

Connecticut's Partnerships for Success (PFS)
Year 3 Evaluation Findings and Annual Report

Introduction

Connecticut's Partnership for Success (PFS) initiative has completed three years of implementation of the Strategic Prevention Framework, following five years of learning and working through the data-driven strategic planning steps under CSAP's Strategic Prevention Framework – State Incentive Grant (SPF-SIG) grant. During the past three years of the PFS, the Department of Mental Health and Addiction Services (DMHAS) has addressed the priority problem of underage drinking through: data-driven strategic planning; data collection and data systems development; State and community capacity building for prevention; leveraging, re-directing and re-aligning statewide funding for prevention; and funding and oversight of 19 PFS sub-recipients to implement underage drinking prevention activities and coalition processes on the community level.

The overall goals of Connecticut's PFS initiative are to:

- 1) Reduce substance abuse-related problems in the State, particularly those related to underage alcohol use;
- 2) Prevent the onset and reduce the progression of substance abuse, including underage drinking;
- 3) Strengthen state and community-level capacity and infrastructure in support of substance abuse prevention; and
- 4) Leverage, redirect and realign statewide funding streams for prevention.

In order to attain these goals, DMHAS established the following specific objectives:

Objective 1.1: Conduct biennial state and regional needs assessments to support the development, implementation and sustainment of the comprehensive strategic prevention plan for Connecticut and to measure underage drinking performance targets.

Objective 1.2: Maintain the Connecticut State Epidemiological Outcomes Workgroup (SEOW) and the Community Needs Assessment Workgroups (CNAWs) in each of DMHAS' 14 RAC sub-regions to collect and analyze epidemiological data for Connecticut populations across the lifespan, including assessment of the magnitude of substance abuse and related mental health problems, risk and protective factors associated with these problems, community assets and resources, gaps in services and capacity, and community readiness to implement recommended strategies.

Objective 1.3: Utilize the Connecticut Alcohol and Drug Policy Council's (ADPC) Substance Abuse Prevention Advisory Committee to serve as an advisory committee and to implement recommendations regarding inter-agency coordination, increased enforcement of existing laws, use of evidence-based policies, programs and practices, and engaging the media, educational institutions and the health care community to encourage parents, legislators and others to mobilize resources in a concerted statewide effort to reduce underage drinking and related consequences.

Objective 1.4: Provide ongoing training and technical assistance to state and community partners to enhance the success of funded communities/coalitions to achieve underage drinking performance targets over five years.

Objective 2.1: Select and fund 20 pre-screened sub-recipients through the Connecticut PFS Initiative Request for Qualifications to ensure that all sub-recipient communities are ready to implement the five SPF-SIG steps (i.e., conducting community needs assessment, capacity building, developing a strategic plan, implementing evidence-based prevention strategies, and evaluation and monitoring of community-specific strategies) of the Connecticut PFS Initiative within the first six months of the grant.

Objective 2.2: Identify strategies to sustain implementation and expansion of effective evidence-based programs and infrastructure activities across Connecticut's communities.

Objective 2.3: Achieve, monitor and document reductions in underage drinking, as well as other behavioral and health outcomes, for youth ages 12 to 20.

Year 1:

The initial year of the Connecticut's PFS initiative focused on transitioning from the SPF initiative, which was in its final year, focusing the SEOW, and funding of community-level grantees to implement underage drinking prevention utilizing the SPF-framework. During the initial year of the PFS Initiative, DMHAS worked to engage key State agency stakeholders and leverage support and involvement of State agencies in all aspects of PFS planning and implementation through collaborative efforts and Memoranda of Agreement (MOA). DMHAS chose to base their initial PFS strategic planning on the strategic plan and logic model developed for the SPF, planning to re-visit it over time with the help of an identified workgroup of state agency stakeholders. The SPFA Advisory Council, established through the support of the Governor and a MOA with key State stakeholders, was convened in May 2010. This group was envisioned to function in part as the PFS advisory council, with the primary role of the PFS Initiative being to strengthen state-level coordination and collaboration on strategies aimed at reducing and preventing underage alcohol use.

DMHAS worked with the Regional Action Councils (RACs) to conduct sub-regional needs assessments and priority setting using data on alcohol and other substances. RACs were provided with a standardized profile document, as well as access to state-level, subregional, and community-level social indicator, community readiness, and other data via the SEOW website maintained by the University of Connecticut Health Center (UCHC) Evaluation Team. To build data capacity, work toward data infrastructure sustainment, and streamline the data processes of the PFS, the UCHC Evaluation Team worked to update and expand the SEOW Data Resource Guide to facilitate the transition of oversight for the SEOW website from the UCHC Evaluation Team to the DMHAS Data Manager. The SEOW met regularly during Year 1, to receive briefing on the PFS, updates on epidemiological data, and plan for data coordination and use going forward, as well as utilization of the sub-regional profiles. The SEOW also discussed the prospect of replacing the SEOW data website with a statewide data repository through the Connecticut Data Quality and Access Initiative, refocusing the SEOW to more of a working data collaborative, with the repository as a central tool for access and use of state agency and other state data.

In January, 2010, in compliance with CSAP's requirement that community-level grantees be funded within six months of State grant award, 19 community-level grantee communities (pre-screened via an RFQ process for eligibility) were notified of PFS award. Contracts were executed by March, 2010. In order to expand the use of the data-driven planning framework, build capacity across DMHAS funded programs, and expand the reach of the PFS, DMHAS re-aligned the Block Grant-funded Best Practice programs to utilize the strategic planning framework, including needs assessment and strategic planning, and to employ evidence-based practices to target underage drinking and substance abuse. DMHAS provided technical assistance and capacity building support to the PFS and Best Practice community-level grantees through Learning Communities (five in Year 1), guidance documents, and review and assessment of coalition developed needs assessment and strategic planning documents by DMHAS and the Governor's Prevention Partnership (GPP) Technical Assistance (TA) partners. Continuation of the TA partnership with the GPP allowed for individualized technical assistance to community-level grantees based on their assessed level of capacity and need. Monthly TA Planning Meetings between GPP, DMHAS, UCHC, and the Multicultural Leadership Institute supported the technical assistance process.

One key focus of Year 1 was the development of a PFS evaluation plan and alignment of the state PFS evaluation with CSAP's expectations for performance targets, process and outcomes measures. To arrive at meaningful outcomes measures and a reasonable performance target, the UCHC Evaluation Team considered effect size and documented rationale and process for arriving at performance target for Connecticut's PFS underage drinking prevention efforts. In response to CSAP's requirement that grantee states set a three-year performance target that is "realistic and robust," the team consulted national and state trends in past 30-day alcohol consumption, as well as reductions in recent alcohol consumption from the SPF-SIG initiative. The CT PFS team established 30-day alcohol use rate among 12 to 17 years olds as measured by the estimates from the National Survey of Drug Use and Health (NSDUH) as the basis of its statewide performance target for the PFS. As approved by CSAP, the Connecticut PFS performance target is a decrease in the prevalence of past 30-day alcohol use among 12 to 17 year olds from 19.6% according to the 2006-2007 NSDUH baseline to 18.1% in the 2009-2010 NSDUH. The 12 to 17 year old population was chosen because the majority of Connecticut's PFS effort was directed toward that age group and we expected to have a greater impact on drinking among younger adolescents compared to 18 to 20 year olds.

The NSDUH was chosen for the PFS performance target because it is the only data source that provides annual alcohol use rates for Connecticut youth, as required by CSAP. Connecticut does not have a standardized statewide survey. While the Youth Risk Behavior Surveillance (YRBS) Survey would have been preferable as a more valid measure of the prevalence of alcohol use among youth, in the past Connecticut has had unsuccessful implementation of the YRBS when too few school districts participated and the obtained sample of respondents was too small to provide reliable estimates of health behavior for the state. In addition, the YRBS survey, which is administered by the Connecticut Department of Public Health, is conducted every other year, not annually. Despite meetings to do so it was not possible to guarantee that the YRBS data would be available on an annual basis, the NSDUH was chosen to meet the CSAP requirement.

The CT PFS Evaluation Team, in conjunction with DMHAS, also identified several additional quantifiable statewide consumption, consequence and intervening variable outcomes related to underage drinking. A five-year evaluation plan, state-level and community-level data

collection and evaluation protocols, and a semi-structured community-level process assessment tool, the Annual Grantee Interview (AGI), were also developed during this period. Using these protocols, baselines were established and data collected on the state- and community-levels as a basis for process and outcome evaluation going forward.

Year 2

Year 2 of the CT PFS focused on data collection, support of community-level grantees for SPF-based processes of strategic planning, coalition capacity building, needs assessment, implementation, and evaluation. Local PFS-funded coalitions utilized data in development of their strategic plans, for needs assessment and to identify outcomes/benchmarks in evaluation of their local PFS efforts. The first and second Local Evaluator workgroup meetings were convened by the UCHC Evaluation team with the goal of increasing local capacity to utilize data for planning and assessment and to work toward some standardization of outcomes measures among communities with similar strategies. One focus of the work with community-level grantee evaluators was the compilation of community-level student survey data to measure consumption-based outcomes on a local level. Without a standardized statewide student survey, consumption data at the community level in Connecticut are collected using different instruments, populations, and time periods, making outcomes monitoring across communities difficult.

Process data were collected through participant observation and collection of archival materials from SEOW meetings, TA Planning Meetings, Learning Communities, and other meetings held as part of the PFS initiative. Process data on the community level were also collected using the AGI semi-structured interview conducted with community grantees and their evaluators. The purpose of the AGI is to collect qualitative data that more richly describe the nature and scope of the intervention(s) being implemented, as well as the community, organizational and other contextual factors which may affect implementation of the local PFS plan. Outcome data were collected from state agency sources, such as the Unified Crime Report (UCR), FARS, Liquor Control, and other sources. In August, Connecticut responded to a request from CSAP for Year 1 GPRA data by community-level grantee. The GPRA elements provided included: number of interventions; number of interventions funded outside of PFS funding (i.e., by other initiatives or funding streams); number of interventions that were evidence-based practices; and baseline past 30-day alcohol use based on student surveys conducted in the targeted communities.

In Year 2, the UCHC Evaluation Team and DMHAS staff participated in the refinement of the Grantee Level Instrument (GLI) and Community Level Instrument (CLI) tools for CSAP's cross-site evaluation. In Winter, 2011, the UCHC Principal Investigator and Project Director participated in cross-site workgroups to review and recommend changes to the cross-site instruments, including participation in eight conference calls focused on various aspects of these instruments. While the cross-site evaluation was eventually cancelled, elements of these instruments were incorporated into the CT PFS evaluation on the state and community levels, with the GLI being added as a process measure for the State-level evaluation and measures from the CLI being incorporated into the Community Coalition Survey (CCS) as part of the AGI with subrecipients.

Connecticut's SEOW met on a quarterly basis during Year 2 to discuss data sharing and use and development of the data repository. Data provided through the SEOW was utilized to

create the State Epidemiological profile, which described the types and extent of substance use problems in the state for the 2011 State Block Grant report.

DMHAS continued to supplement existing resources and services through the pursuit of new federal funding opportunities. DMHAS applied for and was awarded \$8.3 million across three years in federal funding to support the implementation of the Connecticut Screening, Brief Intervention and Referral to Treatment (CT SBIRT) Program, designed to increase identification and treatment of adults, ages 18 and older, at-risk for a substance use disorder. The Connecticut Tobacco Enforcement Program was also funded in the amount of \$1.9 million by the Food and Drug Administration over three years. Another initiative, the Connecticut Campus Suicide Prevention Initiative (CCSPI) was funded to bring evidence-based suicide prevention and mental health promotion policies, practices and programs to scale at institutions of higher education statewide for students up to age 24. Additionally, DMHAS was awarded a total of \$1.4 million by the Center for Mental Health Services (CMHS) for a three-year project period to enhance and expand the statewide prevention infrastructure to promote emotional health and reduce the likelihood of substance abuse and their related consequences. Finally, DMHAS was awarded a one-year \$600,000 grant by CSAP to plan for expansion and strengthening of the prevention infrastructure. Although this funding is not directly targeted at underage drinking, it enhances the connective elements to the larger system, and strengthens prevention practice by increasing staff, services, and infrastructure that will benefit efforts to address underage drinking as well as these associated problems.

Year 3

Year 3 of the CT PFS was characterized by ongoing monitoring and TA of community-level implementation of the PFS, as well as State-level data collection and analysis, and the sub-regional RAC priority setting process. The 2012 Community Readiness Survey (CRS) was administered in Spring, 2012, and analyses conducted thereafter, with subregional reports disseminated to RACs along with the state-level report for use in planning and prioritization.

DMHAS worked with the RACs to conduct sub-regional needs assessments again this year, using data on alcohol and other substances. Every RAC began the development of a biennial Sub-regional Profile for their region using a DMHAS established process and format for assessing use of alcohol, marijuana, cocaine, heroin, tobacco, prescription drugs, and impact of gambling and suicide. The sub-regional profiles provide guidance and data to local coalitions as they re-visit their needs assessments and strategic plans.

During this period, several shifts occurred, one key shift being from a statewide to a regional approach to the Learning Community model for provision of technical assistance to subrecipients. This shift corresponded with a re-focus on coalition capacity building by many of the community-level grantees in the midst of implementation activities. The regional Learning Community model was designed to promote peer learning, collaboration, and resource sharing between communities in regions of the state, as a way of further expanding the reach of PFS resources and influence, and to strengthen linkages between the RACs to PFS communities in their catchment areas as key resources for guidance and technical assistance. DMHAS envisions two to three learning communities, hosted and facilitated by the RACs, per region per state fiscal year, for the remainder of the PFS. The Local Evaluator Meetings, which occurred semi-annually during this reporting period, may undergo a similar shift to regional workgroups,

as Local Evaluators and Prevention Coordinators have expressed a desire to meet regionally to network and troubleshoot evaluation process and practice.

The SEOW continued to meet during this period, but without key products developed or a strong directional role at this time. The group continues to work through the difficult process of revitalizing its membership and populating the SEOW web-portal.

The Evaluation Team continued to work with state agency and federal sources to access updated performance outcome data, including consumption data and event surveillance data. Updated data were obtained for all key outcomes on the state level, except for the CORE data measuring alcohol consumption by university students and certain NOMS indicators that had previously been available through the state-specific reports from the NSDUH (ie., age of first initiation of alcohol use and disapproval of alcohol use). A significant portion of the second half of the year was spent on data analysis and reporting to assess progress on PFS goals and objectives relative to outcomes indicators.

The Advisory Council functions for the Initiative were transitioned to a sub-committee of the Juvenile Justice Advisory Council. This sub-committee, staffed by the CT Office of Policy Management also oversaw the Enforcing Underage Drinking Laws money. Members of the former SAC also served on the JJAC sub-committee so merging the two groups eliminated duplicative meetings. DMHAS also partnered with the CT Office of Policy and Management, and other state agencies during this period to develop and implement the statewide media campaign (SetTheRulesCT.org) that kicked off in May, 2012.

Planning and Implementation of Grantee Level Local Evaluation Plan.

Data Collection Update

Since the inception of the PFS grant, one key focus has been the collection of process and outcome data on the state and community levels. Process data collection continued during the past year, through: participant observation and collection of archival materials from SEOW meetings, TA Planning Meetings, Learning Communities, and other meetings held as part of the PFS initiative; compilation of guidance documents, reports, and MOA; and through administration of the AGI on the community subrecipient level. The Evaluation Team also collected outcome data. The table below summarizes the outcome data collected or obtained by CT PFS to date. Years in italics denote data that is expected to become available through the end of the project. A second table details capacity and infrastructure outcomes, which are being monitored on an annual basis, and which will be assessed at the end of the project.

