (Hubberstey et al., 2021).

Client feedback on the wraparound programs in the CCE study was very positive; having a range of health and social care services in one place helped them participate in programming, attend various appointments, address multiple needs at the same time, and build trusting relationships with care providers (Rutman et al., 2020). Some of the key elements appreciated by clients included the program approaches (relational, harm reduction, trauma informed, and culturally safe), support related to child welfare, access to key parenting and pediatric services for their children, and opportunities to be introduced to or re-engage with Indigenous programming and traditional cultural activities and ceremonies (Rutman et al., 2020). The most frequently reported "most significant change" that took place for clients since participating in their program was quitting or reducing their substance use, and 79% of respondents agreed or strongly agreed on the client questionnaire that the program had helped them quit, reduce, or engage in safer substance use (Hubberstey et al., 2019).

The reduction in substance use was often intertwined in clients' responses with other themes, illustrating the importance of addressing multiple needs in efforts to reduce alcohol-related harms for individuals who are pregnant or parenting. Other frequently reported "most significant changes" were strengthened parent-child connection and sustained or regained custody, improved wellness and mental health, increased perceived support (both professional and peer), access to safe and adequate housing, increased self-confidence/self-esteem, reduced isolation, and increased self-compassion and self-determination (Hubberstey et al., 2019). Although pre-post assessments of substance use and substance-use related harms were not reported in this series of articles, the array of benefits reported by both professionals and clients suggest that multi-service programming is an effective form of collaboration for addressing the prevention of alcohol-related harms and associated challenges among individuals who are pregnant and/or parenting.

3.3. Barriers and facilitators to collaborative inter-professional care and programming

Successful intersectoral and interdisciplinary collaborations are likely to have structured frameworks for communication and feedback, clear agreements that involve key decision makers and can be flexible/re-negotiated, shared and/or consensus-based decision making, reflexive practices, ongoing trust-building activities among team members, committed sponsors, and

effective champions and leadership (Bryson et al., 2006 and 2015; Chircop, Bassett, & Taylor, 2015).

Many of these factors were mentioned in discussions of barriers and facilitators to collaborative interprofessional care and programming related to the prevention of alcohol-related harms. In their review of strategies to facilitate integrated care for people with alcohol and other drug problems, Savic et al. (2017) found that strong interagency relationships were critical to the success of interprofessional referrals, information sharing, joint programming, and consultation. A major barrier to these models is the tendency for different institutions to be siloed, which may be exacerbated by complexities associated with reimbursement, incompatible organizational structures, different collective interests vs. individual organization priorities, and lack of broader institutional or sector support, buy in, and knowledge about the collaborative program or service (Auschra, 2018; Gulbransen et al., 2024; Haque & Leggio, 2014; Hubberstey et al., 2021). As one example, a challenge reported for programs serving pregnant and parenting individuals with substance use issues was tension between programs and child welfare authorities that arose from differences in philosophy and risk tolerance levels, institutional barriers, and low engagement and knowledge about the program because of frequent turnover among child welfare staff (Hubberstey et al., 2021). Robust structures for interprofessional communication are therefore crucial to the success of interprofessional care models. These structures may include regular meetings, joint assessment or case review, joint development of care plans, secondary consultation, and shared locations for storing data such as electronic health records (Gulbransen et al., 2024; Kools et al., 2022; Moriarty, 2020; Savic et al., 2017). Although individuals in professional roles that are more peripheral to a program or a client/patient's situation can be brought into regular communications on a need or consultation basis, it is important to have a core base of stable members who are frequently present (Kools et al., 2022).

