

**Connecticut Statewide Prevention Enhancement
Initiative to Strengthen the Statewide Alcohol Tobacco
and Other Drug Prevention Infrastructure**

Five Year Strategic Prevention Plan

2012 – 2016

Prepared by
The Connecticut Department of Mental Health and Addiction Services

On behalf of
The Strategic Prevention Enhancement Consortium
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Acknowledgements

The plan builds upon nearly 30 years of initiatives and investments to build effective local, regional, and statewide ATOD prevention partnerships. It is important to recognize the countless partners that invested resources to build the existing statewide ATOD prevention infrastructure that serves as the foundation for this five year plan.

The Connecticut Department of Mental Health and Addiction Services thanks the Consortium members who dedicated their time to share their insights, perspectives and experiences, and created a planning and implementation environment conducive to strengthening relationships and identifying common ground to advance ATOD prevention and health promotion initiatives in a more coordinated and effective manner. The Connecticut DMHAS recognizes the professional staff members of the Prevention and Health Promotion Unit for their role in the development of the plan as well as the Centers for Substance Abuse Prevention for funding this planning effort.

Executive Summary

The Center for Substance Abuse Prevention awarded The Connecticut Department of Mental Health and Addiction Services (DMHAS) a grant intended to enhance Connecticut's statewide alcohol, tobacco and other drug (ATOD) prevention infrastructure and to promote health and reduce the likelihood of substance abuse and related consequences. The grant funds supported a 12-month planning process that resulted in the development of a five year prevention plan that provides the framework to advance multi-partner prevention and health promotion efforts at the state, regional, and local levels.

Over 3.5 million people live in Connecticut's 4,842 square miles. Connecticut contains 738.1 persons per square mile, far exceeding the national average (87.4). Of the total population, 82.3% are White, 11.1% are Black, and 13.8% are persons of Hispanic or Latino Origin. Approximately 0.2% of Connecticut's residents are American Indian/Alaskan Native. Connecticut has two federally recognized tribal nations. Over 235,000 living veterans reside in Connecticut, including 21,000 who are or have served since 2001. One in five persons above age five speaks a language other than English at home. 88.6% of persons above age 25 have earned a high school degree or higher, with 35.7% earning a Bachelor's degree or higher. The per capita money income in the past 12 months (in 2011 dollars) equaled \$37,627 (\$10,000 above the national average) and the median household income equaled \$69,243 (\$17,000 above the national average).

The Statewide Epidemiological Outcomes Work Group tracks epidemiological data on alcohol, tobacco, marijuana, heroin, prescription drugs, and cocaine.¹ At the state, regional and sub-regional levels, alcohol misuse and abuse, especially underage drinking, continue to be the highest prevention priority. Marijuana remains the most commonly used illicit drug in Connecticut. Tobacco use in children under age 12 has steadily declined for more than six years, mirroring declining usage nationwide, and tobacco use by adults 18 and older (27.6%) falls below the national rate. Approximately 4% of the adult population reported non-medical use of painkillers in the previous year with young adults age 18-25 experiencing the highest rate of past-year medical use of painkiller of all age groups (11.27%). Limited state and community level data collection exist to document the prevalence of heroin and cocaine use. Demand for heroin remains high with easy accessibility. The state's 18-25 year olds remain the greatest consumers of cocaine (6.5% of all users). The Connecticut Department of Health tracks closely the burden of chronic diseases and conditions related to ATOD use. Heart disease, stroke, cancer, diabetes, and chronic lower respiratory diseases are among the leading causes of death in Connecticut, accounting for over half of all resident deaths. Connecticut's racial and ethnic minorities experience disparities in chronic diseases and their risk factors.

In Connecticut, several state agencies as well as statewide, regional, and local efforts support prevention and health promotion. The Connecticut Department of Mental Health and Addiction Services (DMHAS) serves as Connecticut's single state agency for substance abuse prevention and treatment services. Connecticut DMHAS holds the responsibility to maintain a statewide Strategic Prevention Framework consistent with federal guidelines set forth by the SAMHSA Center for Substance Abuse Prevention. The DMHAS organizes its Prevention and Health Promotion Division to provide accountability-based, developmentally appropriate and culturally sensitive behavioral health services based on scientific models and best practices, through a comprehensive system that matches the services to the needs of the individuals and 169 local communities. The DMHAS uses 13 subdivisions across Connecticut as the geographic basis for prevention services and activates a network of statewide service delivery agents to

¹ Please refer to the Statewide Epidemiological Outcomes Workgroup 2010 profiles for a more information.

provide technical assistance, training, and prevention-related service delivery. The Prevention Infrastructure links to other State Advisory Councils such as the Connecticut Alcohol and Drug Policy Council (ADPC).

DMHAS convened a Statewide Prevention Enhancement Consortium comprised of diverse partners from state agencies, divisions, departments, as well as Tribal Nations and relevant statewide partners such as the Connecticut Youth Services Association. Each of the SPE Partners conducts its own form of ATOD prevention programming. The Consortium members participated in a 10-month long planning process. The planning process consisted of: eight Consortium meetings; completion of a gap analysis of the statewide prevention infrastructure that included a survey of Consortium members and an analysis of prevention funding, among others; identification of capacity building projects and implementation of projects by Consortium partners; and development of a Five Year Plan including input through focus groups with target populations and a commitments for ongoing participation in the form of a Memorandum of Understanding.

Upon completion of the gap analysis, the SPE Consortium identified nine, short-term capacity building projects that will create an immediate impact on the ATOD prevention infrastructure using \$395,000 of CSAP funding. These projects touch all of the SPE partners and cut across all components of the Plan (e.g., data collection, service coordination, training and technical assistance). The projects correspond with common ground and/or statewide priorities in which communities and families will benefit from multiple SPE Partners working together.

The Consortium developed a five year plan with four high level objectives that will improve the statewide ATOD prevention infrastructure and in turn help families and communities to prevent or delay the use of alcohol, tobacco, and other drugs. The plan objectives closely align with SAMHSA's Initiative #1: Creating communities where individuals, families, schools, faith-based organizations and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse (including tobacco and alcohol), and suicide.

- Objective 1. Improve ATOD prevention data collection, analysis and reporting. A *Statewide Epidemiological Outcomes Work Group* (SEOW) will support planning and accountability across the ATOD prevention infrastructure by organizing cross partner data and planning experts to coordinate data collection processes and timing, identify opportunities to streamline (e.g., online methods) data collection and data sharing, and provide technical assistance and training to local communities as needed.
- Objective 2. Collaborate and coordinate efforts across multiple sectors to implement ATOD prevention programming across identified priorities. The *SPE Consortium* will continue to meet regularly and share information about ATOD prevention efforts and funding levels across partners. The Consortium discussions will inform statewide ATOD prevention priorities and capacity building actions including the implementation of three SPE Work Groups. The success of the Consortium will be determined by the depth and breadth of cross partner networks, leveraging of resources, streamlining demands associated with local and regional planning processes, and extent to which the State achieves progress on target indicators. A Memorandum of Understanding documents the Consortium Partners commitment to the process.

- Objective 3. Maximize the ATOD training and capacity building infrastructure. A *Training and Technical Assistance Work Group* will enhance and expand existing training and technical assistance offerings available through the SPE partners and the statewide service delivery agents (see page #) for the express purpose of increasing professional skills of the ATOD prevention workforce, building capacity of local prevention councils to implement effective prevention models, and develop effective prevention networks within and across regions and/or counties. A *Local Implementation Work Group for Statewide SPE Priorities* will convene to support the successful implementation and/or expansion of effective prevention models across Connecticut. This work involves assembling cross partner teams that can develop new and/or adjust existing protocols and models for roll out at the local level. This effort recognizes that successful efforts require a simultaneous top-down and bottom-up approach with ample room to make mid-course adjustments in response to changing conditions at the local level. The table below outlines the action plan to improve technical assistance and training infrastructure.
- Objective 4. Monitor and evaluate ATOD prevention program performance. The *Statewide Epidemiological Outcomes Work Group* will support planning and accountability across the ATOD prevention infrastructure by organizing cross partner data and planning experts to coordinate data collection processes and timing, identify opportunities to streamline (e.g., online methods) data collection and data sharing, and provide technical assistance and training to local communities as needed. The table below shows activities to increase monitoring and evaluation capacity.

Achieving the plan objectives will result in Connecticut reaching or exceeding benchmark sets on ATOD prevention indicators such as: increasing the age of onset for tobacco use; reducing excessive alcohol use (i.e., binge drinking); and reducing ATOD health disparities.

The plan sets forth performance measures to track progress and to review and adjust the plan annually based on changes in circumstances. The plan will increase the State's prevention return on investment and link ATOD prevention strategies to health care reform and other emerging funding opportunities. A memorandum of understanding (MOU) articulates that partner's ongoing commitment to support, update, and sustain the statewide prevention enhancement initiative.

The Connecticut DMHAS will serve as the project lead to convene this initiative. For more information, contact Carol Meredith, Director, Health Promotion and Prevention Services (e-mail: carol.meredith@ct.gov).

The Need for an Enhanced ATOD Prevention Infrastructure

Demographic Overview of Connecticut

Over 3.5 million people live in Connecticut's 4,842 square miles. Connecticut contains 738.1 persons per square mile, far exceeding the national average (87.4). Of the total population, 82.3% are White, 11.1% are Black, and 13.8% are persons of Hispanic or Latino Origin. One in five persons above age five speaks a language other than English at home. 88.6% of persons above age 25 have earned a high school degree or higher, with 35.7% earning a Bachelor's degree or higher. The per capita money income in the past 12 months (in 2011 dollars) equaled \$37,627 (\$10,000 above the national average) and the median household income equaled \$69,243 (\$17,000 above the national average). Table 1 (page 2) shows selected urban centers and towns as compared to the statewide and national reference points. The table illustrates the appreciable variation across population demographics and income within Connecticut.

Connecticut's population continues to face significant demographic shifts. The state's residents represent the nation's 7th oldest population. During the past decade, the 15 to 24 year old age group grew by almost 15%. The Asian, Hispanic/Latino, and Black or African American populations in Connecticut showed the largest growth from 2000-2010, at 61.6%, 45.9%, and 13.9% respectively. Furthermore, the percentage of Connecticut's population who self-identified as two or more races grew by 20.5%, while the population identifying themselves as Some Other Race grew by 32.1%. Approximately 0.2% of Connecticut residents are American Indian

Connecticut contains eight counties. However, county government does not exist in Connecticut. Connecticut's 169 towns serve as the local unit of government. Over 265,000 residents live in 58 rural towns spread across five Connecticut counties. The area population is predominantly white non-Hispanic (county range, 80% to 92%), as is the U.S. (84%) and Connecticut (88%), with county percentages of blacks ranging from 0.8% to 5% and Hispanics from 4% to 9%.

Approximately 0.2% of Connecticut's residents are American Indian/Alaskan Native. Connecticut has two federally recognized tribal nations, the Mashantucket Pequot Nation (pop. 227), on one of America's oldest reservations, established in 1666; and the Mohegan Tribe (pop. 1,700); and three state recognized tribal nations, the Eastern Pequot Nation, the Golden Hill Paugusset Tribe, (pop. 150), and the Schaghticoke Indian Tribe (pop. 300). A seventh tribal nation, Nipmuc Indian Association of Connecticut, is currently seeking federal recognition. Members of the Cherokee tribal grouping (948); the Chippewa tribal grouping (228); the Navajo tribal grouping (25) and the Sioux tribal grouping (55) live in Connecticut.

According to the Connecticut Department of Veteran's Administration, over 235,000 living veterans and 21,000 who are or have served since 2001.

Table 1. Demographics of selected urban centers and towns in Connecticut

Geographic Area	Total Population	% under 18 years	% White	% Black	% Hispanic Origin	Language other than English spoken at home (age 5+)	Per Capita Money Income past 12 months (2011 dollars)	Persons below poverty level (2007-2011)
Bridgeport	145,638	25%	39.6%	34.6%	38.2%	45.7%	\$19,979	21.9%
Hartford	124,867	25.8%	29.8%	38.7%	43.4%	47.4%	\$16,959	32.9%
New Britain	73,261	23.3%	63.6%	13.0%	36.8%	48.5%	\$20,768	20.9%
New London	27,569	20.4%	60.4%	17.4%	28.3%	31.5%	\$22,386	17.9%
New Haven	129,585	22.8%	42.6%	35.4%	27.4%	32.8%	\$22,814	26.3%
Stamford	123,868	21.6%	65.0%	13.9%	23.8%	45.2%	\$44,595	11.0%
Waterbury	110,189	25.6%	58.8%	20.1%	31.2%	31.6%	\$22,004	20.6%
Willimantic	17,737	21.5%	66.0%	7.5%	39.8%	37.8%	\$19,164	26.0%
Connecticut	3,580,709	22.4%	82.3%	11.1%	13.8%	20.8%	\$37,627	9.5%
USA	311,591,917	23.7%	78.1%	13.1%	16.7%	20.3%	\$27,915	14.3%

Source: US Census Bureau 2010 census and 2011 estimates

ATOD and Other Related Indicators in Connecticut

Alcohol, tobacco, and other drug abuse in Connecticut cut across all geographic, socio-economic, racial, linguistic and ethnic boundaries – underscoring the need for a strong infrastructure. The Statewide Epidemiological Outcomes Work Group tracks epidemiological data on alcohol, tobacco, marijuana, heroin, prescription drugs, and cocaine.² In general:

- At the state, regional and sub-regional levels, alcohol misuse and abuse, especially underage drinking, continue to be the highest prevention priority
- Marijuana remains the most commonly used illicit drug in Connecticut and in the United States
- Tobacco use in children under age 12 has steadily declined for more than six years, mirroring declining usage nationwide, and tobacco use by adults 18 and older (27.6%) falls below the national rate
- Approximately 4% of the adult population reported non-medical use of painkillers in the previous year with young adults age 18-25 experiencing the highest rate of past-year medical use of painkiller of all age groups (11.27%)
- Limited state and community level data collection exist to document the prevalence of heroin and cocaine use. Demand for heroin remains high with easy accessibility. The state's 18-25 year olds remain the greatest consumers of cocaine (6.5% of all users)

The Connecticut DMHAS monitors several leading indicators to understand the current status of ATOD use in Connecticut as well as areas of emerging concern. Table 2 (page 4) contains ATOD indicators that relate more directly to data sets that document the underlying risk and protective factors as well as intervening variables relevant for ATOD prevention and health promotion.³ The appendices contain a list of behavioral indicators collected by the Statewide Epidemiological Outcomes Work Group (SEOW). The Connecticut Department of Health tracks closely the burden of chronic diseases and conditions related to ATOD use. Heart disease, stroke, cancer, diabetes, and chronic lower respiratory diseases are among the leading causes of death in Connecticut, accounting for over half of all resident deaths. Connecticut's racial and ethnic minorities experience disparities in chronic diseases and their risk factors. Statewide, compared to white residents, blacks have higher age-adjusted death rates for heart disease, stroke, cancer, and diabetes, and higher prevalence rates for diabetes, high blood pressure (HBP), obesity, and physical inactivity. Hispanics have higher rates of diabetes, obesity, and physical inactivity, whereas their heart disease and cancer mortality rates are significantly lower. From 2007 to 2009, rates of obesity, physical inactivity, HBP, and high blood cholesterol (HBC) increased with age. Educational attainment, income, and poverty are recognized determinants of health, and Connecticut residents with lower socioeconomic status tend to have more risk behaviors and worse health outcomes. Compared to college graduates, for example, state residents with less than a high school education were more likely to smoke, be obese, physically inactive, to have HBP, HBC, diabetes, and not ever had their cholesterol tested.

² Please refer to the Statewide Epidemiological Outcomes Workgroup 2010 profiles for a more information at <http://www.ct.gov/dmhas/prevention>.

³ The analysis of underlying risk and protective factors and intervening variables includes the following: Low Perceived Harm of ATOD Use; Favorable Parental Attitudes and Involvement in the Problem Behaviors; Social Access/ Community Laws and Norms Favorable to Drug Use; Law enforcement; Family Norms; Peer Norms; Retail Availability; Commitment to School; Extreme Economic and Social Deprivation; and Community Support for Substance Abuse Prevention.

Table 2. Connecticut ATOD Indicators (The Statewide Epidemiological Outcomes Work Group will update this table during 2013)

Domain	Indicator	Data Source	Population	Baseline *	Five Year Target *
Consumption	30-day alcohol, tobacco, marijuana and other drug use	BRFSS	Age 18+	TBD by Statewide Epidemiological Outcomes Work Group	TBD by Statewide Epidemiological Outcomes Work Group
		YRBSS/CT SHS	Grades 9-12	TBD	TBD
	Age of Initial Use	BRFSS	Age 18+	TBD	TBD
		YRBSS/CT SHS	Grades 9-12	TBD	TBD
	Binge drinking	BRFSS	Age 18+	TBD	TBD
		YRBSS/CT SHS	Grades 9-12	TBD	TBD
	Illicit drug use	BRFSS	Age 18+	TBD	TBD
		YRBSS/CT SHS	Grades 9-12	TBD	TBD
Other Social Consequences	School Suspensions/ Expulsions (AOD-related)	CT SDE	Grades 6-12	TBD	TBD
	Children Substantiated as Abuse/Neglect/Uncared for	CT DCF	Age 0-18	TBD	TBD
	Other	TBD	TBD	TBD	TBD
Morbidity / Injury	Hospital admissions related to alcohol and/or drugs	OCHA	All ages	TBD	TBD
	DUI Arrests	CT DPS	Age 16+	TBD	TBD
	Other	TBD	TBD	TBD	TBD
Mortality	Fatal Crashes and Percent Alcohol-Impaired Driving, by Time of Day and Crash Type	FARS	All ages	TBD	TBD
	Alcohol Related Liver Cirrhosis Death Rate	CT DPH	All ages	TBD	TBD
	Other	TBD	TBD	TBD	TBD

* To Be Determined (TBD) by the Statewide Epidemiological & Outcomes Workgroup

Connecticut's Statewide ATOD Prevention Infrastructure

In Connecticut, several state agencies as well as statewide, regional, and local efforts support prevention and health promotion. Alcohol, tobacco and other drug (ATOD) prevention refers to measures that stop or delay the onset of drug use and protect against progression to more frequent or regular use amongst at risk populations. Alcohol, tobacco, and other drug prevention work concentrates on the categories of primary prevention and secondary prevention.

Primary prevention targets the entire population and/or sub-populations and aims to prevent or delay the use of drugs (e.g. tobacco laws, drug and alcohol policies, partnerships to build community capacity, social marketing campaigns).

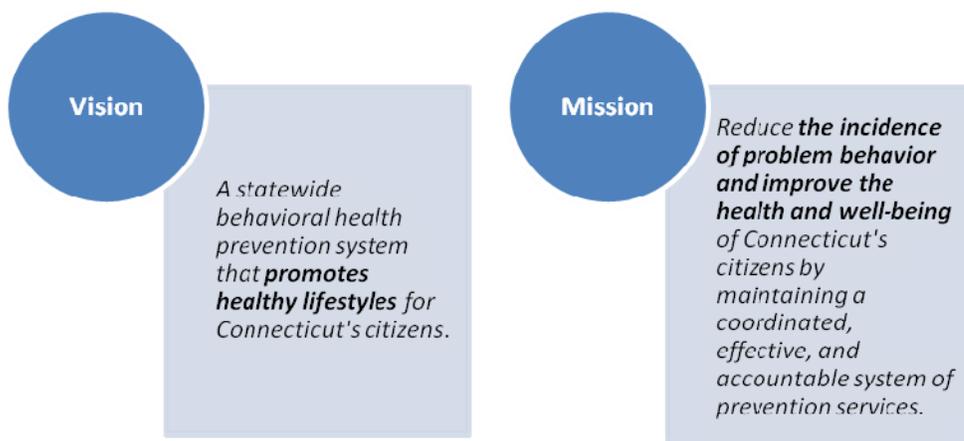
Secondary prevention targets groups and individuals at risk of using or currently using drugs, and aims to prevent use, problematic use and harm (e.g. responsible service of alcohol, Safer Venues, designated drivers, social marketing campaigns).