CT PFS Outcome Indicators for Alcohol Consumption

Indicator	Data Source	Unit of Analysis	Years Available**
<i>Alcohol Consumption</i>			
<ul style="list-style-type: none"> • Past month alcohol use* • Past month binge alcohol use • Age of initiation* • Perceived Risk* • Disapproval* 	SAMHSA NSDUH	State	2002/2003-2009/2010 <i>2010/2011 -2011/2012</i>
<ul style="list-style-type: none"> • Past month alcohol use* • Past month binge alcohol use • Age of first drink* 	CT DPH YRBS	State	2005, 2007, 2009,2011 <i>2013</i>
<ul style="list-style-type: none"> • Past month alcohol use* • Past two week binge alcohol use • Perceived risk * 	Core Survey	State, Community (Universities)	2004, 2006, 2008 <i>2010, 2012</i>
<ul style="list-style-type: none"> • Past month alcohol use* • Past month binge alcohol use • Age of initiation* • Perceived Risk* • Disapproval* 	Student and Other Community Surveys (Variable by community)	Community (Sub-recipient- specific)	2002-2010 <i>2011-2014 (Variable by community)</i>
<i>Alcohol-Related Consequences</i>			
Alcohol-Related Motor Vehicle Accidents*	DOT	State, Community	2002-2010, <i>2011-2012</i>
Fatal Alcohol-Related Crashes*	FARS	State	2002-2010 <i>2011-2012</i>
<i>Intervening Variables</i>			
Underage Liquor Law Violations*	DPS	State, Community	2002-2010 <i>2011-2012</i>
Underage DUI Arrests*	DPS	State, Community	2002-2010 <i>2011-2012</i>
Compliance Checks <ul style="list-style-type: none"> • Number • Failure Rate 	GPP, Sub-recipients	State, Community	2003-2011 <i>2012-2014</i>
Community Readiness for Substance Abuse Prevention	DMHAS Community Readiness Survey	State	2006, 2008, 2010, 2012 <i>2014</i>

* CSAP NOMS indicator

**Italics show future expected data collection years

CT PFS Outcome Indicators for Prevention System Change

Indicator	Data Source	Unit of Analysis	Years Available**
<i>Capacity and Infrastructure</i>			
Sustain the SEOW	DMHAS	State	2009-2012 <i>2013-2014</i>
Establish a web-based data system	DMHAS	State	2009-2012 <i>2013-2014</i>
Increase the availability of needs assessment data	DMHAS	State, Region	2009-2012 <i>2013-2014</i>
Increase readiness to collect data, identify resources, and utilize data for planning	CRS	State, Region	2010, 2012 <i>2014</i>
Increase collaboration with state agencies for substance abuse prevention	DMHAS, GLI	State	2009 <i>2014</i>
Provide ongoing training and technical assistance	DMHAS, Community Coalition Survey	State, Community	2009-2012 <i>2013-2014</i>
Increase the number of sub-recipient communities funded to implement the SPF approach*	DMHAS	State	2009-2012 <i>2013-2014</i>
Increase EBPPPs implemented to reduce underage drinking	MDS, PBPS	State, Community	2006-2009 <i>2010-2014</i>
Increase the number of persons served through EBPPPs*	MDS, PBPS	State	<i>2009-2014</i>
Increase use of environmental strategies to reduce underage drinking	MDS, PBPS CRS	State, Community	<i>2009-2014</i>
Increase community readiness for substance abuse prevention	Community Readiness Survey	State, Region, Community	2008, 2010, 2012 <i>2014</i>
Increase leveraging, redirection and realignment of funding for substance abuse prevention	DMHAS, GLI	State, Community	2009 <i>2014</i>

* CSAP NOMS indicator

**Italics show future expected data collection years

DMHAS has continued its work to build data capacity in collaboration with the SEOW. In the final year of the SPF-SIG, DMHAS began contracting with Data Haven to develop and populate the data repository, designed as an interactive data clearinghouse for Connecticut's prevention data. That vision has grown into the SEOW Web Portal. Data population of the SEOW web portal remains a charge of the SEOW, as guided by the DMHAS Data Manager.

The UCHC Evaluation Team conducted the Grantee Level Infrastructure and Implementation Surveys with key DMHAS prevention staff in October, 2011, based mainly on Year 1 of the PFS. In the absence of the cross-site evaluation, for which the GLI was developed, these data provide a descriptive baseline of Connecticut's prevention system and DMHAS' role and efforts in the PFS and other prevention initiatives. This instrument will be completed again in the final PFS project year to assess changes in state-level infrastructure and implementation. In March and April, 2012, DMHAS, UCHC and the Connecticut Clearinghouse partnered to conduct the 2012 Community Readiness Survey with key informants.

In addition to the data listed above, the UCHC Evaluation Team has worked to obtain and compile updated or new community-level data using the Survey Data Submission Form (SDSF), for community-level student survey data, variable constructs, and other methodological information, such as sampling and statistics. The SDSF is provided to community subrecipients semi-annually, with requests for updates on a quarterly basis, to collect any new student survey data that has become available during that quarter. The data are then entered into the PMRT and into the community-level dataset maintained by the UCHC Evaluation Team. Five PFS communities provided updated data during this reporting period. Several other communities reported having conducted surveys, but the data from their surveys were not currently available. Those data will reported once they are released.

Data on community-level implementation have also been collected on a quarterly basis using the Community-level Implementation Data Form. This form, which is completed by Local Evaluators and Prevention Coordinators, collects information on implementation activities, evidence-based strategies, and numbers served or reach, in accordance with CSAP's GPRA data reporting requirements. These data have also been entered into the PMRT, and are maintained in the community-level evaluation dataset.

The AGI was conducted in August through early September, 2012, with all 19 community-level subrecipients. Community level grantees also completed fidelity assessments of their environmental strategies and coalition capacity building, as well as the Community Coalition Survey, which included measures from the CLI developed through the CSAP cross-site evaluation.

Data Uses.

On the state and regional levels, PFS data have been and continue to be used for various purposes, including the RACs' biennial priority setting planning process, which was repeated this year. Outcomes data were available through the SEOW website and CRS data were disseminated to RAC directors for use in this process. DMHAS has also used the needs assessment data to successfully obtain additional external funding, such as for suicide prevention and higher education initiatives.

CT PFS data, and data from the SEOW, have also been utilized in Block Grant reporting, state results-based accountability (RBA) reports and prevention planning by DMHAS, and to leverage prevention funds on the state and federal levels via funding applications and grant writing. These data are also regularly presented to the Alcohol and Drug Policy Council and other prevention entities, in the form of project updates and presentations. Data have also been presented at national conferences, such as the National Prevention Network conference and CSAP grantee meetings.

CT PFS data have been used in needs assessment and strategic planning on the community level by sub-recipients, as well as by the UCHC Evaluation Team to assess outcomes over time. UCHC has worked closely with Local Evaluators in PFS and Best Practice communities to foster the use of data compiled centrally by UCHC as well as data collected locally, for use in evaluation of community-level prevention efforts and local planning efforts.

Data Reporting/Sharing.

Data collected in conjunction with the PFS have been shared in various ways on the State, regional, and community levels. Data from the PFS are routinely shared with the SEOW and are slated for inclusion in the SEOW interactive website/data portal maintained by DataHaven. The SEOW is currently in the process of working with state agency representatives to provide the raw data necessary to populate the interactive website. Data also continue to be posted periodically on the UCHC SEOW website, even though data collection and website maintenance was transitioned to the DMHAS Data Manager. The UCHC Evaluation Team, which managed the SEOW data collection and website management for the SPF, transitioned SEOW data collections and website maintenance to the DMHAS Data Infrastructure Manager during year 1 of the PFS, to build capacity for collecting, analyzing, and disseminating social indicator and other archival data relative to Substance Abuse including documenting trend data.

The 2012 CRS data were shared with RAC directors in the form of RAC-level reports and a State report, both of which were used for the 2012 RAC priority setting process. Local PFS and Block Grant funded coalitions have also been provided with data in creation of their strategic plans, for needs assessment, and to develop outcomes/benchmarks in evaluation of their local PFS efforts. The Evaluation Team convenes the Local Evaluator Workgroup semi-annually, sharing state and community-level data with Local Evaluators and Prevention Coordinators. One goal of the ongoing Evaluator Workgroups is to increase local capacity to utilize data for planning and assessment, and to work toward some standardization of outcomes measures among communities with similar strategies.

Data collected through the PFS evaluation has also been used to create information briefs for dissemination to state and community stakeholders, legislators and the general public. Each brief discusses recent findings on key outcomes of interest pertinent to the efforts of the PFS. These information updates serve to model the use of data for its recipients and to raise awareness about underage drinking and the PFS, as well as data driven prevention efforts in general. Information briefs have been created on the following topics: "Underage Alcohol Arrests in Connecticut," which outlined recent findings related to trends in rates of underage DUI and liquor law arrests; outcomes from the Strategic Prevention Framework (SPF) initiative; compliance check data; Emergency Department admissions; and the results of the 2010 Community Readiness Survey (CRS). The CRS information brief was sent to all CRS respondents in March, 2012, just prior to the launch of the 2012 CRS. The DMHAS

Communications Committee is determining how best to systematically disseminate these briefs going forward. Two information briefs on the 2012 CRS data, one for key informants who completed the survey, and one for public dissemination, are planned for November, 2012.

The Evaluation Team continues to share data with DMHAS and community-level grantees in various other ways, including the bi-annual Evaluator Workgroup Meetings. One goal for these ongoing Evaluator Workgroup meetings is to facilitate the transfer and sharing of data between DMHAS, UCHC and the community-level grantees. This is especially important for data that are being collected locally and compiled in a more timely manner than the community level data compiled by state agencies. The tradeoff is that local data may be aggregated differently than agency-compiled community-level data. The most recent Evaluator Workgroup was held April 2, and was opened to all community-level Prevention Coordinators in addition to Local Evaluators. The meeting focused on the sharing of updated data by the Evaluation Team and presentation on local evaluation approached by two Local Evaluators, followed by a discussion of data collection challenges and approaches. The next Evaluator Workgroup Meeting is scheduled for December, 2012.

Review of Data/M Measurement Challenges or Issues Occurring in Past Year

State-level.

Lag time in availability of data from state agencies, as well as other survey data, remains a key challenge for the PFS. Budget cuts statewide and the re-organization of community agencies has exacerbated the problem over time by limiting and changing those responsible for compiling and processing the data for dissemination. Release of the 2010 NSDUH data, integral for monitoring progress on meeting the State's performance target, was greatly delayed due to a change in format and technical issues in the processing of the national data. The data were not released until early Fall, 2012. Similarly, the most recent 2011 YRBS data was not released until late Summer, 2012. Release of the 2010 Connecticut CORE data, the university-level student survey used for collecting data on substance use, consequences, and attitudes, has also been delayed. Some local universities who participated have received their results, which have been collected as available for subrecipient outcomes monitoring and reporting to CSAP. The statewide 2010 data, however, were not yet publicly available as of this report.

In addition, the discontinuation of the cross-site evaluation resulted in a loss of key data from the Grantee Level Instrument (GLI), the Community Level Instrument (CLI) and the Participant Level Instrument (PLI) data collection that were integrated into the State evaluation plan. The loss of the CLI data was particularly challenging given the federal (CSAP) directive to submit GPRA data. In order to collect those data, key CLI elements that collect data on the GPRA measures were extracted to create a tool and protocol for community-level submission of implementation data by grantees. Additional items from the CLI were garnered to create the Community Coalition Survey, for completion by community-level grantees as part of the second wave of AGI interviews, conducted in August, 2012. The GLI was conducted with key DMHAS staff as a process measure to collect baseline descriptive data in October, 2011, and will be completed again in the final year of the project.

The SEOW Web Portal is up and running, but the flow of data to populate the system has been slower than initially expected. The SEOW is the key mechanism for data sharing via the portal. One key issue is the need for state agency data in the raw, on the individual level, and

with data constructs specified, so that the data can be used interactively by the system users. While data in the system is secure and access protected, state agency buy-in to the data repository before raw datasets can be released remains a barrier to the free flow of data into the system. Until state agencies can work with existing data in the system, and see the benefits of housing their data there, buy-in will be slow. Given that the portal is only as useful as the data within it, the SEOW must continue to work on marketing approaches to the SEOW web portal and its capabilities to key stakeholders statewide in order to enhance use and commitment to the repository.

The Evaluation Team faced a couple of challenges in completing trend analyses of event surveillance data. In 2007, there was a shift in measurement, as described earlier, in the manner in which motor vehicle accidents were reported to be more inclusive of accidents occurring on private property. The UCHC Data Analyst investigated various models and approaches to account for the reporting shift and to measure change over time. In addition, the availability of the 2010 census data as a base for calculating rates has created a challenge for trend analysis of event surveillance data. Statistical analyses of change in trends since the CT PFS baseline were based on estimates taking into account the change in population size between 2000 and 2010. The plotted figures, however, show rates based on the 2000 census in the interests of providing data consistent with earlier reports. Guidance on use of appropriate denominators in trend analyses where there are population changes over time will be sought for future reports.

Community-level

Delays in the shift from the Management Data System (MDS) to the Performance Based Prevention System (PBPS) have resulted in a gap in reporting of implementation and service provision (performance monitoring) data by community-level grantees, which has resulted in a gap in community-level data for the state evaluation and for quarterly implementation (GPRA) reporting to CSAP. The goal was to have grantees up to date in their service reporting by July, 2012. The only way to get data out of the PBPS is to design reports that are then created by the PBPS developers, Kit Solutions, which can then be accessed by users. To that end, user groups have been convened by DMHAS since the launch of the PBPS, to identify data reports that would be useful as a means of accessing, analyzing, and reporting their data. To fill the reporting gap, the Evaluation Team worked closely with sub-recipient Prevention Coordinators and Evaluators to develop an Implementation Data Submission Form to collect current year first and second quarter data on implementation activities, outside funding, and number served/reached. The reported data will be compared with PBPS reporting data once it is confirmed that those data are complete. This same process was utilized to collect Quarter 3 and 4 data on community-level implementation. As part of enhancing the prevention data infrastructure DMHAS will receive on-site technical assistance from the PBPS developers to assist DMHAS, PFS, and Best Practice PBPS users in utilizing the system and developing reports for use going forward. The PBPS developer will spend hours on site at DMHAS during the next quarter to be available for technical assistance.

Another challenge centers around the lack of a statewide student survey to collect community-level outcomes. While there is no single standardized school survey instrument being used across communities, all community-level grantees are required to measure the NOMS alcohol consumption measures. Each sub-recipient community is using their locally selected instrument (e.g., GPIY, Search Institute, Communities That Care, Core Survey, American College Health Survey). In some PFS communities, the same instrument has been administered

multiple times over the past several years. However, the target populations, sampling methodologies, and timing of survey administration vary across communities. These methodological differences across communities limit comparative analyses across PFS sub-recipients, but the use of a comparable past-month alcohol use item (yes/no) will facilitate an assessment of change in the prevalence of underage drinking among sub-recipients. It will not be possible to compare alcohol consumption between PFS and non-funded communities because of the lack of a standardized community level school survey in the state. Also, there will be uncertain access to any town-specific school surveys conducted by towns/municipalities that do not receive state or CSAP funding for substance abuse prevention. The UHC Evaluation Team continues to utilize the Survey Data Submission Form (SDSF) to collect updated student survey data on the core outcomes measures from the PFS and Best Practice local evaluators as data become available.

Understanding and utilizing data appropriately continues to be a challenge for some communities. To build capacity among community-level providers, evaluators and to standardize processes, as well as support local evaluators in data collection and submission, the Evaluation Team opens one of its two Evaluation Workgroup Meetings a year to Prevention Coordinators as well as Local Evaluators. The format of these larger meetings is less of a traditional workgroup and more of a framework for building data capacity, sharing new data and updates, and exchanging information on process issues.

System/Process Outcomes

Performance Management System.

The Connecticut performance monitoring system is the Performance Based Prevention System, or PBPS, a database tracking software package that replaced the MDS as Connecticut's performance management system in July, 2011. The system is based on CSAP's Minimum Data Set (MDS), a nationally recognized standard. The use of these standards provided a consistent and comprehensive basis to collect and analyze data in the PBPS. The PBPS includes additional features that were added onto the MDS standard to allow greater flexibility and customization, while incorporating science-based or evidence-based programs into the prevention application. The software, based on the Strategic Prevention Framework planning model, is designed to use a Needs Assessment to choose targeted risk factors, base goals and objectives on these risk factors, track prevention activities aimed at accomplishing the goals and objectives, and evaluate the progress of the goals and the outcomes (success) of the programs. In addition, Connecticut PBPS facilitates information sharing and tracking meeting results between the Prevention Partners and Coordinating agencies. Two central features of the re-design of Connecticut's performance management system are enhanced data security, including an automatic log-out after 30 minutes of inactivity, and tighter log-in protocol than MDS, as well as enhanced report capabilities. One drawback of the design focused on enhanced security is that the resulting system is less interactive for the user. While grantees can request reports from the Developer, they cannot develop them in the system, thus limiting the interactive capabilities for the users themselves. To address this issue, DMHAS assembled user groups to brainstorm report designs for use across sub-recipients and individual communities. What is lost in this approach is the ability to interact with the raw data on a local level.

Progress/achievements

Training for users occurred during Fall of 2011. DMHAS developed a comprehensive data entry workbook based on the improved logic of the PBPS, and instituted a workbook approval process prior to data entry in the system. DMHAS staff worked closely with sub-recipients to navigate the process of converting portions of their needs assessments and strategic plans into PBPS data elements. This approach was taken to enhance data quality and give sub-recipients a guided interface with the requirements of the new system. The target date for approval of workbooks was December, 2011, with data entry to occur immediately thereafter. However, system challenges regarding expansion of character limits in the narrative fields delayed the process by several weeks. Sub-recipients with approved workbooks were cleared for data entry in January, 2012. Quality control assessments by DMHAS of the entered data are ongoing, and DMHAS has been responsive to grantee issues and discrepancies through contact, TA, and additional training sessions. In January, 2012, DMHAS developed and circulated an approach to capture coalition work by linking it as a strategy to risk factors. A guidance document, in the form of a coalition template, was issued in late January, 2012.