Co-location was noted as a factor that can facilitate strong interprofessional communication as well as facilitate client access to care/services (Hubberstey et al., 2021; Savic et al., 2017). Hubberstey et al. reported that co-location helped collaborative partners understand clients' experiences and challenges, which assisted them in developing an approach to care that was trauma-informed, harm-reduction focused, and non-judgmental. Other facilitators of successful collaborative interprofessional care and programming include robust training and education to increase all collaborators' knowledge of pertinent topics related to alcohol-related harms, emphasizing shared goals and purpose within collaborative efforts, and ensuring that all providers have a clear understanding of their role (Kools, 2022; Moriarty, 2020; Savic et al., 2017). Finally, lack of effective leadership and coordination can hinder collaborative efforts; having strong leadership as well as committed champions may facilitate interprofessional collaborative models (Auschra, 2018; Kools et al., 2022).

4. Prevention of Alcohol-Related Harms Through Collaborative Community Based Prevention Models

4.1 Collaborative community-based prevention of alcohol-related harms

Community-based models aim to address the prevention of alcohol-related harm across a whole community, which can include both place-based communities and distinct sub-populations (i.e., based on common identity/demographic factors, substance abuse risk, common purpose like a school) (Walmisley et al., 2024). Community-based harm prevention models may include policies and interventions on the "supply" side, which aim to decrease the physical and economic accessibility of alcohol, as well as the "demand" side, which aim to modify individuals' desires and behaviours related to alcohol consumption (Kypri & Connor, 2018; Stockings, Shakeshaft, & Farrell, 2018). In their review of community approaches for reducing alcohol-related harms, Stockings et al. (2018) found that population-level demand-reduction strategies, such as public health messages, community outreach, and school-based education were the most utilized community-based prevention strategies. "Supply" side strategies were underutilized, which is unfortunate since research suggests that policies like increases in taxation and prices of alcohol are effective in decreasing alcohol consumption at the population level and are associated with decreases in alcohol-related hospital admissions, mortality, violence, crime, road fatalities, and sexually transmitted infections (Burton et al., 2017). Another, more recent review (Porthé et al., 2021) found that effective community-based interventions to reduce alcohol consumption and related harms shared three components: community mobilization (consisting of education and sensitization of different agents across multiple sectors), law enforcement (enhancing compliance with rules around alcohol and sanctioning non-compliance), and media campaigns (awareness and prevention messages via different media).

Importantly, community-based prevention models need to be based on the specific needs and goals of the community and are ideally collaborative efforts informed by stakeholders from multiple different sectors; they also need to be grounded in the community's cultural worldviews and concepts of health and wellness (Miller et al., 2024; Walmisley et al., 2024, Wolfson et al., 2019; Subba et al., 2018). This is critical when developing models to prevent alcohol-related harms within First Nations and Métis communities (Freeman et al., 2019; Wolfson et al., 2019). Freeman and colleagues (2019) described an Indigenous community-led collaborative model of prevention in Australia, developed by Aboriginal Community Controlled Health Service (Congress) that provides primary health services to Indigenous people in the area. Congress's model has included a number of activities to prevent or reduce alcohol-related harms, including: screening and brief intervention for alcohol use; health education; early childhood programs; a night shelter and pick up service to reduce incarceration for public intoxication; supply reduction measures to reduce take-away hours, outlets, and remove cheap alcohol from the market; and a multidisciplinary treatment program that includes intensive case management as well as a social and cultural support stream that addresses positive social and cultural determinants of health (Freeman et al., 2019). Congress's prevention efforts are community led, with a community board driving program planning and service delivery and engagement in many community forums to understand community needs. Congress is also a leading partner in the People's Alcohol Action Coalition, a community coalition that advocates for evidence-based alcohol supply measures.

