Partnership for Success 2015
Community-Level Data Collection
Guidance Document

Assessment Guidance for Underage Drinking, Prescription Drug Abuse/Misuse and other Substances of Concern in Communities
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INTRODUCTION

Since February 2006, community-based coalitions throughout Connecticut have been using the Strategic Prevention Framework (SPF) to understand and address underage drinking and later other substances. More than one-third of communities throughout the state have implemented the SPF. With the October 2015 Partnerships for Success (PFS 2015) award of funding from the Center for Substance Abuse Prevention, Connecticut’s Department of Mental Health and Addiction Services expanded the reach of the SPF to additional communities.

PFS 2015 will fund communities targeting underage drinking (UAD) for ages 12-20 and non-medical use of prescription drugs (NMUPD) for ages 12-25. PFS 2015 coalitions are also welcome to address another substance in addition to UAD and/or NMUPD, as determined by their needs and capacity assessment. Populations experiencing health disparities will be of special emphasis in this PFS 2015 cohort. PFS 2015 Coalitions will be provided focused technical assistance for data collection, planning and implementation to address identified high need groups.

Assessment, step one of the Strategic Prevention Framework, is a crucial step in creating population level reductions in UAD and NMUPD and related consequences. A thorough understanding of community-specific causal factors, and the scope of the problem of UAD and NMUPD is necessary to prepare for and engage in strategic planning. In other words, knowing what UAD and NMUPD “look like” and the local conditions that drive these problems will help identify the most effective strategies for addressing and reducing them.

PURPOSE OF GUIDANCE DOCUMENT

This document takes prevention coalitions through one component of the Assessment step of the SPF, data collection. Collection of data will later support analysis of factors that contribute to UAD and NMUPD. A workbook has been provided with some community specific data “pre-populated” or included. This document serves as a “parking lot” for placing local data in one place. Later this will support interpretation of what data are missing and how your coalition’s data compare to the surrounding region and state.

The action oriented steps of this document are divided into the following sections:

- Section 1: Establish A Culturally Competent Data Collection Team
THE STRATEGIC PREVENTION FRAMEWORK AT THE COMMUNITY LEVEL

The SPF is grounded in outcomes-based prevention, as depicted in the diagram below. The theory behind the model is that a combination of causal factors such as risk factors, and underlying conditions collectively contribute to substance abuse in communities and that population-level changes in consumption and consequences are brought about by impacting these factors. In short, it begins with the end in mind. Therefore, in order to plan for and direct desired outcomes, coalitions must develop a solid understanding of underlying conditions by examining community-level data, including information on gaps, and resources. Only then can priorities be set and appropriate strategies be identified to reduce substance abuse and related problems.

As a foundation for the community needs assessment process, UConn Health has provided the Data Definition Packet, which highlights the strengths and limitations of certain indicators as well as how related indicators can apply to substance abuse. Also provided is the PFS2015 Needs Assessment Workbook. This Excel document has been prepopulated with town level data including demographics, consumption and consequences. PFS2015, will expand upon this data with their own knowledge of local data sources.

Additionally, the Regional Action Councils (RACs) for substance abuse prevention, have access to sub-regional, and in many cases, local data on UAD, NMUPD, other substances and behavioral health concerns. The RACs have established Sub-Regional Profiles of substance use consumption and consequence data. These can be found through contact with your local RAC at http://ctprevention.org/. 
IMPORTANT REMINDERS AND CONSIDERATIONS

The data collection activities described in this document provide a foundation for analysis of UAD and NMUPD problems in your community. Data collection must be informed by a group process of coalition and community members. For data collection, community coalitions need to include a broad representation of stakeholders, either as current coalition members or coalition partners, that are knowledgeable of and interested in prevention and health issues across the lifespan. These stakeholders should reflect the many domains of diversity of the community being served.

Engaging partners in this initial step will not only improve the breadth and quality of data collected, but will drive stakeholders investment in the next steps of the SPF as the coalition moves forward in analysis of data and strategic planning.