Leveraging of Funds

Progress/achievements.

DMHAS has made significant movement to leverage resources in various ways, from pursuit and access of additional grant funding for prevention, re-focusing the approach of existing funded programs, and by linking substance abuse efforts to violence prevention and mental health.

DMHAS applied for and was awarded \$12 million in new federal funding to support the implementation of innovative enhancements to Connecticut's substance abuse and mental health system, including one-year grant by CSAP to plan for expansion and strengthening of the prevention infrastructure.

DMHAS was one of nine states to receive \$8.3 million over five years to fund the Connecticut Screening, Brief Intervention and Referral to Treatment Program (CTSBIRT Program), designed to increase identification and treatment of adults, ages 18 and older, who are at-risk for substance misuse or diagnosed with a substance use disorder. The Connecticut Tobacco Enforcement Program was also funded by the Food and Drug Administration over three years to enhance current efforts to prevent tobacco use among minors across the state by decreasing the number of merchants that sell tobacco products to them.

The Connecticut Campus Suicide Prevention Initiative (CCSPI) will bring evidence-based, suicide prevention and mental health promotion policies, practices and programs to scale at institutions of higher education statewide for students up to age 24. The CCSPI is a collaborative partnership among DMHAS, other State agencies, and the Connecticut state university/college systems.

Additionally, DMHAS was awarded funding by the Center for Mental Health Services (CMHS) for a three-year project period, to enhance and expand the statewide prevention infrastructure to promote emotional health and reduce the likelihood of substance abuse and their related consequences.

Although this funding is not directly targeted at underage drinking, it enhances the connective elements to the larger system, and strengthens prevention practice by increasing staff, services, and infrastructure that will benefit efforts to address underage drinking as well as these associated problems.

In order to further expand the reach of the PFS, DMHAS has required its existing Best Practice grantees to adapt the SPF planning model to address the common statewide goal to reduce underage drinking in Connecticut. The application of the data-driven strategic planning process into its existing SAPT Block Grant and state-supported programs builds upon the changes initiated through the SPF-SIG in DMHAS's substance abuse prevention infrastructure, including its regional planning agencies, the Regional Action Councils (RACs), and other DMHAS Resource Links. The further integration and expansion of the SPF process both vertically and horizontally is expected to increase the impact and effectiveness of the substance abuse prevention efforts in the state and result in measurable reductions in the prevalence of underage alcohol use and its consequences statewide as well as at the community level.

In addition to leveraging and re-directing funding, DMHAS expands the reach of its community-based initiatives through funding of 156 LPCs (local prevention councils), to facilitate the development of ATOD abuse prevention initiatives at the local level with the support of the Chief Elected Officials and Regional Action Councils, to conduct strategic planning and facilitate prevention efforts in their sub-regions. DMHAS has also partnered with the Connecticut Office of Policy and Management, and other State agencies to develop and implement the statewide media campaign (SetTheRulesCT.org), which launched in May, 2012.

Statewide Prevention Priority Need, Performance Target, and Associated Intervening Variables

Population descriptors.

Based on the 2010 U.S. Census, Connecticut's population was 3,574,097 people, up from 3,405,565 persons in 2000. The adult population grew by 193,205 to a total of 2,757,082 (77%) in 2010; however, the juvenile population decreased in 2010 by 24,673 to 817,015 (23%) in 2010. Currently, 444,072 persons (12.4%) are aged 12-20. Connecticut's ethnic/racial makeup is becoming increasingly diverse. In 2010, 79% of the population were non-Hispanic Caucasians. Approximately 13.4% of Connecticut's total population in 2010 self-identified as Hispanic/Latino compared to 12% in 2000. The Black/African American population grew from 9.3% in 2000 to 11.3% in 2010. Currently, 3.8% self-identify as Asian, 2.2% as two or more races, and 0.3% as American Indian/Alaska Native. Thirteen percent (13%) of people living in Connecticut in 2010 were foreign born, and 20.6% spoke a language other than English at home. Connecticut's urban centers are stressed by significant social problems, having among the highest national rates for crime, violence, school dropout, teen pregnancy, drug arrest, and unemployment. In 2010, 9.2% of the total population lived in poverty, and 6.5% of families in Connecticut lived below the poverty line.

Connecticut, through its SAMHSA-funded SPF SIG SEOW, generated data up through 2008 to strategically plan a comprehensive prevention system. Epidemiological data were

collected on the consumption and consequences for alcohol, tobacco, marijuana, heroin, cocaine, and prescription drugs that were misused. Data were collected from a variety of national, state, and local sources, including SAMHSA State Epidemiological Data Set; National Household Survey of Drug Use and Health (NSDUH); The National Tobacco Survey (NTS); CDC Youth Risk Behavior Surveillance System (YRBS) and Behavior Risk Factor Surveillance System (BRFSS); CT 2003-2004 Adult Household Survey; Core Survey of Alcohol/Drug Use on Campus (Core Survey); and archival data collected by Connecticut's state agencies, including data on mortality, morbidity, motor vehicle accidents, arrests, liquor and tobacco compliance checks, arrests, and school attendance, graduation, and substance-related suspensions and expulsions. These data indicated that alcohol is the most commonly used and abused substance in Connecticut and that underage drinking in particular was a priority public health concern. As it had done with the SPF-SIG initiative, the PFS continued to target the prevention and reduction of underage drinking.

Measures.

In 2010, in consultation with CSAP, Connecticut identified a single performance target based on data from the National Survey of Drug Use and Health (NSDUH). The agreed upon performance target was a reduction in the percentage of 12 to 17 year old persons who report alcohol use in the past 30 days from 19.6% in 2006-2007, the baseline year, to 18.1% in 2009-2010. Attainment of this target objective would realize a 7.7% reduction in the prevalence of alcohol use among 12 to 17 year olds in Connecticut. This target was set in response to CSAP's requirement that grantee states set a three-year performance target that is "realistic and robust." The performance target was based on national and state trends in past 30-day alcohol consumption, as well as reductions observed in Connecticut's SPF-SIG initiative. The 12 to 17 year old population was chosen because the majority of Connecticut's PFS effort is directed toward that age group and we expect have a greater impact on drinking among younger adolescents compared to 18 to 20 year olds. The NSDUH data was used as the basis of its statewide performance target for the PFS because the NSDUH was the only data source that had reliably provided annual alcohol and other drug use rates for Connecticut youth, as required by CSAP.

According to the most recent state estimates available from the 2006-2007 NSDUH (SAMHSA, 2010), Connecticut's 19.60% (95% prediction interval 17.15% – 22.30%) past month rate of alcohol use among 12 to 17 year olds was the fifth highest in the U.S, surpassing the national average of 16.28%. Based on calculations taking into account both prediction intervals and projected effect size, Connecticut proposed a PFS 3-year performance target of 18.1% as measured by the 2009-2010 NSDUH state estimate. If Connecticut was able to reduce the baseline past month alcohol use rate by 7.7%, it would represent a meaningful and robust change in the state rate.

It was projected that the effect size would be in the "small" range (Cohen, 1988). As Cohen noted, small effect sizes usually characterize "phenomena under study [that] are typically not under good experimental or measurement control" (Cohen, 1988, p. 25). This is an appropriate characterization of the conditions under which the CT PFS impact on underage alcohol consumption is being evaluated. A variety of factors are expected to influence the magnitude of the effect size at the state-level, such as variation in the type, number, intensity, and fidelity of implementation of prevention strategies across communities and occurrence of alternative factors that can affect the direction of change (e.g., legislation to increase alcohol taxes and raise the

purchase price of alcohol or change in socioeconomic conditions statewide). The PFS-funded communities represent less than one-fourth of the total population, and given the limited reach of the community-specific initiatives, the state-level impact is likely to be less than the observed community-specific impact.

In addition, Connecticut identified several other state-level performance targets to be accomplished over the course of the five-year PFS. Although the State decided it could not rely on the YRBS data to meet the federal performance target, if those data were available, the YRBS would be used to measure reductions in the prevalence of both past month alcohol use and binge drinking among high school students. Further, the State expected reductions in 30-day alcohol use and binge drinking among the broader population of 12 to 20 year olds as measured by the NSDUH from baseline (2006-2007) to the final year for which NSDUH data will be available (2011-2012). It was also expected that consequences directly related to underage drinking – alcohol-involved motor vehicle accidents among young drivers 16 to 20 years of age – would be reduced. Certain intervening variables associated with implementation of environmental strategies supported and encouraged through the SPF and PFS initiatives – juvenile DUI arrests from sobriety checks and enforcement of intoxicated driving laws and juvenile liquor law violations and compliance checks, again associated with increased enforcement of existing laws – were expected to increase initially in SPF and the beginning of PFS and then decline as access to liquor and changes in social norms regarding underage drinking changed. Finally, it was hypothesized that community readiness and capacity to implement effective substance abuse prevention would increase over time statewide, especially in communities funded by the SPF-SIG and PFS to utilize data-driven planning process to assess needs, build capacity, identify and implement evidence-based practices, and monitor and evaluation their progress. Community readiness for substance abuse prevention was identified as a key intervening variable that has been assessed every two years since 2006 through the CRS. As a PFS GPRA measure, the percentage of evidence-based practices and programs funded by DMHAS was also tracked to determine if there was an increase over time.

Analytic Strategy

The major objective of the outcome evaluation has been to determine the impact of the CT PFS on the consumption, consequences and intervening outcomes related to underage alcohol use and on the substance abuse prevention system infrastructure. The outcomes analysis has utilized a quasi-experimental time series design with repeated measures comparisons of survey (e.g., NSDUH, YRBS, Core Survey, MDS, GLI, CLI and CRS) and event surveillance data to assess the impact of the CT PFS at both the state and community levels. The PFS evaluation has continued much of the collection and analysis of trend data from the SPF initiative forward to assess changes in consumption, consequences, intervening variables, and prevention infrastructure over since 2002 where those data were available.

Descriptive statistics and trend analyses have been used to evaluate and report on state and community characteristics and outcomes. In the final analysis at the project end in 2014, baseline differences between communities with PFS funding in the intervention group will be compared to those without PFS funding using analysis of variance/covariance methods. Discrete measures have been evaluated with a Chi-square test for independence or with logistic regression. Trends in consumption outcomes from the Connecticut NSDUH and YRBS data have been analyzed as independent samples with one-way tests of significance. The NSDUH

and YRBS both use two-stage cluster random sampling schema to survey adolescents, so sample weights created by each are taken into account for these sampling designs.

In the final report, one set of analysis will focus on determining whether PFS funding at the community level has resulted in greater improvements in epidemiological outcomes and community readiness. In this interim report, only statewide change over time has been analyzed. Multilevel modeling was employed to assess evidence of changes in community readiness over time with available town/municipality level data. Specifically, hierarchical linear growth models have been carried out on sets of continuous dependent measures that were hypothesized to change across time using SAS (PROC MIXED). For the final report, a within-between cross-level interaction will be used to assess whether changes over time occur differentially between PFS-funded communities and non-funded communities. The unit of analysis in these models is the Connecticut communities. When data are available at the town-level for all communities in Connecticut, outcomes for PFS communities will be compared to non-PFS communities. This analysis is delayed until there are sufficient points in time to have enough power to detect significant differences according to funding status.

Examples of consequence and intervening variable data that have been available consistently over time across all towns/municipalities include: alcohol-related motor vehicle accidents, juvenile liquor law violations and DUI arrests, and community readiness and community attitudes toward underage drinking as measured by the Community Readiness Survey (CRS). For this report, the respondents to the CRS and consequence data have been aggregated within those categories to produce mean rates of community level readiness. The CRS data have been weighted to account for community size with respect to the state as well as to adjust community averages that are populated with more versus fewer respondents/records. In this way, those community averages that are driven by more respondents are given more weight than those community averages that are calculated with fewer respondents.

In order to determine if there were statistically different changes in underage alcohol consumption and alcohol-related consequences over the period of the PFS, a p-value based on a Chi-square for trend or the Cochran-Armitage Trend Test was derived for selected CT PFS indicators. Changes in the state trends for the following consumption indicators were assessed: past 30-day alcohol use among 12 to 17 year olds based on the population-level data from the 2006-2007 to 2009-2010 NSDUH surveys (the CT PFS target performance indicator); past 30-day binge drinking among 12 – 17 year olds as measured by NSDUH; past 30-day alcohol use among 12 – 20 year olds in the NSDUH; past 30-day binge drinking among 12 – 20 year olds in the NSDUH; perception of great risk of drinking five or more drinks once or twice a week among 12 to 17 year olds in the NSDUH; past 30-day alcohol use among high school students as measured by the 2009 and 2011 YRBS surveys; and 30-day binge alcohol use measured by the YRBS surveys. Consequence indicators that were assessed for statistical change at the state level included: alcohol-related motor vehicle accidents; alcohol-related motor vehicle accidents among 16 – 20 year olds; alcohol-related fatalities; underage liquor law violation arrests; and DUI arrests among those 10 – 20 years of age. Data are also presented on the number of compliance checks and failure rates for sales to underage persons, but these data were not subjected to statistical analyses because the compliance data are a census of statewide activities.

In addition, trend analyses were conducted on community readiness for substance abuse prevention based on the CRS data collected biannually between 2006 through 2012. State level changes in CRS indicators, including the index measuring key informant's overall rating of their

community's level of readiness, were assessed both since the SPF SIG was initiated and during the PFS period (2008 – 2012).

The following table shows the indicators being tracked in the PFS evaluation and the data source, the unit of analysis, and the years of data coverage for each indicator. These indicators of consumption, consequences and intervening variables reflect those that are considered directly related to the underage drinking initiative and the expected system changes.

Connecticut PFS Targets and Goals

PFS Progress:

Performance Target and Evaluation Benchmarks

Indicator	Source	Year 1 (Baseline)	Year 2	Performance Target (Year 3)	Year 3	Evaluation Benchmark (year 5)
Past 30 day use, 12-17 *	NSDUH	19.6% (2006-07)	18.3% (2007-08)	18.1%	17.8% (2009-10)	17.6%
Past 30 day use, 12-20	NSDUH	32.8% (2006-07)	32.4% (2007-08)		31.9% (2009-10)	29.5%
Past 30 day use, high school students	YRBS	43.5% (2009)			41.5% (2011)	39.2%
Past month binge alcohol use, 12-20	NSDUH	23.5% (2006-07)	24.3% (2007-08)		22.3% (2009-10)	21.8%
Past month binge alcohol use, high school students	YRBS	24.2% (2009)			22.3% (2011)	21.7%
Level of statewide community readiness for substance abuse prevention	Community Readiness Survey	4.3% (2006)	4.6% (2008)		5.1% (2012)	statistically significant increase

*Connecticut's 3-year PFS performance target.

In the original CT PFS proposal, we had proposed using data collected through the Community-Level Instrument (CLI) that was going to be used for the CSAP-funded cross-site evaluation. We chose to rely of the CLI data instead of collecting our own community level data about interventions implemented by grantees to avoid overburdening the grantees with duplicative reporting. Unfortunately, in Year 2 of the PFS initiative, the cross-site evaluation was discontinued before any community level data were collected. This change in the national

evaluation plan meant that Connecticut does not have community level baseline data for the PFS evaluation. However, the UCHC evaluation team did adapt some of the items from the CLI to administer to grantee recipients that was implemented in July through September of this year. Those Grantee Level Instrument (GLI) descriptive data of past year activities and experiences are included in this report together with information collected through semi-structured interviews with sub-recipients.

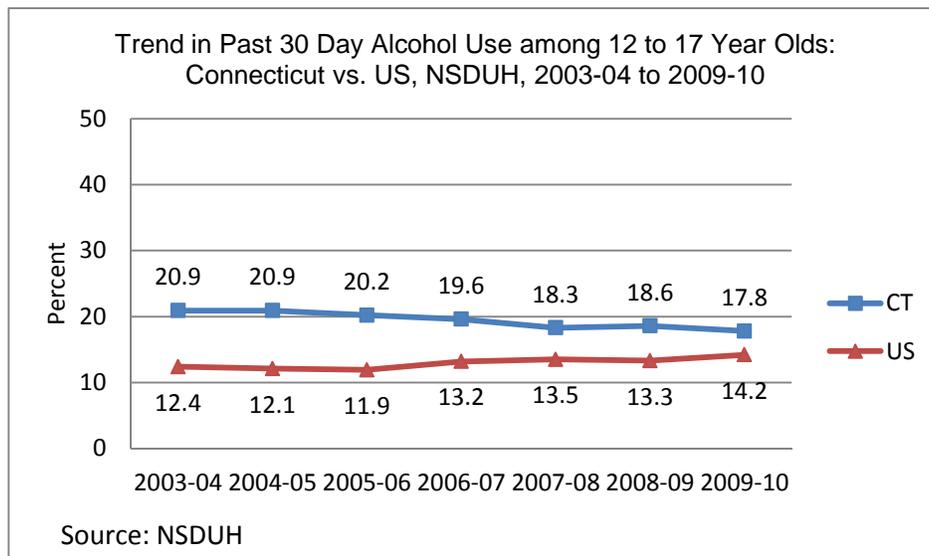
Results

Underage Alcohol Consumption.