Finally, collaborative efforts with other sectors (e.g., employment, education, housing) are aimed at addressing the social determinants of Aboriginal health and indirectly reducing alcohol-related harms (Freeman et al., 2019). Critically, Congress's activities to prevent and reduce alcohol-related harms are grounded in Indigenous knowledge and worldviews and aim to empower individuals in the community and support self-determination. Congress's collaborative work has also included anti-racism activism, to increase awareness of racism in the health system (Freeman et al., 2019). Congress's efforts to prevent and reduce alcohol-related harms are in line with Wolfson et al.'s (2019) calls for FASD prevention in Indigenous communities to reflect the Eight Tenets for Enacting the Truth and Reconciliation Commission's Call to Action #33, which calls on governments to prioritize the prevention and management of FASD and collaborate with Indigenous people to deliver culturally appropriate programming. The Eight Tenets (Figure 1) were developed based on research and the perspectives of expert stakeholders, via dialogues organized by the Centre of Excellence for Women's Health, the Thunderbird Partnership Foundation, and the Canada FASD Research Network[3].

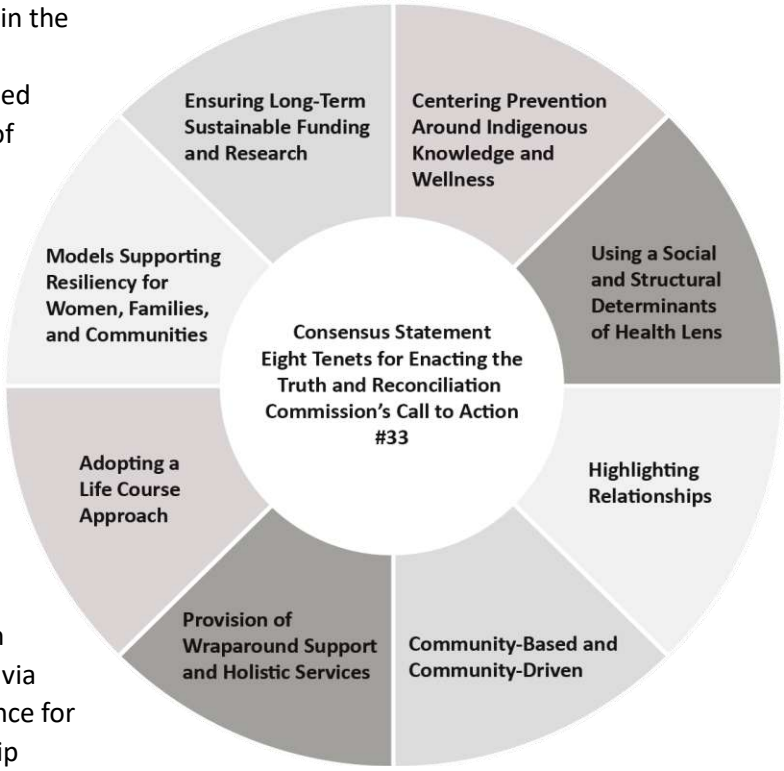

Figure 1. From Wolfson et al., 2019, p. 1593

4.2 Strategies to collaborate with community in the development of community-based prevention models

Stockings et al. (2018) found that community mobilization was a widely used strategy in the development of community prevention models. Mobilization involved the formation of local coalitions and community action teams, whose purpose was to identify community-specific risks and needs and develop partnerships between community leaders and key stakeholders across relevant sectors (Stockings et al., 2018). Similarly, Walmisley and colleagues (2024) reported in their scoping review that core components of successful interventions were community coalitions or networks, incorporation of community norms, community engagement via community meetings, and support/awareness raising. By bringing together community members and other key stakeholders from relevant sectors, communities can develop plans to reduce alcohol-related harm that are grounded in community needs and culture.

[3] The Eight Tenets Consensus statement can be accessed here: Consensus-Statement-Eight-Tenets-June-1.pdf

Community coalitions and communities of practice can function as part of the implementation of alcohol strategies or frameworks, as described in the discussion of the Strategic Prevention Framework and Communities that Care, below. Community coalitions are groups made up of different stakeholders within the community (e.g., representatives of service organizations, health care organizations, government agencies, local business, educators, informal and formal community leaders) who work collaboratively towards prevention goals (Flewelling et al., 2005 and Zakocs & Edwards, 2005; as cited in Maslowsky et al., 2017). Flewelling and Hanley (2016) identified several "noteworthy examples" of programs that involve community coalitions and have been rigorously evaluated: the Community Trials Project, Communities Mobilizing for Change on Alcohol, Reducing Youth Access to Alcohol, PROSPER, and Communities That Care. Communities That Care is described in detail below, as an example of this type of collaborative community action to prevent alcohol-related harm.