Tertiary Prevention targets individuals and aims to prevent further harm from problematic drug use (i.e. drug and alcohol treatment services).

Primary prevention holds the broadest and greatest potential for sustainable positive impact because it focuses on entire populations and influences social change. This broad perspective relies significantly on successful partnerships across diverse state, regional, and local partners and intermediaries (i.e., a prevention infrastructure). Prevention efforts reduce factors known to cause illness and problem behaviors and promote factors that reduce vulnerability and increase good health. Prevention and health promotion are the first two steps in the substance abuse and mental health continuum of care.

The Connecticut Department of Mental Health and Addiction Services (DMHAS) serves as Connecticut's single state agency for substance abuse prevention and treatment services. Connecticut DMHAS holds the responsibility to maintain a statewide Strategic Prevention Framework consistent with federal guidelines set forth by the SAMHSA Center for Substance Abuse Prevention. Figure 1 shows Connecticut's vision and mission for strategic prevention. The Strategic Prevention Framework Enhancement Project (CT SPE) intends to strengthen Connecticut's substance abuse prevention system with input from diverse stakeholders, including State agencies involved in substance abuse prevention and health promotion efforts.

Figure 1. Connecticut's Strategic Prevention Direction



The DMHAS Prevention and Health Promotion Unit staff members guide the implementation of Connecticut's strategic prevention initiatives. The DMHAS organizes its Prevention and Health Promotion Division to provide accountability-based, developmentally appropriate and culturally sensitive behavioral health services based on scientific models and best practices, through a comprehensive system that matches the services to the needs of the individuals and 169 local communities. The DMHAS uses 13 subdivisions across Connecticut as the geographic basis for prevention services. The prevention infrastructure, in its present form, consists of the following components:⁴

- **Four Statewide Service Delivery Agents support prevention programs statewide:**
 - ***DMHAS Prevention Training Collaborative*** is comprised of community agencies that provide training/ TA across all domains of substance abuse prevention, building on Connecticut's capacity to implement the strategic prevention framework (SPF) and evidence based practices (EBPs) at the state and community levels by investigating and gathering current data and effective strategies for prevention, training community needs assessment workgroups to complete data collection and analysis and providing training / technical assistance on evidence-based strategies, practices, and programs to improve the quality of Connecticut's prevention workforce.
 - ***The Multicultural Leadership Institute (MLI)*** works with agencies statewide to promote culturally and linguistically proficient ATOD prevention services for African origin, Latino, and other disenfranchised groups. MLI offers training and technical assistance to community agencies on cultural competence. Additionally, MLI assesses products and processes, sub-regional profiles, community needs assessment and strategic plans to ensure cultural competence and inclusiveness. They also assist in identifying and assessing the needs of diverse and underserved populations.
 - ***The Connecticut Clearinghouse/ Connecticut Center for Prevention, Wellness and Recovery (CCPWR)*** is a comprehensive information resource center that makes available thousands of books, tapes and printed reports, and provides electronic access to the latest information on substance abuse, mental health and a variety of other issues. The Clearinghouse provides staffing, logistical support, meeting space and coordination of activities related to the successful implementation of the Best Practices, Partnerships for Success, Tobacco Prevention and Enforcement and Healthy Campus initiative.
 - ***The Governor's Prevention Partnership (GPP)*** is a statewide organization comprised of public/ private partnerships designed to change the attitudes and behaviors of youths and adults toward substance through its School, Campus, Workplace and Media Partnerships. GPP's involvement in the SPF and PFS initiatives has included providing ongoing technical assistance to community grantees on the 5 Step process and implementation of environmental strategies. Additionally, GPP has been instrumental in providing data and

⁴ For more information, please refer to the State of Connecticut Department of Mental Health and Addiction Services document titled, "Prevention & Health Promotion Division System of Services – 2010". Use the following link to access a PDF file: <http://www.ct.gov/dmhas/lib/dmhas/prevention/PHPCompendum.pdf>

technical assistance on compliance checks that includes the recruitment, training and scheduling as well as supervising youth for compliance checks.

- **Statewide Epidemiological Outcomes Work Group (SEOW)** is comprised of representatives from several state agencies and meets on a regular basis to discuss pertinent data related issues with an emphasis on ATOD prevention and use data.
- **13 Regional Action Councils (RACs)** operate as subcontractors to DMHAS to carry out ATOD prevention initiatives, among their other mission driven objectives. These private non-profit organizations, comprised of a board of directors of community stakeholders build capacity of communities to conduct data driven decision making and effective substance abuse prevention. The RACs may conduct comprehensive analyses of community needs and response capacity data and produce Sub-Regional Profiles to establish local substance abuse prevention priorities.
- **132 Local Prevention Councils (LPCs)** address primary prevention in the 169 communities throughout the state of Connecticut. The LPCs contain representatives who are elected officials, police officers, educators, faith / spiritual leaders, business leaders, social and human service providers, and parents, among others.
- **Campus/Community-Based ATOD Prevention Initiatives** including:
 - ***Best Practice Programs/Coalitions.*** The 14 Best Practice programs/coalitions implement evidence based strategies to prevent underage drinking using the Strategic Prevention Framework (SPF) 5 Step process. Many of the Best Practice programs use the SPF 5 Step process to address other priority substances such as marijuana and Prescription Drug abuse.
 - ***Partnerships for Success (PFS) Community Grantee Coalitions.*** The 19 Community PFS grantees implement evidence based strategies to address underage drinking at the community level using the Strategic Prevention Framework (SPF) 5 Step process in order to meet statewide reduction targets.
 - ***A Statewide Healthy Campus Coalition*** is comprised of Connecticut colleges and universities who are participating in activities to address the reduction of ATOD use and abuse amongst their student populations.
 - ***A grant-funded Connecticut Campus Suicide Prevention Initiative (CCSPI)*** that seeks to put into practice sustainable evidence based suicide prevention and mental health promotion policies, practices and programs at institutions of higher education throughout the state for students up to age 24.
 - ***A Tobacco Prevention and Enforcement Program (TPEP)*** implemented by the DMHAS Prevention staff implements as part of the Synar Amendment requirements. Activities include un-announced inspections of retail outlets for compliance with age and photo identification and advertising and labeling restrictions. TPEP administers a Merchant Education and Awareness Campaign throughout the state as well as the federal FDA Tobacco Prevention and Enforcement program statewide.

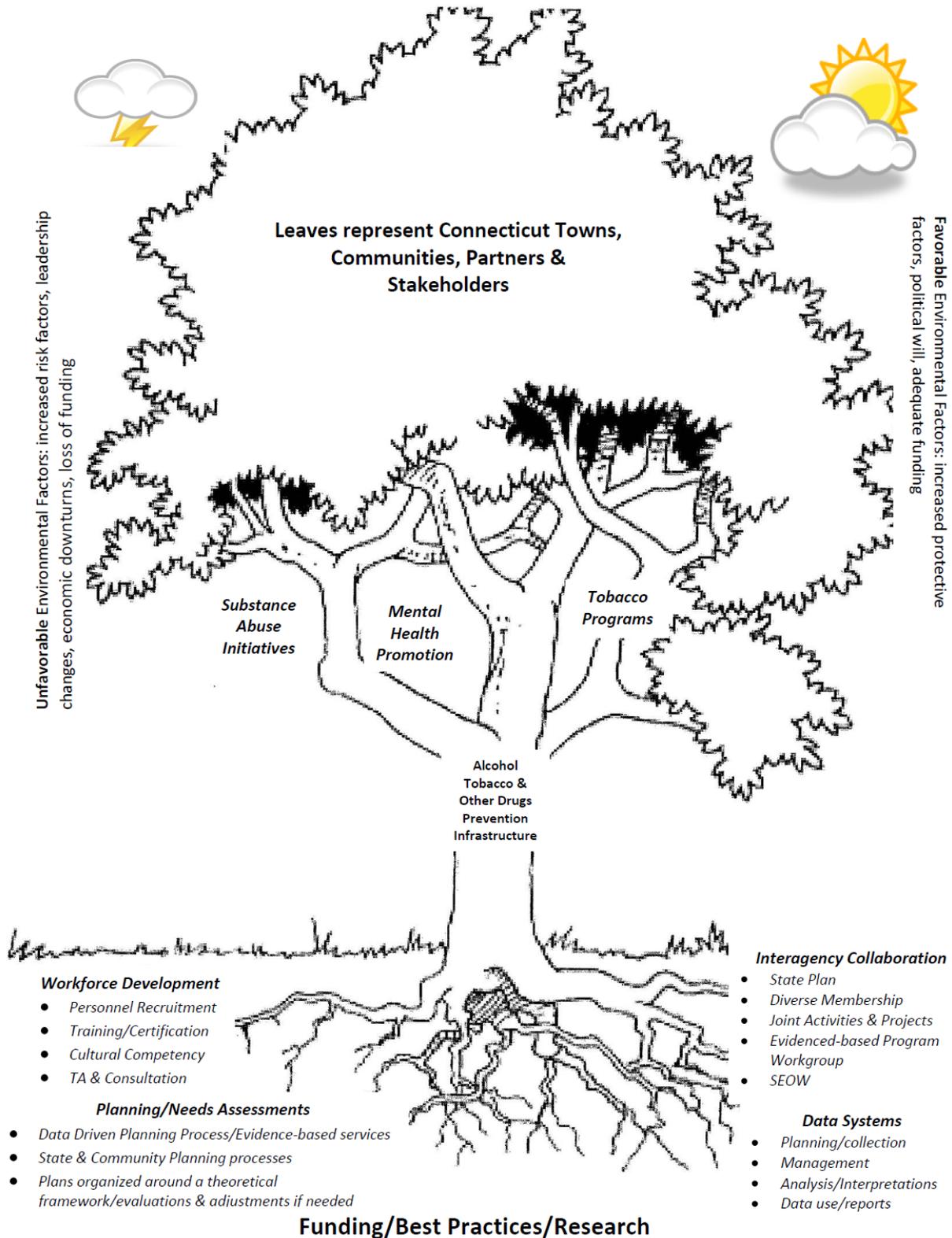
- **The Performance Based Prevention System (PBPS)** captures provider activities as they relate to the implementation of evidence based strategies to address identified risk factors. The DMHAS reports PBPS data to the federal Substance Abuse and Mental Health Services Administration.

The Prevention Infrastructure links to other State Advisory Councils such as the Connecticut Alcohol and Drug Policy Council (ADPC). Established in 1996 via Executive Order of the Governor, the ADPC is comprised of key state agencies with ATOD prevention and treatment resources and charged with recommending strategies to reduce the harmful effects of substance abuse. The ADPC serves as conduit for Connecticut's Strategic Prevention Enhancement Consortium to move forward recommendations.

Figure 2 (page 9) shows a visual metaphor of the statewide Prevention Infrastructure introduced by the DMHAS project leaders to the SPE Consortium Members. The visual metaphor uses the image of a tree to show: the fundamental components of the infrastructure (i.e. roots); the major investors in the infrastructure (i.e. trunk); the state's investment of programs and services (i.e. branches); and how the infrastructure supports partnerships at the community level (i.e. leaves).

When environmental factors within the state are favorable (i.e. increased protective factors, political will, adequate funding, etc.), the ATOD infrastructure is stronger, promotes growth and is more likely to achieve outcomes. Conversely, when there are unfavorable environmental conditions (i.e. increased risk factors, leadership changes, economic downturns, loss of funding), the system remains stagnant and less likely to achieve measurable gains. Additionally, the visual metaphor presents information in a way that aligns with the areas associated with SPE capacity building and infrastructure enhancements. The visual metaphor remains a work in process by the DMHAS and will undergo additional refinements during the five year implementation period.

Figure 2. A visual metaphor of the statewide Prevention Infrastructure



Connecticut’s Statewide Prevention Enhancement Consortium

The SAMHSA’s Center for Substance Abuse Prevention award to the Connecticut Department of Mental Health and Addiction Services of a 2011 Strategic Prevention Framework State Prevention Enhancement grant permitted DMHAS to convene a diverse SPE Consortium. Comprised of representatives from state and local agencies involved in substance abuse prevention and related problems, the SPE Consortium oversaw the grant and informed the development of the 5-year Strategic Plan. Table 3 shows a roster of agencies and organizations participating in the SPE Consortium.

Table 3. SPE Consortium Members	
SPE Partner Organization	Connection to ATOD Prevention
Board of Pardons and Parole (BPP)	Facilitate the successful reintegration of suitable offenders into the community via a range of programs including ATOD prevention to offenders and family members.
Community Health Care Center of Connecticut (CHCCC)	Enhance the access and availability of primary care and behavioral health and social services to Connecticut’s underserved population via federally qualified health centers (FQHCs).
Department of Children & Families (DCF)	Strengthen families and help children & youth reach their fullest potential via ATOD prevention to families and at-risk children; special initiatives such as drug endangered children; workforce training.
Department of Consumer Protection (DCP)	Enforce the state’s liquor laws via control and enforcement; merchant training programs; and other supply-side efforts
Department of Corrections (DOC)	Provide ATOD treatment to offenders and prevention for family members which willing inmates may utilize to improve themselves and the success of their eventual reintegration into society.
Department of Education (SDE)	Pursue the success of all students by providing ATOD prevention in school settings; drug free schools; health promotion; school health clinics/services; youth development.
Department of Emergency Services and Public Protection (DESPP)	Protect and improve the quality of life for drug endangered children by all by providing enforcement activities to break the cycle of abuse and neglecting resulting from drug manufacturing use or trafficking and providing referral services for offenders and their children.
Department of Mental Health & Addiction Services (DMHAS)	Provide behavioral health services that improve quality of life; building capacity; strengthening communities via a comprehensive, coordinated ATOD Prevention Infrastructure.
Department of Motor Vehicles	Prevent crashes, injuries and deaths among drivers through awareness and education programs targeting at-risk or high-risk

Table 3. SPE Consortium Members

SPE Partner Organization	Connection to ATOD Prevention
(DMV)	drivers (e.g., teen; young adult).
Department of Public Health (DPH)	Protect the health and safety of all citizens; preventing disease; promote wellness; health care reform; initiatives building community coalitions and health equity.
Department of Social Services (DSS)	Provide services for individuals and families to achieve and maintain full potential for self-direction, self-reliance and independent living.
Department of Transportation	Provide ATOD awareness, education and enforcement initiatives to ensure a safe, efficient, transportation system.
Department of Veteran Affairs (DVA)	Provide general medical care, substance abuse treatment, educational and vocational rehabilitation, job skills development, self-enhancement workshops, employment assistance and transitional living opportunities to veterans and their families.
Judicial Branch – Court Support Services Division (CSSD)	Provide Supervision and ATOD prevention programming for high risk populations through special initiatives to increase public safety and reduce recidivism.
Mashantucket Pequot Tribal Nation (MPTN)	Enhance the quality of life for all Mashantucket Pequot Tribal members by providing quality healthcare, behavioral health and ancillary services.
Mohegan Tribe (MT)	Provide a range of services including SA treatment and counseling, prevention and education and case management services to children, adolescents and adults experiencing emotional, behavioral or mental health difficulties.
Office of Policy and Management (OPM)	Improve the effectiveness of state services and ensure the efficient use of resources by overseeing the distribution of funds to support youth development and prevent child poverty, underage tobacco and alcohol use.
Connecticut Youth Services Association (CYSA)	The state association of organizations responsible for planning, evaluation, coordination, and implementation of a network of resource, programs and s and opportunities for children, youth, and their families.

The Consortium members participated in a 10-month long planning process. Figure 3 (page 13) shows a logic model for the planning process that consisted of:

- Eight Consortium meetings

- Completion of a gap analysis of the statewide prevention infrastructure that included a survey of Consortium members and an analysis of prevention funding, among others
- Identification of capacity building projects and implementation of projects by Consortium partners
- Development of a Five Year Plan including input through focus groups with target populations and a commitments for ongoing participation in the form of a Memorandum of Understanding

The SPE Consortium members recognized early on the challenges facing multi-partner, cross-agency initiatives. The DMHAS project leaders used a participatory process that incorporated values set forth by SAMHSA for a well functioning Consortium as well as lessons learned from previous multi-partner, cross-agency initiatives. The SPE Consortium values include:

- *Vision matters.* The federal government sets forth a vision for the ideal statewide prevention infrastructure and provides an excellent reference for Connecticut’s SPE Consortium to build a responsive and effective infrastructure. Health promotion and prevention benefits and impacts every area of society.
- *Diversity matters.* Partners support what they help create. Involving stakeholders and partners in meaningful ways permit authentic voices and diverse interests to enrich the process.
- *Science matters – build a foundation with facts.* In the era of diminishing resources and increased accountability, using evidence-based practices and solid data represents a fundamental value. The SPE process relies upon scientifically valid assessments of ATOD issues as well as the use of a public health model (i.e., population change) and evidence-based practices.
- *Leadership matters.* Cross-sector partnerships require multiple champions and strong, effective leadership. The SPE Consortium members recognize working within silos no longer produces optimal change for individuals, families, and communities. Developing leaders involves deliberate cultivation and support across diverse partners and stakeholders of the prevention infrastructure.
- *Communication matters.* Building any type of cross-sector partnership requires communication to define the issue, articulate roles and responsibilities, and assess progress. The SPE Consortium creates a vehicle to enhance, expand, and extend critical relationships and resource networks.
- *Community matters.* This value acknowledges that local people solve local problems the best. The enhancements to the Statewide Prevention Framework should help local communities to help themselves and statewide or regional intermediaries to support the community process.
- *Innovation matters.* The convergence of external forces such as health care reform and fiscal constraints create environments for deliberate innovation. The SPE Plan must identify opportunities and leverage them to promote system change.
- *Results matters.* All partners will continue to implement solutions and administer funding streams with or without an SPE process. Multiple partners working toward changing the same performance measures and indicators will produce a more significant collective impact than one community or one agency working independently.