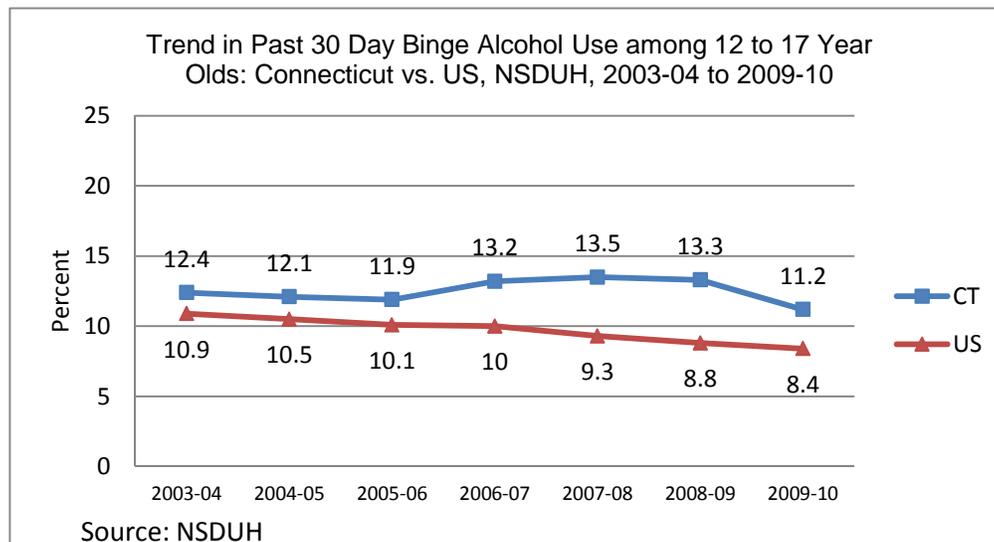
National Survey of Drug Use and Health

The NSDUH is the primary source for Connecticut's population data on alcohol, tobacco and other drug use behavior and related risk factors. The Office of Applied Studies (OAS) at the Substance Abuse and Mental Health Services Administration (SAMSHA) provides annual state estimates based on a representative sample of respondents in each state aged 12 and older. State estimates are based on a survey-weighted hierarchical Bayes estimation approach and combines two years of survey data (e.g., 2007-2008, 2008-2009) to ensure greater reliability of estimates (SAMHSA, 2010). The NSDUH state data are reported for different age groups (i.e., 12+, 12-17, 18-25, 26+, and 12-20); this analysis relied particularly upon the small area estimates for Connecticut for 12 to 17 year olds and 12 to 20 year olds. While the trend tables below display the NSDUH data extending from 2003-2004 to 2009-2010, the 2006-2007 data serve as the baseline for the PFS evaluation and the most recent 2009-2010 NSDUH data as the outcome point. The analysis of statistical changes is for the 2006-2007 through 2009-2010 period only.

Alcohol use in the past month among 12 to 17 year old persons. The data in the table below show that the prevalence of adolescent alcohol use has been higher in Connecticut than in the U.S. for the past several years. The difference, however, has narrowed as Connecticut's rate has declined. The percentage of 12 to 17 year olds who report past month use of alcohol has decreased since 2004-2005 when the percentage was 20.9% to its current low of 17.8% for 2009-2010. In the baseline year of the PFS, when the percentage of youth reporting 30 day alcohol use was 19.6% according to the 2006-2007 NSDUH data, Connecticut's PFS performance target for past month alcohol use among 12 to 17 year olds was set at 18.1% as measured by the state's 2009-2010 NSDUH survey. The 2009-2010 data show that the performance target was surpassed. The 2009-2010 prevalence rate of 17.8% represents a 9.2% decrease in past month alcohol use in Connecticut's PFS target group of 12 to 17 year old youth since 2006-2007. This decrease is not statistically significant ($p = 0.231$), but it is consistent with the reduction expected.

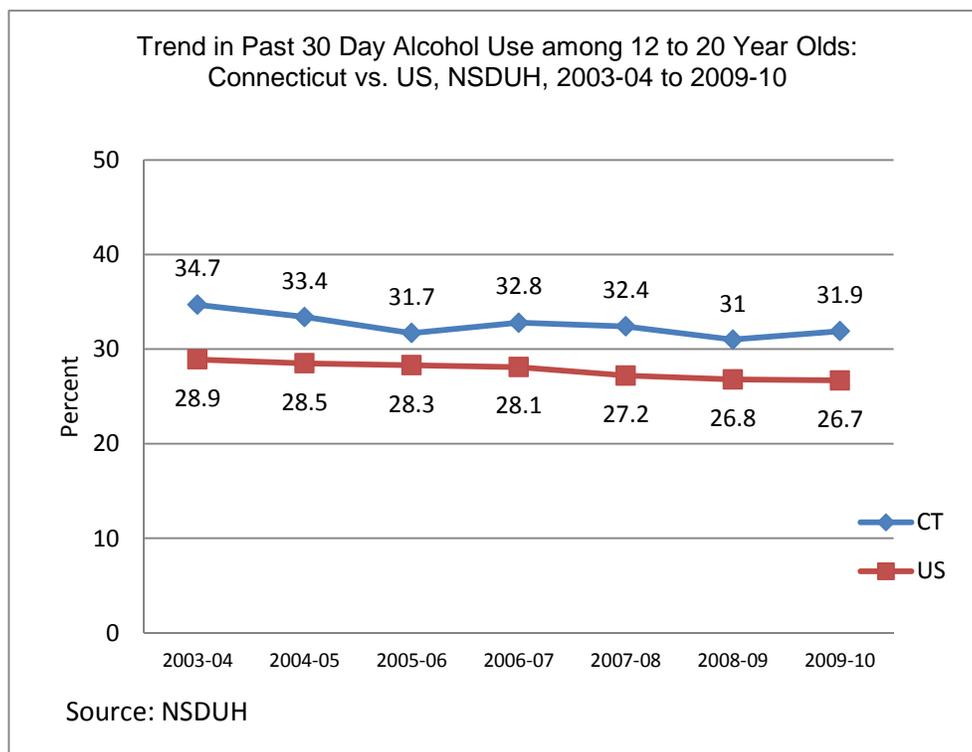


Binge drinking in the past month among 12 to 17 year old persons. The NSDUH survey measures binge drinking by asking respondents if they have had five or more drinks on the same occasion on at least one day in the past 30 days. The biannual estimates displayed in the figure below reveal that while binge drinking in this age group has declined since 2003-2004 in the U.S. overall, in Connecticut it rose from a low of 11.2% in 2002-2003 to a high of 13.5% in 2007-2008. However, the 2008-2009 and 2009-2010 data show that the rates have declined to a low of 11.2% in the most recent NSDUH year. This represents a 17% decrease in the rate of binge drinking for Connecticut's 12 to 17 year old youth that may at least in part be attributed to state and community efforts to reduce underage drinking through the SPF-SIG and PFS initiatives. There was a 15.2% reduction since the CT PFS baseline year (2006-2007). Again, this was not a statistically significant change as measured by a Chi square trend test, but it is a meaningful reduction ($p = 0.165$). The gap between the state and national prevalence rates continues (11.2% vs. 8.4% respectively), although Connecticut has experienced a steeper decline in the binge drinking rate among youth than seen nationally.



Alcohol use in the past month among 12 to 20 year old persons. The NSDUH data in the graph below show the pattern of alcohol use among 12 to 20 year olds. These trend data indicate that the rate of underage drinking among 12 to 20 year olds in Connecticut remained higher than the national average so that in 2009-2010 the prevalence of underage drinking in this age group was 31.9% in the state versus 26.7% nationally. However, the prevalence of past month alcohol use in this broader age group has declined from 2003-2004 when 34.7% of underage youth reported drinking in the past 30 days to a low of 31% in 2008-2009. Unfortunately, there was a slight increase from 2008-2009 to 2009-2010. Although it is a decrease, the change in the NSDUH estimate between 2006-2007 and 2009-2010 was not statistically significant ($p = 0.283$).

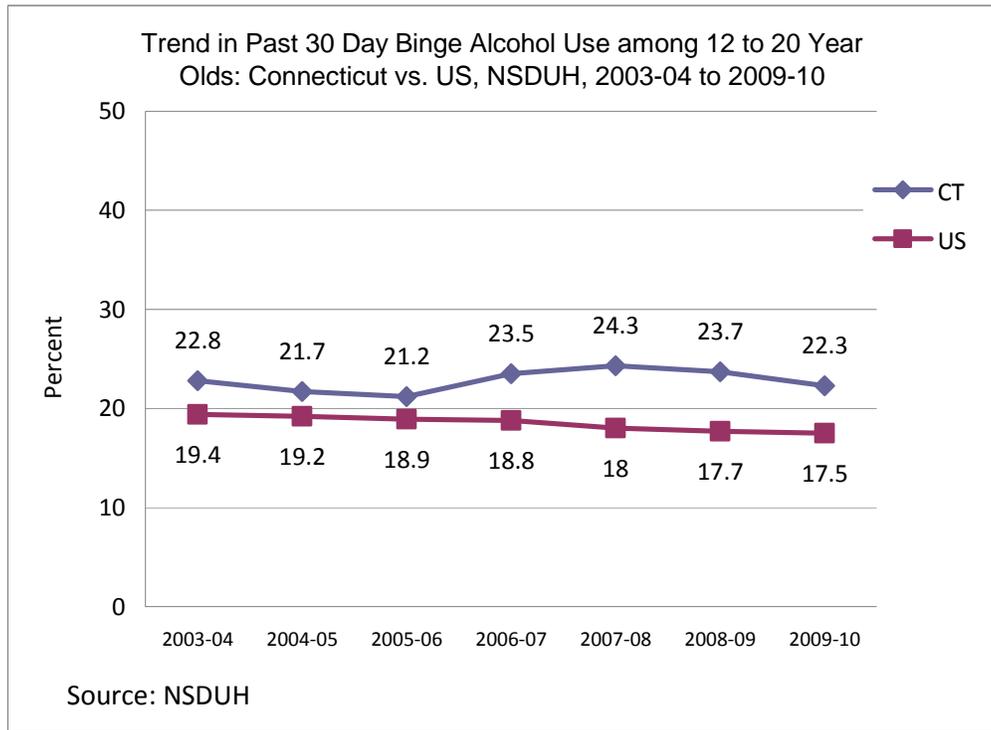
The pattern seen among 12 to 20 year olds is not consistent with the decrease in use reported by the 12 to 17 year olds participating in the NSDUH, suggesting that older adolescents have been less affected by the PFS underage drinking initiative. Younger adolescents 12 to 17 appear to have responded to the strategies to reduce and prevent underage drinking while older adolescents have maintained use in recent years. This makes sense since the majority of funded communities have been focusing on the 12 to 17 year old age group.



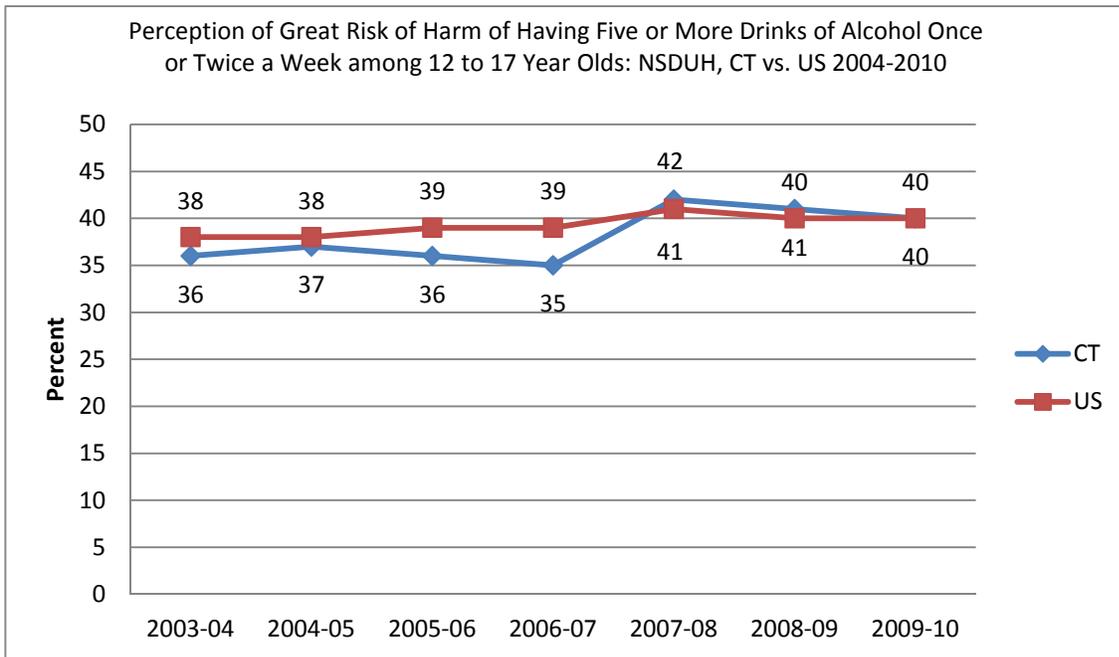
Unfortunately, at this point in time the Core Survey data for Connecticut college students under age 21 are not available from 2010 to independently confirm this observed flattening of the trend rate among older adolescents during the first three years of the PFS.

Binge drinking in the past month among 12 to 20 year old persons. On a more positive note, the data in the figure below indicate that the rate of binge drinking in the larger group of underage youth 12 to 20 decreased from a high of 24.3% in 2007-2008 to 22.3% in 2009-2010. The most recent prevalence estimate is an 8.2% reduction in the rate of binge drinking among all youth 12 to 20 since 2007-2008, and a 5.1% decrease since 2006-2007, the baseline year for the

CT PFS. It was not, however, a statistically significant change ($p = 0.259$). The data in the graph also show that the percentage of youth 12 to 20 in Connecticut who report past month binge alcohol use continues to exceed the national percentage, but the gap is narrowing.



Perception of great risk of harm from having five or more drinks of an alcoholic beverage once or twice a week among 12 to 17 year olds. Prior to the PFS, youth in Connecticut were less likely than their peers nationwide to report that there was great risk in weekly binge drinking. In 2006-2007, 35.2% of Connecticut youth aged 12 to 17 perceived great harm in weekly binge drinking compared to 39.4% nationwide. But by 2008-2009 and 2009-2010 the percent who perceived great risk rose to closely match the national rate at approximately 40% each. The change from 2006-2007 to 2009-2010 represented a 14.4% increase in perceived risk of binge drinking, a statistically significant improvement ($p = 0.016$).