Miller and colleagues' (2024) harm reduction collaboration framework also highlights the importance of including individuals who use substances as key stakeholders in the development of policy, systems, and environmental change[4]. Their framework encourages collaboration between individuals and organizations, so that the interests of both the organization and those who use substances are jointly reflected in partnerships with other organizations and sectors. Service providers and key stakeholders can also ensure that community policies and programs to reduce alcohol-related harm are developed in collaboration with broader community members and service users, so they are community-driven, culturally appropriate, and will meet the needs of those at risk of alcohol-related harms. These individuals can be part of community coalitions, action groups, and communities of practice, or they can be included in co-designing specific interventions, programs, and services. For example, Vallentin-Holbech and colleagues (2020) provided an in-depth description of the collaborative co-design of a virtual alcohol prevention simulation (VR-FestLab) with young adults, illustrating how such collaboration can be done successfully. Another good description of co-design processes is offered by Hall et al. (2023), who explain the process, principles, and tools used by multiple stakeholders (including intersectoral service providers and families) to co-design an integrated health and social care Hub for families experiencing adversity.

4.3 The Strategic Prevention Framework

The Substance Abuse and Mental Health Services Administration (SAMHSA) developed a data-driven framework to help guide communities' efforts to prevent harm related to alcohol and other substances. The framework, entitled the Strategic Prevention Framework (SPF), is specifically designed to facilitate community-based prevention and emphasizes collaboration between diverse partners within the community (SAHMSA, 2019). The framework guide[5] walks service providers, prevention professionals, and other stakeholders in prevention through five

[4] While this framework was developed specifically in relation to harm reduction with people who inject drugs, it can be applied to harm reduction related to use of other substances as well.

[5] The Strategic Prevention Framework guide can be accessed here: https://store.samhsa.gov/sites/default/files/strategic-prevention-framework-pep19-01.pdf

steps, which are depicted in Figure 2 and described below. The inner circle emphasizes the importance of cultural competence (ability to understand and value the importance of cultural worldviews and engage effectively with people from diverse cultural groups) and sustainability (the need for the community to be able to maintain positive prevention outcomes over time) in all prevention efforts (SAMHSA, 2019).

Figure 2. SPF steps, From SAHMSA, 2019, p. 4

The first step in the Strategic Prevention Framework is *Assessment*. This involves the collection or collation of data by practitioners and planners about the substance use problem/s and related behaviours within the community. By assessing the nature of the substance use problems and related harmful behaviours, their prevalence, where they are happening, and who is the most impacted, stakeholders can determine community priorities for prevention. If data is not available for collation from various sources within the community already, it may need to be collected. Stakeholders involved in prevention planning will want to collaboratively consider the magnitude, severity, trends over time, and potential changeability of problems and harmful behaviours to determine priorities. Planners will also need to examine the risk and protective factors that are associated with the substance problem and behaviours within their community. Stakeholders involved in prevention planning also need to assess the capacity for prevention, which includes both resources and community readiness. Readiness is dependent on knowledge of the problem/behaviours, existing efforts to address them, availability of resources, support of local leaders, and community attitudes towards the problem. This stage should include representatives from all relevant sectors within the community, including conversations with local decision makers and public opinion leaders. Once a needs and capacity assessment has been completed, key findings need to be communicated to prevention stakeholders, and further input on results (including from the general community) should be obtained (SAMHSA, 2019).

The second step in the SPF is *Capacity*, which involves building on the resources and readiness that currently exist. Capacity building involves engagement of diverse community stakeholders, including general community members, service providers across relevant sectors, and community leaders. SAMHSA's guide to the Strategic Prevention Framework includes specific suggestions for how to initially engage stakeholders and how to encourage further involvement from those who are already engaged, reproduced in the table below.

