HHS Public Access

Author manuscript

J Health Commun. Author manuscript; available in PMC 2024 October 06.

Published in final edited form as:

J Health Commun. 2023 October 03; 28(10): 699–705. doi:10.1080/10810730.2023.2262948.

Lessons Learned from Developing Tailored Community Communication Campaigns in the HEALing Communities Study

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Abstract

This paper outlines lessons learned from tailoring communication campaigns to increase demand for, and reduce stigma towards, evidence-based practices to reduce opioid overdose deaths in 66 communities participating in the HEALing (Helping to End Addiction Long-term[SM]) Communities Study (HCS). We present nine lessons about how to engage local communities in both virtual and in-person opioid messaging and distribution between February 2019 and June 2022. The research team created four communication campaigns and did extensive, tailored marketing and promotion to assist communities in implementing evidence-based clinical activities to reduce opioid overdose mortality. Various strategies and venues were used to amplify HCS messages, using free and paid outlets for message distribution, focusing primarily on social media due to the COVID-19 pandemic. Increasing the availability of medications for opioid use disorder and naloxone, as HCS attempted, is not enough; getting people to accept and use them depends on communication efforts. This paper focuses on the process of preparing communities for communication campaign activities, which we hope can help guide other communities preparing for opioid or substance-related campaigns in the future.

Keywords

opioid; overdose; community-based; communications; intervention

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Declaration of Interest Statement

The authors report there are no competing interests to declare.

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Introduction

Communication campaigns have long played an important role in improving public health. To help prevent disease and promote healthy behaviors, communication campaigns are instrumental in raising awareness, increasing knowledge, changing attitudes and health behaviors, and mobilizing action to improve health outcomes. Rogers & Storey (1987) characterize a communication campaign as having four essential features: (1) intends to stimulate outcomes or effects, (2) spreads across a relatively large group of people, (3) occurs within a specific period of time, and (4) utilizes an organized set of communication activities. Several reviews of the literature have concluded that health communication campaigns, when they follow a set of evidence-based principles and practices in their development and implementation, can have moderate effects on a variety of health behaviors (Willoughby & Noar, 2022; Pirkis et al., 2019; Snyder, 2007; Wakefield et al., 2010).

The overall approach to health communication planning usually takes one of three approaches: centrally developed and disseminated on a national level (e.g., the National truth® campaign to reduce smoking initiation, Farrelly et al., 2009; the VERB™ campaign to increase physical activity among youth, Huhman et al., 2010) or state level (e.g., the Florida "truth" campaign, Sly et al., 2001; "The Bigger Picture" youth-focused campaign to prevent Type 2 diabetes, Rogers et al., 2014), or they are locally developed in communities (e.g., the "1% or less" nutrition campaign, Reger et al., 1998; the Staten Island safe opioid prescribing campaign, Volpe & Conte, 2021). The outcome of each approach is influenced by: the financial and professional resources to design, produce and distribute campaign assets; the readiness of a community to actively participate in a campaign; and the use of materials and distribution channels that are more generic (e.g., use of stock photos and paid media channels versus the use of local spokespersons and distribution channels).

The method of campaign design and delivery has an impact on the degree to which sources, message content, channels for message delivery, and calls-to-action can be tailored. Just as tailoring has been discussed in the literature with a focus on individuals or segments of a population (see Ghalibaf et al., 2019; Kreuter & Wray, 2003; Noar et al., 2010), it can also be applied to unique features of communities (Chen et al., 2013; Gilmore et al., 2020; Pleasant et al., 2020).

This paper outlines the lessons learned from communication campaigns developed for the HEALing (Helping to End Addiction Long-term℠) Communities Study (HCS). The study is a multi-site, parallel-group, community-level cluster randomized wait-listed trial supported by the National Institutes of Health (NIH) and Substance Abuse and Mental Health Services (SAMHSA) that seeks to test the effectiveness of an intervention for reducing opioid overdose deaths in 67 rural and urban communities across four states (Kentucky, Massachusetts, New York, and Ohio) heavily impacted by the opioid crisis. The HCS tests the Communities That Heal (CTH) intervention which deploys a community-engaged, data-driven process and tailored communication campaigns to assist communities in adopting and implementing evidence-based practices (EBPs) to reduce opioid fatalities (HEALing Communities Study Consortium, 2020). Community engagement within the CTH relies on the development of opioid-focused coalitions formed from rosters provided by

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leaders of existing substance and tobacco use community coalitions or networks in the public health and substance use treatment sectors. The primary goal is to reduce opioid-related overdose deaths by 40 percent in communities receiving the HCS intervention (Wave 1) during the second year of implementation compared to communities that will receive the intervention after the second year (Wave 2).