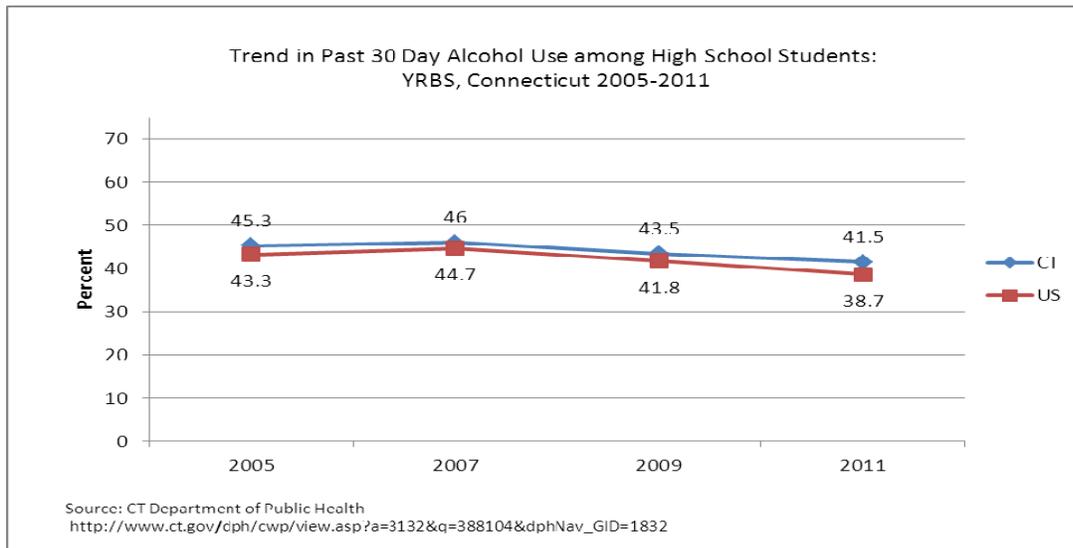


Youth Risk Behavior Survey

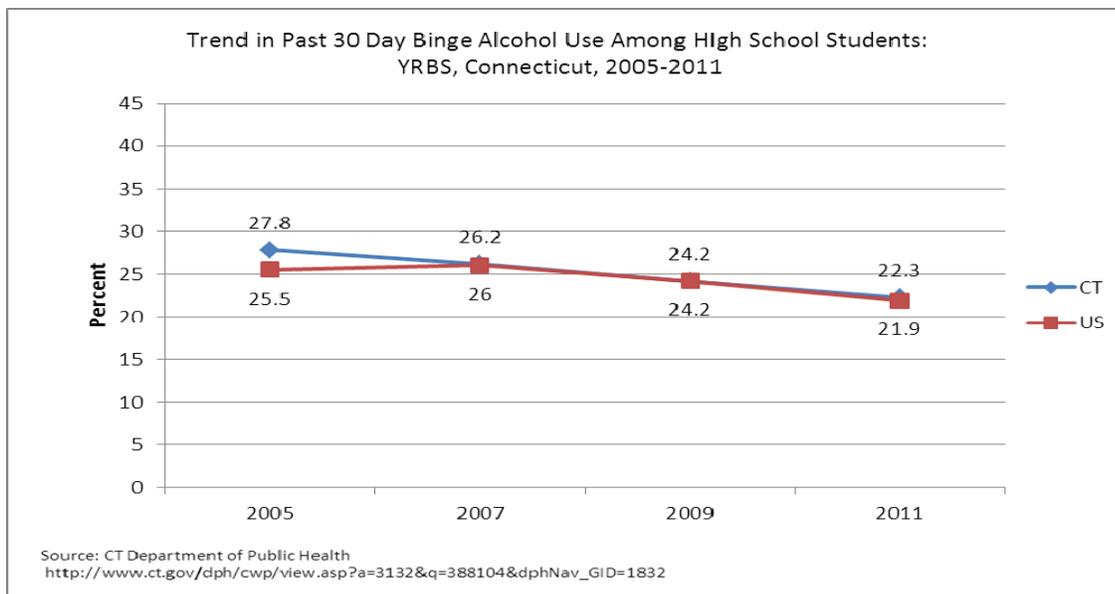
Connecticut now has four years of Youth Risk Behavior Surveillance (YRBS) Survey data that are available to track trends in alcohol use behavior among youth during the CT SPF – SIG and PFS initiatives: 2005, 2007, 2009 and 2011. As noted earlier, at the point when Connecticut’s performance target was being set, it wasn’t certain that the YRBS data would be consistently available throughout the PFS period given that survey’s uneven history of administration in this state. If available, the final administration of the YRBS in 2013 will be used to monitor changes in underage drinking rates during the full CT PFS project period. These data are among the best available to the State to evaluate the impact of the statewide initiative because of their timing and the representativeness of the sample at the state level. It may be argued that the YRBS data tell a more accurate story regarding changes in patterns of alcohol use among Connecticut’s youth compared to the NSDUH in part because the estimates are more reliable than NSDUH data given the sample sizes. Given the great discrepancy in the YRBS and NSDUH prevalence rates (almost two to one for alcohol use), the anonymous, group administered YRBS is more likely to reflect actual levels of alcohol and other drug use in this population. Also, the population targeted by the CDC-funded survey (i.e., high school students) is the group most likely to be reached by the CT PFS initiative. The following discussion of the YRBS data reflect the status of underage drinking based on student self-reports from 2005 to 2011, although only the changes between 2009 and 2011 were subjected to tests of statistical significance.

Past month alcohol use among high school students. With regard to the prevalence of past month alcohol use, the YRBS data in the figure below indicate that 14 to 18 year old students attending public high schools in Connecticut reduced their drinking behavior from 45.3% in 2005 to 41.5% in 2011, an 8.4% reduction in use over the six-year period. The declining trend in past month use among high school students in Connecticut has closely mirrored the national trend. Since 2009, the baseline year of the CT PFS, there has been a 4.6% reduction in past month drinking among Connecticut’s students. This is not a statistically significant decrease (p

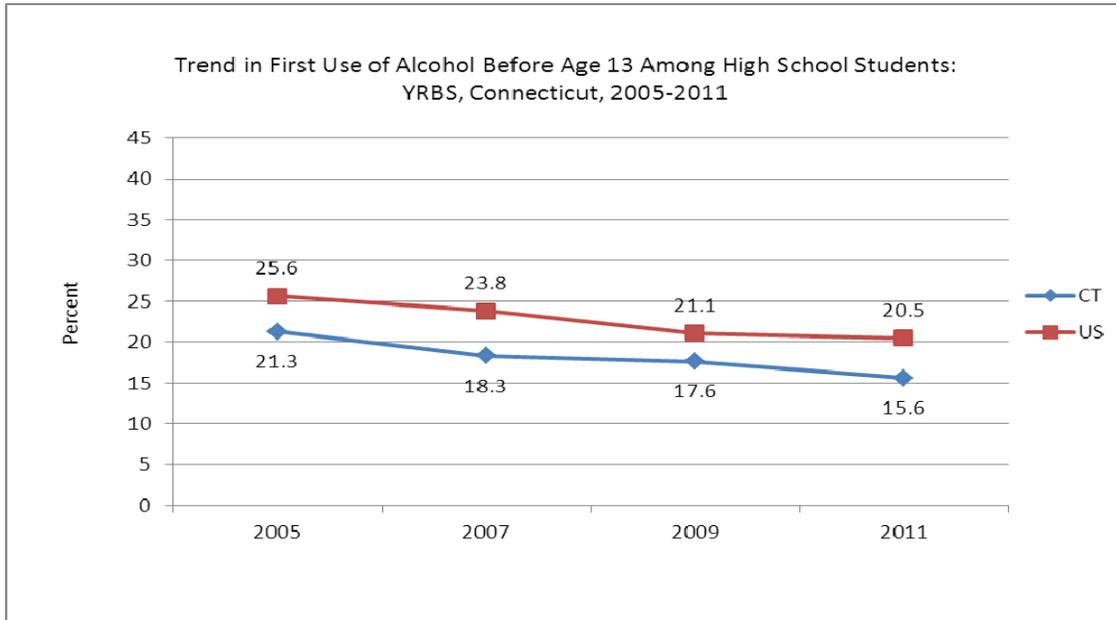
= 0.200), although it is consistent with expectation and the pattern seen in the NSDUH estimates for 12 to 17 year old adolescents. The YRBS data are also consistent with the NSDUH trend data in showing that youth in this state drink at a higher rate than seen nationwide.



Past month binge drinking among high school students. As the YRBS data below show, approximately half of high school students that recently drank alcohol reported binge drinking. The YRBS data also indicate that Connecticut has witnessed a steady decrease in adolescent binge drinking. According to the YRBS, past month binge drinking among high school students dropped from 27.8% in 2005 to 22.3% in 2011, a 19.8% reduction over the six-year period. This reduction has exceeded the national decrease in the rate of binge drinking (14.1%) during this same period. Since 2009, there was a 7.9% reduction in the percentage of high school students who reported past 30-day binge drinking in Connecticut. While this was meaningful continuation in the decline in binge drinking among high school students, it did not reach statistical significance ($p = 0.200$).

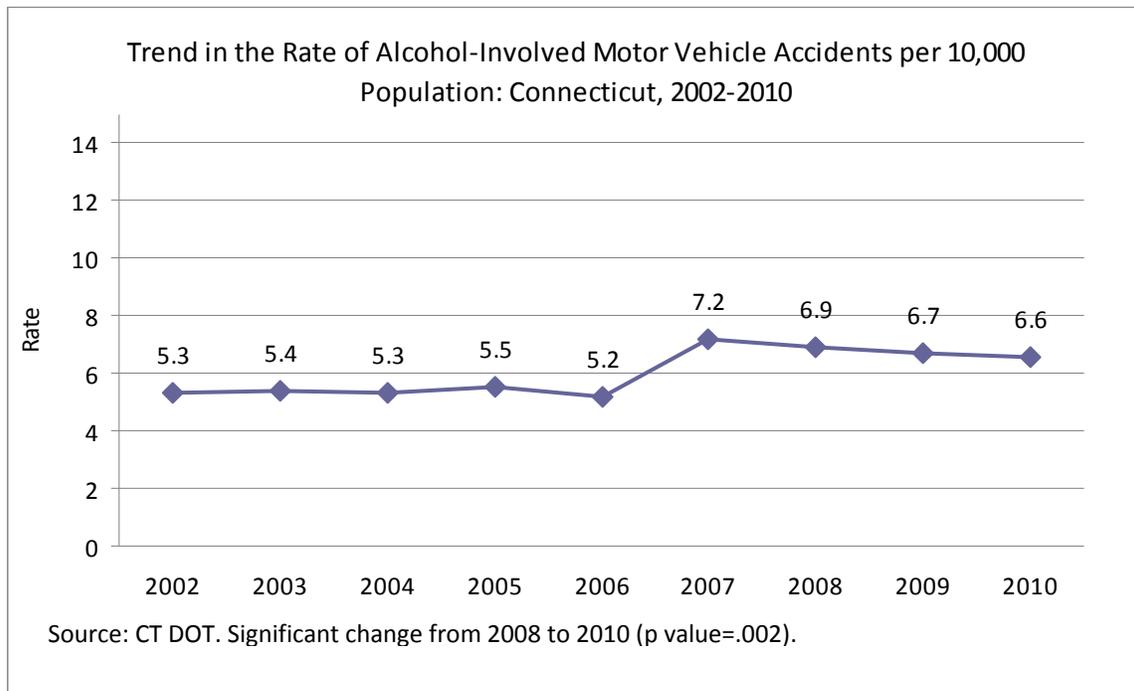


First alcohol use before age 13. Consistent with the decreases in current alcohol use and binge drinking, the YRBS trend data reveal that fewer high school students were reporting early initiation (i.e., before 13 years of age) of alcohol use from 2005 to 2011 (21.3% to 15.6%, respectively). Connecticut saw a 26.8% reduction in the percentage of youth reporting early initiation of drinking from 2005 to 2011, and an 11.4% reduction since the CT PFS began in 2009. These data also show that the rates of early initiation have been lower in Connecticut than nationally since 2005.



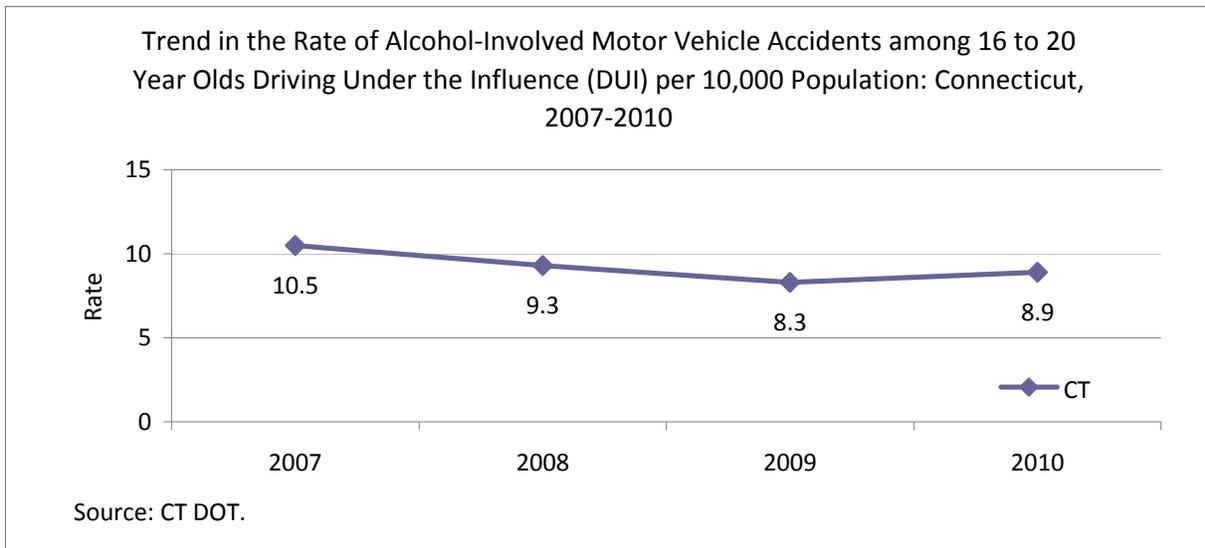
Alcohol-Related Consequences

Alcohol-related motor vehicle accidents. The UCHC Evaluation Team has collected motor vehicle accident data at the town-level from 2002 through 2010 to determine if there have been any changes in that alcohol-related indicator over time that might be attributed to Connecticut’s SPF-SIG and PFS initiatives. Unfortunately, in 2007 the Connecticut Department of Transportation changed its operational definition of motor vehicle accidents. In 2007, “Property Damage Only” accidents occurring on locally maintained roadways were added to the accident count; prior to December 31, 2006, these accidents were not included in the accident file. As the data in the figure below reveal, the addition of this category of accidents inflated the annual accident rate per 10,000 persons dramatically from 5.21 in 2006 to 7.15 in 2007, providing a misleading impression that the accident rate had increased. However, prior to 2006 there was very little change in the alcohol-related motor vehicle accident rate, although there had been a slight decrease from 2005 to 2006 (5.47 to 5.21). The accident rate from 2007 onward, however, indicate that the downward trend continued through 2010, the most recent year for which alcohol-involved accident data are available. The overall state rate has dropped from 6.91 per 10,000 persons in 2008, the baseline year for the CT PFS, to 6.29 per 10,000 population in 2010, representing a 9% reduction over the 3-year period, a statistically significant decrease (p=0.002).

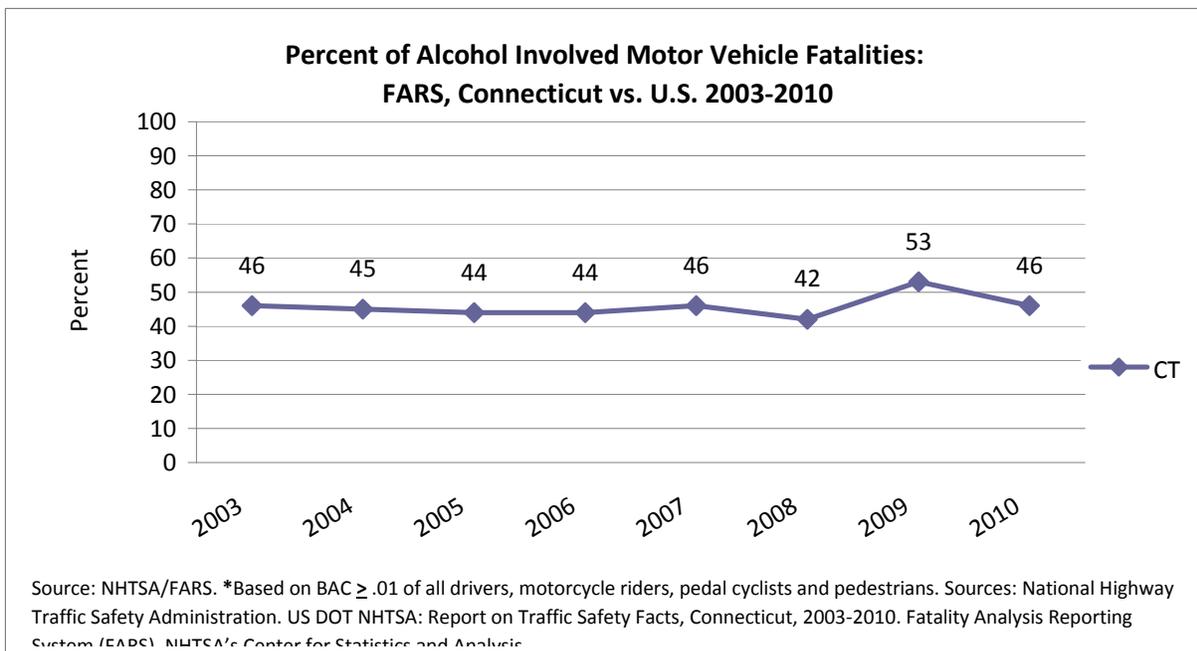


Comparable data for young drivers in the target population (16 to 20 year olds) was only available from 2007 forward. The analysis of those data shows that there was also an overall decrease in the rate of alcohol-related motor vehicle accidents in this age group in the first three years of the PFS. However, this reduction did not reach statistical significance ($p = 0.480$). In fact, there was a slight increase in the rate for 16-20 year olds between 2009 and 2010 from 7.17 per 10,000 underage drivers to 7.55 per 10,000.

It should be noted that the rate of alcohol-related motor vehicle accidents among 16 to 20 year olds is higher than the rate for the total population, underscoring the importance of alcohol use as a risk factor among young drivers.