The Capacity step also involves the development or strengthening of the prevention team/task force. This team should be a subset of the relevant stakeholders who have been identified and be representative of multiple sectors. Finally, capacity building includes raising community awareness about the problem, which can be done through a variety of means including (but not limited to) public opinion leaders, distribution of information through task force members, media and social media outlets, and community events. (SAHMSA, 2019).

Table 2. Strategies for engaging stakeholders (from SAMHSA, 2019, p. 12)

Initial invitations for engagement	Strategies to strengthen involvement
Call known contacts, particularly those with overlapping interests	Meet face-to-face to discuss overlapping goals and agendas
Attend and speak up at community meetings and events	Extend an invitation to attend a prevention team or task force meeting
Ask partners to contact their partners	Once prevention planning is underway, make specific requests for involvement
Keep potential partners well informed about prevention activities and progress	Extend invitations to attend future prevention events and activities
Meet with key players, including public opinion leaders and local decision makers	Maintain relationships by keeping stakeholders informed of prevention activities and progress made
Anticipate and overcome roadblocks (e.g., address the concerns of those who might oppose or hinder prevention efforts	

The third step in the SPF is *Planning*. The planning process involves prevention team stakeholders working together to consider the risk and protective factors that were identified during assessment and selecting appropriate programs and practices to address those that are deemed to be the priority. The largest impact will come from prioritizing risk and protective factors that are high in both importance and changeability. When choosing the prevention activities or practices to implement, it is important to consider its conceptual fit (does it directly address one or more of the priority risk and protective factors); the evidence base for its effectiveness, and its practical fit (e.g., cultural relevance, community capacity to sustain it, fit with existing services or prevention activities)[6]. It is useful to develop a logic model, which maps out the connections between the problem/behaviours, underlying factors, programs/practices to effect change, and intended outcomes. The logic model can then be shared with both prevention partners and other prevention stakeholders who are not yet involved in the prevention efforts (SAHMSA, 2019).

The fourth step in the SPF is *Implementation*. This is the phase when the community's prevention plan is put into action. There are many factors that combine to influence the success of prevention efforts. These include the involvement of experts, leadership and administrative support, selection of appropriate providers, provider training and support, a clear implementation

[6] SAHMSA has also developed a guide for choosing best-fit prevention practices and programs, which can be accessed here: https://store.samhsa.gov/sites/default/files/selecting-best-fit-programs-pep19-02.pdf.

plan, and implementation monitoring to ensure that the program or practice is functioning as intended (SAHMSA, 2019).

The final step in the SPF is *Evaluation*. Evaluation activities help communities to systematically document prevention activities, meet the information needs of prevention stakeholders, improve programs and practices, demonstrate the impact of programs and practices, identify which parts of a comprehensive prevention plan are working well, and build credibility and support for effective prevention programming within the community. Evaluation should focus on both the process and outcomes of prevention activities. As with the other steps in the framework, evaluation efforts should be collaborative and include diverse stakeholders (SAHMSA, 2019).

There is some research to support use of the Strategic Prevention Framework in community-based prevention of alcohol-related harms, particularly in relation to the successful implementation of policies and strategies to reduce adolescents' access to and use of alcohol, including binge drinking (Anderson-Carpenter et al., 2016; Eddy et al., 2012; Flewelling & Hanley, 2016; Peterson, et al., 2019). Eddy and colleagues (2012) provided a good description of the implementation and outcomes of the SPF in Eau Claire County, Wisconsin, where under-age drinking was identified as a major problem. Organizations across the County Health Department, school districts, law enforcement, physicians, and youth organizations formed a collaborative alliance to lead prevention efforts. Prevention focused on evidence-based school-based programming for youth, parent programming to teach parents strategies for setting and enforcing clear standards of behaviour while strengthening family bonds, and a multi-faceted environmental program to raise community awareness and pursue policy and practice changes. Community action teams in four municipalities were also developed through the implementation process, which worked on their own priorities to address underage drinking. Using the SPF as a model, the initiative developed countywide assessments of underage drinking, developed and strengthened prevention alliances, and measured significant countywide reductions across the prevention initiative period in monthly alcohol use (8.6%) as well as binge drinking (5.8%). There was also a 20.5% decrease in students who reported that alcohol was easy to get, and the age at which students first reported use of alcohol increased by almost a year (Eddy et al., 2012).