Figure 3. Connecticut’s logic model to guide development of the five year plan

Purpose Connect substance abuse prevention and behavioral health to the current community systems of care in anticipation of the changes to the state and federal health care system.			
Goal Enhance the statewide substance abuse prevention infrastructure to promote health and reduce the likelihood of substance abuse and related consequences.			
INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES and IMPACT
<i>We will use human, financial, organizational, and community resources to reach our goal</i>	<i>We will accomplish the following activities to address our problems</i>	<i>Our activities will produce evidence or service delivery (*illustrative examples)</i>	<i>The activities will produce changes in the short- and long-term. (*illustrative examples)</i>
<ul style="list-style-type: none"> • Participation and information from diverse prevention partners (i.e., SPE Consortium) • Epidemiological reports and data from Statewide Epidemiological Outcomes Workgroup • Five resource link agencies such as the Multi-cultural leadership institute, Prevention Training Collaborative and 13 Regional Action Councils • 19 Partnership for Success and 14 Best Practices community coalitions conducting complementary, comprehensive prevention interventions addressing community-specific risk factors • 132 Local Prevention Councils conducting primary prevention • Initiatives targeting priority issues and populations (funded by partner operating budgets and/or other funding) • Governor’s Prevention Budget • Other federal, state, and local resources 	<ul style="list-style-type: none"> • Convene an SPE Consortium with diverse partners • Convene a Statewide Epidemiological Outcomes Workgroup • Assess needs on multiple levels (state, region, community, provider) • Complete a gap analysis using the “ideal” prevention infrastructure • Invest in activities that leverage and/or enhance the capacity of the prevention infrastructure <ul style="list-style-type: none"> ○ Technical assistance and training ○ Data collection, analysis & reporting ○ Coordination of services ○ Performance & evaluation • Develop a multi-year Statewide Prevention plan • Monitor, evaluate, and continuously improve 	<ul style="list-style-type: none"> • Increased awareness of prevention resources and the existing prevention infrastructure • A multi-year strategic plan • Memorandum of Agreements with partners related to ongoing work and implementing the multi-year plan • Changes in professional networks and relationships between prevention personnel across agencies • More effective use of existing prevention infrastructure (e.g., coordination of training, data collection) • Higher level of coordination in geographic areas and/or target populations that experience health disparities • Position coalitions to partner and advance health promotion and prevention efforts related to healthcare reform 	<p>Short Term (years 1 to 3)**</p> <ul style="list-style-type: none"> • Streamlined planning processes • More efficient and effective data dissemination • Co-investment (funding) of programs and coordination of programs (SPE Consortium) • More strategic use of existing infrastructure • Policy and legislative changes <p>Long Term (years 4 to 6)**</p> <ul style="list-style-type: none"> • Increase age of first use for tobacco and alcohol • Reduce past month use for ATOD • Reduce binge use for alcohol • Reduce ATOD-related school suspensions & expulsions • Reduce adult DUI arrests • Reduce HIV, Hepatitis and sexually transmitted disease rates • Reduce drug-related emergency room usage • Reduce child abuse / neglect rate • Coordination of prevention investments • Policy and legislative changes <p>Longer Term (7 years and beyond)</p> <ul style="list-style-type: none"> • Reduce lung cancer deaths • Reduce cardiovascular disease deaths • Reduce chronic liver disease • Reduce economic costs associated with ATOD (e.g., \$2 billion annually for tobacco; underage drinking \$621 million) • Quality of life indicators (e.g., health status, crime rates) • Educational outcomes

Gap Analysis of Connecticut's Statewide ATOD Prevention Infrastructure

The implementation of the Connecticut SPF SIG from 2006 to 2010 provided a solid foundation upon which to understand strengths, opportunities, and weaknesses associated with the statewide Prevention Infrastructure. The Connecticut DMHAS deliberately designed a gap analysis process to reach out across SPE Consortium members, and to understand data sets and partner relationships outside of the funds administered by Connecticut DMHAS.

Method

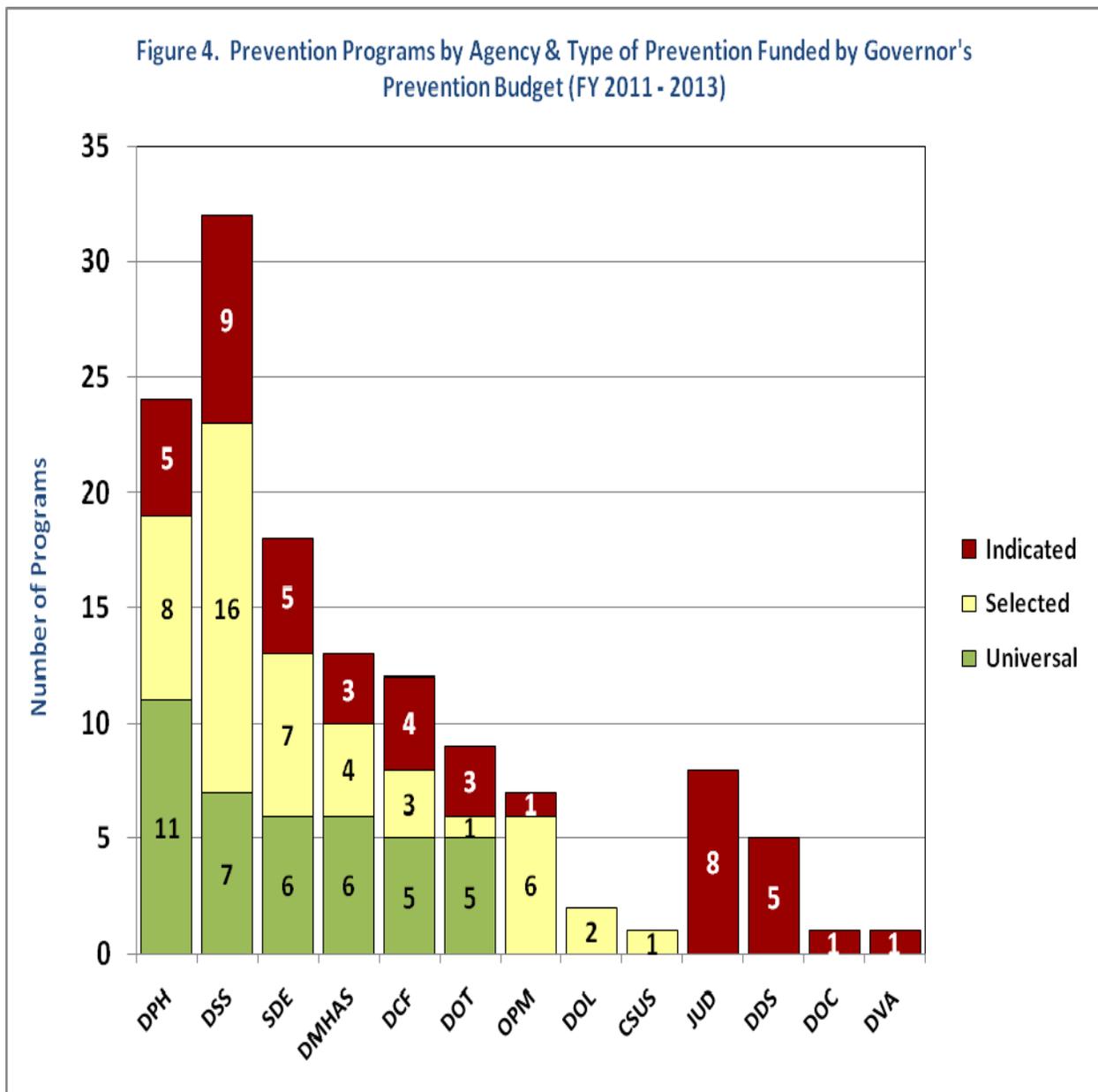
The process incorporated multiple data sources and data collection activities including but not limited to:

- DMHAS used information from prior initiatives involving the statewide ATOD Prevention Infrastructure to conduct a preliminary gaps analysis. (This information was included in the Statewide Prevention Enhancement grant application and augmented by other surveys such as the Community Readiness Survey.)
- SPE Consortium Members completed a structured survey and/or a structured interview that provided additional information about prevention activities by partners, knowledge of the Prevention Infrastructure, and involvement with other partners on prevention-related initiatives and/or programs.
- SPE Consortium Members used SPE Consortium meetings to learn more about the SPE process, their current and potential role, their partner's roles, as well the existing Prevention Infrastructure.
- SPE Consortium Members provided ideas and suggestions about capacity building and infrastructure enhancement projects through face-to-face meetings, telephone interviews, and written concepts.
- The DMHAS convened meetings with its Prevention and Health Promotion staff to identify capacity building and infrastructure enhancement opportunities.
- The DMHAS issued a web-based survey to prevention contractors asking for input and suggestions for capacity building and infrastructure enhancement opportunities.
- The SPE project staff reviewed documents from other states as well as Connecticut related to needs assessments, strategic plans, gap analyses, and areas of focus related to capacity building and infrastructure enhancement.
- The SPE project staff completed other analysis (e.g., Governor's FY 2011 – 2013 Prevention Budget, review of community readiness survey findings) to understand how the SPE could facilitate connections across.

The DMHAS introduced findings of the analyses into the SPE Consortium meeting process as a way to activate partners, to increase clarity of partner's roles and/or opportunities for increased coordination, and to complete a more extensive gap analysis table.

Analysis of Governor’s Prevention Budget

The SPE Consortium reviewed an analysis of the Governor’s Fiscal Year 2011 – 2013 Prevention Budget. Consortium members used this analysis to identify a broad array of existing prevention investments and to identify opportunities for collaboration and more effective use of the existing statewide ATOD prevention infrastructure. For example, Figure 4 shows prevention programs by state agency and by type of prevention (i.e., indicated, selected, or universal). This analysis led to several discussions about how to align universal prevention efforts and activities, how to coordinate activities within a target area, and how to increase the effectiveness of prevention investments for target populations.



Similarly, an analysis using a program focus and the type linkage by the state agency allowed the Consortium members to discuss potential for improved coordination across intermediaries (i.e., contractors) as well as opportunities to leverage other existing service delivery infrastructures (e.g., health, employment, education). Table 4 provides a high level summary of this analysis for programs targeting all populations (e.g., adults, children, families).

Table 4. Crosswalk of the Fiscal Year 2011-2013 Governor’s Prevention Budget by program, program focus, type of prevention, and resource link agencies.

Program	Program	Program Focus								Type of Prevention			Link	
		ATOD	Health	Family Support	Early Childhood	Youth Development	Suicide	Youth Jobs	Other	Universal	Selected	Indicated	Intermediaries	Direct Service
DPH	16	1	12	1	4	0	1	0	2	11	8	5	11	7
DSS	28	1	11	14	10	6	0	0	11	7	16	9	26	3
SDE	17	1	3	4	5	10	0	0		6	7	5	16	1
DMHAS	10	8	1	1	0	0	0	0	0	6	4	3	7	1
DCF	11	0	1	4	3	3	1	1	0	5	3	4	8	3
DOT	8	8	0	0	0	0	0	0	0	5	1	3	5	3
OPM	7	1	0	0	0	5	0	0	2	0	6	1	6	0
DOL	2	0	0	0	0	0	0	1	1	0	2	0	2	0
CSUS	1	1	0	0	0	0	0	0	0	0	1	0	0	1
JUD	8	2	4	4	0	4	0	0	7	0	0	8	4	4
DDS	5	0	0	4	1	0	0	0	0	0	0	5	4	1
DOC	1	1	0	0	0	0	0	0	0	0	0	1	1	1
DVA	1	1	0	0	0	0	0	0	0	0	0	1	0	0
ALL	115	25	32	32	23	28	2	2	23	40	48	45	90	25

The original SPE Request for Applications (RFA) identified components of an ideal prevention infrastructure that reflected the roles and responsibilities of the state in supporting communities in developing and implementing strategies that achieve outcomes. Table 5 shows the preliminary gap analysis conducted and submitted with the initial application based on these ideal components, a preliminary gap analysis was conducted and submitted with the initial application. This preliminary analysis helped to clarify objectives and informed the action steps and survey questions for the more comprehensive assessment.

Table 5. Gap analysis conducted prior to the planning process.	
Current State	Gap Analysis
<p>Ideal Component 1. A functioning State SPE Policy Consortium comprised of State-level decision makers from agencies involved in substance abuse, education, justice, public health, highway safety, law enforcement, behavioral health programs and primary health care.</p>	
<ul style="list-style-type: none"> • CT has a new Governor and several newly appointed heads of state agencies, and two existing statutory policy bodies, the Alcohol and Drug Policy Council and the Child Poverty and Prevention Council. These bodies comprise representatives from key state agencies with substance abuse prevention resources, including substance abuse, education, justice, public health, highway safety, law enforcement, and behavioral health. • Lessons learned from prior successful partnerships provide a solid foundation for facilitating interagency/ key stakeholder collaboration for the CT SPE. • Memoranda of Understanding with state agencies with substance abuse prevention resources are currently in place to address underage drinking and promote statewide healthy campuses. These are based on a history of collaboration regarding the prevention of underage drinking, youth violence, and suicide. • State agency and key stakeholder collaboration exists for underage drinking, adolescent health, suicide prevention, coordinated school health, early childhood, chronic disease prevention, tobacco prevention and cessation, bullying, and healthy campuses. 	<ul style="list-style-type: none"> • Although two prevention policy bodies exist, a high-level body charged with improving coordination of interagency prevention resources and developing a 5-year strategic plan does not currently exist. • It will be crucial to ensure that SPE Policy Consortium members have the authority to carry out the work required to successfully implement CT SPE Project goals and objectives. • The SPE Policy Consortium will use a Memorandum of Understanding consistent with the SPE goals that define the expectations, roles and responsibilities of each agency/ authority represented. • Primary health care agencies have not yet been brought to the table. • Additional SPE goals related to healthcare reform, workforce development and credentialing will need to be addressed.
<p>Ideal Component 2. A sound, functioning, and well-organized community prevention infrastructure, with support from a State Epidemiologic Outcomes Workgroup, including data-driven State and community epidemiologic profiles that incorporate all substance abuse related components and indicators, including evidence of associated problems.</p>	
<ul style="list-style-type: none"> • CT has disparate state agency and federal resources that support 1) direct service programs that work with targeted population or high need communities; 2) needs assessment, planning and coordination; 3) information packaging and dissemination; 4) cultural competence; and 5) state-of-the-art training and technical assistance. • The CT SEOW, fully convened in 2007, has members representing several state agencies with resources in substance abuse prevention data. The CT SEOW shares data. However the level of collaboration or braiding of research funds is low. • The SEOW has identified specific state-level 	<ul style="list-style-type: none"> • The disparate resources presently funding prevention services are not coordinated through a statewide interagency strategic plan that incorporates goals, objectives, outcomes, benchmarks and timelines for achieving federal and state outcomes. • The SEOW does not interact with the most influential persons in the state for establishing prevention policy or researchers from key local and state agencies who meet formally to review and discuss quantitative and qualitative data related to substance abuse. • The CT SEOW Data Repository is not user friendly

Table 5. Gap analysis conducted prior to the planning process.	
Current State	Gap Analysis
<p>indicators that it has monitored over time. With these data, biannual state epidemiologic profiles are produced, which describe alcohol, tobacco, marijuana, prescription drug, cocaine and heroin use and consequences, The SEOW also publishes town and regional data for local priority setting.</p> <ul style="list-style-type: none"> DMHAS prevention service data system tracks contract performance and provides resource data for needs assessment and strategic planning of state and community prevention efforts. 	<p>and does not easily offer access to current data describing the burden of substance abuse in CT. Other than providing data, the CT SEOW does not take an active role in the production of community epidemiologic profiles.</p> <ul style="list-style-type: none"> The present DMHAS prevention service data system tracks output rather than outcomes. The new Performance Based Prevention System will help to fill this gap.
<p>Ideal Component 3. A functioning State training and technical assistance system that is responsive to current and emerging needs in the areas of substance abuse prevention, including 1) developing and implementing a comprehensive data-driven strategic prevention plan; 2) implementing selected evidence-based prevention practices with fidelity; and 3) developing and implementing process and outcomes evaluations.</p>	
<ul style="list-style-type: none"> DMHAS has a well-developed training and technical assistance system (described in Section A); it provides ongoing training and TA on data-driven strategic planning; implementing evidence-based practices with fidelity; and process and outcomes evaluation. The Prevention Training Collaborative, whose catalog is informed by a biennial assessment of the state’s prevention workforce and emerging federal trends, offers training to all residents. Scholarships to the New England Institute of Prevention Studies are provided by DMHAS. TA to subrecipients is provided upon request by the Multicultural Leadership Institute, Regional Action Councils, Governor’s Prevention Partnership and the CT Center for Wellness and Recovery. In 2004, DMHAS published its Prevention Program Operating Standards, with its expectations for excellence in prevention. DMHAS Contract Managers are responsible for ensuring that subrecipients conduct a Standards Self-Assessment and using this tool to guide and support quality improvement. The state has an International Certification and Reciprocity Consortium’s (ICRC) Certified Prevention Specialist credential. 	<ul style="list-style-type: none"> While DMHAS has a comprehensive prevention training and technical assistance system, myriad other resources are spread among several state agencies and are somewhat fragmented. There is no method for inventorying these disparate resources and coordinating them through a statewide interagency strategic plan. The efforts of the Prevention Training Collaborative and the catalog of offerings might also be informed by an analysis of participant evaluation data. The SPE may serve as a vehicle to enhance interagency training and TA. CT lacks the methodology to evaluate the technical assistance provided to subrecipients to ensure that it is being provided in an effective, efficient manner. The Prevention Program Operating Standards need to be aligned with the SPF. DMHAS Contract Managers need to update the Prevention Program Operating Standards to improve monitoring and compliance. Credentialing is an important aspect of a highly qualified prevention workforce, however, is not required of any agency.
<p>Ideal Component 4. Sound, ongoing State level processes for assisting communities with assessment of substance abuse related issues and problems; underlying risk and protective factors, the ability to update assessments; prevention system needs; and capacity building.</p>	
<ul style="list-style-type: none"> All DMHAS-funded sub-recipients attend required learning communities that provide information 	<ul style="list-style-type: none"> Community-based providers funded by other state

Table 5. Gap analysis conducted prior to the planning process.	
Current State	Gap Analysis
and skills necessary to implement all aspects of the SPF.	agencies are not required to follow the SPF.
Ideal Component 5. Enhancement/ Expansion of a State Evidence-based Workgroup to oversee and implement a process and criteria for selecting evidence-based practices for substance abuse prevention.	
<ul style="list-style-type: none"> Through its existing prevention training and technical assistance system, DMHAS consistently promotes the use of evidence-based practices. 	<ul style="list-style-type: none"> A formal EBP Workgroup must be established, using CSAP's <i>Identifying and Selecting Evidence-based Interventions</i> to guide the selection of interventions.
Ideal Component 6. Effective data-driven funding allocation methods related to high need communities.	
<ul style="list-style-type: none"> The allocation approach used in CT ensures that all funded policies, practices, and programs support data driven, community-level reductions in ATOD consumption and consequences. Allocation of funds is based on priority setting reports, funding mandates and recommendations from policy/advisory bodies. 	<ul style="list-style-type: none"> Through the SPE Consortium, funding allocation may be brought to scale in high need communities currently not receiving funds.
Ideal Component 7. Expansion of available funds for high need communities to implement their strategic prevention plans.	
<ul style="list-style-type: none"> DMHAS has begun to use SAPT BG funds to support underage drinking prevention in high need communities. 	<ul style="list-style-type: none"> DMHAS should identify all high needs communities and redirect/ leverage funds to support these services.
Ideal Component 8. An established organizational structure with multiple agencies and stakeholders working together to coordinate and allocate funding to high need communities.	
<ul style="list-style-type: none"> DMHAS has experience with a state agency workgroup that coordinated services/allocated resources. 	<ul style="list-style-type: none"> DMHAS can use the lessons learned from the prior State Agency Workgroup to accomplish this goal.
Ideal Component 9. Established, effective State and community-level data collection systems.	
<ul style="list-style-type: none"> The DMHAS, in collaboration with other state agencies, has leveraged federal funding to continue to enhance its capacity for obtaining, using, and disseminating interagency data. Since 2005, through funding from the CSAP, the DMHAS has supported the efforts of the SEOW to promote the use of substance abuse prevention and mental health promotion data to guide funding. The SEOW is replacing its web-based data repository with an interactive site that will enable any registered user to access prevention and mental health promotion indicator data and produce high-quality visualizations (maps, graphs, etc.). These reports may be used to produce community profiles, assess service needs, and measure program effectiveness. The new site is expected to go live by July 2011. 	<ul style="list-style-type: none"> Staff dedicated to data collection, analysis and reporting data is an issue at the State level, where one person is allotted. It will be necessary for DMHAS to continue to ensure that the new SEOW database project remains on schedule. At the community level, DMHAS requires all funded prevention providers to develop a logic model as part of their strategic planning process and has incorporated the process in its new Performance Based Prevention System database. Community providers require will require training and TA on the new data system. RACs and other SPE stakeholders need training and TA on effectively using the PBPS.