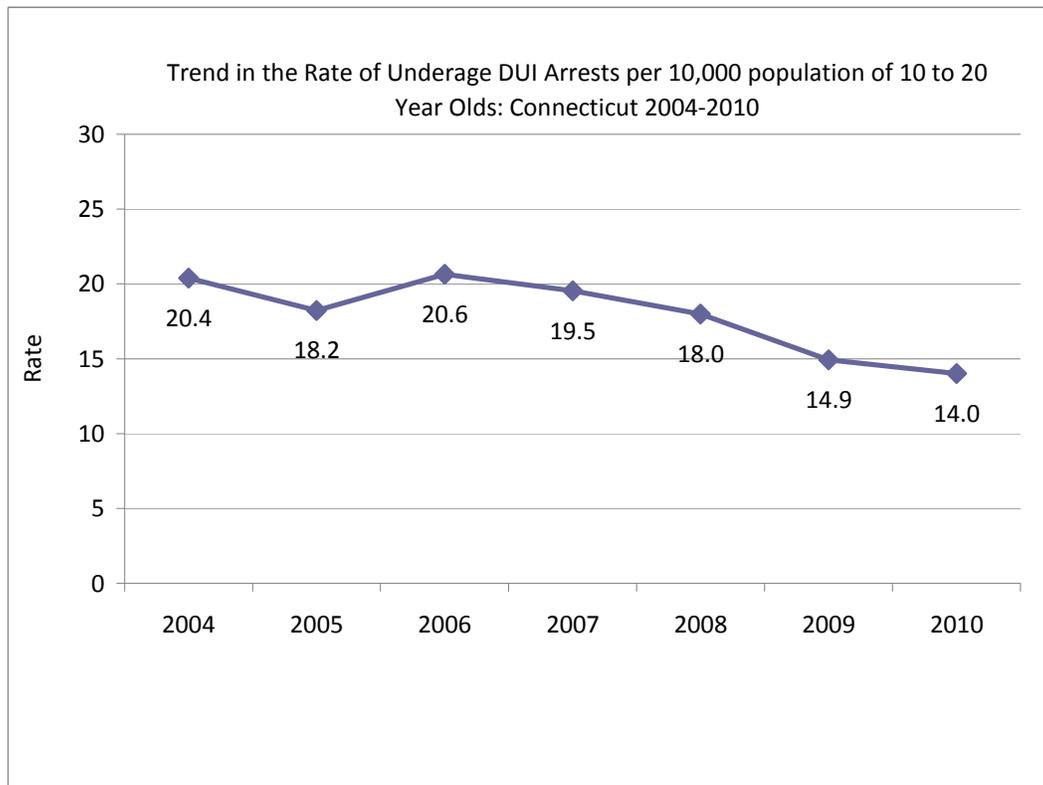


Alcohol-involved fatal motor vehicle crashes. Another indicator of adverse consequences related to drinking and driving is alcohol-involved motor vehicle fatalities. Data on the number of fatal accidents involving alcohol are collected annually by each state's department of transportation and made available through the U.S. Department of Transportation NHTSA's Fatality Analysis Reporting System (FARS). Connecticut's rate of fatal motor vehicle accidents per 100,000 population fell between 2008 and 2009 (8.87 to 6.29), but in 2010 the rate returned to and slightly exceeded the baseline rate (8.92 per 100,000 persons). The graph below shows that the percentage of alcohol-involved motor vehicle fatalities has not improved over the past several years. There had been a slight downward trend from 2003 to 2008, but in 2009 the percentage of alcohol-involved fatalities jumped from 42% to 53%. It was 46% in 2010, exactly what it had been in 2007. This indicator is not useful to examine change in fatalities among young drivers because age-specific information about motor vehicle fatalities is not available and the numbers would be too small for reliable measurement of change.



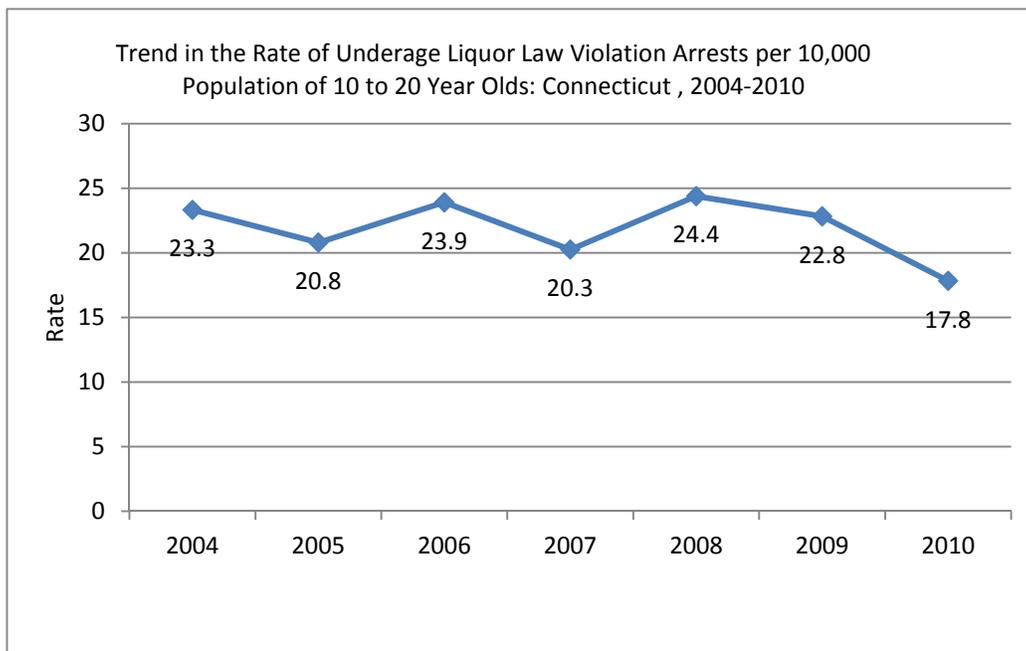
Underage DUI Arrests. The trend in the rates of driving under the influence (DUI) arrests of drivers aged 10 to 20 for 2004 through 2010 is shown in the graph below. The data indicate that the rate of underage DUI violations decreased to its lowest rate in eight years (14.0 DUI violations per 10,000 persons aged 10 to 20). Since the PFS began in 2009, the rate has decreased from 18.0 per 10,000 youth ages 10 to 20, a 22.2% reduction in the rate that it is statistically significant ($p=0.0001$).

It should be noted that a graduated license law was implemented in Connecticut in October 2006 that required that a parent or other adult accompany a juvenile driver in the first six months after receiving his/her license. It also restricted night driving from 11:00 p.m. to 5:00 a.m. for drivers under age 18. As this law has been more consistently followed over time, it may have contributed to a reduced number of at-risk juvenile drivers on the road.

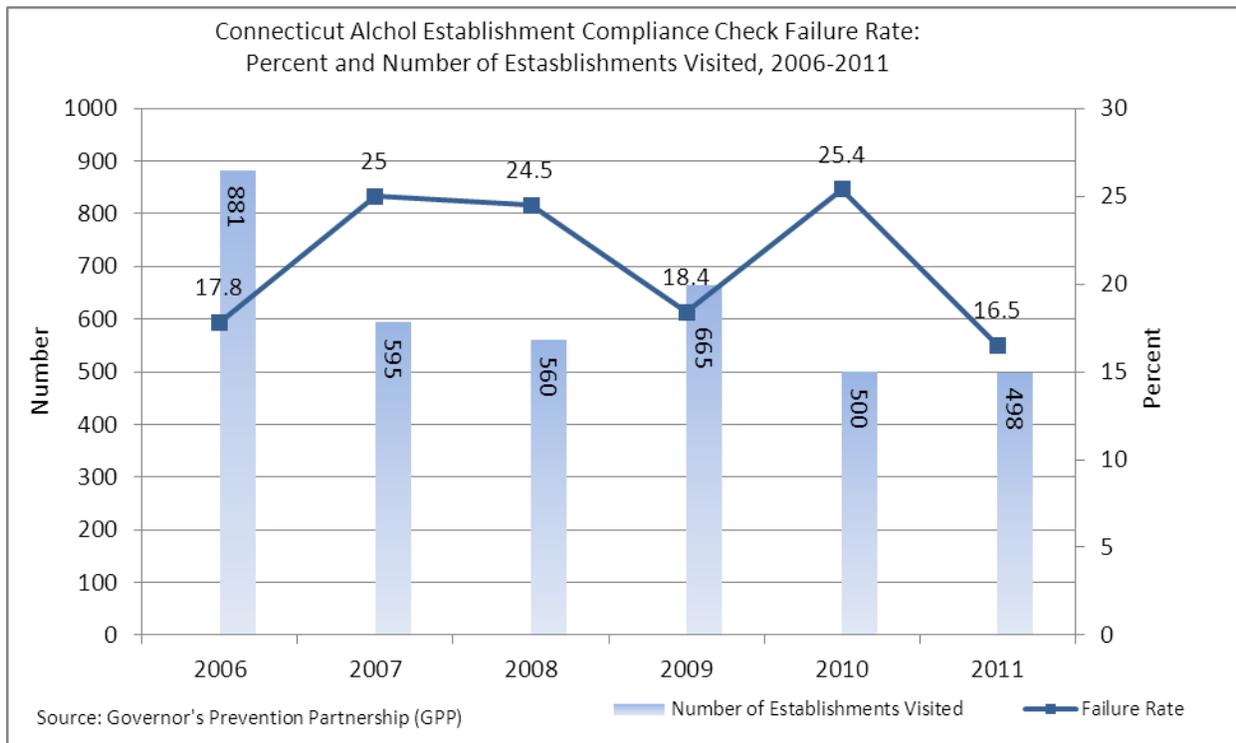


Underage liquor law violations. Connecticut's underage drinking prevention initiatives have focused on environmental prevention strategies that would limit underage access to alcohol, including compliance checks, merchant training and Shoulder Taps. When these strategies were first initiated under the SPF-SIG initiative, it was expected that the rate of underage liquor law violations would rise, followed by a decline as these community interventions were sustained over the course of the SPF-SIG and PFS initiatives. The statewide trend data in the graph below indicate that the results are somewhat as expected. In 2008, the first year the SPF-SIG was fully implemented at the community level, the rate of underage liquor law violations was at its highest level (24.4 per 10,000 10 to 20 year old persons). From that time, the underage liquor law

violation rate declined to the lowest level since 2004, 17.8 per 10,000 underage youth in 2010. This represents a decrease of 27.0% since 2008, a statistically significant change ($p = 0.0001$).



Compliance checks Connecticut's Department of Consumer Protection (DCP) has supported and coordinated alcohol compliance checks with local police since 2003, and since 2006, several SPF-SIG and PFS-funded communities used their grant monies to support local compliance checks, as well. Data showing the number of compliance checks conducted statewide annually from 2003 to 2011 and the failure rates associated with those checks are found in the graph below. The number of compliance checks completed ranged from 186 in the first year to 881 in 2006. In 2009, the baseline year for the PFS evaluation, a total of 665 compliance checks on alcohol retail establishments were conducted, but in 2010 and 2011 the number of establishments visited fell to 500 and 498 respectively. These data show that the lowest percentage of failures occurred in 2006, 2008 and 2011 (17.8%, 18.3% and 16.5%, respectively). The state-level compliance checks in 2011 had the lowest failure rate in the seven year period, but it is not clear that this was due to the PFS. Since 2007 and 2008 were the first years of community-level initiation of the SPF-funded compliance checks and 2010 was the first implementation year of the PFS, the higher rates of failure may reflect periods of policing activity in new communities. The lower rates the following years may reflect more reactive caution on the part of liquor merchants and bars following a wave of negative publicity the previous year. However, the dips in rates seems unrelated to the number of compliance checks completed. Further, it must be acknowledged that very few Connecticut towns/municipalities conduct compliance checks in subsequent years. Most activity takes place in different towns from year to year.



Community Readiness for Substance Abuse Prevention.

The evaluation of the CT PFS was designed to assess changes in community capacity and readiness to implement effective substance abuse prevention strategies as measured by the Community Readiness Assessment Survey (CRS). Community readiness for prevention was conceptualized as an intermediate variable leading to greater community effectiveness in reducing and preventing underage drinking and its consequences. First developed to measure the impacts of the CT SPF-SIG, the CRS has been administered biannually since 2006 to key informants in every town and municipality in the state. The CRS measures perceived community capacity and readiness to implement data-driven planning and evidence-based practices and programs at the community level. The community-level implementation of the CT SPF planning process is expected to lead to greater implementation of evidence-based practices, especially environmental strategies, which would in turn result in reductions in underage drinking. More specifically, as a result of the CT SPF-SIG and PFS initiatives, it was hypothesized that in the following improvements in substance abuse prevention infrastructure and community readiness would occur:

- Increased community concern about alcohol and other drug use;
- Increased community support for substance abuse prevention;
- Increased availability of environmental strategies;
- Fewer perceived barriers to substance abuse prevention;
- Greater use of data for prevention;
- Fewer barriers to data-driven prevention; and
- An increased stage of community readiness for substance abuse prevention.

The previous evaluation of the CT SPF-SIG initiative found a statistically significant increase in community readiness for substance abuse prevention in Connecticut between 2006 and 2010 (Ungemack et al., 2011). The current report focuses on determining whether there have been further improvements in community readiness since before the PFS was initiated (2008) to Year 3 of the PFS (2012).

The following section describes the findings with relation to key informants' perceptions of the following: community attitudes about substance abuse issues and substance abuse prevention, the availability of prevention activities and strategies, prevention planning and program implementation activities, barriers to prevention, availability and use of data, and rating of community readiness for prevention.

Community concern about substance use Consistent with the findings of the CT SPF-SIG, there was no evidence of increased concern about alcohol and drug use among community youth at the state level after three years of the PFS ($p = 0.703$). The earlier SPF-SIG analysis had shown that there had been a statistically significant difference between SPF-funded and non-funded communities with CRS key informants in SPF-funded communities over the project period more likely to report increased concern in their community. For this report, there was insufficient power to reliably measure differences between PFS-funded and non-funded communities. That analysis, however, will be done in the final CT PFS evaluation report.

Community tolerance of underage drinking and marijuana use The analysis of the weighted data between 2008 and 2012 indicate that there was no difference by time in community tolerance of underage drinking and marijuana use at the state level ($p = 0.916$). This is disappointing finding given that most of the funded communities have been targeting changes in social norms around underage drinking.

Community support for substance abuse prevention There was likewise no statewide change in community support for substance abuse prevention programming over the PFS project period ($p = 0.703$), nor had there been any observed change during the SPF-SIG initiative.

Availability and effectiveness of prevention resources in the community In the CRS, key informants were asked about the availability and effectiveness of a wide variety of prevention activities and resources in the community targeting alcohol and other drug use. These ranged along the continuum of prevention activities and strategies. The list included environmental strategies (e.g., laws and policies, enforcement, and social marketing), traditional prevention programming (e.g., information dissemination, life skills training, peer mentoring, and school-based education), alternative activities (e.g., teen drop-in centers, after school programs, and youth development activities), identification and referral, and treatment interventions (e.g., adult and adolescent substance abuse treatment programs and recovery supports). An item analysis indicated that there were four underlying types of prevention strategies that were compiled into four different composite indexes: environmental strategies, traditional prevention strategies, alternative activities, and targeted interventions.

One of the primary objectives of both the CT SPF-SIG and CT PFS was to increase the use of environmental strategies for underage drinking at the community level. All SPF and PFS sub-recipients were required to include one or more environmental strategies in their community. Earlier, the SPF-SIG evaluation had shown that there was an increase in the availability and perceived effectiveness of environmental strategies in SPF-funded communities, indicating that the CT SPF-SIG was successful in promoting community use and support of evidence-based public health approaches to prevent underage drinking in funded communities. However, the analysis of CRS data from 2008 through 2012 do not show that statewide there was an increase

in the use of environmental approaches ($p = 0.234$). It will be interesting to determine, however, if the observed differences in use of environmental strategies for funded communities over non-funded communities persists during the full PFS period.

There was a statistically significant increase statewide in traditional prevention programming between 2008 and 2012 ($p = 0.007$). This reflects greater use of strategies such as information dissemination, youth and parent skills training and school-based ATOD education programs

There was no change statewide in reported use of alternative activities for youth to prevent alcohol and drug use ($p = 0.130$). The CRS data did show that there was an overall increase in early intervention and treatment services in Connecticut between 2008 and 2012 ($p = .0001$), consistent with statewide substance abuse treatment initiatives being implemented by DMHAS and DCF independent of the PFS initiative. Since these types of services are funded independently of substance abuse prevention, it is unlikely that the PFS funding would be associated with these changes in their availability.