Data collection is an opportunity to get to know the community and coalition members. Each member of a coalition is a resource with a unique perspective and access to different data and information. Harnessing this intelligence and gathering these facts in an appropriate and respectful manner is an important aspect of coalition building and sustainability.

It is important to recognize that data collection, like all aspects of the SPF, is on-going. The process will continuously collect, incorporate and respond to new information on UAD and NMUPD, community resources and readiness as it becomes available.

This initial step of the PFS 2015 SPF process, data collection, will include the following actions, detailed below:

1. Establish a culturally competent data collection team (Community Needs Assessment Workgroup, (CNAW))
2. Examine the PFS 2015 Needs Assessment Workbook, the data that were outlined as available locally in your coalition’s RFS response, the Data Definition Packet and available RAC data
3. Use the PFS 2015 Needs Assessment Workbook to collect local data on substance use problems (UAD and NMUPD) and the sub populations with higher need or health disparities
4. Draft an outline of the data collection process, strengths and data gaps.

RESOURCES FOR PFS 2015 SUB-RECIPIENTS

DMHAS has established great infrastructure to support PFS 2015 sub-recipients throughout the SPF process.

The prevention Training and Technical Assistance Service Center (TTASC), staffed by John Daviau and Lisa Mason, was established by the Connecticut Department of Mental Health and Addiction Services to increase prevention workforce competencies and improve access by prevention workers to the most relevant, responsive, and culturally appropriate prevention education and training resources. TTASC is available to support PFS2015 grantees in their data collection efforts as well as throughout their work to implement the SPF.
To contact TTASC:
John Daviau- E: john.daviau@gmail.com; P: 203.530.4314
Lisa Mason- E: mason@xsector.com; P: 203.772.2050 x 10

The Center for Prevention Evaluations and Statistics (CPES), staffed by Jane Ungemack, Dr. PH., Principal Investigator, and Jennifer Sussman, Coordinator, was established to support DMHAS in its prevention and health promotion efforts through the identification, collection, analysis, interpretation and dissemination of data pertaining to substance abuse prevention, mental health, and health disparities. The CPES will convene, support and chair the State Epidemiological Outcomes Workgroup (SEOW) which supports the PFS Evaluation Team in identifying, accessing and assessing indicator data including but not limited to those identified for the priority substances; provide research and statistical expertise and support, as well as training and technical assistance on evaluation and data use (with TTASC); track behavioral health indicators, and develop and maintain an interactive data repository available to DMHAS, its state agency partners and key stakeholders.

To Contact CPES:
Jennifer Sussman- E: sussman@uchc.edu; P: 860.679.5409

UConn Health- PFS 2015 State-wide Evaluation Contractor-staffed by Jane Ungemack, Ph.D., Principal Investigator and Bonnie Smith, MPH, Project Evaluator, is responsible for implementation of the state-wide evaluation plan and reporting. This includes providing evaluation technical assistance to subrecipient coalitions, and their contracted evaluators, on the collection of process and outcome data in accordance with the state-wide and national evaluation requirements.

To Contact PFS State-wide Evaluation Team:
Bonnie Smith- E: bsmith@uchc.edu; P: 860.679.5557

Regional Action Councils (RACs) are legislatively created public-private partnerships comprised of community leaders, of which there are 13, state-wide. The RACs’ purpose is to establish and implement a strategic plan to develop and coordinate needed substance abuse prevention and mental health promotion services in their respective subregions. RACs, with their community partners, collect community and subregional data to fulfill their management objectives of;

1. Conducting a data driven needs and resource assessment;
2. Developing a biannual report that includes epidemiologic profiles of substance use/abuse, problem gambling, and suicide.

For more information or to contact your local RAC please see:

CT Prevention Network (CPN): http://ctprevention.org/
SECTION 1 | ESTABLISH A CULTURALLY COMPETENT DATA COLLECTION TEAM

Following a review of this guide, each coalition must identify members to participate in and develop a local process for identifying, gathering, organizing data and information related to UAD and NMUPD in their community, this group will be called the Community Needs Assessment Workgroup (CNAW).