The HCS communication campaigns had three overarching objectives: (1) increase demand for naloxone (an opioid overdose reversal medication) and medications for opioid use disorder (MOUD) that include buprenorphine, methadone; (2) increase prescribing of MOUD; and (3) increase access to, and availability of, MOUD and naloxone. Campaign strategies were based on the constructs of social cognitive theory, including: enhancing self-efficacy or confidence in performing specific behaviors such as carrying naloxone or finding a health care provider who has the authority to prescribe methadone or buprenorphine; increasing positive outcome expectancies, especially that MOUD can be a path to recovery from OUD and cues to action to stimulate demand for EBPs; and individual-level behavior change through information on the HCS website. Agenda-setting theory was employed to direct coalition attention to how media coverage not only influences what people think and talk about with each other, but also the opinions they have about topics such as acceptance of naloxone and MOUD and stigmatizing attitudes and behaviors (Lefebvre et al., 2020). The Community-Based Prevention Model was used to guide local implementation efforts with the full involvement of each coalition (see Lefebvre et al., 2020, for more details).

A workgroup of communications experts from the HCS Data Coordinating Center, the research sites (Boston Medical Center, Columbia University, University of Kentucky, The Ohio State University), National Institute on Drug Abuse (NIDA) and SAMHSA, and Oak Ridge Associated Universities (ORAU), an outside consultant on the study, developed a standardized strategy and approach for each of the four campaigns for the study. Each campaign provided communities with a set of customizable social media and print materials (assets), a website linking community members to additional information and local resources related to each campaign theme, and technical assistance and training for developing and implementing data-driven, community-informed campaign distribution plans. Distribution planning, conducted with coalition involvement, included where and how to most effectively place media in communities, how to leverage paid and unpaid social media placements, and strategies for placing op-eds in local print and online news media. HCS staff created a ‘campaign dashboard’ for monitoring progress of each community in developing the distribution plan, launching the campaign, tracking distribution, completing the campaign, and doing an ‘after-action debrief’ (qualitative assessment). Communities were on the same cadence of dates for when campaigns were launched and completed.

The campaign assets were designed with ‘core’ (immutable) messages and calls to action. Campaign assets could be locally tailored with options including imagery (local faces and places), content (medication(s), language, personal testimonials/quotes), product (type of material, format, size, design specifications), and destination (local provider, website, phone number). In the end, campaigns were presented through owned, earned, and paid media. Of note, during Wave 1 of the CTH intervention (February 2019 – June 2022), campaign and other intervention activities were often interrupted or delayed by COVID-19,

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with a significant portion of dissemination activities taking place online or virtually versus in-person.

The following is a list of lessons learned, collected by the study team about how to engage local communities with both virtual and in-person opioid messaging. The list focuses on the process of preparing communities for communication campaign activities, which we hope can help guide other communities preparing for opioid or substance-related campaigns in the future.

Communication Lessons Learned

Lesson 1: BUILD COMMUNICATION PLANS: Integrate communications into community interventions.—Since the HCS focused on increasing the availability and use of naloxone and MOUD within participating communities, communication campaigns were designed to increase awareness about and adoption of these evidence-based practices (EBPs). Coalitions used a data-informed approach to select a series of EBP interventions that were linked to communication and marketing tactics to increase awareness and adoption among intended audiences. EBP intervention examples included the setting up of new methadone and buprenorphine treatment sites, hospital-to-community bridge clinics, and naloxone distribution centers. These EBP interventions are only successful if policymakers, service providers, priority users, patients and their family members became aware of their availability and are motivated to take action. Therefore, communication and marketing plans must be developed, tailored, and integrated into any new community intervention service being introduced and implemented in a community.

Prior to the selection of EBP interventions and the development of communication and marketing plans, coalitions were encouraged to conduct a landscape analysis of existing MOUD and naloxone resources and a needs assessment of communications and marketing activities. Having this foundational understanding allowed coalitions to integrate communications and marketing planning with EBP implementation strategies. Similarly, a landscape analysis of existing opioid-related communication campaigns devised by national, state, or county health authorities allowed for coordination with new campaigns under consideration.