Barriers to Substance Abuse Prevention Key informants reported on a variety of barriers that might limit successful planning and implementation of effective substance abuse prevention strategies in their community. The factor analysis of these items indicated three underlying factors that were compiled into composite indexes: insufficient community resources, including financial resources, knowledge of effective strategies and trained staff; lack of community support; and lack of organizational resources, including leadership, volunteers, coordination and consensus among stakeholders, and strategic planning. It was hypothesized that DMHAS's support for the strategic planning process, including training and technical assistance to funded communities and the RACs, would lead to fewer barriers over time to prevention planning and activities as capacity for substance abuse prevention grew. While the prior SPF-SIG evaluation did not find the expected difference over time, the PFS analysis did show that there were improvements in perceived barriers in the state between 2008 and 2012.

Based on the key informants' reports, there was a statistically significant change in access to community resources such as funding, knowledge about substance abuse prevention strategies, and trained and culturally competent staff ($p = 0.006$). The analysis of the CRS data also showed that there was a statistically significant improvements over time at the state level in perceived community support ($p = 0.013$) and organizational resources ($p = 0.024$).

Data for Substance Abuse Prevention The evaluation of the CT SPF-SIG initiative had found a statistically significant increase in data availability for planning purposes, especially in funded communities (Ungemack et al., 2011). Even though the data did show that the mean number of types of data reported by CRS key informants has increased steadily and at a statistically significant level since 2006 through 2012 ($p = 0.0003$), the change did not reach statistical significance between 2008 and 2012 ($p = 0.144$).

There was a comparable pattern in the number of ways that data for were used for substance abuse prevention in communities. Again, there was a significant increase in the number of data informed applications reported by key informants between 2006 and 2012 ($p = 0.004$), but there wasn't a statistically significant change evident during the initial period of the PFS ($p = 0.315$).

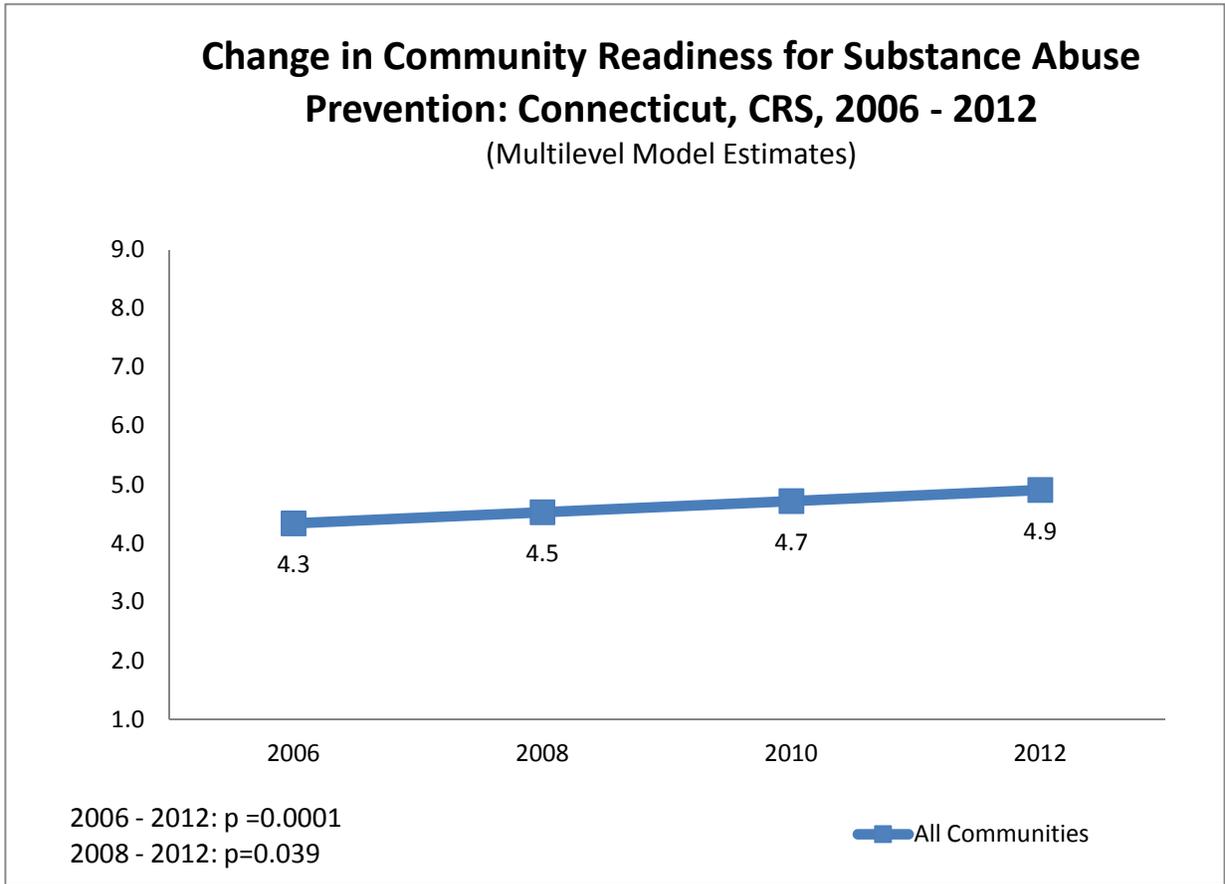
There was, however, a statistically significant difference between 2008 and 2012 in the number of barriers limiting the community's ability to collect data for substance abuse prevention ($p = 0.003$). As was found in the SPF-SIG evaluation, key informants reported fewer barriers to data collection over the course of the CT PFS initiative. The CRS data analysis also

showed that there was a statistically significant improvement in communities' ability to collect data for prevention between 2006 and 2012 ($p = 0.0003$). This is expected to continue through the remaining PFS period.

While not always reaching statistical significance for the PFS period, the overall trend patterns for each of these indicators – availability of data, data-informed applications, and barriers to data collection – from the beginning of the SPF-SIG through the first three years of the PFS support the conclusion that the data-driven planning process has increased community-level capacity for data-driven substance abuse prevention.

Community readiness for substance abuse prevention As noted earlier, CRS key informants were asked to rate their community's stage of readiness for substance abuse prevention based on the nine stages of readiness categories identified by researchers at the Tri-Ethnic Center for Prevention Research (Oetting et al., 1995). In the state trend analysis of the CRS data between 2008 and 2012, a statistically significant increase in community readiness for prevention in Connecticut was observed. The CRS data analysis, as displayed in the table and figure below, shows that there have been steady and statistically significant improvements in community readiness for prevention in Connecticut since the CT SPF-SIG was first initiated ($p = 0.0001$). In 2008, 21% of key informants reported that their communities had taken steps to implement programs and strategies in their town or municipality to address substance abuse problems; by 2010, 31% of key informants reported active prevention programs and practices in their communities. These results are consistent with the hypothesized intermediate outcomes expected from both the SPF-SIG and PFS initiatives, and as the PFS moves forward, community readiness is expected to continue to increase over time.

Key Informant Ratings of the Community Stage of Readiness for Substance Abuse Prevention: CRS, Connecticut, 2008 and 2012.		
Stage of Readiness	2008	2012
1) Tolerates or encourages substance abuse	1%	1%
2) Has little or no recognition of substance abuse problems	11%	11%
3) Believes a substance abuse problem exists, but awareness is only linked to one or two incidents involving substance abuse	17%	13%
4) Recognizes a substance abuse problem and leaders on the issue are identifiable, but little planning has been done to address problems and risk factors	24%	23%
5) Planning for substance abuse prevention is focused on practical details, including seeking funding for prevention	17%	15%
6) Has enough information to justify a substance abuse prevention program and has great enthusiasm for the initiative	5%	6%
7) Has created policies and/or more than one substance abuse prevention program is running with financial support and trained staff	9%	10%
8) Views substance abuse programs as valuable, new programs are being developed for at-risk populations and there is ongoing evaluation	7%	13%
9) Has detailed knowledge of prevalence, risk factors and program effectiveness, and programs are tailored by trained staff to address community risk factors	5%	8%



Community-Level Descriptive Data

The data in this section comes from various sources, including the AGI (methodology below), conducted by the UCHC Evaluation Team, the Community Coalition Survey and fidelity assessments, completed by PFS community-level grantees (subrecipients) in as part of the AGI process, and information collected through the bi-quarterly Technical Assistance Planning meetings with DMHAS and GPP TA partners. The information that follows is descriptive in nature. Changes over time compared to the 2011 AGI data are discussed where they are pertinent to the PFS implementation. A complete report of the 2012 AGI findings, CCS and fidelity assessment will be available and submitted electronically to the MRT in the next reporting quarter.

The Annual Grantee Interview The AGI is a telephone assessment conducted during the third quarter of each project year, beginning with year 2. The interview functions as a detailed check-in with grantees, in order to collect qualitative and quantitative data in the absence of a formal site visit process. The purpose of the AGI is to collect qualitative data that more richly describes the nature and scope of the intervention(s) being implemented on the community level, as well as the community, organizational and other contextual factors which may affect implementation of

the local PFS plan. These annual interviews gather process information related to the types of prevention activities and strategies implemented; the issues encountered, and the ways they impacted decisions made by the community coalition; challenges and barriers encountered in implementing the strategic plan; and any modifications made to the strategic plan. The 2012 AGI was conducted via phone with the PFS Project Coordinator and Local Evaluator from each of the funded subrecipient communities between July and September, 2012. In conjunction with the interviews, communities were asked to assign fidelity scores to their environmental strategies and capacity building, using CSAP's established fidelity rubric.

Each grantee coalition received a copy of the AGI interview form to review prior to their scheduled interview, as well as fidelity assessment forms on capacity building and any environmental strategies being implemented on the community-level. Grantees were asked to assess their communities' implementation fidelity using the fidelity assessment tools developed by the fidelity subcommittee as part of the Strategic Prevention Framework cross-site evaluation. New this year, UCHC introduced the PFS Community Coalition Survey (CCS), an instrument that includes items from the Community Level Instrument developed for the PFS cross-site evaluation. Grantees were asked to complete and return the CCS, along with the Fidelity workbook, prior to the scheduled call.

The Community Coalition Survey (CSS) is a self-administered survey, designed for completion by community level Prevention Coordinators and their Local Evaluators, in conjunction with members of their coalitions. The instrument includes items from the Community Level Instrument developed by the PFS cross-site evaluation workgroup, as well as items from the Community Readiness Assessment. The CSS was completed for the first time this year by PFS subrecipients in preparation for the Annual Grantee Interview Process.

The Fidelity Assessment Tools are a set of scoring rubrics developed under the SPF-SIG initiative by a cross-site workgroup centered on evaluation of environmental strategies. As in 2011, subrecipients self-scored their adherence to implementation fidelity constructs for environmental strategies they implemented during the past year, as well as a scoring tool for coalition capacity building, in conjunction with the AGI process.

Grantee Capacity and Technical Assistance Leveling

The TA Planning Meetings have focused on updates of grantee progress within the PFS, Best Practice, and SPF initiatives. GPP technical assistance staff initially prioritized PFS and Best Practice (BP) grantee communities based on their level of functioning and technical assistance needs. TA providers regularly re-leveled their grantees according to need and capacity, as a means of triaging grantee needs. This approach allows for tailoring of technical assistance for grantees on a regular basis as their need/capacity changes. The chart below shows how grantee community need/capacity levels have changed since their leveling at initial funding. The majority of grantees were in the low need/high capacity or medium need/capacity category at funding, with established coalitions and data collection processes, as dictated by the funding criteria for the PFS grant. Madison, as the only PFS grantee not to have had a SPF grant prior to PFS, was placed in the high need/low capacity category at funding, allowing TA partners to work intensively with the community to get it up to speed. Grantees have shifted in their need and capacity over time, based on staff turnover, coalition issues, and community dynamics, so the changes shown in the chart below exist as a snapshot of where grantees were at the end of this reporting period. As the chart shows, two grantees, Madison and McCall Foundation,

increased in their capacity since their initial leveling, moving from high need to low need and medium need to low need respectively. Five communities were shifted to increased level of TA need as of the end of this reporting period. Three communities moved from low need to medium need, and two from medium need to high need. Reasons for these changes in leveling are complex, and are based on an overall view of the community's coalition and implementation functioning, but changes driving technical assistance need include: staff turnover; coalition issues and changes in functioning; shifts in approach to implementation and capacity building; community issues; deliverables issues; and changes in responsiveness.

PFS Grantee Need/Capacity Level Changes, 2010 to 2012

High Need (Low Capacity)	Medium Need (Medium Capacity)	Low Need (High Capacity)
Madison >> (to low need)	Glastonbury	Branford
	Groton	Clinton
	Ledyard	CCSU
	McCall > (to low need)	< ECSU (to med need)
	< New London (to high need)	Fairfield University
	Rushford	< Ellington (to med need)
	< WCSU (to high need)	Enfield
		< Newtown (to med need)
		Positive Directions
		Trumbull

Coalition Capacity Building

Re-conceptualizing, refocusing and re-branding of coalitions was a recurring theme that emerged from the AGI across the community-level grantees. Communities that did not re-brand or refocus their coalition during the past year saw the need for it in their coalition processes, which were lagging or stagnant. As one grantee put it, “We spent a lot of time during the past year pulling back a bit, refocusing our energy to decide who we are, what we want to be, and how we can get there in a *positive* fashion.” A number of the communities re-branded themselves, coming up with fresh names, slogan, logos, and mission statements. Those communities either kicked off in the late Spring or plan a roll out in some capacity for Fall, 2012

Coalition characteristics and functioning

Based on responses from the Community Coalition Survey, grantees range significantly in the characteristics of their coalitions. Based on founding year, over a third of coalitions are over 10 years old, while over 40% were established after 2007. Overall, almost 60% of coalitions were in place prior to the start of the PFS, a lower percentage than one would expect since an existing

coalition was one of the prerequisites for consideration for local PFS funding. What this suggests is that a portion of grantees with coalitions formed under the SPF initiative re-tooled or formed new coalitions for the PFS.

Sector representation in grantee coalitions changed differentially from coalition to coalition in the past year. The table below shows sector representation across coalitions. Items in red represent membership gains since 2011. It should be noted that information on sector representation in 2012 was gathered using the Community Coalition survey and corroborated by the AGI, while 2011 sector representation was garnered from the AGI interviews alone. This shift in methodology may result in slightly more complete data for 2012 than 2011. Based on comparison of the 2011 and 2012 data, gains were made in four communities in the faith based sector and in three for health care providers. Some gains were made in strengthening sectors that were weak. Overall, civic organizations (7/19 missing) and the faith based sector (5/19) are the biggest gaps in sector representation, followed by media, business sector, and healthcare professionals (4/19 missing).

Coalition Activities and Roles

While PFS coalitions have various organizational structures, compositions, and role designations, all PFS community coalitions are staffed by a local PFS Prevention Coordinator. In some coalitions the PC acts as chair or leader of the coalition, and in others, community members assume that leadership role. The same dynamic exists with regard to workload and coalition activity. The CCS asked respondents about key coalition prevention activities and who contributes to the accomplishment of these activities, in order to assess coordination between staff and members, and the integration of the coalition in prevention activities.

While coalition members and PFS staff (Prevention Coordinator and support staff) collaborate to some degree on most prevention activities, staff plan and implement process or outcome evaluation of interventions almost exclusively in 79% of communities (15/19). PFS staff also leverage outside funding without coalition efforts in slightly over half the communities (53%). Staff take the lead in ensuring cultural competency is addressed in nearly 40% of communities (7/19), but collaborate with coalition members in over 50% of PFS communities.

Coalition members or committees were most likely to work independently of staff on outreach to solidify the coalition as a community resource of respondents, but the number of coalitions in which that was the case was still small (21%, or 4/19), and coalitions and staff actually worked together on this activity in nearly three fourths of PFS communities. Both coalitions and staff in over half of the communities (10 of 19) work together to ensure that PFS funded prevention intervention(s) address issues related to cultural competence; 37% (7/19) communities rely only on staff to ensure cultural competency is addressed in prevention activities.