4.4 Communities That Care

Like the Strategic Prevention Framework, Communities That Care (CTC) is a collaborative, community-based harm prevention framework aimed at addressing priority risk and protective factors for substance use as well as other behaviours that may cause harm. Its focus is specifically on prevention activities with early adolescents. As with SPF, evidence-based prevention activities are selected for implementation that are based on the specific profile of the community via assessment of the presence of problems, identification of risk and protective factors, existing prevention resources, and determining prevention priorities (Hawkins, Catalano, & Arthur, 2002). The CTC involves five phases, summarized below in Table 2:

Table 2: The 5 Phases of Communities That Care (The Centre for Communities That Care, 2024)

Phase	Activities
Phase 1- Get Started	• Establishment of a group of key community leaders • Determining interest in and readiness for CTC • Identification of a lead organization • Hiring a community coordinator/facilitator
Phase 2- Get Organized	• Formation of a community board or selection of an existing coalition • Creation of a vision statement • Learning about prevention science • Organization of workgroups and timelines
Phase 3- Develop a Community Profile	• Collection and review of data from the community's youth survey • Identification of priority risk and protective factors for targeted problems/behaviours • Assessment of current resources addressing the priority factors • Identification of gaps and prevention needs
Phase 4- Create a Community Action Plan	• Creation of a prevention plan for the community, to reduce risk factors and strengthen protective factors • Defining clear, measurable outcomes • Selection of evidence-based policies and programs
Phase 5: Implement and Evaluate	• Implementation of selected programs and policies • Monitoring and evaluation

Like the SPF framework, Communities That Care emphasizes collaboration between different stakeholders across multiple sectors (Hawkins et al., 2002; Quinby et al., 2008; Shapiro, Oesterle, & Hawkins, 2015). The formalization of a community coalition, who receives training and technical assistance to develop their capacities related to prevention, is the central force in planning and implementing prevention efforts within the community (Quinby et al., 2008). A goal of the CTC framework is to create commitment and a sense of shared "ownership" over prevention initiatives among coalition members. To meet this goal, CTC creates opportunities for coalition members to learn about prevention science and programming, and develop skills in collaboratively assessing community priorities, strategic prevention planning, and evaluation (Hawkins et al., 2002). These activities are thought to create stronger bonds and collaboration among members and organizations who are from diverse sectors within the community (Hawkins et al., 2002). The CTC does not prescribe who leads prevention efforts; collaborative leadership from a variety of organizations is encouraged (Hawkins et al., 2014). Shapiro et al. (2015) found that CTC coalition members from 12 communities implementing the CTC reported that diverse sectors were "somewhat involved", suggesting that some sectors may dominate these coalitions. The sectors most frequently reported as being "very involved" by coalition members were social service providers, school district administrators, and teachers and school staff, although between 30% and 40% of members also reported community residents, law enforcement, and recreation

officials as being very involved in coalition efforts (Shapiro et al., 2015). Other sectors who were sometimes reported by the coalition members as very involved (suggesting that they were key players in a small minority of coalitions) were religious leaders, unelected and elected leaders, parents, youth, business leaders, and media representatives.