Table 5. Gap analysis conducted prior to the planning process.	
Current State	Gap Analysis
Ideal Component 10. Established, well functioning process for conducting State and community-level process and outcome evaluation.	
<ul style="list-style-type: none"> CT DMHAS contract management process supports continuous quality improvement, performance management, and achievement of goals and objectives. Process and outcome measures are used in evaluating performance and place strong emphasis on the state’s duty to determine and to meet subrecipient capacity building needs. 	<ul style="list-style-type: none"> While there is a process for conducting State and community-level process and outcome evaluation, it is not as strong as it could be. The Performance Based Prevention System will greatly expand the State’s and communities’ ability to collect, analyze and report data. Training and TA will be required.
Ideal Component 11. Established, well functioning process for ensuring cultural competence at both the State and community-levels.	
<ul style="list-style-type: none"> Through the Multicultural Leadership Institute, DMHAS provides individualized training and TA to its funded subrecipients. DMHAS and all of its funded providers have adopted cultural competence practices that require organizations to have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally. 	<ul style="list-style-type: none"> MLI is a valuable resource, but its methods, breadth and scope of training and TA should be evaluated to be more effectively managed. For the CT SPF, MLI systemically measured cultural competence at the community level, using the Organizational Assessment of Cultural Competence. With a response rate of 79%, DMHAS should use these data to guide capacity building efforts.

Findings of the Gap Analysis

The sections below organize the main findings of the gap analysis by capacity building component identified by the Centers for Substance Abuse Prevention.

Gaps Related to Data Collection, Analysis, and Reporting Systems

Major themes emerging from the gap analysis included:

- The majority of SPE Consortium members⁵ do not know about the Statewide Epidemiological Outcomes Work group (SEOW)
- Limitations exist in the accessibility and meaningful use of the SEOW data repository
- Significant issues exist with respect to interoperability of state agency data systems. Budget constraints limit the opportunities to propose major overhauls
- Minor gaps exist in existing data collection efforts associated with core measures and indicators. For example, some gaps exist in the high school survey process (i.e., activating all high schools). Also, opportunities exist to streamline the process using web-based approaches, and to re-purpose staff time to other meaningful activities
- Specific programmatic gaps exist in data collection. For example: a) not all SPE Partners ask individuals about their status as a Veteran (or spouse of a Veteran). Resources exist to assist Veterans. Without asking the question, however, the referral process will not occur; or b) data collection backlogs exist (e.g., liquor enforcement) that could be solved by entering data (real time) in the field
- Limitations exist in terms of sampling methodology and the cultural sensitivity of instruments for specific populations (e.g., Tribal Nations, Asians)
- Multiple efforts within SPE Consortium member partners exist to consolidate data sets; few of these efforts, however, involve multiple agencies that identify the same performance measures or indicators as a measure of success
- Various initiatives across SPE Consortium members require communities to conduct multiple, discrete needs assessments across different time periods and involving different stakeholders. Opportunities exist to coordinate the methodology and timing of community-level needs assessment processes

⁵ The DMHAS project leaders used the survey information to structure the SPE Consortium meeting agendas and to work one-on-one with SPE Consortium Partners. For example, the DMHAS Director of Prevention and Health Promotion held individual reflection and strategy sessions with SPE Consortium Members from the Tribal Nation. Similar strategy sessions occurred with other SPE Consortium Members, particularly those partners, such as the Department of Corrections and Office of Parole and Probation, that held less experience with and connections to the ATOD Prevention Infrastructure.

Gaps Related to Coordination of Services

Major themes emerging from the gap analysis included:

- The majority of SPE Consortium members, prior to the SPE Project, did not understand well the components of the statewide Prevention Infrastructure. The majority acknowledged that someone in their agency may hold this information in an uneven or fragmented manner
- The majority of the respondents indicated they operate some type of “prevention” program. The leading program areas included ATOD, mental health/suicide; physical health and the target areas covered youth and adults. Figure 3 (page 15) shows prevention programs by agency and type of prevention funded by the Fiscal Year 2011-2013 Governor’s Prevention Budget. Table 3 (page 15) shows a more detailed agency crosswalk by program, program focus, type of prevention, and resource link agencies. Opportunity exists to improve coordination, leverage resources, and improve outcomes
- The SPE Consortium member respondents did not operate with current knowledge about all of the prevention funding administered by their agency/organization unless their responsibilities included oversight of the prevention funds. A number of agencies struggled to understand their role and place in a prevention planning effort or opportunities to partner with other SPE Consortium members
- The SPE Consortium Members with the most “interactions” or cross-partner initiatives included: DMHAS; DCF; OPM; SDE; DPH; DOC; Judicial. Unless the agencies/organizations implement a specific program initiative, the connections tend to be infrequent (e.g., annually, quarterly or less)

Most respondents rated all of the elements (e.g., goal, vision, mission, collaboration) of the strategic plan as very important but felt that the current circumstances (e.g., budget cuts; widespread retirements) represent significant barriers to the SPE Consortium process; budget cuts and staffing issues tend to produce “reactive” responses.

Gaps in Technical Assistance and Training

Major themes emerging from the gap analysis included:

- Few SPE Consortium Members understood the existing reach of the training and technical assistance resources
- Multiple SPE Consortium Members operate internal training academies to support professional development and/or comply with federal and state mandates for continuing education / certification
- Internal training academies offer curricula that can benefit other stakeholders; however, few opportunities exist to conduct “cross training” and/or invite workforce from other partners to participate in the training
- Several significant initiatives target common communities through various lenses such as high risk populations, urban communities, reducing health disparities, promoting health equity, and reducing chronic disease. Opportunities exist to coordinate technical assistance and training on

topics such as coalition building, health prevention and promotion, and ATOD as modifiable risk factors for chronic disease, among others

- Opportunities exist to move ATOD prevention training options on-line and to improve web sites that offer information and data in support of technical assistance and training efforts
- Gaps exist in training offerings to increase cultural competence associated with Tribal Nations and Veterans, among others
- Specific SPE Consortium Member partners who serve high risk populations operate with little training and/or limited evidence-based ATOD prevention curricula (e.g., Department of Corrections youth facilities)

Gaps in Performance and Evaluation Systems

Major themes emerging from the gap analysis included:

- Uneven implementation exists within DMHAS staff and across user communities (e.g., prevention contractors) with the Performance-based Prevention System
- SPE Partners lack a clear process for tying their performance measures into ATOD outcomes at the population level, the community level, and the county / state level

Several of the gaps from the analysis of the data collection, analysis and reporting systems applied to this area as well.

Connecticut's Five Year Strategic Prevention Plan

Each of the SPE Partners conducts its own form of ATOD prevention programming. The Plan identifies areas of common ground and/or statewide priorities in which communities and families will benefit from multiple SPE Partners working together. Through the implementation of the plan, Connecticut will have a coordinated prevention and health promotion system operating at the state, regional and local levels. This system calls for prevention services that are based on identified needs, are well coordinated and use resources with maximum efficiency and effectiveness.

Goal

The Statewide Prevention Enhancement Initiative will enhance Connecticut's statewide alcohol, tobacco and other drug (ATOD) prevention infrastructure to promote health and reduce the likelihood of substance abuse and related consequences.

High Level Objectives

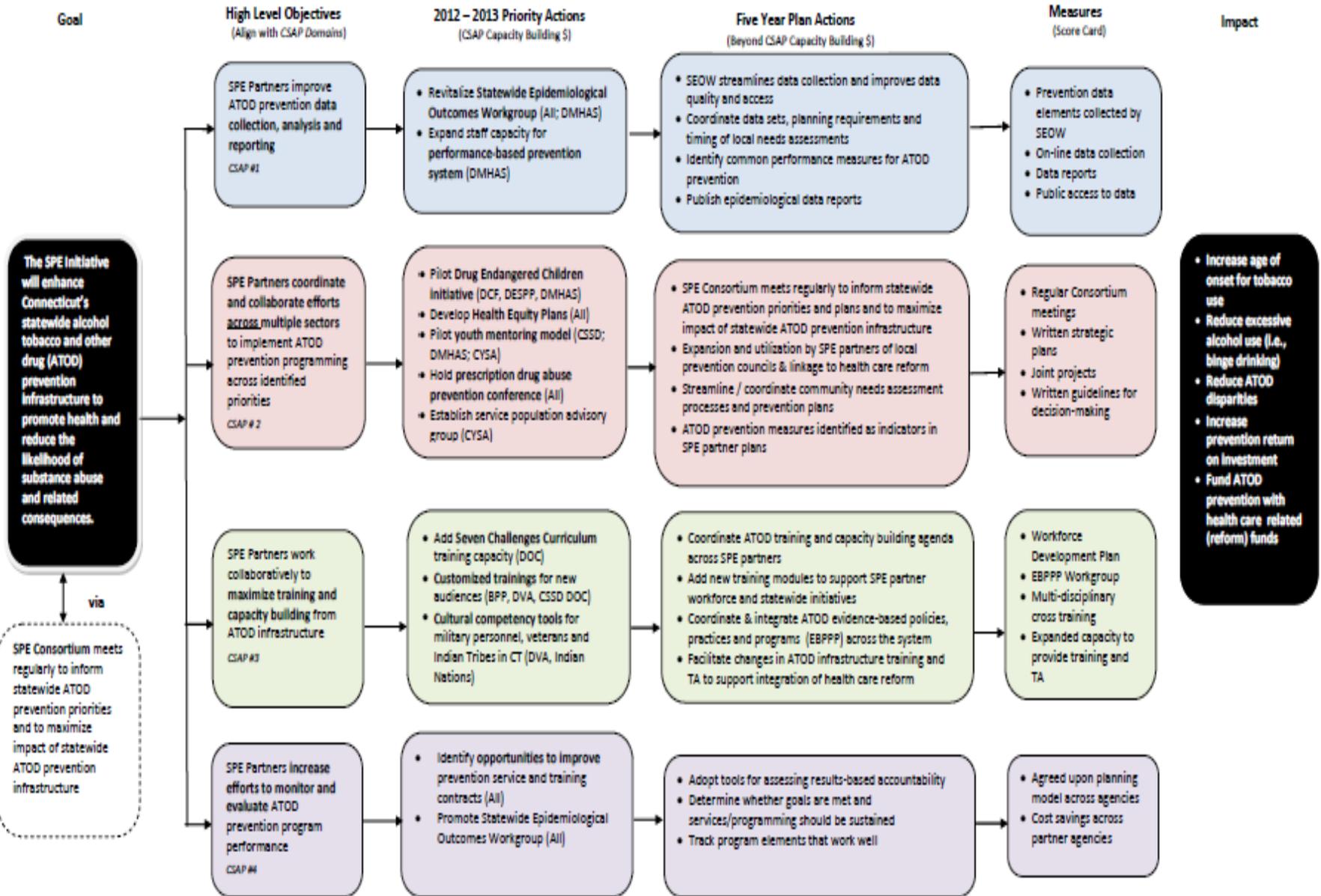
The plan objectives closely align with SAMHSA's Initiative #1: Creating communities where individuals, families, schools, faith-based organizations and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse (including tobacco and alcohol), and suicide. The Plan identifies four high level objectives that will improve the statewide ATOD prevention infrastructure and in turn help families and communities to prevent or delay the use of alcohol, tobacco, and other drugs:

- Improve ATOD prevention data collection, analysis and reporting
- Collaborate efforts across multiple sectors to implement ATOD prevention programming across identified priorities
- Maximize training and capacity building from ATOD infrastructure
- Monitor and evaluate ATOD prevention program performance

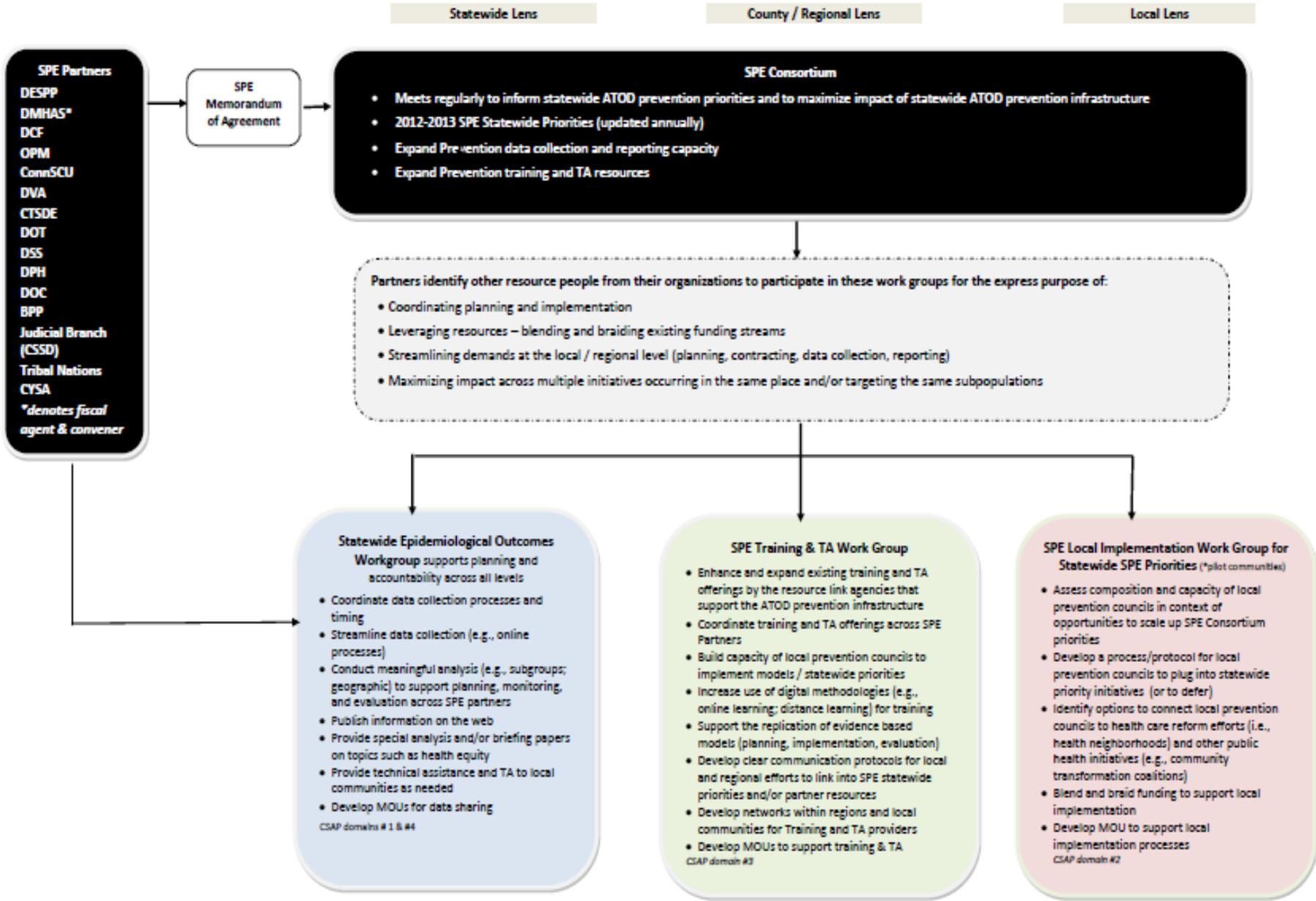
Schematic 1 (page 24) shows the logic model for Connecticut's Statewide Prevention Enhancement project. The model shows high level objectives as well as short- and mid-term actions. Schematic 2 (page 25) shows the proposed organizational structure developed by the Consortium to accomplish the work. By design, these groups support actions at the statewide level, the county/regional level, and at the local (town/city) level – providing coverage to Connecticut's 169 towns.

The plan development process included input from two focus groups with target populations with additional focus groups scheduled to occur in 2013. Individuals from target populations will serve as Consortium members starting in 2013. See page 27 for additional detail on this capacity building enhancement effort; the appendices contain a summary of two consumer advisory group input sessions. The *Plan Components* section provides more detail about the action plan and capacity building projects funded by the Center for Substance Abuse Prevention.

Schematic 1. Logic Model for Connecticut Statewide Prevention Enhancement Project



Schematic 2. SPE Work Group Process to Facilitate Change and Build Cross Partner Networks for the Statewide ATOD Prevention Infrastructure (participants identified by SPE Partners from their organizations / networks)



SPE Capacity Building Projects

Pursuant to federal grant requirements SPE Consortium Members discussed the Prevention Infrastructure and provided input and suggestions about capacity building activities and priorities that could be funded under the initiative. Additionally, the Connecticut DMHAS used an online survey to collect input and ideas about capacity building from its prevention contractors. The DMHAS project leaders compiled the project ideas into a summary matrix and presented the information to the SPE Consortium Members. The Consortium Members discussed potential projects at a SPE Consortium meeting. The SPE Project staff followed up individually with SPE Consortium Members (or designated individuals) through face-to-face meetings or telephone conversations to gain a better operational understanding of proposed projects. The SPE Project staff used the information to develop more concrete project implementation plans and cost estimates, and to understand the benefits of a proposed project.

DMHAS project leadership then developed a short-list of capacity building and enhancement projects using the following criteria:

- The project advanced one or more goals associated with the SAMHSA Strategic Prevention Enhancement initiative
- The project aligned with the values identified by the Strategic Prevention Enhancement Consortium members
- The project addressed a critical gap in the Statewide Prevention Infrastructure
- The project represented an opportunity to engage new partners and more effectively leverage the Statewide Prevention Infrastructure
- The project implementers showed evidence of sustaining the project over time
- The project implementers could complete the project in the available time frame and with available resources
- The project implementers could document short- and long-term outcomes associated with implementation

The DMHAS Project leadership compiled a list of the most viable capacity building and infrastructure enhancement projects, and presented the information to the SPE Consortium Members for additional feedback. The SPE Consortium identified nine, short-term capacity building projects that will create an immediate impact on the ATOD prevention infrastructure. These projects touch all of the SPE partners and cut across all components of the Plan (e.g., data collection, service coordination, training and technical assistance). The subsequent paragraphs outline capacity building projects for each component.

- Enhance data collection and reporting capacity for the SEOW (\$48,280 of CSAP funding). The SEOW has identified specific state-level indicators that it has monitored over time. With these data, biannual state epidemiologic profiles are produced, which describe alcohol, tobacco, marijuana, prescription drug, cocaine and heroin use and consequences, The SEOW also publishes

town and regional data for local priority setting. The SEOW does not interact with the most influential persons in the state for establishing prevention policy or researchers from key local and state agencies who meet formally to review and discuss quantitative and qualitative data related to substance abuse. The SEOW data repository is not user friendly and does not easily offer access to current data describing the burden of substance abuse in Connecticut. Other than providing data, the SEOW does not take an active role in the production of community epidemiologic profiles. The SEOW does not proactively interface with other existing public health reform efforts at the regional and local levels. The DMHAS will hire a 0.5 Full Time Equivalent Research Analyst to: a) assist in the coordination, collection, and analysis of statewide epidemiological data; b) prepare raw data for upload to SEOW Behavioral Health Indicators Portal; and c) prepare written and graphic interpretation of state level behavioral health indicators. The implementation partners include the DMHAS and SPE Consortium partners that participate on the SEOW. The project addresses ideal prevention infrastructure element #2 (epidemiological workgroup); #6 (data-driven funding allocations); #9 (effective state and community level data systems); #10 (support for outcome evaluations) as well as SAMSHA prevention goals 1.1; 1.2; and 1.3

Above and beyond investments in the Consortium infrastructure, one capacity building project targets coordination of services plan totaling \$20,000 and involves primarily one lead partner that represents over 100 affiliates and will increase involvement of target populations.

- Establish a Service Population Advisory Group to improve the quality and utilization of the Prevention Infrastructure (\$22,000). The current statewide prevention infrastructure reaches across numerous partners and collects regularly ATOD related data to understand incidence and prevalence, among others. The Department of Mental Health and Addiction Services, in partnership with resource links, offers tools for local communities to conduct needs assessments and gap analyses, among others. Some of these communities established themselves as Best Practice Coalitions.⁶ A gap exists in the state's capacity to 'scale up' conversations with service populations, particularly to support the development of statewide health promotion and ATOD prevention plans. Currently, over 100 Youth Service Bureaus serve 134 communities across Connecticut – many of them serving as the Local Prevention Coalitions.⁷ YSBs represent partnerships between State and local government. Local towns must match every dollar the State provides. Total funding across all YSBs approaches \$20 million. YSBs provide juvenile justice, mental health, youth development, community outreach, family involvement, teen pregnancy prevention, and child welfare services, and represent an excellent vehicle to reach priority service populations. The Connecticut Youth Services Association will develop a protocol to engage and include ATOD prevention service populations in the local, regional and statewide planning dialogue. The CYSA will roll out the protocol in approximately 15 community settings as well as provide training as necessary to additional communities to use the protocol, record the results, and interpret the information in the context of the community (and statewide) needs assessment processes. The protocols will be integrated as a best practice into the prevention infrastructure tool box. DMHAS will work with the CYSA to establish a regular schedule to engage and include

⁶ These Best Practice Coalitions rely on more robust processes to engage and to include service populations through methods such as focus groups and community conversations that reach these target groups.