Lesson 2: DEVELOP PARTNERSHIPS: Engage community partners early and throughout the planning and delivery of communication activities.—While the HCS campaigns provided the backbone for EBP education and promotion, local partnerships within participating communities helped maximize outreach to intended audiences. Across the four states, coalitions partnered with Mayors' offices, local and State Departments of Public Health (DPH), existing substance use helplines, local addiction service recovery care and support centers, and many others. These partners collaborated with coalitions to implement dissemination tactics outlined in the campaign and EBP communication and marketing plans. Dissemination tactics included publishing articles in local news outlets, displaying print materials in local business and office buildings, publishing posts on coalition social media channels, and placing ads on digital platforms such as social media and streaming audio.

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For all communities, there were challenges in working with partners. Most notably was the desire to ensure that both the HCS and partner branding and resources were recognized and promoted. For example, partners of a coalition held a news conference to announce HCS in the local community and to encourage community influencers to post HCS campaign messages via social media. The HCS guidance required HCS branding and the HCS webpage URL on public materials funded by the study for evaluation purposes. However, the hospitals and community-based organizations (CBOs) partnering with the coalition wanted their branding and website as well to promote their organization and services. Many coalitions members representing local CBOs thought that intended audiences would not trust the messaging if they did not see a local organization that they recognized and trusted while some did not want HCS logos on materials at all due to sustainability concerns after the HCS ended. To address these concerns, coalitions were allowed to co-brand materials funded by the HCS and include a local organization's phone number or website.

Lesson 3: BUILD COMMUNITY COMMUNICATION CAMPAIGN SKILLS. Many coalitions have limited resources or expertise to develop and implement communication and marketing plans.—Communication and marketing expertise required by the study included creating data-informed dissemination plans, advice on how to use available data to identify priority audience segments, how to customize core campaign materials to meet the unique needs and characteristics of priority audience segments in their community, and more. As a result, research sites developed and implemented robust communications training and technical assistance plans that improved the coalition's capacity to successfully plan for and implement campaign strategies and tactics and set them up for success for future opioid communications and marketing efforts.

One effective tool utilized by the research sites to train coalition members and the media was learning collaboratives. A Learning Collaborative was convened with coalitions from all four research sites to share tips and showcase accomplishments. A 90-minute virtual session featured unique community approaches used to develop distribution plans and offered an interactive exercise to brainstorm and collectively identify lessons learned to improve the upcoming campaign. In Kentucky, a statewide Learning Collaborative for coalitions showcased the evolution of the language of addiction; how those trends changed media coverage; and how to frame messages to reduce stigma, which included local reporters covering addiction.

Another effective tool was holding regular "Communications Office Hours," a space for coalition members and leaders to meet regularly to identify and provide communication technical assistance needs, share local best practices, and address common challenges. Meetings covered topics such as social media metrics and reporting, paid media advertising, campaign tracking and assessment, newsletters, resource guides, and community forums.

Additionally, the HCS developed technical assistance guides and resources that helped coalitions plan for, implement, and record evaluation data. Included in this list of resources were six guides or "Playbooks," that offered step-by-step instructions and links to resources. Examples included: "How to Build Relationships with Local Media" and "How to Create Your Communication Campaign's Distribution Plan."

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Lesson 4. STRUCTURE COMMUNICATIONS LEADERSHIP: Clearly define the process needed for recruiting skilled communications champions and teams who will lead planning and dissemination efforts.—As coalitions formed and began to understand the HCS communications requirements, many coalitions indicated that they did not have the expertise to lead communications planning and implementation efforts. As a result, many coalitions indicated the desire to recruit a local Communications Champion. The Communications Champion was recruited from the coalition to serve as the main point of contact, or as a liaison, between the research site team and the coalition. The Communications Champion was responsible for coordinating the completion and submission of all study communications deliverables on behalf of the coalition. Most Communications Champions were recruited due to their local connections and did not possess communications and marketing skills and had to be trained. Some coalitions opted for part-time Communications Champion positions (~5–8 hours per week dedicated to HCS communications work) and some coalitions offered compensation for their time.