Evidence from a longitudinal, randomized community trial of Communities That Care across 24 communities (12 intervention communities and 12 matched controls) in the United States suggests that this prevention framework can successfully guide prevention efforts at the community level (Hawkins et al., 2008; Kim et al., 2015; Hawkins et al., 2014; Oesterle et al., 2018). Intervention communities used the CTC framework to identify community-specific problems and associated risk and protective factors and implemented a variety of prevention programming at the school, community, and family levels to address them. The literature cited above describes the long-term follow-up of youth from CTC and matches communities from fifth grade until age 21. Data from this large trial showed early positive effects of CTC prevention programming on delinquent behaviour, but not initiation of alcohol and other substance use (Hawkins et al., 2008). As programming continued and youth aged from grade seven to grade ten, reductions in risk factors for problem behaviours as well as the incidence and prevalence of delinquent behaviours and substance use were observed in CTC communities compared to control communities (Hawkins et al., 2009; Hawkins et al., 2012). CTC community youth also reported higher levels of several protective factors compared to control community youth: community opportunities for prosocial involvement; school recognition for prosocial involvement; interaction with prosocial peers; and social skills (Kim et al., 2015).

Eight years after implementation of the CTC framework, ten of the twelve community coalitions were still active and implementing prevention activities aimed largely at early adolescents (Hawkins et al., 2014). Follow up of the initial cohort of youth (now in grade 12) showed that youth in CTC communities were more likely than control community youth to have abstained from alcohol, cigarettes, and marijuana through grade 12, and were less likely to have engaged in delinquent or violent behaviours. Risk factors at this time point and current *prevalence* of drug use, and delinquent or violent behaviours did not differ between control and CTC communities. Follow up at 21 years of age showed that youth in CTC communities were still more likely to report sustained abstinence from alcohol, tobacco, and marijuana and were less likely to have ever reported antisocial or violent behaviours, suggesting that the use of the CTC framework to implement community-based prevention programming can achieve positive effects that are sustained long term (Oesterle et al., 2018).

4.5 Barriers and facilitators to collaborative community-based prevention models

Collaborative community-based prevention models typically involve a broad range of stakeholders and multiple large-scale prevention activities, so collaborative relationships and coordination can be challenging. Some potential barriers to implementing intersectoral prevention models identified in the reviewed literature include differences between organizations or sectors related to funding and agendas/goals, political climate, inconsistent or incompatible legal regulations, bureaucratic inefficiencies, and the need to manage broader community perceptions of interventions (Andrade et al., 2014; Eddy et al., 2012; Miller et al., 2024). There may also be barriers specifically related to the involvement of individuals with lived experience in prevention

efforts, such as the toll it can take on individuals to provide input based on their lived experience, and power imbalances that make it hard for individuals to express critical views or leave them feeling on the periphery of decision-making (Hall et al., 2023; Piakowski & Kill, 2024). To address these barriers, it is important to build trust among collaborators and ensure that people with lived experiences not only have a voice but also are true leaders in policy decision-making (Hall et al., 2023; Piakowski & Kill, 2024). Additionally, many important stakeholders may not realize they can play a part in intersectoral prevention collaboration, so it is necessary to find ways to effectively engage relevant stakeholders within the community (van Rinsum et al., 2017). The concept of a health broker may be of use in community-based prevention models. A health broker is a formalized role within a system or sector that is specifically focused on supporting the development and maintenance of intersectoral collaboration to improve health promotion (Harting et al., 2011; van Rinsum et al., 2017). These individuals can locate and seize opportunities for new collaborations, create connections between relevant stakeholders, facilitate communication, and assist with the incorporation of knowledge into prevention efforts (Harting et al., 2011; van Rinsum et al., 2017).