⁷ Mandated by Connecticut General Statute section 10-19m, a Youth Service Bureau (YSB) is an agency operated directly by one or more municipalities that is designed for planning, evaluation, coordination, and implementation of a network of resources and opportunities for children, youth, and their families. In addition, YSBs provide services and programs for all youth to develop positively and to function as responsible members of their communities.

the service populations. CYSA will identify opportunities to link this effort to other planning and assessment initiatives. Implementation partners include: Connecticut Youth Services Association; Department of Mental Health and Addictions Services; Department of Children and Families; Court Support Services Division; State Department of Education; The Statewide Epidemiological Outcomes Work Group; Regional Action Councils; Local Prevention Coalitions. The project addresses ideal prevention infrastructure elements #3 (technical assistance responsive to needs); #4 (capacity building & development); #5 (enhancement of evidence-based workgroups); #11 (cultural competency) as well as SAMSHA prevention goals 1.1; 1.2; and 1.3.

Six immediate capacity building projects target technical assistance and training plan improvements totaling \$215,960 and will activate nearly all SPE Consortium members and numerous other community partners.

- Expand capacity of Prevention Service Providers to address prescription drug misuse and abuse (\$20,000). Non-medical use of prescription drugs remains a concern among the youth and other high risk populations. For example, 9.6% of high school students reported (in 2009) taking a prescription drug to “get high”. State of Education Department reports 2.6% of all ATOD school suspensions and expulsions involved over-the-counter and/or prescription medications. State public safety and law enforcement officials indicate a growing concern related to the impact of non-medical use of prescription drugs. Local Prevention Coalitions express similar concerns. Medication use exists as a ‘routine practice’ in society with prescription and over-the-counter medication existing in most homes (i.e., access concern). No mechanism exists in the statewide prevention infrastructure to advance the dialogue across all prevention partners and stakeholders. The funds will pay for the Connecticut Clearinghouse (a Prevention Infrastructure Statewide Service Delivery Agent) to coordinate a statewide conference including the development of an conference agenda that includes a plenary speaker; a data presentation; a set of three to four break-out groups that allow participants to attend at least two different tracks with the potential to earn continuing (medical) education credits and/or learning about how to build local capacity to assess and address this need. The Connecticut Clearinghouse will provide a synopsis of the conference proceedings and post the information on the website to support information dissemination and capacity building. Funds will support honorariums for speakers as well as the development of materials for marketing, registration, and conference packets. The funds will cover expenses associated with facility rental and food/beverage service. DMHAS will work with State partners and the representatives from various medical industries to secure funds for a follow-up conference within the five-year planning period. DMHAS will program additional course content into the Prevention Training Collaborative to support ongoing efforts at the regional and local level. The Statewide Epidemiological Outcomes Work Group will update regularly a data profile on non-medical use of prescription drugs. Implementation partners included: Department of Mental Health and Addiction Services; SPE Consortium members including Department of Public Health, Department of Social Services; Department of Public Safety; Department of Transportation; and Connecticut Clearinghouse. The project addressed ideal prevention infrastructure elements #3 (system responsive to current and emerging needs); #4 (assist communities with ATOD needs assessments and prevention needs); #5 (enhancement of evidence-based workgroups); #9 (state and community level data systems) as well as SAMSHA prevention goals 1.1; 1.2; and 1.3.
- Strengthen Department of Correction’s Youth Prevention Programming and transitions to Communities (\$40,000). The Connecticut Department of Corrections operates facilities that detain

juvenile offenders. ATOD prevention services for this high risk population remain uneven at best while the offenders remain inside the facility. Gaps exist in the continuity of prevention programming at the Department of Corrections and within communities that youth will re-enter upon their release. The proposed project will elevate significantly the level of prevention partnership between the Department of Corrections and other SPE Consortium members. Local prevention providers, particularly Youth Service Bureaus, face increasing pressure to implement cost-effective and evidence-based programming for high risk youth – at a time when the economic downturn affects resources that support police presence, positive youth development activities, and after school programming, among others. The project will equip the Department of Corrections staff at youth facilities to implement the Seven Challenges program.⁸ In the Seven Challenges program, counselors and clients identify the most important issues at the moment and discuss these issues while the counselor seamlessly integrates a set of concepts called the seven challenges⁹ into the conversation. The concepts help youth make decisions and follow through on them. Sessions integrate skills training, problem solving, and even family participation to address drug problems, co-occurring problems, and life skills deficits. The Seven Challenges reader, a book of experiences told from the perspective of adolescents who have been successful in overcoming problems, is used by clients to generate ideas and inspiration related to their own lives. Youth write in a set of nine Seven Challenges Journals, and counselors and youth engage in a written process called cooperative journaling. The program is flexible and can be implemented in an array of settings, including inpatient, outpatient, home-based, juvenile justice, day treatment, and school. The DOC will train a cadre of trainers to train other prevention providers and to support ongoing implementation of the Seven Challenges program in the Department of Corrections and in community settings. Finally, funds will support the purchase additional Seven Challenges products to scale up the programs in community settings that experience a disproportionate level of youth behavioral issues and demonstrate readiness to implement this type of program. The Department of Consumer Protection will integrate the new capacity into its operating budget and use the protocols developed to train any new or additional staff. The Department of Consumer Protection will use data collected from the effort to demonstrate increased efficiency and partner with DMHAS and the Statewide Epidemiological Outcomes Work Group to assess the community impact associated with the new capacity. Implementation partners will include: Department of Corrections with assistance from the Department of Mental Health and Addictions Services and other Statewide Service Delivery Agents (as needed). The project addresses ideal prevention infrastructure elements: #3 (technical assistance responsive to needs); #4 (capacity building & development); #5 (enhancement of evidence-based workgroups); #11 (cultural competency) as well as SAMSHA prevention goals: 1.1; 1.2; and 1.3.

- Expand TA resources for implementing a statewide mentoring approach to youth involved with CSSD (\$48,057). Research shows that juveniles ages 10 to 17 referred to the Superior Court for Juvenile Matters such as delinquency and Family with Service Needs referrals benefit from the involvement in mentoring relationships. Over 150 mentoring programs operate in Connecticut. Program models vary appreciably from one-on-one, to group mentoring, and even e-mentoring. Youth outcomes correlate directly with the quality of mentoring programs. The MENTOR/National

⁸ The Seven Challenges, first implemented in 1990, has been used in approximately 35 States by more than 300 agencies.

⁹ The challenges include (1) talking honestly about themselves and about alcohol and other drugs; (2) looking at what they like about alcohol and other drugs and why they are using them; (3) looking at the impact of drugs and alcohol on their lives; (4) looking at their responsibility and the responsibility of others for their problems; (5) thinking about where they are headed, where they want to go, and what they want to accomplish; (6) making thoughtful decisions about their lives and their use of alcohol and other drugs; and (7) following through on those decisions.

Mentoring Partnership offers materials and tools that provide step-by-step information for building effective program operations, management and mentoring strategies. The process as currently formulated does not leverage the Prevention Infrastructure. Youth mentoring continues to emerge as an effective approach to increase ATOD resistance in high risk youth (ages 10-17) such as those involved in the Juvenile Justice System. The Governor's Prevention Partnership recently launched an effort to increase mentoring capacity for high risk youth. Specifically, the Governor's Prevention Partnership will facilitate a statewide mentoring approach on behalf of the Court Support Services Division. Common ground exists between the statewide mentoring project and the statewide prevention infrastructure. An opportunity exists to leverage funding and to scale up the program across additional communities and/or SPE Consortium Partners. Funds will support the Governor's Prevention Partnership to expand the capacity of the statewide mentoring program by linking it to Regional Action Councils and Local Prevention Coalition partners. The protocols will be integrated as a best practice into the prevention infrastructure tool box. DMHAS will work with the Governor's Prevention Partnership and CSSD to secure additional funding to expand the program to additional sites. The Governor's Prevention Partnership will conduct an evaluation that will show the impact of the mentoring initiative. Implementation partners include: The Governor's Prevention Partnership; Court Support Services Division; Connecticut Youth Services Association; Department of Mental Health and Addictions Services; Department of Children and Families; State Department of Education; Regional Action Councils; Local Prevention Coalitions. The project addresses ideal prevention infrastructure elements: #3 (technical assistance responsive to needs); #4 (capacity building & development); #5 (enhancement of evidence-based workgroups); #11 (cultural competency) as well as SAMSHA prevention goals: 1.1; 1.2; and 1.3.

- Create more inclusive, accessible, culturally competent and sustainable organizations and programming for intended service communities via training and technical assistance to state agencies on health equity plans (HEPs) (\$22,000). Health care reform and health equity continue to reshape the health promotion and prevention landscape. Population-based prevention and disease analysis continue to inform policy and service delivery (i.e., target populations, evidence-based models, geographic areas). Several State agencies (e.g., DPH, DMHAS, OPM) use the health equity construct to guide the strategies and service delivery system. Many of these agencies produce health disparities data reports and articulate the role of ATOD. The Office of Policy and Management will continue to encourage agencies to address health equity in their strategic planning and service delivery. A vehicle exists within the State ATOD prevention infrastructure to deliver professional development and workshops and to distribute information about health equity. No health equity course content exists to systematically build capacity (i.e., knowledge, skills, abilities) in the state agency workforce, or the workforce of service providers and community-based organizations. The Multicultural Leadership Institute will integrate a health equity component into the existing cultural competency training for service providers (i.e., state contractors, prevention contractors, community organizations) and community leaders. The course once developed will be offered regularly through its inclusion in the Prevention Training Course Catalog (see www.ctclearinghouse.org). The Department of Mental Health and Addictions supports annual prevention training, and will work with the other agencies (e.g., OPM, DPH) to identify additional resources and support more trainings as needed. Implementation partners will include: Multicultural Leadership Institute; Department of Mental Health and Addiction Services; Department of Public Health; Department of Education; Department of Veteran Affairs; Tribal Nations; Department of Children and Families; The Statewide Epidemiological Outcomes Work Group; Regional Action Councils; Local Prevention Coalitions. The project addresses ideal

prevention infrastructure elements: #3 (technical assistance responsive to needs); #4 (capacity building & development); #5 (enhancement of evidence-based workgroups); #11 (cultural competency) as well as SAMSHA prevention goals: 1.1; 1.2; and 1.3.

- Expand culturally competent infrastructure to address issues related to Military Personnel and Veterans and Indian Tribes in Connecticut (\$8,800). A significant Veteran population (approximately 230,000) lives in Connecticut. Resources exist to serve Veterans. However, few services and/or organizations ask questions about status as a Veteran or the spouse of a Veteran. Addressing the issue as a matter of cultural competence creates immediate impact to help Veterans access services (as compared to changing all data collection systems and protocols across State agencies and contractors to include a question (and database fields) on Veteran status). Similarly, Connecticut remains home to two federally recognized Tribal Nations and 5 State-recognized Tribal Nations. Tribal members rely on a patchwork of services offered by the Bureau of Indian Health Services, Tribal Nations, as well as state and local resources. A workshop by the Multicultural Institute targets prevention providers who desire to build group capacity through building relationships across lines of difference. This experiential workshop is intended for building basic awareness and skills required for working with an array of human diversity. Workshop areas cover inclusionary practices vs. exclusionary practices, cross cultural communication, understanding and managing our privilege, modeling championing behaviors, and respecting generational differences. These skill sets help to create meaningful dialog towards building effective and lasting community involvement, and solid relationships that will ultimately influence one in the workplace, but also help one to influence current and future prevention program planning and implementation. However, the workshop does not specifically address issues of cultural competence with respect to Tribal Nations and Military Personnel and Veterans. The Multicultural Leadership Institute (a Statewide Service Delivery Agent) will develop a specific training / workshop curriculum that provides core knowledge to build cultural competencies with respect to Tribal Nations and Military Personnel and Veterans. The training will be offered regularly through as a core part of the menu of prevention training courses (see www.ctclearinhouse.org). Implementation partners will include: Multicultural Leadership Institute; Department of Veterans Affairs; Mohegan Tribe; Mashantucket Pequot Tribal Nation; Department of Mental Health and Addiction Services; other SPE Consortium Partners. The project addresses ideal prevention infrastructure elements: #3 (technical assistance responsive to needs); #4 (capacity building & development); #5 (enhancement of evidence-based workgroups); #11 (cultural competency) as well as SAMSHA prevention goals: 1.1; 1.2; and 1.3.
- Scale up Prevention trainings offered by the Training Collaborative to target new audiences (\$76,603). Local prevention councils and Regional Action Councils as well as SPE Consortium partners report gaps on various issues that relate to building local coalitions, understanding the impact of health care reform on local and regional prevention efforts, and promoting diversity, among others. The DMHAS offers a menu of prevention training courses (see www.ctclearinhouse.org) scheduled in advance. Demand exists for additional courses and no resources exist in the current budget to support these requests. Specific gaps exist in the knowledge of the Prevention Infrastructure by SPE Consortium Member program personnel. For example, nearly 200 staff members at the Department of Pardons and Paroles interact regularly with high risk populations and their family members. These staff members hold an uneven understanding of the statewide prevention infrastructure and how these resources – particularly at the local level, can benefit parolees, probationers and/or their family members. The staff can play a vital role in providing resource information to clients and their family members. Similarly,

other efforts exist between and among SPE Consortium Member Partners in the areas of coalition building for health promotion and (disease) prevention. Opportunities exist to coordinate training and coalition building activities across SPE Partners by introducing new training curriculum and/or workshops as well as expanding the offerings of existing, relevant trainings and workshops. The Connecticut Clearinghouse (a State Service Delivery Agent) will develop specific training and information workshops to address existing and emerging needs. 200 plus probation and parole staff members will be trained on the prevention infrastructure and how it can benefit their clients and families, and provide collateral materials customized for local areas that can be given to clients and their family members to facilitate issue identification and connection to local resources. Similarly the Connecticut Clearinghouse will work with the Department of Public Health to support the effective roll out of a “community transformation” process that involves building local coalitions to promote health (including ATOD prevention). Implementation partners will include: The Connecticut Clearinghouse; the Department of Mental Health and Addictions; the Department of Pardons and Parole; the Department of Veterans Affairs; the Department of Public Health; the Department of Education. The project addresses ideal prevention infrastructure elements: #3 (technical assistance responsive to needs); #4 (capacity building & development); #5 (enhancement of evidence-based workgroups); #11 (cultural competency) as well as SAMSHA prevention goals: 1.1; 1.2; 1.3.

One immediate capacity building project targets performance and evaluation plan improvements totaling \$46,280, and involves primarily DMHAS as well as all of the prevention contractors and intermediaries.

- Enhance DMHAS’ Performance-based Prevention System (PBPS) to better meet agency, state and federal requirements. (\$110,760; \$46,280 for staff + \$64,480 for increased technical support from software vendor). The DMHAS recently upgraded its prevention service data system (Performance Based Prevention System) to track outcomes (as well as outputs). However, the pace of the transition process remains slow and does not reach effectively all relevant stakeholders, and the information protocols related to meaningful use of the data remain underdeveloped. DMHAS will hire a 0.5FTE Research Analyst to: a) Oversee change management processes and procedures for the application; b) Work individually and collectively with staff to increase their in depth knowledge and use of the PBPS; c) Identify additional projects or enhancements that should be completed for the PBPS application; d) Share methods, tools, ideas, and potentially resources to assist with related work issues across the agencies’ user communities; and e) Recommend solutions for, and address major issues that have escalated - from the user community. Additionally, DMHAS will increase the amount of external (i.e., software vendor) technical support to maintain and support the PBPS. Implementation partners will include: the Department of Mental Health & Addiction Services and prevention contractors. The project will address ideal prevention infrastructure elements: #10 (process and outcome evaluations); #2 (epidemiological workgroup); #4 (assist communities with ATOD needs assessments and prevention needs); #5 (enhancement of evidence-based workgroups); #6 (data-driven funding allocations); #9 (state and community level data systems) as well as SAMSHA prevention goals: 1.1; 1.2; and 1.3.

The DMHAS SPE Project Director (Carol Meredith) and Project Manager (Dawn Grodzki) will oversee the administration and monitoring of capacity building and infrastructure enhancement projects as well as the ongoing plan implementation. In many instances, the capacity building and infrastructure enhancement projects involve partners (or contractors) already working with or under contract by

DMHAS. These existing relationships will expedite the contracting process and facilitate rapid implementation. An MOU will facilitate cross agency interactions.

Five Year Plan Components

The Consortium members extended the discussion and dialogue to develop and refine the objectives and activities of the Five Year Strategic Plan. Input from the target population focus groups informed the development of plan activities across all plan objectives. For example, target population representatives requested easier access to ATOD information and resources (objective 1 & 3) as well as a role on the Consortium (objective 2). The appendices contain a summary from two consumer advisory group input session. Each of the Plan’s four high level objectives aligns with the Center for Substance Abuse Prevention’s strategic enhancement framework.

Data Collection, Analysis, and Reporting Systems

Objective: Improve ATOD data collection, analysis and reporting

Plan to achieve: A *Statewide Epidemiological Outcomes Work Group* (SEOW) will support planning and accountability across the ATOD prevention infrastructure by organizing cross partner data and planning experts to coordinate data collection processes and timing, identify opportunities to streamline (e.g., online methods) data collection and data sharing, and provide technical assistance and training to local communities as needed. The table shows the action plan to improve ATOD prevention data collection, analysis and reporting in Connecticut.

Objective 1. Improve ATOD prevention data collection, analysis and reporting			
Activity	Milestones	Responsibility	Timeline
1.1 Update core ATOD indicators relevant to SPE plan	<ul style="list-style-type: none"> Updated agreements and protocols to access relevant data Published core ATOD indicators relevant to SPE Plan 	SPE Consortium / DMHAS (SEOW)	2012 Annually 2012 - 2016
1.2 SEOW meets quarterly	<ul style="list-style-type: none"> Increased vitality and value of Statewide epidemiology network Increased executive support for and coordination of planning, analysis and evaluation efforts 	SPE Consortium / UCONN Health Center (DMHAS staff as lead support)	2012 –16
1.3 Increase capacity of SEOW	<ul style="list-style-type: none"> Established protocols for special analyses (e.g., health equities, geographic subareas) Trained staff on web-based approaches to collect and present information 	DMHAS (external consultant)	Targeted capacity building 2012 – 2013 Ongoing 2014 – 2016
1.4 Increase statewide web-based data collection processes	<ul style="list-style-type: none"> Additional schools administering online surveys with ATOD-related questions ATOD-related questions added into other relevant statewide survey and data collection efforts 	DMHAS (DPH, SDE, DSS, DCF)	December 2014 Other web-based efforts 2015-2016

Objective 1. Improve ATOD prevention data collection, analysis and reporting			
Activity	Milestones	Responsibility	Timeline
1.5 Improve data supports for local assessment and planning	<ul style="list-style-type: none"> Local needs assessment processes (timing and scope of data elements) streamlined local needs assessment processes Support health collection of data elements relevant to health care reform and health equity 	Local Implementation Work Group (DMHAS, DPH, DCF, DSS)	2012- 2014 2014 – 2016 Ongoing

Coordination of Services

Objective: Coordinate and collaborate ATOD efforts across multiple sectors

Plan to achieve: The *SPE Consortium* will continue to meet regularly and share information about ATOD prevention efforts and funding levels across partners. The Consortium discussions will inform statewide ATOD prevention priorities and capacity building actions including the implementation of three SPE Work Groups. The success of the Consortium will be determined by the depth and breadth of cross partner networks, leveraging of resources, streamlining demands associated with local and regional planning processes, and extent to which the State achieves progress on target indicators. A Memorandum of Understanding documents the Consortium Partners commitment to the process.