Coalitions and staff work together to plan and implement prevention interventions in nearly 80% of the grantee communities (15/19). Together they collect and organize data to help change community capacity in nearly 60% of communities (11/19), and to educate others about needed changes in substance abuse policy at the organizational, local, or state level in 58% of communities. They also work together to influence or set substance abuse policy at the organizational, local, or state level 68% of the time (13/19 grantees). These data show a high level of collaboration between coalition members and PFS staff, which seems to indicate that coalition members are engaged and active. The low level of self-direction of coalition members

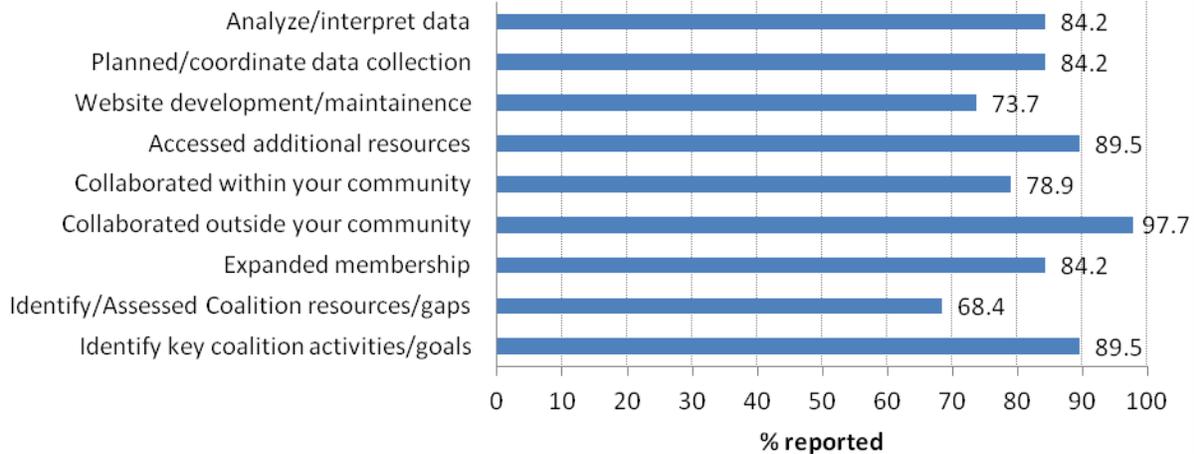
in the absence of PFS staff could prove problematic for sustainability of coalition efforts once PFS funding ends.

When asked on the CCS to rate their agreement with statements on different structural and functional dimensions of a coalition on a 1-5 likert scale (strongly disagree to strongly agree) as they pertains to their coalition, respondents most strongly endorsed positive coalition characteristics. The most heavily endorsed negative statement had to do with community apathy as a barrier to coalition effectiveness, and communities were split in their agreement with that statement (31% agreed or strongly agreed). This sense and dynamic in some communities could be a contributing factor to the growing emphasis on re-energizing coalition efforts in so many of the PFS communities. The table below details the results.

<i>Coalition Functional dimension:</i>	% Strongly agree/ Agree
The coalition has a clear vision and focus.	100%
The coalition has a broad-based, diverse membership that represents the various groups and organizations involved in substance abuse prevention.	94.7%
The coalition has a process for tracking decisions.	78.9 %
The coalition has collaborative leadership.	73.7%
Responsibilities among coalition members are fairly and effectively delegated.	57.9%
The coalition does not monitor whether or not there is follow-through on decisions.	0%
Within the coalition, there is too much talking and not enough follow-through with actions.	15.8%
The coalition needs more structure in order to be effective.	21.1%
Denial and apathy among community members toward local substance use issues is a major barrier to our coalition’s effectiveness.	31.6%

When asked about coalition activities to improve coalition resources in the past year, nearly all grantees (97.7%) reported collaboration outside their communities as an activity they employed. This perceived value of regional collaboration was mirrored in communities’ AGI responses. Community respondents expressed a desire for more contact and sharing of resources across communities for simple things like which suppliers have the best prices, provide good service, or for something larger like sharing a campaign expense, and response to the prospect of regional Learning Communities was overwhelmingly positive. As one grantee expressed: “The kids come into the towns from across communities so why shouldn’t the resources from the towns be shared?” Identifying key coalition activities and goals, and accessing additional resources were also widely reported improvement activities, with nearly 90% of communities reporting these activities. Expansion of coalition membership and data related activities were also widely reported, by 85% of communities. The chart below details the results.

Most Frequently Reported Activities Conducted to Improve Coalition Resources



Capacity building: Data Use

Community grantees were asked on the CCS to report on activities they employed to develop or enhance their community's data use capacity in the past year. Dissemination of data in the community was by far the most widely employed means of building community data capacity across subrecipients (89.5%, or 17/19 communities). Implementation of community-level survey and enhancement of local stakeholder skills were also reported by over half of grantees (53%). Data systems capacity building activities (creation of or participation in a centralized data base) were only endorsed by 3 of the 19 grantees (16%). The table below details the results.

<i>How have you worked to develop or enhance the community's capacity to use data for needs assessment, planning, and evaluation during this reporting period?</i>	% Endorsed
Disseminated data	89.5%
Developed or implemented a community-level survey data collection effort	52.6
Enhanced skills or expertise of local stakeholders in understanding and using data	52.6
Developed or implemented a community-led qualitative data collection effort (e.g., interviews, focus groups)	47.4
Developed mechanisms for reporting data to key stakeholders	47.4
Developed or enhanced systems for accessing data from other agencies or organizations (e.g., law enforcement, schools, hospitals)	42.1
Created or enhanced a local database to house community, program, or participant data	15.8
Developed procedures for participation in a state/jurisdiction/primary grantee database	15.8

Implementation

There were few changes in grantees' chosen strategies over the last year. Three grantees each added one additional strategy to their plans to address access, in the forms of compliance checks, merchant education, and party patrols, but otherwise communities stayed the course set in their strategic plans.

The results of the 2012 fidelity assessments of environmental strategies and capacity building by community grantees appear in the table below. The mean community fidelity score for each grantee takes into account the implementation fidelity scores for all environmental strategies scored by that grantee. The mean score does not include capacity building, which is a composite score of capacity building elements and is listed in its own column.

Some community level grantees improved in their implementation fidelity scores for individual strategies from 2011 to 2012, while others went down. Because the communities self-scored, the decrease in fidelity scores could indicate an increased awareness of what fidelity of implementation entails for a given strategy. The fidelity rubrics were provided to community level grantees as a capacity building tool as much as a performance monitoring tool, providing detailed descriptions of the key components of environmental strategies implemented with fidelity. The mean fidelity scores are perhaps a better measurement of overall functioning, taking into account functioning across strategy implementation. As of 2012, nearly half of community level grantees (9/19) improved in their mean fidelity scores, while only 20% (4/19) decreased in their mean fidelity scores, showing that overall PFS communities are moving closer to implementation fidelity of environmental strategies. A similar result can be seen for the capacity building scores, where nearly 50% of grantees increased in their composite capacity building scores. The internalization of implementation fidelity of coalition capacity building by PFS communities fits with many of the CCS results, and may explain the general move by PFS grantees to re-visit and re-tool their coalitions where necessary. Overall, at this point in the PFS, these results show progress toward implementation success on the community level.

PFS Community Level Implementation Fidelity Scores, 2012

Name of Agency	Compliance checks	Party patrols	Sobriety checkpoints	Media advocacy	Social marketing	Getting to know legislator **	Mean Community Fidelity Score for Env. Strategies	Coalition Capacity Building Score
<i>Branford Counseling Center</i>	2.29 ↓	1.57 ★	2.21	2.5 ↓	2 ↓	2.5	2.18 ↓	2.44 ↑
<i>Clinton</i>	2.67	2.71		3.0	2.67		2.76 ↑	2.22 ↑
<i>Ellington, Town of</i>	2.67 ★	1.14 ★		2.67 ↑	2.0 ★		2.12 ★	1.78 ↑
<i>Enfield, Town of</i>	2.73 ↑	3.0 ↑		3.0 ★			2.91 ↑	3.0 ↑
<i>Glastonbury, Town of</i>	2.67 ↓	3.0		3.0			2.89 ↓	2.78 ↓
<i>Groton Ledge Light</i>	2.7 ★	Not submitted this yr			2.83 ↓		2.77 ↑	2.33 ★
<i>Ledyard Ledge Light</i>		1.75		2.67	3.0		2.47	3.0
<i>Madison</i>	2.8 ★			3.0 ↑	3 ↑	2.6 ★	2.85 ↑	2.89 ↑

Name of Agency	Compliance checks	Party patrols	Sobriety checkpoints	Media advocacy	Social marketing	Getting to know legislator **	Mean Community Fidelity Score for Env. Strategies	Coalition Capacity Building Score
McCall Foundation		3.0	3.0	3.0	3.0	3 ★	3.00	2.78 ↑
New London *	2.83 ★			2.33 ★	2.83 ★		2.66 ★	2.44 ★
Newtown Youth & Family Services				3 ★	1.67 ↑	1.25 ★	1.97 ↑	2.55 ↑
Rushford Center (Meriden)	2.53 ↑	2.75 ↑		3.0	2.5	3 ★	2.76 ↑	2.33 ↓
Positive Directions (Westport, Weston, Wilton)	2.94			3.0 ↑	2 ↑		2.65 ↓	2.67 ↑
Stratford, Town of	3.0 ↑	3.0 ↑			1.67 ★		2.56 ↑	2.0 ↓
Trumbull, Board of Education	2.3 ↓	2.14 ↑		Not submitted this yr	2.5 ★		2.31 ↓	2.33 ↑
CCSU	2.47 ★	2.86 ★	2.53 ★	1.83 ★		1.88 ★	2.31★	1.67 ★
ECSU							N.A .	2.33 ★
Fairfield U	2.62 ↑				1.83 ↑		2.23 ↑	2.33 ↑
WCSU	2.57 ↑		2 ↑		2.33 ↑		2.30 ↑	2.67 ★
Average score by strategy, across communities:	2.65	2.45	2.44	2.77	2.39	2.37	2.53	2.45

Key: ↑ = improved ↓ = lower ★ = new score 2012 (no 2011 comparison)

** = "Getting to know legislator" worksheet was not offered in 2011 as it is not a strategy included in the SP; we included it in 2012 because a number of grantees mentioned policy issues in 2011.

Sustainability

When questioned on the CCS about activities in the past year to ensure that prevention activities and outcomes continue after the PFS, about half the grantees reported leveraging other funding sources or in-kind resources (e.g., used the success of the PFS efforts to secure other funds) and working to ensure that prevention staff positions are folded into other organizations or funding mechanisms. Sustainment of the coalition was the most widely endorsed sustainment priority, as efforts toward that end were endorsed by nearly 70% of grantees (13/19). Incorporation of prevention activities into the goals/objectives of existing organizations was also reported by over 60% of grantees (12/19). Results are represented in the table below.

<i>How have you worked during this reporting period to ensure that prevention activities and outcomes continue after PFS funding has ended? (Select all that apply.)</i>	<i>% Endorsed</i>
Worked to ensure that the coalition will continue to function beyond the end of the grant period	68.4%
Worked to ensure that prevention activities are incorporated into the missions/goals and activities of other organizations (e.g., school districts, law enforcement agency)	63.2
Leveraged other funding sources or in-kind resources (e.g., used the success of PFS efforts to	52.6

secure other funds)	
Worked to ensure that prevention staff positions are folded into other organizations or funding mechanisms (e.g., school districts, community agencies)	47.4
Worked to gain <i>formal</i> adoption of prevention activities into other organizations' practices (e.g., school district curriculum, organizational policy change)	31.6
Worked to implement local level laws, policies or regulations to guarantee the continuation of prevention activities or outcomes	26.3

Data driven prevention planning has been a central base component of the SPF process. PFS subrecipients who participated in the SPF initiative have had several years of SPF to integrate data driven planning into their community processes, plus the past 3 years of the PFS to solidify data driven planning as a practice and build community capacity around the use of data in prevention planning. When asked in the CCS about sustainment of data driven planning processes, 58% of community level grantees (11/19) identified the adoption of program evaluation as a routine part of their efforts as one key way they have worked to sustain data driven processes. Establishing resources for continued data collection was another means of sustainment endorsed by slightly over half of community subrecipients. Nearly half (47.4%) of community level grantees reported adopting routine needs assessments as sustainment mechanism in the past year. Moreover, a third of grantees had established ongoing procedures for utilization of data provided by the State, DMHAS, or the UCHC evaluation team, and slightly over one fourth of grantees reported establishment of ongoing procedures for accessing local data. The table below details the findings. These results demonstrate the extent to which data driven processes are becoming embedded in the community practice in PFS communities.

<i>How have you worked to ensure that data-driven planning processes continue after PFS funding has ended? (Select all that apply.)</i>	<i>% Endorsed</i>
Adopted program evaluation as a routine part of efforts	57.9 %
Established resources for continuation of community data collection efforts	52.6
Adopted needs assessment updates as a routine part of efforts	47.4
Established ongoing procedures for utilizing data provided by the state/primary grantee	31.6
Established ongoing procedures for accessing data from other local agencies	26.3

Outcomes: Past 30 day Use

Community Level Outcomes: Past 30 day Use.

Connecticut's community grantees were required to have baseline alcohol consumption data and to administer at least one follow-up school survey during the course of the CT PFS to be funded through this initiative. The tables below show the baseline data reported by each grantee for past 30 day use of alcohol for each total survey sample. The grades included in these community surveys varied, although all but the universities included at least 9th and 10 graders.

This age group will be used as the common data point to measure changes in underage drinking across the funded communities for the final evaluation report. For those grantees that had available follow-up data, those data on past month alcohol use are provided in the tables. In most cases, follow-up data were available for the total sample, but in one community, Ledyard, the data were only available for 9th-10th grade students, and thus should be compared to the 9th-10th grade baseline rate.

While only eight communities were able to provide follow-up survey data by the end of Year 3, all of these communities reported decreases in past 30 day use among their survey populations. Several additional grantees have conducted surveys but the analyses weren't complete and the results are not yet available. Data will be compiled on an ongoing basis, but the limited results to date are promising and support the state-level evidence of a reduction in underage drinking.

Past 30 Day Alcohol Use at Baseline and Follow-up among PFS-Funded Community

PFS Sub-recipient Communities	Baseline Past 30 Day Alcohol Use by Youth Ages 12-17: Total School Population Surveyed	Follow-up Past 30 Day Alcohol Use by Youth Ages 12 to 17: Total School Population Surveyed	Baseline Past 30 Day Alcohol Use by Youth: 9 th -10 th Grades Only	Follow-Up Past 30 Day Alcohol Use by Youth: 9 th -10 th Grades Only
Branford	2010, 7 th -12 th : 45.0%		2010	
Clinton	2010, 7 th – 12 th : 27.6%		2010 31%	
Ellington	2009, 6 th -12 th : 23.3%		2009 27.4%	
Enfield	2009, 6 th -12 th : 29.8%		2009 29.7%	
Glastonbury	2009, 7 th -12 th : 15.0%		2009 12.7%	
Groton	2010, 7 th -12 th : 23.6%	2012: (7 th – 12 th): 18.4%*	2010 27.1%	
Ledyard	2009, 7 th -12 th : 15.6%		2009 26.9%	2011: (9 th – 10 th) 21.6%*
Madison	2009, 7 th -12 th : 24.18%	2011 (7 th -12 th): 23.1%*	2009 20.4%	
Torrington	2010, 7 th -11 th : 24.1%		2010 27.6%	
New London	2010, 7 th -12 th : 18.1%		2010 24.1%	
Newtown	2009, 7 th -12 th : <i>Total % could not be calculated based on the data provided</i>		2009 <i>9th-10th grade % could not be calculated based on the data provided</i>	
Weston	Weston, 2008, 7 th -12 th : 32.8%		Weston, 2008 33.6%	
Westport	Westport, 2011, 7 th -11 th :		Westport, 2011	

Wilton	26.7% Wilton, 2007, 7 th -12 th : 29%	Wilton, 2011 (7 th -12 th): 24.8%*	30.9% Wilton, 2007 26.4%	
Meriden	2009, 7 th -12 th : 32.1%		2009 34.4%	
Stratford	2008, 7 th -12 th : 33.2%	2011: (7 th -12 th): 28.0%*	2008 34.4%	
Trumbull	2010, 7 th -12 th : 31.7%	2011: (7 th - 12 th): 26.5%*	2010 30.1%	

Past 30 day Alcohol Use at Baseline and Follow-up among PFS-Funded University Grantees

Sub-recipient Communities	Baseline Past 30 Day Alcohol Use	Follow Up Past 30 Day Alcohol Use
Central Connecticut State University - New Britain	Baseline year: 2008 78.7%	Follow-up year: 2010 72.1%*
Eastern Connecticut State University - Windham	Baseline year: 2008 82.9%	
Fairfield University	Baseline year: 2010 74.0%	
Western Connecticut State University - Danbury	Baseline year: 2008 75.8%	Follow-up year: 2010 72.1%

Summary of Connecticut's PFS Outcomes and Accomplishments at the End of Year 3

At the end of Year 3 of the CT PFS, the cumulative evidence indicates that the state has been successful in reducing and preventing underage drinking in Connecticut. The target performance indicator for Connecticut's PFS project was exceeded. Past month alcohol use among 12 to 17 year olds dropped from 19.6% in the 2006-2007 baseline year to 17.8% in 2009-2010 as measured by the National Survey of Drug Use and Health (NSDUH), surpassing Connecticut's CSAP-approved performance target of 18.1%. Underage drinking among the state's population ages 12 to 17 decreased 9.2% in the three-year period.

In sum, in the first three years of the Connecticut has been able to successfully enhance and continue the data-driven strategic planning process begun under the SPF-SIG initiative and has realized important reductions in underage drinking and the intervening variables and consequences associated with underage alcohol use. Further improvements are expected as the State continues this public health approach to safeguarding the welfare and future of its youth.

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