While coalitions were given the flexibility to determine how they would like to plan for implementing HCS communications efforts, most opted to create separate Communications workgroups that included major labor categories (e.g., health communications specialist, social media manager, data specialist, graphic/web designer, journalists) as well as members of the campaign priority audience groups (e.g., people with living experience, key influencers) and partner organizations.

Throughout Ohio, during Wave 1, the communities that created communications subcommittees were more effective than coalitions conducting communications activities in the full group setting. In Lucas County, for example, the HCS team worked with the community coalition to create a large communications subcommittee (more than 15 people) comprised of community members who work in treatment and recovery, media, local government, and law enforcement. Over the course of Wave 1, the group produced several videos, executed powerful geo-targeted digital displays of campaign materials, and distributed press releases, op-eds, and print materials.

In Kentucky, entrenched beliefs about addiction rooted in outdated information was an obstacle. It was challenging to engage some of the coalitions who were busy with their jobs and families in counties hard hit by both the pandemic and the opioid crisis. They started Campaigns 1 and 2 (naloxone and MOUD) by encouraging coalitions and partners to post campaign messages on social media but observed mixed results. By campaign 3, they recognized gaps across the counties in their willingness to use and engage on social media. The state team stepped in to create *HEAL KY* Facebook pages for each county as a primary distribution channel for campaign messages and created Facebook standard operating procedures to bridge “digital divide” gaps in some communities.

Lesson 5. ADDRESS CULTURAL DISDAIN: Information gaps that encourage stigma and promote misinformation about medication treatment need to be filled.—Trying to encourage the use of medications for opioid use disorder is fraught with stigma and misinformation. Biased attitudes against people who use drugs have been traditionally seen as an individual or moral failing. The public and even many professionals

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in the healthcare and criminal justice systems have ingrained attitudes against the use of proven medications in treatment. Many believe that the use of medication such as methadone or buprenorphine is seen as "replacing one drug with another" and not "real recovery."

The HCS urgently wanted local communities to implement campaigns that would reduce stigma and educate communities about the scientific evidence supporting the use of medications and counter "intervention stigma" (Madden, 2019; Madden et al., 2021). Research has shown that it matters how we refer to people who struggle with addiction (Kelly & Westerhoff, 2010); sites were trained on how to destigmatize language, and campaign messages were carefully constructed to reduce stigma. To ensure standardized explanations to the media and the public, written materials were produced and made available to community-based staff with topics such as: *Stigma, Medications for Opioid Use Disorder; How Addiction Changes the Brain; The Urgency of Treating Opioid Use Disorder in the Time of COVID-19*. Additionally, anti-stigma messaging – including attention to the images used in materials – was integrated throughout all the HCS campaigns.

The Kentucky research site observed that some providers were hesitant to promote MOUD to young adults, with a perception that recreational drug use will phase out over time and should be viewed as distinct from OUD. There was also reluctance in some communities to offer harm reduction strategies, including syringe services programs and distribution of naloxone as these were seen as encouraging continued drug use. Working with the local faith-based community as links to substance use treatment; incorporating people's lived experiences and stories from community neighbors affected by the opioid crisis; using quotes that describe local places, people, and events; and paying attention to local nuances around culture, language and other substance use related issues led to shifts in perspectives.

Lesson 6. CUSTOMIZE MATERIALS: A community-engaged approach requires data-informed, locally-tailored materials—Many national organizations and agencies rely on the development of one-size-fits-all campaigns. However, the HCS communications campaigns used a community-engaged and data-informed approach to adapt core campaign materials needed to effectively implement tactics outlined in campaign dissemination plans and meet the unique needs and characteristics of priority audience segments identified by coalitions. This hyper-local approach allowed coalitions to review and understand their local overdose and demographic data to think critically about who was at highest risk of overdose in their community, geographically where they were, the channels for how best to reach them, and what customized campaign materials were needed. As part of a campaign dissemination toolkit, the HCS offered coalitions a core set of social media graphics or videos that supported each campaign's objectives, key messages, and calls to action. To aid coalitions with the process for customizing materials, the research sites and ORAU developed a *Campaign Dissemination Form* which allowed coalitions to identify the size and type of material needed, the priority audience group the coalition intended reaching to ensure the correct call to action was used, and the addition of coalition partner logos. Additionally, the form allowed coalitions to request customizations such as switching out images of people with stock images or spokespersons, the use of local landmarks in the background, and translation to other languages to ensure the materials resonated with intended audience segments.