The SPE Consortium and planning process represents a significant investment of SPE grant funds and a vehicle to address service coordination, coordination of technical assistance and training, and longer term budget and policy-related outcomes. The SPE Consortium will target in its 5-Year plan cross cutting efforts that involve ATOD prevention such as the development of agency level Health Equity Plans, and health promotion and prevention efforts involving coalition-building or health care reform, among others. The SPE addresses many of these (short-term) via training and technical assistance investments. The table below outlines proposed activities to coordinate efforts across multiple sectors to implement ATOD prevention programming across identified statewide priorities. These efforts will involve increased participation from target populations.

Objective 2. Coordinate and collaborate efforts across multiple sectors to implement ATOD prevention programming across identified statewide priorities			
Activity	Milestones	Responsibility	Timeline
2.1 SPE Consortium meets quarterly	<ul style="list-style-type: none"> Review implementation progress Review ATOD indicators Review SPE score card Identify and recommend statewide priorities Develop annual report 	SPE Consortium (DMHAS staff support)	2012-2016

Objective 2. Coordinate and collaborate efforts across multiple sectors to implement ATOD prevention programming across identified statewide priorities			
Activity	Milestones	Responsibility	Timeline
2.2 SPE Consortium informs ATOD strategies and policies	<ul style="list-style-type: none"> Issues updates to Alcohol Drug Policy Council Publishes briefing memos and other publications 	SPE Consortium (DMHAS staff support)	2012-2016
2.3 Increase visibility of statewide ATOD prevention efforts	<ul style="list-style-type: none"> Host national prevention conference Present at Alcohol and Drug Policy Council Endorse model programs and partnerships 	SPE Consortium (DMHAS staff / national prevention network staff)	2013 Ongoing
2.4 Facilitate networking of professionals, community members and resource partners	<ul style="list-style-type: none"> Facilitate SPE work groups Adjust training and technical assistance protocols and opportunities (see objective 3) 	SEOW; Training and Technical Assistance Work Group; Local Implementation Work Group	2013 – 2016 2012 – 2016 2013 - 2016
2.5 Support and replicate best practices as well as model and innovative programs	<ul style="list-style-type: none"> See 2013 capacity building project schedule for detail Support local implementation (see objective 3) Integrate health care reform efforts into local models Increase funding at local level Convene evidence-based work group as warranted to support SPE decision-making 	SPE Consortium	2012 - 2016
2.6 Involve target populations in the planning process	<ul style="list-style-type: none"> Conduct focus groups Adjust planning processes and SPE Consortium process Conduct community readiness survey and share information 	CYSA; DMHAS; statewide service delivery agents; RACs; LPCs	2012 - 2013 2013 - 2016 Annually

Technical Assistance and Training

Objective: Maximize ATOD training and capacity building

Plan to achieve: A **Training and Technical Assistance Work Group** will enhance and expand existing training and technical assistance offerings available through the SPE partners and the statewide service delivery agents (see page #) for the express purpose of increasing professional skills of the ATOD prevention workforce, building capacity of local prevention councils to implement effective prevention models, and develop effective prevention networks within and across regions and/or counties.

A **Local Implementation Work Group for Statewide SPE Priorities** will convene to support the successful implementation and/or expansion of effective prevention models across Connecticut. This work involves assembling cross partner teams that can develop new and/or adjust existing protocols and models for roll out at the local level. This effort recognizes that successful efforts require a simultaneous top-down and bottom-up approach with ample room to make mid-course adjustments in response to changing conditions at the local level. The table below outlines the action plan to improve the technical assistance and training infrastructure.

Objective 3. SPE partners work collaboratively to maximize training and capacity building from ATOD infrastructure			
Activity	Milestones	Responsibility	Timeline
3.1 SPE partners implement capacity building enhancement projects	<ul style="list-style-type: none"> • See schedule of specific outcomes for capacity building projects (2013) • Sustain and scale projects 	SPE Partners (DMHAS)	2012 – 2013 (plus sustainability)
3.2 Technical assistance and training work group meets quarterly	<ul style="list-style-type: none"> • Establish work group • Prioritize opportunities to improve and expand training and TA • Recommend actions to improve training and TA delivery at regional and local level (as well as for statewide workforce) • Parlay effort into evidence-based work group 	SPE partners (DMHAS)	2013 – 2016 2013 – 2016 2013 - 2016
3.3 Training and TA providers expand options and coordinate delivery	<ul style="list-style-type: none"> • Assemble training partners • Adjust training modules, timing and delivery (e.g., online) • Coordinate training and TA at local level and regional levels • Improve web-based capacity to deliver relevant information 	SPE partners; training and technical assistance work group; statewide service delivery agents; RACs; LPCs	2012 – 2013 2013 – 2016 2013 – 2016 2013-2016
3.4 SPE Consortium supports scale up of evidence-based models and	<ul style="list-style-type: none"> • Establish local implementation work group • Local prevention councils field test 	SPE Partners; statewide service delivery agents; RACs; LPCs	2013 – 2016 2012 - 2016

Objective 3. SPE partners work collaboratively to maximize training and capacity building from ATOD infrastructure			
Activity	Milestones	Responsibility	Timeline
innovative programs	<ul style="list-style-type: none"> Support regional and statewide delivery agents Seed additional communities to implement approaches 		2012 – 2016 2014 - 2016
3.5 SPE partners increase social marketing and health promotion messages	<ul style="list-style-type: none"> Coordinate prevention messages across SPE partners Emphasize health promotion and social marketing in local action plans Align with health care reform emphasis on health promotion 	Local implementation work group; DMHAS; statewide service delivery agents; RACs; LPCs	TBD

Performance and Evaluation Systems

Objective: Increase efforts to monitor and evaluate ATOD prevention program performance

Plan to achieve: A *Statewide Epidemiological Outcomes Work Group* (SEOW) will support planning and accountability across the ATOD prevention infrastructure by organizing cross partner data and planning experts to coordinate data collection processes and timing, identify opportunities to streamline (e.g., online methods) data collection and data sharing, and provide technical assistance and training to local communities as needed. The table below shows activities to increase monitoring and evaluation capacity.

Objective 4. SPE partners increase efforts to monitor and evaluate ATOD prevention program performance			
Activity	Milestones	Responsibility	Timeline
4.1 DMHAS staff increase capacity to implement performance based prevention system (PBPS)	<ul style="list-style-type: none"> Hire consultant Add staff Implement staff training Adjust data systems Generate regular reports Generate special reports (e.g., population based analyses; geography based analysis) 	DMHAS; external consultant	2012-2013 2012-2013 2013-2016 As needed 2013 - 2016
4.2 SPE partners (and their contractors) adopt common performance measure	<ul style="list-style-type: none"> Core performance measures identified Performance measures included as standard language in contracts Ongoing data collection and oversight 	DMHAS; SPE partners	2012-2013 2012-2014 Ongoing

Objective 4. SPE partners increase efforts to monitor and evaluate ATOD prevention program performance			
Activity	Milestones	Responsibility	Timeline
4.3 Build SPE partner and provider capacity to monitor and evaluate programs	<ul style="list-style-type: none"> Encourage use of PBPS Add specific tools Train staff on existing and new tools Provide training and TA supports across all levels of ATOD infrastructure Increase access to tools (e.g., online) 	DMHAS; statewide service delivery agents; RACs; LPCs	2013-2016 2013-2016 2013-2016
4.4 Assess implementation process	<ul style="list-style-type: none"> SPE reviews PBPS reports Collect data from SPE partners on implementation Update and share score card with SPE partners SPE reflects on results and recommends mid-course adjustments 	SPE partners; evidence based work group (subset of SPE Consortium)	2012-2016

Outcomes and Impact

The implementation of the Plan will result in Connecticut achieving benchmark sets on ATOD prevention indicators (see Table 2, page 4) such as:

- Increasing the age of onset for tobacco use
- Reducing excessive alcohol use (i.e., binge drinking)
- Reducing ATOD health disparities

The plan will also increase the State's prevention return on investment and link ATOD prevention strategies to health care reform and other emerging funding opportunities. The plan sets forth performance measures to track progress along the way (see section on Monitoring Performance).

Project Milestones

Table 6 below identifies major project milestones during the course of plan implementation.

Table 6. Connecticut State Prevention Enhancement Activity Timeline for 2012					
Implementation Milestones	2012	2013	2014	2015	2016
Quarterly SPE Consortium Meetings	●	●	●	●	●
Refinement of the Five Year Strategic Prevention Plan	●	●	●	●	●
Completion of targeted capacity building projects (CSAP \$)	●	●			
Technical Assistance and Training Work Group Meetings		●	●	●	●
A Prevention Workforce Development Plan		●			
Statewide/national ATOD and related prevention conference			●		
Coordinated ATOD and related prevention workshops delivered annually across the state		●	●	●	●
An Interactive Behavioral Health Indicator Portal informed by the SEOW		●			
A well represented Statewide Epidemiological Outcomes Work Group		●			
Local Implementation Work Group Meetings		●	●	●	●
Annual consumer surveys to inform prevention plans and processes		●	●	●	●
Publish enhanced data reports that tracks the movement of behavioral health indicators		●	●	●	●
An interagency plan for evaluating data and assessing prevention outcomes	●				
Increase data sharing capacity (i.e., web based)			●	●	●
Established Evidence Based Work Group (grows from TA/Training)			●	●	●
Catalog of Evidence-Based Prevention Policies, programs and strategies used in Connecticut			●		
A formula for allocating prevention resources to communities based on identified needs			●		
Increase data collection capacity (i.e., online, coordinated)			●		
Progress Reports to Alcohol & Drug Policy Council		●	●	●	●

Monitoring Performance

Connecticut DMHAS will use a four tiered approach to monitoring performance of ATOD prevention initiatives.

- Publish **ATOD indicators** identified in Table 2 (page 4) and make these indicators available to prevention partners. These indicators result from valid and reliable methodologies that align with federal and state surveillance and reporting mandates.
- Report **Statewide Prevention Enhancement Initiative Progress Measures** as required by the Center for Substance Abuse Prevention.
- Update an annual **Statewide Prevention Enhancement Initiative Score Card** that tracks annual progress in developing the statewide ATOD prevention infrastructure. The score card reflects four capacity building areas relevant to the statewide ATOD prevention infrastructure. Table 7 (pages 41-42) shows an example of the score card. See appendix for full score card. Connecticut DMHAS will collect data via a SPE Consortium partner survey and integrate it with information from other existing processes (e.g., community readiness survey).
- Use a **Performance Based Prevention System** (PBPS) to captures how prevention providers implement evidence based strategies to address identified ATOD risk factors. The DMHAS reports PBPS data to the federal Substance Abuse and Mental Health Services Administration.

The Connecticut DMHAS will lead the performance monitoring effort with assistance from the SPE Consortium partners. The information provided by the score card will inform ongoing training and technical assistance priorities as well as opportunities to expand prevention partnerships as external conditions continue to change (e.g., funding climate, regional and local infrastructure).

Color Rating Scale to Track Progress			
Low	Medium	High	High

Table 7. SPE Consortium Score Card

CSAP Domain 1 - Data Collection, Analysis & Reporting	2012	2013	2014	2015	2016
1. Collect ATOD prevention-related epidemiological data elements in Partner databases					
2. Coordinate regional / local ATOD data collection and needs assessment requirements with ATOD infrastructure					
3. Implement streamlined or on-line data collection					
4. Routinely share ATOD data sets and/or analyses with local/regional stakeholders					
5. Involve partner's data experts in ATOD data analysis and interpretation					
6. Collect information on existing capacity of ATOD Prevention systems					
7. Allow public access to state epidemiological data systems and ATOD-related data sets					
8. <i>Others</i>	TBD				
CSAP Domain 2 - Service Coordination	2012	2013	2014	2015	2016
1. SPE Consortium meets regularly (& well attended)					
2. Facilitate meaningful interactions among and between SPE partners					
3. Establish and update (annually) a plan to improve the ATOD prevention infrastructure					
4. Establish and modify formal agreements with community partners to improve the ATOD prevention infrastructure					
5. Update MOAs/ MOUs to reflect formal interagency agreements to improve the ATOD prevention infrastructure					
6. Set statewide priorities					
7. Jointly fund / sponsor ATOD prevention initiatives/activities					
8. Increase funding opportunities for ATOD initiatives					
9. Use local ATOD prevention council infrastructure to scale up evidence-based models					
10. Develop written guidelines for and standardize decision-making (extracting data, process, outcome & fidelity monitoring, selecting evidence-based programs)					
11. Save or contain costs by blending and braiding funding streams					
12. Demonstrate increased sustainability of ATOD Prevention programs (e.g., results, cost savings, policy shifts)					
13. <i>Others</i>	TBD				

Color Rating Scale to Track Progress			
Low	Medium	High	High

Table 7. SPE Consortium Score Card

CSAP Domain 3 - Training & Technical Assistance	2012	2013	2014	2015	2016
1. Coordinated process for assessing ATOD prevention (training) needs of workforce					
2. Establish, update and implement an ATOD prevention Workforce Development Plan					
3. Provide ATOD TA for other partners					
4. Receive ATOD TA from other partners					
5. Provide ATOD TA within organization (and contractors)					
6. Use ATOD prevention planning tools or incorporate relevant components into existing tools					
7. Participate in and/or sponsor ATOD prevention training and/or cross training for staff members					
8. <i>Add others</i>	TBD				
CSAP Domain 4 - Performance & Evaluation	2012	2013	2014	2015	2016
1. Meet or exceed minimum level of funds for evidence-based ATOD prevention programs					
2. Implement a planning model that links substance abuse problems, risk/protective factors, evidence-based programs and outcomes					
3. Monitor / evaluate ATOD changes at the population and subpopulation level					
4. Connect ATOD prevention fiscal data to program data to determine return on investment / unit costs					
5. Use data to make ATOD prevention policy and program decisions					
6. Use formal electronic prevention data system					
7. Organize and participate in structured dialogue to discuss evaluation issues (results, challenges) and improve programs					
8. Establish standard ATOD prevention data elements for evaluation and monitoring					
9. <i>Add others / See also CSAP domain 1</i>	TBD				

Sustainability

SPE Consortium partners committed via a memorandum of understanding (MOU) to support the five year plan implementation process in several ways:

- Identify a specific liaison to serve as the primary contact during implementation and operation of the plan
- Participate in the SPE Consortium that will advise the initiative, implement and update the five year plan to strengthen the state and community ATOD prevention infrastructure
- Provide feedback and guidance to staff partners with the intent of responding to needs of Connecticut's citizens as well as meet relevant state and federal requirements
- Participate actively and facilitate access to information and relevant resources in support of work groups including but not limited to the statewide epidemiological outcomes work group; a training and technical assistance work group; and a local implementation work group
- Complete an annual survey of alcohol and tobacco and other drug efforts across participating agencies and organizations to assess coordination, management and sustainability of substance abuse prevention and health promotion efforts in accordance with the goals and objectives outlined in the five year plan

The short-term capacity building projects and the proposed action plan identify areas that tie in directly with larger federal and state public health (i.e., health promotion) and health care initiatives. The existing ATOD prevention infrastructure can and should play an important role in advancing and coordinating community initiatives that address prevention, health promotion, and health equity. The SPE Consortium serves as the conduit to spark connections, innovations, and capacity building across statewide, regional and local partners.

Appendices

- A-1 Memorandum of Understanding
- A-2 Statewide map of 169 towns and Regional Action Council service areas
- A-3 Consortium member survey instrument
- A-4 Summary of service population advisory group input
- A-5 Statewide Epidemiological Outcomes Work Group behavioral health indicators inventory

APPENDIX A-1
CONNECTICUT'S STRATEGIC PREVENTION FRAMEWORK STATE
PREVENTION ENHANCEMENT (SPE) INITIATIVE
FOR SUBSTANCE ABUSE PREVENTION INFRASTRUCTURE
MEMORANDUM OF UNDERSTANDING

PART 1
STANDARD TERMS AND CONDITIONS

1.1 TERM OF AGREEMENT

The agreement will begin on January 2, 2013 and shall continue until terminated by the parties. The agreement shall be reviewed at least annually to determine if an amendment is necessary, but may be reviewed more frequently if requested by the parties.

1.2 CONTRACT REVISIONS or AMENDMENTS

This agreement may be amended any time by written agreement.

1.3 LIAISONS

All parties agree to have specifically named liaisons at all times. These representatives of the parties will be the first contacts regarding any questions and problems that arise during implementation and operation of the agreement. Any changes to the liaison may be communicated to the parties via email and shall not require an amendment to the agreement. Initially, the liaisons associated with State Departments, Divisions and Partners for the Consortium included:

Carol Meredith, Mental Health and Addiction Services

Nancy DiMauro, Children and Families

John Suchy, Consumer Protection

Linda Kendrick, Corrections

Scott Newgass, Education

Captain Dale Hourigan, Emergency Services & Public Protection

Daisy Ortiz, Judicial Branch – Court Support Services Division

David Krause, Office of Policy and Management

David Rentler, Pardons & Parole

Renee Coleman-Mitchell, Public Health

Sylvia Gafford-Alexander, Social Services

Joseph Cristalli, Transportation

Felice Guberman, Veteran Affairs

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1.4 REPORTING

The Departments, Divisions and Partners (i.e., SPE Consortium) entering into this agreement shall develop a joint annual report to be presented to the Connecticut Alcohol & Drug Policy Council (ADPC), with the first report being due on June 30, 2013. This annual report will provide information about the implementation of the Five Year Plan. The Department of Mental Health and Addiction Services will compile information from each respective agency liaison identified in this agreement and draft the report. The report will be presented to the Department of Mental Health and Addiction Services once reviewed and approved by all parties.

1.5 NON-FINANCIAL AGREEMENT

This is a non-financial agreement. Any costs incurred by any party during the performance of the tasks identified herein shall be the responsibility of the individual agency incurring the expense.

PART 2
SCOPE OF WORK

2.1 PURPOSE

WHEREAS, the Executive and Judicial Branches are implementing a Statewide Substance Abuse Prevention Infrastructure Plan and policy recommendations as members of the Connecticut Alcohol and Drug Policy Council (ADPC), established under Connecticut General Statutes 17a-667; and

WHEREAS, top priority areas of concern of the ADPC Statewide Substance Abuse Plan and the Connecticut Substance Abuse Prevention and Treatment Block Grant Plan are the promotion of emotional health and prevention of substance abuse and its related consequences; and

WHEREAS, the Federal Department of Health and Human Services Substance Abuse Mental Health Services Administration (SAMHSA) Strategic Prevention Framework State Prevention Enhancement (SPE) Grant is consistent with and promotes the policy recommendations of these Connecticut plans; and

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WHEREAS, the SPE provides funding to:

- Enhance the statewide substance abuse prevention infrastructure to promote emotional health and reduce the likelihood of mental illness, substance abuse and their related consequences;
- Integrate Connecticut's substance abuse prevention and mental health promotion activities into a unified vision;
- Develop strategic plans to address gaps;
- Strengthen capacity and infrastructure at the state and community-levels in support of prevention; and
- Leverage, redirect and realign statewide funding streams for prevention; and

WHEREAS, the SPE provides an effective prevention process, a direction, and a common set of goals, expectations, and accountabilities to be adopted and integrated at all levels; and

WHEREAS, the officials below will cooperate via a statewide SPE Policy Consortium in the planning and development of the statewide SPE Initiative, consistent with SAMHSA's Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness and the sub-goals:

- 1.1 With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness;
- 1.2 Prevent or reduce consequences of underage drinking and adult problem drinking;
- 1.3 Prevent suicides and attempted suicides among populations at high risk, especially military families, LGBTQ youth, or American Indians and Alaska Natives; and
- 1.4 Reduce prescription drug misuse and abuse; and

WHEREAS, the SPE is being implemented through partnerships and collaborative efforts between State and local partners to ensure that plans and strategies will be tailored to State and local needs;

NOW, THEREFORE, we, the Commissioners and Chief Executives of SPE Consortium members agree to maintain an active commitment and level of participation in efforts that further the objectives of the SPE grant, both within our respective agencies and as interagency partners. It is in the best interest of our agencies and those we serve to offer coordinated services, to ensure continuity of service, to heighten the impact and avoid duplication of services and provide the most comprehensive services.