Some researchers have specifically examined the collaborative mechanisms within SPF, since collaboration and mobilization of actors from diverse sectors to implement prevention strategies is key in use of the framework (Peterson et al., 2019). Some factors that facilitate the ability of community coalitions/action groups to develop and implement interventions, practice changes, and policy are: presence of strong leadership, widespread sharing of information among stakeholders; collaboration among sectors; having a clear mission, collaborative leadership; diverse membership; fair delegation of responsibilities; procedures for ensuring follow through on plans; strong community connections and outreach activities; diversity of funding sources; and having opportunity for role structures that are empowering, in that they encourage participants to assume a diversity of roles and take charge of different aspects of the group's functioning (Anderson-Carpenter et al., 2014; Flewelling & Hanley, 2016; Peterson et al., 2019). The use of various forms of technology may also be helpful to build communities of practice, to facilitate communication and collaboration in the development and implementation of prevention strategies in communities (Anderson et al., 2014). The structure of collaborations, including mechanisms for communication, is very important to the successful implementation of community-based prevention models.

5. Conclusions

This review described different ways in which health care and service providers can collaborate to prevent alcohol-related harm. Collaborative prevention efforts in the literature reviewed focused on identifying individuals at risk and intervening to prevent harm, interprofessional care teams and wraparound programming, and community-level prevention models. Many of the prevention efforts were targeted towards individuals at risk of or already experiencing alcohol-related harm. However, collaborative community-level prevention models and screening incorporated general early-stream prevention (e.g., Eddy et al., 2012; Gance-Cleveland et al., 2019; Hawkins et al., 2015; Oesterle et al., 2018; Maslowsky et al., 2017). Collaboration occurred in many forms, including interprofessional information sharing, joint meetings, structured multidisciplinary teams and programs, the formation of community coalitions and advisory boards, cross-sector education, intervention planning and

evaluation, and referral/partnership networks. Similarly, collaboration to prevent alcohol-related harm involved many different actors across multiple sectors, depending on the type of collaboration and the focus of prevention efforts.

As described in each section of this review, there may be barriers that impact different types of collaborative prevention efforts that should be considered when such efforts are being developed. For example, disciplinary silos and rigid institutional processes and protocols may hinder the development of interprofessional teams (Kools et al., 2022; Haque & Leggio, 2014); privacy legislation and internal organization rules may need to be accommodated to successfully share information and engage in collaborative planning or care (Auschra, 2018; Nilson, 2016). Auschra (2018) described several barriers to the integration of care across organizations, including but not limited to confidentiality issues, inadequate communication, lack of mutual understanding and trust, resistance to change, organizational interests that conflict with the interests of the collaboration, incompatible organizational structures, lack of leadership and coordination, and lack of external and/or internal funding. While barriers may function as obstacles, many obstacles can be successfully overcome. Factors that may address barriers and facilitate collaboration include co-location of collaborators, the availability of funding, strong mechanisms for information sharing/communication, adequate time, continuous participation in trust-building activities, the existence of committed champions, strong leadership, well-defined problems and shared goals, and building on existing partnerships (Bryson et al., 2006; 2015; Kousgaard et al., 2019; van Rinsum et al., 2017). It is important to note that while this review offers a brief discussion of barriers and recommendations for each category of prevention models, a full examination of potential barriers and facilitators that are specific to the model being considered and the context of implementation should be part of initial efforts to establish collaborative prevention efforts.

Finally, the reviewed literature suggested how collaborative prevention efforts can reduce alcohol-related harms for those who are “targets”, but it is important to emphasize that collaboration also appears to have benefits for service providers and other professionals. These include increased understanding of addictions and interconnected issues, including the impacts of trauma; increased knowledge and skills related to prevention; more compassionate and trauma-informed approaches to service provision; shared resources/ time burden; increased trust and collaboration (outside of the formal collaborative prevention activities) between actors in different sectors; and a better understanding of available resources and the work that different organizations and individuals do (Brown & Newberry, 2015; Hubberstey et al., 2021; Hunt et al., 2022; Kools et al., 2022; Maslowsky et al., 2017; Shapiro et al., 2015). These findings suggest that there are a lot of secondary benefits for becoming involved in collaborative approaches to prevention, which may strengthen both individuals’ knowledge and skills as well as their connections and relationships with others.

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