Later in the process the CNAW will prioritize the substance problems in the community and “drill down” to the sub population(s) most effected by this/these substances.

Coalitions Will:

1. **Identify coalition members** and other stakeholders to serve on the CNAW. CNAW membership should consist of the twelve identified community sectors to the extent possible. Plan to recruit new community members to your CNAW. Stakeholders who cannot commit to coalition membership should be encouraged to support data collection as a short-term commitment.

2. **Identify necessary skills** within the coalition that are utilized in the data collection process, such as an understanding of data, strong community contacts, and culturally competent communication skills.

3. **Determine specific roles**, such as collecting data, organizing data, and connections with groups who may contribute with qualitative data such as:
   - Focus groups with youth, parents, educators, etc. to gather additional information or help interpret existing information and;
   - Key leader interviews with local law enforcement, medical personnel, hospital representatives, school administrators or juvenile justice staff, and others who may have qualitative and quantitative data to share.

4. **Identify additional expertise** that may be needed and potential sources and recruitment of that expertise.

5. **Establish and communicate a task oriented plan** with outcomes and dates to guide the CNAW’s process (see workbook for template)

6. **Ensure that diverse cultural and social groups are involved** in all aspects of the process, including;

7. **Consider aspects of culture, personal and familial history** such as; language, including speakers of English as a second language age, gender, ethnicity, religion, disability status, sexual/affectional orientation, reading or developmental levels, socio-economic status, veterans, people in recovery from addiction or mental illness, etc. (see workbook, “demographics” tab to “park” some of these data). These factors are associated with health disparities. See the following page for more on health disparities.

   - Defining Health Disparities: “A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups
of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.” (Healthy People 2020: http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities)

- The CDC Provides a list of populations considered “at-risk,’ framed around Age, Gender, Geography or Socio-Economic Status. Examples of groups the CDC considers at-risk include; Disability, Age, Gender, Sexual Minority, Geography, SES, Cancer Survivors, Immigrants and Refugees, Incarcerated Men and Women, Persons who Use Drugs, Pregnant Women, Veterans. (CDC: http://www.cdc.gov/minorityhealth/populations/atrisk.html)

- The Center for Application of Prevention Technology (CAPT), considers Adverse Childhood Experiences (ACE’s) in the assessment of Risk and Protective Factors. ACEs include:
  - Physical abuse
  - Sexual abuse
  - Emotional abuse
  - Physical neglect
  - Emotional neglect
  - Mother treated violently
  - Substance misuse within household
  - Household mental illness
  - Parental separation or divorce
  - Incarcerated household member


8. **Identify what persons and groups are and are not being** represented in the data collection process. Seek out traditionally underrepresented groups in your community and recruit them to your CNAW. Consider in the CNAW or coalition who is the most appropriate person to extend the invitation.

9. **Identify community supports or technical assistance needs** for bridging any data or information gaps.

When examining information on consumption patterns and consequences, look to answer who, what, where, when, how, how much, as well as the how much more for one group over another.
SECTION 2  EXAMINE THE DATA DEFINITIONS PACKET, RAC DATA AND PFS 2015 NEEDS ASSESSMENT WORKBOOK

A. First coalitions will review the PFS 2015 Data Definition Packet to understand the strengths, weaknesses and availability of secondary data.

B. Then coalitions will review the PFS2015 Workbook (Excel Spreadsheet) to determine what data are available at the state, regional or local level. School survey or other population level survey data such as CORE (college survey) should be emphasized. If your community does not have community specific data consider utilizing another similar community’s data. For assistance with this please be in touch with the UConn Evaluation Team. Additionally, RACs may have existing sub-regional reports or town level data to support this process.