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CONNECTICUT'S STRATEGIC PREVENTION FRAMEWORK STATE
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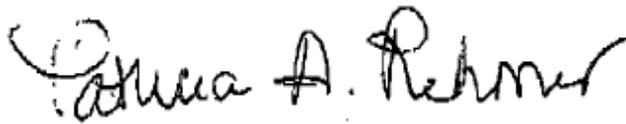
Specifically, we agree to:

- Participate in a SPE Policy Consortium that will act as advisory to the initiative and develop a comprehensive 5-year Strategic Plan to support communities to implement a sound state and community prevention infrastructure.
- Provide feedback and guidance to staff and partners, ensuring that the initiative addresses the needs of Connecticut's citizens and satisfies the requirements of the federal grant.
- Participate actively and facilitate access to information and linkage to relevant resources in support of:
 - A statewide epidemiological outcomes work group (SEOW) which coordinates data collection processes and timing; identify opportunities to streamline data collection and data sharing; provides technical assistance and training to local communities as needed; and develops state and community epidemiological profiles that incorporate all substance abuse related components and indicators, including evidence of associated problems (e.g., school dropouts, delinquency, depression, suicide, and violence).
 - A training and technical assistance work group charged with: i) enhancing and expanding existing training and technical assistance programs for behavioral health, prevention and primary care professionals throughout the state to provide greater responsiveness to the needs of the community, and create commonalities in these training programs for the express purpose of increasing professional skills of the ATOD prevention workforce; and ii) building capacity of communities to implement effective evidence-based prevention programs, policies and practices with fidelity, and develop and implement a process and outcomes evaluation; and iii) developing effective prevention networks within and across regions and/or counties.
 - A local implementation work group for statewide SPE priorities charged with supporting the successful implementation and/or expansion of effective prevention models across Connecticut. This work involves assembling cross partner teams that can develop new and/or adjust existing protocols and models for roll out at the local level. This effort recognizes that successful efforts require a simultaneous top-down and bottom-up approach with ample room to make mid-course adjustments in response to changing conditions at the local level.
- Complete an annual survey of alcohol tobacco and other drug efforts across our respective agencies and organizations to measure how we are effectively coordinating, managing and sustaining substance abuse prevention and health promotion efforts in accordance with the SPE's goals.

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CONNECTICUT'S STRATEGIC PREVENTION FRAMEWORK STATE
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2.3 AUTHORITY

Authority is granted to enter into an agreement by the leader of participating Departments, Divisions and Partners.



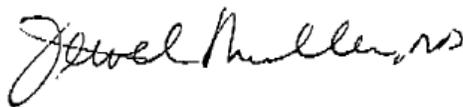
Patricia Rehmer, Commissioner
Mental Health and Addiction Services



Erika Tindill Esq., Chairperson
Board of Pardons & Paroles



Reuben F. Bradford, Commissioner
Emergency Services and Public Protection



Dr. Jewel Mullen, Commissioner
Department of Public Health

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2.3 AUTHORITY (continued)

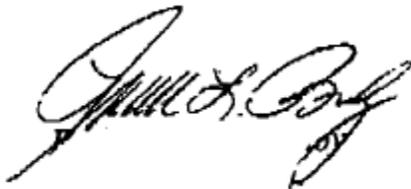
Authority is granted to enter into an agreement by the leader of participating Departments, Divisions and Partners.



William M. Rubenstein, Commissioner
Department of Consumer Protection



Leo C. Arnone, Commissioner
Department of Correction



Roderick L. Bremby, Commissioner
Department of Social Services



DEPUTY SECRETARY FOR

Benjamin Barnes, Secretary
Office of Policy and Management

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2.3 AUTHORITY (continued)¹⁰

Authority is granted to enter into an agreement by the leader of participating Departments, Divisions and Partners.



Joette Katz, Commissioner
Department of Children and Families



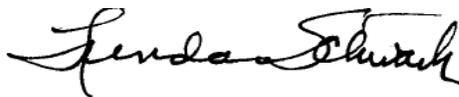
Stefan Pryor, Commissioner
Department of Education



William H. Carbone, Executive Director
Judicial Branch



James P. Redeker, Commissioner
Department of Transportation

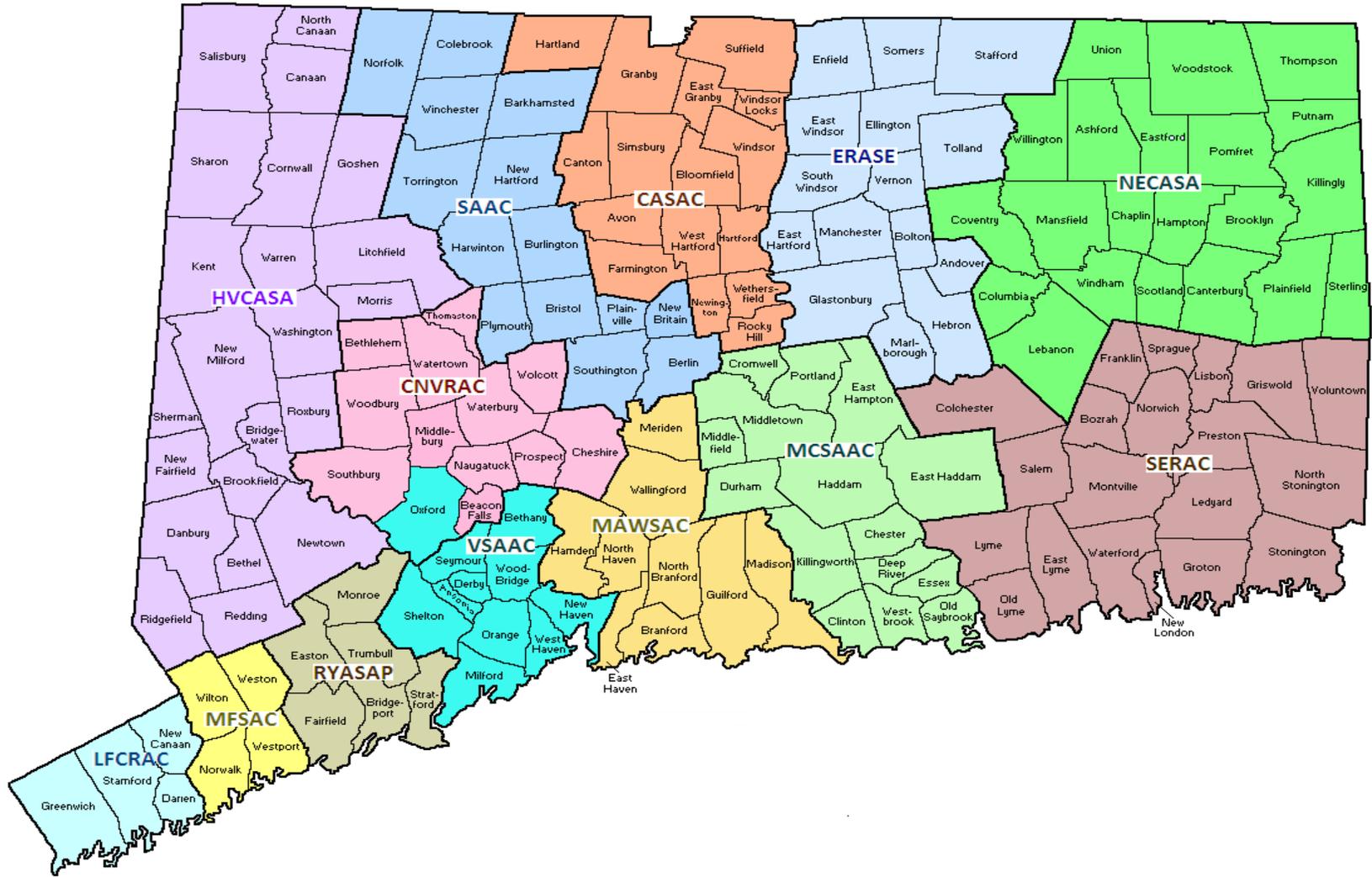


Dr. Linda S. Schwartz, Commissioner
Department of Veteran Affairs

¹⁰ Signature collection will continue during the first part of January 2013.

APPENDIX A-2

Connecticut's 169 Towns and Regional Action Council Service Areas



APPENDIX 3
SPE Consortium Member Survey

January 13, 2012

Dear SPE Consortium Member:

Thank you for agreeing to serve on the SPE Consortium and to help Connecticut develop a comprehensive coordinated statewide substance abuse Prevention Framework and 5-year plan. The process relies heavily on Consortium members sharing information about their alcohol, tobacco, and other drug (ATOD) prevention efforts. This survey allows us to advance the information sharing process.

Your survey responses will help the SPE Consortium to understand the current status of Connecticut's ATOD prevention infrastructure, and how collectively we can make improvements that benefit our communities, residents, and implementation partners.

Please complete the survey by January 23, 2012. This will give us sufficient time to compile the results and discuss them at our first SPE Consortium meeting. The survey will take you approximately 30 minutes to complete. Most of the questions involve multiple choice responses. Some questions ask specific information about programs, documents, and budgets, and may require assistance from other colleagues in your agency.

You can complete the survey electronically (a Survey Monkey link will be sent to you in a separate e-mail) or using the attached word document – completing it by pen and paper or inserting responses directly into the document.

Also, prior to the first SPE Consortium meeting, a SPE project staff member will contact you to review your survey responses and to record any additional and/or missing information.

Thank you in advance for your commitment to improving the ATOD prevention infrastructure in Connecticut.

Sincerely,

Carol Meredith, Director
DMHAS Prevention and Health Promotion

APPENDIX 3
SPE Consortium Member Survey

****For multiple choice answers use your "x" key to type in an ☒***
****For open ended answers – type words into the box.***

A. The first set of questions asks general information about you.

What is your name ?	
What agency do you work for?	

How long have you worked at this agency . Since...	
--	--

What is your job title ?		
How long have you been in your current job position ?	month	year

	Yes	No
Are or have you ever been involved in the Strategic Prevention Framework State Incentive Grant (SPF SIG) ?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a member of ?		
Connecticut Alcohol & Drug Prevention Council (ADPC)	<input type="checkbox"/>	<input type="checkbox"/>
Child Poverty & Prevention Council	<input type="checkbox"/>	<input type="checkbox"/>
Other Statewide/Community ATOD Groups	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what groups ?		

	Yes	No
Are you aware of the State Epidemiological Outcomes Workgroup (SEOW) ?	<input type="checkbox"/>	<input type="checkbox"/>
Do you or a representative from your agency participate on the SEOW ?	<input type="checkbox"/>	<input type="checkbox"/>
If yes , what is the name of the person from your agency who currently participates on the SEOW?		

APPENDIX 3
SPE Consortium Member Survey

B. This series of questions is about the prevention programs and services offered by your Agency.

Please list the prevention programs/services offered by your agency/organization and indicate the target population and the program focus area	Program Focus Area						Target Population				Other (list)
	ATOD	Domestic Violence	Mental Health / Suicide	Violence	Physical Health	Advocacy	Youth	Adult	Families	Other (list)	
Program 1 (name)	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
Program 2	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
Program 3	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
Program 4	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
Program 5	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
Program 6	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
Program 7	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						
Program 8	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>						

Please indicate your level of **annual funding** for your Agency prevention programs/services

\$ amount

% Total

Federal	\$	__%
State	\$	__%
Local	\$	__%
Other (list)	\$	__%
Other (list)	\$	__%
Total agency prevention funding	\$	100%

What **percentage of the prevention** programs, policies and practices being funded and/or implemented by your agency are **evidence-based**?

%

APPENDIX 3
SPE Consortium Member Survey

C. This series of questions asks about ATOD Prevention infrastructure from your Agency's perspective.

	Yes	No	Not Applicable
Is a representative from your Agency serve on statewide groups or local coalitions involved in the ATOD prevention?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who ?			
Is your Agency currently a part of an ATOD prevention Memorandum of Understanding that defines your expectations, role, and responsibility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what agencies?			
Do these groups consistently include representation and participation from diverse cultural groups ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your Agency directly or through an intermediary or entity provide technical assistance or support to the clients, customers or consumers of your ATOD Prevention programs/services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what is the name of the intermediary?			
Does your Agency hold formal agreements with community-level organizations to develop prevention plans that serve targeted populations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what partner typically leads the community effort ?			
Is your Agency required by federal or State mandates to use a specific theoretical prevention framework or construct to organize the prevention planning process?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what framework ?			
Is your Agency required by federal or State mandates to use specific prevention planning tools (e.g., logic model process) to complete the planning process?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what tools ?			
Does your Agency conduct ATOD prevention planning processes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If NO or NA, skip to page 6 – open ended questions about capacity building	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, at what level of geography?	Yes	No	
County	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agency service region	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local (e.g., cities, towns)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your Agency ATOD prevention planning efforts identify gaps in policy at the statewide or local levels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your Agency involve data experts such as epidemiologists in ATOD prevention planning efforts to understand diversity related to age, gender, ethnicity, and income, among others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

APPENDIX 3
SPE Consortium Member Survey

	Yes	No
Does your Agency analyze, interpret and disseminate ATOD prevention data as part of the ATOD prevention planning process?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what documents/publications?		
Does your Agency complete a financial and program resource inventory as part of the ATOD prevention planning process?	<input type="checkbox"/>	<input type="checkbox"/>
Does your Agency prevention planning process use needs assessment and outcomes data to make ATOD prevention-related decisions?	<input type="checkbox"/>	<input type="checkbox"/>
Does your Agency prevention planning process place an emphasis on increasing the reach of evidence-based programs and/or services?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what reference document explains those evidence-based standard(s)?		
Does your Agency align its ATOD prevention plan objectives with any federal indicators or benchmarks?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what federal indicators?		
What is the typical time frame when your agency conducts planning efforts involving an ATOD prevention component?	Yes	No
Every year	<input type="checkbox"/>	<input type="checkbox"/>
Every other year	<input type="checkbox"/>	<input type="checkbox"/>
Every 3 years	<input type="checkbox"/>	<input type="checkbox"/>
Every 4 to 5 years	<input type="checkbox"/>	<input type="checkbox"/>
Other (list)		
When was the last year your Agency completed an ATOD prevention plan?		
Does your Agency report progress on ATOD prevention efforts in a federal reporting document?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what report(s)?		
Does your Agency report progress to a State legislative committee and/or commission?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what committee or commission?		
If applicable, explain any recent changes within your Agency to increase the capacity for ATOD prevention planning . (Examples may include re-organizing departments or units; adding staff; analyzing data; changing the process to increase stakeholder participation)		

APPENDIX 3
SPE Consortium Member Survey

From your Agency's perspective	Short Answer – can be explained in depth during follow-up conversation
What gaps exist in your Agency's capacity to engaging diverse stakeholders in ATOD prevention planning efforts?	
What gaps exist in the availability or usefulness of ATOD prevention data sets?	
What gaps exist in ATOD prevention planning processes – such as the timing, stakeholders, focus areas?	
What gaps exist in ATOD prevention training processes?	
What gaps exist in the application of evidence-based ATOD prevention programs/services?	
What gaps exist in using performance measures and/or evaluating ATOD prevention efforts?	

APPENDIX 3
SPE Consortium Member Survey

D. This series of questions asks about the level of collaboration, coordination and integration of Prevention activities that currently exist.

	Not realistic	A little realistic	Moderately realistic	Very realistic
<p><i>The Strategic Prevention Framework State Prevention Enhancement Grant support a goal of developing a comprehensive 5-year Strategic Plan among all of Connecticut's State agencies and Tribal Authorities involved in the prevention of substance use and associated problems to "enhance the statewide substance abuse prevention infrastructure, promote emotional health and reduce the likelihood of substance abuse and their related consequences."</i></p>				
In your opinion, is this a realistic goal ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes, definitely	Possibly	Definitely not
In your opinion, will it be possible to achieve this goal ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In your opinion, will it be possible to build consensus among State agencies and Tribal Authorities to achieve this goal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How would you rate each of the following items as of this point in time:	None	Low	Medium	High
The current level of integration of State/Tribal prevention and health promotion infrastructures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The ability of prevention and health promotion stakeholders to reach consensus on the distribution of resources relative to needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The ability of prevention and health promotion stakeholders to reach consensus on methods to identify emerging needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The ability of prevention and health promotion stakeholders to reach consensus on plans to address emerging trends/needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The ability of prevention and health promotion stakeholders to reach consensus on methods to redistribute resources based on those needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The ability of prevention and health promotion stakeholders to identify innovative data collection and evaluation methods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infrastructure needed to monitor, evaluate and maintain the key elements of an integrated state system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

APPENDIX 3
SPE Consortium Member Survey

For each of the following questions, please indicate your agency's interactions and collaborations with each of the agencies listed.

How familiar are you with the substance abuse prevention programs of each agency listed below?	Not Familiar	A Little Familiar	Very Familiar
Department of Emergency Services and Public Protection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Mental Health and Addiction Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Children and Families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Office of Policy and Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Higher Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Veterans Affairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
State Department of Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Social Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Public Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CT State University System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Corrections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Judicial Branch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

As far as you know, does your Agency interact with staff from each agency listed below regarding substance abuse prevention and mental health promotion programs?	Yes	No
Department of Emergency Services and Public Protection	<input type="checkbox"/>	<input type="checkbox"/>
Department of Mental Health and Addiction Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Children and Families	<input type="checkbox"/>	<input type="checkbox"/>
Office of Policy and Management	<input type="checkbox"/>	<input type="checkbox"/>
Department of Higher Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Veterans Affairs	<input type="checkbox"/>	<input type="checkbox"/>
State Department of Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Transportation	<input type="checkbox"/>	<input type="checkbox"/>
Department of Social Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Public Health	<input type="checkbox"/>	<input type="checkbox"/>
CT State University System	<input type="checkbox"/>	<input type="checkbox"/>
Department of Corrections	<input type="checkbox"/>	<input type="checkbox"/>
Judicial Branch	<input type="checkbox"/>	<input type="checkbox"/>

APPENDIX 3
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For those Agencies with which your staff members interact, what was the **frequency of your agency's interaction with staff from each agency** regarding substance abuse prevention or mental health promotion?

	Weekly	Monthly	Quarterly	Annually or Less
Department of Emergency Services and Public Protection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Mental Health and Addiction Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Children and Families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Office of Policy and Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Higher Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Veterans Affairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
State Department of Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Social Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Public Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CT State University System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Corrections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Judicial Branch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Did your Agency **share any ATOD prevention information or data** with personnel from another Agency?