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Local Resource Maps: Many coalitions indicated that their community members either did not know where MOUD and naloxone were available locally or they had no comprehensive list of these resources. Based on this feedback, HCS worked with coalitions to develop a customized Google map of available resources for each coalition that were featured on the HCS community web pages. These resource maps tagged the physical locations of MOUD treatment providers and naloxone, as well as other optional resources such as emergency naloxone boxes and drug disposal locations.

Local Photos and Videos: To better resonate with audience segments, coalitions were able to customize campaign materials by selecting from a library of stock images or substituting with local spokespersons. Coalitions were encouraged to recruit members of campaign priority audience groups (e.g., people with living experience, key influencers, providers) to feature in their customized campaign materials. For the HCS campaign focused on MOUD retention, the research sites recruited people with living experience from all four research sites who were taking or had taken MOUD as part of their recovery journey and produced testimonial videos designed to motivate people to stay in MOUD treatment for as long as needed.

Kentucky's Kenton County ran two, one-month Facebook ad campaigns on naloxone – one campaign used an advertisement with stock photography and the other used an advertisement with images of local influencers, including the local fire chief, recovery coach, and a well-known mother who had lost her son to overdose. The local images generated 150% more engagement as measured by impressions, click-through-rate, and social media engagement (i.e., likes, comments, shares).

In New York, one community featured a local spokesperson, a recovery support coach at the time, in bus ads, social media graphics, local news articles, and numerous other materials disseminated throughout the community. An individual with opioid use disorder spotted the local spokesperson at a grocery store, approached him, and expressed that he needed help. The spokesperson had become a beacon of hope and was able to initiate the individual into treatment.

The lesson was clear across all four research sites: Faces and voices that are familiar can help drive message receptivity and open doors to treatment conversations.

Lesson 7. CONSIDER IMPLEMENTATION BARRIERS: Pay attention to local cultural and language nuances, keeping an eye on equity.—While many HCS campaign materials were offered in both English and Spanish, some coalitions indicated the need to translate materials into other languages based on their local overdose and demographic data. For example, the Massachusetts research site developed resource guides and ads for some of the campaigns in five languages, including English, Spanish, Portuguese, Cape Verdean, and Haitian Creole. To further reach Creole audience segments in participating communities, the Massachusetts research site coordinated a four-part radio series featuring local, native Haitian and Cape Verdean speakers on a popular radio show for women of Creole descent, which garnered more than 3000 listeners and nearly a 50% share of the local audience.

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Creating materials for non-English speakers from diverse cultures requires careful, deliberate, and comprehensive planning with local partners who work with and represent these populations. To enable continued use of these translated materials, coalitions should identify persons to disseminate the translated resources and forge relationships with CBOs that offer linguistic diversity services. Funding for these efforts should also be included at the outset.

Lesson 8. BUILD SUSTAINABILITY: Sustainability strategies must be considered at the beginning of the study, continue throughout, and be implemented when the study ends.—To support coalitions in the continuation of opioid communication and marketing efforts after the wave 1 intervention ended (June 30, 2022), the HCS developed a Sustainability Committee to explore the strategies and resources needed. As part of this sustainability process, the committee developed two guides offering coalitions step-by-step guidance on how to move forward beyond the HCS. The first, *Building Sustainable Opioid Overdose Communications Beyond HCS*, outlines seven key steps to maintain successes from the intervention, including how to reinforce their existing communication infrastructure, develop partnerships and media relationships, secure funding, identify training needs, and monitor local overdose rates. The second guide, *Navigating the Fundamentals Post-HCS* offers steps for building a campaign, inclusive of health equity determinants, the role of coalitions, identifying campaign goals and objectives, conducting an audience analysis, identifying and testing messages, creating and distributing materials, and incorporating evaluation.

Sustainability requires funding. New research grants or program funding requests written by community teams should include funding for communication activities. To advise communities how to include communication tasks in their grants, the HCS built easy-to-digest guidance on funding issues into its internal materials, including how to add communication tasks into grant applications; how to work within their coalitions to identify funding that can be set aside to sustain communication activities; how to gather information on grant opportunities from county and state departments of public health as well as local sources.