These documents and resources provide a starting point and an example of secondary review of existing, quantitative data. As your data collection process unfolds you will incorporate both qualitative data and anecdotal information from your community and may collect some new local (primary) data to supplement your research and understanding. Together this information describes the underlying conditions that contribute to UAD, NMUPD and other substances in your community. While the state’s overall goal with PFS2015 is to change consumption and consequence patterns at the state level, your data collection process must focus in on the community-level data that identifies your community-level underlying conditions that contribute to substance use. Coalitions will need to determine how best to have their CNAW engaged in these documents and understanding the resources and how they apply to the Coalition’s SPF process.

SECTION 3  COLLECT DATA

In this section, each coalition will examine indicator data for UAD, NMUPD and other substance(s). This process identifies the unique strengths and vulnerabilities impacting the problem locally. To do so, each coalition will gather data that describe precisely what is happening, where it is happening, to whom, and why. Coalitions will review a variety of sources including survey results, focus groups and key informant interviews and supplement existing information with primary data collection where needed.

Below are examples of indicators to consider when assessing UAD, NMUPD and other substances locally.

Coalitions will collect data with Section A being the priority and Section B being secondary:

A. Complete the priority sections of the workbook, with emphasis on indicators below for the community your coalition serves:

1. Demographics of your community including population, racial/ethnic percentages, ages, gender, median income, median housing cost, poverty levels, free and reduced lunch percentages
2. Past-month (30 day) alcohol use (ages 12-20) and prescription drug misuse data (ages 12-25)
3. Alcohol and drug-related consequences (morbidity/mortality*)
4. Alcohol – and drug-related crime data

5. Other alcohol and prescription drug misuse-related social consequence data or impact data as it relates to the problem in terms of social, health, economic and legal costs.

*Morbidity – the rate of disease in a population, incidence of ill health in a population or physical and mental health consequences of substance use in a population

Mortality – the number of deaths that occur in a particular time or place, or death related to substance use

Use the Workbook as a guide to data collection and a “parking lot” for the data you find, in many cases these data will be pre-populated into the Workbook.

B. Identify and collect data on other community level indicators that are not marked as priority within the workbook or that are not included within the workbook, to examine UAD, NMUPD and other substances. Modify the workbook and incorporate these data. For these data consider the prompts and questions below and document within the provided template.

1. Determine sources of community level data for each substance.

2. How often are the data collected?

3. Can you report on trends?

4. What are the limitations of the data and/or the data source?

5. What are the gaps in data?

Section 4 outlines what is within the template, which is provided in a Word document. You may make notes on the responses to these questions within the workbook to support future data collection and analysis.
SECTION 4 | OUTLINE THE DATA COLLECTION PROCESS

In this section the coalition will be asked to outline the data collection process. The intent of this section is for the coalition to document who did what, when and what worked well and what did not, so that in the future the coalition can refer back to this document and make changes accordingly.

Coalitions should include the following for each data indicator that was not already pre populated into the workbook:

(This table and the following questions are included in the Section 4, Word document template and can be altered to fit the coalition’s responses as needed.)

<table>
<thead>
<tr>
<th>Substance</th>
<th>Indicator</th>
<th>Source</th>
<th>How Often Collected?</th>
<th>Trend Available? Y/N – If yes, how far back?</th>
<th>What are the limitations of these data or the data source?</th>
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1. Describe the process used to identify, gather, organize and interpret data.

2. What was most surprising about the CNAW member roles and what was most challenging? What might the coalition do differently in the future?

3. Describe how the CNAW ensured diverse representation among its members, a culturally competent data collection process and data considerations for populations experiencing health
disparities. In other words, how did the CNAW collect data representing diverse cultural and social groups (see page 9 for more details on expectations regarding cultural considerations)?

4. What was the most significant success in terms of cultural considerations in this data collection process? What was challenging? What would the CNAW do differently in the future?

5. Describe how the CNAW worked with the Regional Action Council, TTASC, UConn Health Evaluation Team and CPES or any other consultants in the assessment process.