Other materials were developed to prepare communities for questions from grant reviewers: how will their proposed project help the community; what are the expected outcomes; what is the strategic framework for the outreach initiative; what is the priority audience; what are the key messages (and how will those messages be customized); what formative research will be used; and finally, what are the specific tactics, implementation timeline, and plans for evaluation.

Lesson 9. BUY SMART: Cultivate long-term relationships with local communications vendors such as advertising, graphic design and media buying agencies to receive discounted prices.—Any public health campaign has its own well-documented expenses, such as the cost of developing and printing materials, paying for advertising placements in various media, and paying venues to hold events. Cost-effective management of these strategies can require more than the usual skills possessed by communication staff in many communities.

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In Ohio, several communities experienced success by forming sustainable relationships with local radio stations, print vendors, small businesses, and community organizations. These efforts led to a greater distribution of campaign materials and discounted rates for printing, production, and promotion. In Athens county, for example, the coalition reached out to local movie theaters to inquire about advertising pricing. After hearing about their work, the theater owner offered to play campaign videos at no cost for an extended period of time, and offered future discounted rates for any coalition-related marketing.

In New York, the formation of Communications Workgroups with representatives of varying expertise and relationships led to more cost-effective dissemination of campaign materials. For example, Cayuga county partnered with a local social media manager to post the HCS materials and respond to comments about MOUD and naloxone. Green County's Communication Champion was a former journalist and had existing relationships with local media which led to the publication of several op-eds, articles, and interviews in local news outlets.

Discussion

The HEALing Communities Study (HCS) tested strategies to reduce opioid overdoses during COVID-19, the world's worst infectious disease outbreak in a century. The communication work in the HCS offers valuable insights into how community teams, even during a pandemic, can link the creation of evidence-based clinical services to messaging meant to promote use of these services. The HCS provided only an extremely limited paid media budget and depended on materials developed centrally but adapted locally and based on marketing and promotion to priority audiences. Increasing local availability of MOUD and naloxone is not enough. Increasing adoption of these evidence-based interventions requires increasing awareness and understanding of them through communication and marketing efforts. The HCS approach highlights the need to understand local culture and use of language around health issues, customize materials to better resonate with intended audiences, leverage local partnerships to maximize reach, and build easy-to-use sharing platforms. Most of all, the HCS approach highlights the need to build communications capacity among communities participating in national and state public health initiatives to sustain the work after the initiative ends. The HCS moved forward under the assumption that communication campaigns in combination with strategies to mobilize communities are more effective than community mobilization strategies by themselves (Cuijpers, 2003).

The HCS campaigns provided a very focused project for coalitions to implement while the planning around EBP implementation was taking place. The members of coalitions who wanted to 'do something new!' had someplace to funnel their energies and passions. Still, the clinical trial structure of the HCS created tension from the start. A four-state study required standardization of messaging and the content and sequence of communication campaigns. Production, buying, and placing of advertisements had to be handled centrally and not led by community coalitions. Trying to find a creative and workable path between a community-based intervention philosophy and the technical demands of communication campaign efforts was a central theme of HCS staff efforts.

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The HCS created structural changes in these communities through the creation of new services and better coordinated localized communication channels. Reinforcing strategies such as building of community coalitions may have more positive long-term effects on health. The HCS team hopes that social and activist groups advocating for change in legislative and institutional policies and practices in health care, hospitals, and public health settings will make opioid overdose reduction sustainable. Information and communication campaigns help create a supportive environment that increases access to both information and health care. If successful, the HCS will enable individuals to make health behavior changes—MOUD treatment, widespread naloxone use—that can save lives.

Acknowledgments

This research was supported by the National Institutes of Health and the Substance Abuse and Mental Health Services Administration through the NIH HEAL (Helping to End Addiction Long-term Initiative under award numbers UM1DA049394, UM1DA049406, UM1DA049412, UM1DA049415, UM1DA049417 (ClinicalTrials.gov Identifier: NCT04111939). The study protocol (Pro00038088) was approved by Advarra Inc., the HEALing Communities Study single Institutional Review Board. We wish to acknowledge the participation of the HEALing Communities Study communities, community coalitions, and Community Advisory Boards who partnered with us on this study. We are grateful to Camille Clifford for preparation of this manuscript and work on the Healing Communities Study. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health, the Substance Abuse and Mental Health Services Administration or the NIH HEAL Initiative SM.

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