	Yes	No
Department of Emergency Services and Public Protection	<input type="checkbox"/>	<input type="checkbox"/>
Department of Mental Health and Addiction Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Children and Families	<input type="checkbox"/>	<input type="checkbox"/>
Office of Policy and Management	<input type="checkbox"/>	<input type="checkbox"/>
Department of Higher Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Veterans Affairs	<input type="checkbox"/>	<input type="checkbox"/>
State Department of Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Transportation	<input type="checkbox"/>	<input type="checkbox"/>
Department of Social Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Public Health	<input type="checkbox"/>	<input type="checkbox"/>
CT State University System	<input type="checkbox"/>	<input type="checkbox"/>
Department of Corrections	<input type="checkbox"/>	<input type="checkbox"/>
Judicial Branch	<input type="checkbox"/>	<input type="checkbox"/>

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Did your Agency conduct any joint ATOD prevention planning with personnel from each agency?	Yes	No
Department of Emergency Services and Public Protection	<input type="checkbox"/>	<input type="checkbox"/>
Department of Mental Health and Addiction Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Children and Families	<input type="checkbox"/>	<input type="checkbox"/>
Office of Policy and Management	<input type="checkbox"/>	<input type="checkbox"/>
Department of Higher Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Veterans Affairs	<input type="checkbox"/>	<input type="checkbox"/>
State Department of Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Transportation	<input type="checkbox"/>	<input type="checkbox"/>
Department of Social Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Public Health	<input type="checkbox"/>	<input type="checkbox"/>
CT State University System	<input type="checkbox"/>	<input type="checkbox"/>
Department of Corrections	<input type="checkbox"/>	<input type="checkbox"/>
Judicial Branch	<input type="checkbox"/>	<input type="checkbox"/>

Did your Agency implement any joint ATOD prevention planning with personnel from each agency?	Yes	No
Department of Emergency Services and Public Protection	<input type="checkbox"/>	<input type="checkbox"/>
Department of Mental Health and Addiction Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Children and Families	<input type="checkbox"/>	<input type="checkbox"/>
Office of Policy and Management	<input type="checkbox"/>	<input type="checkbox"/>
Department of Higher Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Veterans Affairs	<input type="checkbox"/>	<input type="checkbox"/>
State Department of Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Transportation	<input type="checkbox"/>	<input type="checkbox"/>
Department of Social Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Public Health	<input type="checkbox"/>	<input type="checkbox"/>
CT State University System	<input type="checkbox"/>	<input type="checkbox"/>
Department of Corrections	<input type="checkbox"/>	<input type="checkbox"/>
Judicial Branch	<input type="checkbox"/>	<input type="checkbox"/>

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Did your Agency receive any technical assistance on ATOD prevention programs or services from personnel in other agencies?	Yes	No
Department of Emergency Services and Public Protection	<input type="checkbox"/>	<input type="checkbox"/>
Department of Mental Health and Addiction Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Children and Families	<input type="checkbox"/>	<input type="checkbox"/>
Office of Policy and Management	<input type="checkbox"/>	<input type="checkbox"/>
Department of Higher Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Veterans Affairs	<input type="checkbox"/>	<input type="checkbox"/>
State Department of Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Transportation	<input type="checkbox"/>	<input type="checkbox"/>
Department of Social Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Public Health	<input type="checkbox"/>	<input type="checkbox"/>
CT State University System	<input type="checkbox"/>	<input type="checkbox"/>
Department of Corrections	<input type="checkbox"/>	<input type="checkbox"/>
Judicial Branch	<input type="checkbox"/>	<input type="checkbox"/>

Did your Agency provide any technical assistance on ATOD prevention programs or services to personnel in other agencies?	Yes	No
Department of Emergency Services and Public Protection	<input type="checkbox"/>	<input type="checkbox"/>
Department of Mental Health and Addiction Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Children and Families	<input type="checkbox"/>	<input type="checkbox"/>
Office of Policy and Management	<input type="checkbox"/>	<input type="checkbox"/>
Department of Higher Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Veterans Affairs	<input type="checkbox"/>	<input type="checkbox"/>
State Department of Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Transportation	<input type="checkbox"/>	<input type="checkbox"/>
Department of Social Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Public Health	<input type="checkbox"/>	<input type="checkbox"/>
CT State University System	<input type="checkbox"/>	<input type="checkbox"/>
Department of Corrections	<input type="checkbox"/>	<input type="checkbox"/>
Judicial Branch	<input type="checkbox"/>	<input type="checkbox"/>

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Did your Agency commit to any joint ATOD prevention funding of programs or services with another agency?	Yes	No
Department of Emergency Services and Public Protection	<input type="checkbox"/>	<input type="checkbox"/>
Department of Mental Health and Addiction Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Children and Families	<input type="checkbox"/>	<input type="checkbox"/>
Office of Policy and Management	<input type="checkbox"/>	<input type="checkbox"/>
Department of Higher Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Veterans Affairs	<input type="checkbox"/>	<input type="checkbox"/>
State Department of Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Transportation	<input type="checkbox"/>	<input type="checkbox"/>
Department of Social Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Public Health	<input type="checkbox"/>	<input type="checkbox"/>
CT State University System	<input type="checkbox"/>	<input type="checkbox"/>
Department of Corrections	<input type="checkbox"/>	<input type="checkbox"/>
Judicial Branch	<input type="checkbox"/>	<input type="checkbox"/>

Did your Agency jointly fund an ATOD prevention position with another Agency?	Yes	No
Department of Emergency Services and Public Protection	<input type="checkbox"/>	<input type="checkbox"/>
Department of Mental Health and Addiction Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Children and Families	<input type="checkbox"/>	<input type="checkbox"/>
Office of Policy and Management	<input type="checkbox"/>	<input type="checkbox"/>
Department of Higher Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Veterans Affairs	<input type="checkbox"/>	<input type="checkbox"/>
State Department of Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Transportation	<input type="checkbox"/>	<input type="checkbox"/>
Department of Social Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Public Health	<input type="checkbox"/>	<input type="checkbox"/>
CT State University System	<input type="checkbox"/>	<input type="checkbox"/>
Department of Corrections	<input type="checkbox"/>	<input type="checkbox"/>
Judicial Branch	<input type="checkbox"/>	<input type="checkbox"/>

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Did your agency jointly design an ATOD prevention program with another Agency?	Yes	No
Department of Emergency Services and Public Protection	<input type="checkbox"/>	<input type="checkbox"/>
Department of Mental Health and Addiction Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Children and Families	<input type="checkbox"/>	<input type="checkbox"/>
Office of Policy and Management	<input type="checkbox"/>	<input type="checkbox"/>
Department of Higher Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Veterans Affairs	<input type="checkbox"/>	<input type="checkbox"/>
State Department of Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Transportation	<input type="checkbox"/>	<input type="checkbox"/>
Department of Social Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Public Health	<input type="checkbox"/>	<input type="checkbox"/>
CT State University System	<input type="checkbox"/>	<input type="checkbox"/>
Department of Corrections	<input type="checkbox"/>	<input type="checkbox"/>
Judicial Branch	<input type="checkbox"/>	<input type="checkbox"/>

Did your Agency jointly coordinate an ATOD prevention program with another Agency?	Yes	No
Department of Emergency Services and Public Protection	<input type="checkbox"/>	<input type="checkbox"/>
Department of Mental Health and Addiction Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Children and Families	<input type="checkbox"/>	<input type="checkbox"/>
Office of Policy and Management	<input type="checkbox"/>	<input type="checkbox"/>
Department of Higher Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Veterans Affairs	<input type="checkbox"/>	<input type="checkbox"/>
State Department of Education	<input type="checkbox"/>	<input type="checkbox"/>
Department of Transportation	<input type="checkbox"/>	<input type="checkbox"/>
Department of Social Services	<input type="checkbox"/>	<input type="checkbox"/>
Department of Public Health	<input type="checkbox"/>	<input type="checkbox"/>
CT State University System	<input type="checkbox"/>	<input type="checkbox"/>
Department of Corrections	<input type="checkbox"/>	<input type="checkbox"/>
Judicial Branch	<input type="checkbox"/>	<input type="checkbox"/>

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Do you anticipate any change in the frequency of your future ATOD prevention-related interactions with other Agencies?	Less	The Same	More
Department of Emergency Services and Public Protection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Mental Health and Addiction Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Children and Families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Office of Policy and Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Higher Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Veterans Affairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
State Department of Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Social Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Public Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CT State University System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Corrections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Judicial Branch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you anticipate any change in the intensity or scope of work in ATOD prevention efforts between your Agency and other Agencies?	Less	The Same	More
Department of Emergency Services and Public Protection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Mental Health and Addiction Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Children and Families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Office of Policy and Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Higher Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Veterans Affairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
State Department of Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Social Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Public Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CT State University System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Department of Corrections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Judicial Branch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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E. This series of questions is about how your Agency views coordination of existing ATOD prevention activities.

	Yes	No
Does your agency have a strategic plan for ATOD prevention ?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, in what year was the plan last updated?	20__	

	Very Important	Somewhat Important	Not at all Important
A shared vision, mission, prevention definition, goals, objectives, prevention theoretical framework and common prevention outcomes with targeted benchmarks and timeline for meeting targets?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Processes for and resources to conduct ongoing assessment of statewide needs, resources and gaps ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collaboration on increasing the prevention budget ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interagency budgeting and pooling of prevention resources ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incorporation of federal and state funding requirements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agreed upon or standardized prevention outcomes ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The establishment of a state evidence-based workgroup to oversee and implement a process and criteria for selecting evidence based practices for prevention programs and services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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F. This series of questions is about how your Agency views data-driven processes associated with existing ATOD Prevention activities.

	Yes	No
Does your agency collect data for needs assessment and outcome planning?	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency collect or link fiscal and programmatic data to track prevention operations and outcome benchmarks?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use prevention needs assessment, outcomes and/or epidemiological data to make prevention-related decisions?	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency have a formal electronic prevention data system to collect, analyze and disseminate prevention data?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who manages that data system?	<input style="width: 100%; height: 20px;" type="text"/>	

Do sufficient resources exist in your Agency to accomplish ATOD prevention tasks...	Yes	No
Collect assessment data?	<input type="checkbox"/>	<input type="checkbox"/>
Maintain performance capacity?	<input type="checkbox"/>	<input type="checkbox"/>
Conduct strategic planning?	<input type="checkbox"/>	<input type="checkbox"/>
Maintain information technology systems?	<input type="checkbox"/>	<input type="checkbox"/>
Implement evidence-based prevention services?	<input type="checkbox"/>	<input type="checkbox"/>
Maintain (ATOD) prevention partnerships?	<input type="checkbox"/>	<input type="checkbox"/>
Evaluate results to accomplish desired outcomes?	<input type="checkbox"/>	<input type="checkbox"/>

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G. This series of questions is about how your Agency views existing ATOD prevention evaluation processes.

	Yes	No
Do you or prevention contractors link outcomes to substance use problems ?	<input type="checkbox"/>	<input type="checkbox"/>
Do you or prevention contractors link outcomes to consequences ?	<input type="checkbox"/>	<input type="checkbox"/>
Do you or prevention contractors link outcomes to risk/protective predictors ?	<input type="checkbox"/>	<input type="checkbox"/>
Does your Agency/subcontractor deliver culturally appropriate prevention services ?	<input type="checkbox"/>	<input type="checkbox"/>
Does your Agency/subcontractor sustain a culturally competent workforce ?	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency regularly monitor and evaluate to track population level changes ?	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency regularly monitor and evaluate prevention programs/services	<input type="checkbox"/>	<input type="checkbox"/>
Does your Agency offer evaluation training and technical assistance ?	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency regularly develop monitoring and evaluation reports ?	<input type="checkbox"/>	<input type="checkbox"/>
Does your agency regularly share monitoring and evaluation reports with partners, providers, consumers and other stakeholders?	<input type="checkbox"/>	<input type="checkbox"/>

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H. This series of questions is about how your Agency views existing ATOD prevention workforce development processes.

Who do you consider as part of your Agency's prevention workforce?	Yes	No
Parents	<input type="checkbox"/>	<input type="checkbox"/>
Clients	<input type="checkbox"/>	<input type="checkbox"/>
Agency contractors	<input type="checkbox"/>	<input type="checkbox"/>
Local providers (other than contractors)	<input type="checkbox"/>	<input type="checkbox"/>
Agency staff	<input type="checkbox"/>	<input type="checkbox"/>
Others (please list)		

What are the credential requirements for a qualified prevention workforce?	Yes	No
None	<input type="checkbox"/>	<input type="checkbox"/>
High School Degree or equivalent	<input type="checkbox"/>	<input type="checkbox"/>
Certification(s)	<input type="checkbox"/>	<input type="checkbox"/>
Associates Degree	<input type="checkbox"/>	<input type="checkbox"/>
Bachelors Degree	<input type="checkbox"/>	<input type="checkbox"/>
Graduate / professional degree	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list)	<input type="checkbox"/>	<input type="checkbox"/>

Does your agency provide any of the following workforce development opportunities?	Yes	No
Workshops & seminars	<input type="checkbox"/>	<input type="checkbox"/>
Continuing Education Credits	<input type="checkbox"/>	<input type="checkbox"/>
Certifications	<input type="checkbox"/>	<input type="checkbox"/>
Training of trainers	<input type="checkbox"/>	<input type="checkbox"/>
None Provided	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list)		

Who does your Agency's workforce development training target?	Yes	No
Agency staff	<input type="checkbox"/>	<input type="checkbox"/>
Agency contractors	<input type="checkbox"/>	<input type="checkbox"/>
Local service providers	<input type="checkbox"/>	<input type="checkbox"/>
None Provided	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list)		

APPENDIX 3
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	Very important	Somewhat important	Not at all important
How important is it to develop a common workforce development plan for state agencies, coalitions, providers and other stakeholders involved in substance abuse prevention as part of the State strategic prevention plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How important is it for the common workforce development plan to include			
A workforce needs assessment conducted every 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Minimal qualifications for prevention personnel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recruitment, employment, sustainability and advancement opportunities (e.g. TA, training, coaching, mentoring) for prevention personnel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Linkages to national standards and performance measures ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monitoring of implementation and progress on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

This completes the survey. Thank you for your time.

APPENDIX 4

Summary of Service Population Advisory Group Input on the Plan

Service Population Advisory Group of the Strategic Prevention Enhancement Initiative

A joint project between Connecticut Youth Services Association (CYSA), East of the River Action Substance Abuse Elimination, Inc. (ERASE) and the Department of Mental Health and Addiction Services

Region 4 & 5 Parent Focus Group Report

Summary: Two focus groups were held on Substance Abuse Prevention initiatives. Region 4 was held in Manchester on November 29, 2012 and Region 5 was held in Waterbury on December 4, 2012. The previously existing groups were affiliated with the Youth Service Bureau in their towns. Childcare, dinner and gift cards for participation were the costs incurred in facilitating these groups. The Waterbury group was all Spanish speaking and was conducted with the assistance of two translators.

Overall themes included parents having a keen interest in their communities and in the members of those communities. They are globally unaware of prevention programming in their neighborhood, town or the school system. State level effort awareness is limited to media campaigns. They also have no knowledge of places to go as a parent for resources to assist in helping their children make good choices including not using substances. Most get their information regarding substance abuse from personal experience, family experience, friends or their own children. They are very eager to share their opinions but don't have the time to go seek out those opportunities. They greatly appreciate the opportunity to talk about these issues, learn something and contribute their own experiences. Two volunteered to be on a parent advisory committee to do just that.

Area of Concern 1: What is the nature, severity and impact of ATOD use and abuse in your community?

Parents reported that substances that are used the most are Marijuana, cigarettes, heroin and alcohol. Use of marijuana seems to be on the rise and some parents felt that the decriminalization of marijuana in CT has given youth the idea that it is no longer illegal. All of the discussion in the past year about decriminalization has blurred the lines for youth and they are now smoking it freely while walking down the street. Some parents mentioned that they have heard of K3 or synthetic marijuana incidents involving youth and again, youth think it is safer because it isn't the real thing. Parents felt that youth begin their experimenting with alcohol but that Black and Hispanic youth specifically begin with marijuana more so than cigarettes or alcohol. One parent shared that she was concerned about her child taking pills because so often children are given Tylenol and other over the counter medications much more readily than in previous times. They are around pills and therefore have access more often. This has dulled the dangerous aspect of medications in general. A parent shared that her child had a very minor procedure and was given a full 30 days worth of prescription pain medication illustrating the increased access. A few parents mentioned children drinking hand sanitizer which is another substance that is readily accessible everywhere.

One parent commented that the stigma of urban youth participating more in substance use is erroneous. She mentioned that as part of her job, she interfaces with youth from the suburbs and they have more money and more options when it comes to accessing substances. There was a discussion around this topic between a number of parents who also shared their own personal experiences either using substances or more often, losing a loved one to drug use. How are youth accessing substances? Very easily: friends, family, schools, the neighborhood Bodegas – it is everywhere. Some parents shared the very real concern of children becoming addicted to substances, committed crime and in some cases murder to get their fixes, ruining more than just their own lives. Some have had this personal experience. All parents felt that substance abuse is a family problem and a community problem. All parents want to keep their children healthy and substance free.

APPENDIX 4

Summary of Service Population Advisory Group Input on the Plan

Area of Concern 2: What kinds of prevention resources/support networks are available and accessed now within the community?

This series of questions and their subsequent discussions were the most troubling. When asked about prevention programming for children, almost all of the parents in both groups said there wasn't any in their community. They said there were some programs for those who are already addicted but as for preventing children from experimenting? Nothing. One mom mentioned the school system but was quickly told by others whose children were in different grades that in fact where there once was prevention education – there is no more. In Manchester, the parents specifically mentioned DARE and how that program is no longer offered. Many of the parents remembered attending DARE themselves. They did mention that it seemed like whatever education or programming was happening it was in the high schools. There were parents there with high school aged children who disagreed with this notion.

When asked about opportunities for parents to get more information, attend a class, etc. that was prevention related they also said they were not aware of any opportunities available to them. The Manchester group meets weekly and discusses issues like these and their group facilitator is an invaluable resource to them when they have questions or problems. But overall, prevention doesn't exist in their experience. **ALL** parents mentioned that they are concerned about their children using substances and try to educate their children themselves. But, they all said that they get their information from friends, family and in some cases, their children themselves regarding substance use and abuse. Their children are often founts of information until they themselves start experimenting, then they stop communicating. It is then parents said they know to be more mindful of what is going on with their children. Sometimes their child mentions something and they don't know how to respond, nor do they even understand what they are talking about. In these instances, they look to their support systems to help them out with an answer. One parent was very clear – we need to teach our children at home about drugs, what they can do to you and why you should stay away because they aren't getting the information anywhere else. What made this part of the discussions particularly troubling to this reporter is that these groups were affiliated with Youth Service Bureaus – often hubs of prevention activities for entire communities. There seems to be a great disconnect.

Area of Concern 3: What is your opinion of the plan's approach?

Given responses to the questions regarding the above concern, parents were pretty removed from a statewide plan. They felt that there needed to be prevention efforts in the schools and at the community level, and its ok if the state departments wanted to get involved. Because they felt that there weren't any programming available, how communities could work on coordinating larger programs was a moot point. There was a discussion about media and its role in society and more importantly with their children. Most parents felt that substance use and exposure starts at home and youth are unattended more often due to parents needing to be at work. Parents also commented on the "Kidifying" of alcohol and cigarettes – media targets youth through labeling and colors. They also mentioned the lack of commercials on TV about substance abuse (many cited the Partnership for a Drug Free America ad campaign "This is Your Brain on Drugs" from the late 1980's and early 1990's.) They mentioned how cartoons are targeted at children and youth but are really inappropriate. Cartoon Network was mentioned in that they disguise swears but allow the characters to use and discuss drugs and alcohol. Shows like "King of the Hill" we cited – in one episode characters were fishing and using crack as bait. The dialogue as well as the animation made light of the fish being high on the bait.

APPENDIX 4
Summary of Service Population Advisory Group Input on the Plan

Area of Concern 4: How should we actively and effectively involve consumers in prevention program planning, implementation, and assessment?

One group's parents were concerned with retaliation. Often their child comes home and tells them events from the day including drug deals in the school bathroom, children faking drug use in the cafeteria, etc. Most parents want to contact administrators but choose not to for fear of their child being labeled a "snitch". The neighborhoods and communities are so close knit that everyone knows everyone else. As a parent if you are in the school, someone is going to see you and tell someone else. The parents suggested that one way to resolve this is to have one open phone line for parents to call in an anonymous way. This group in particular asked for bilingual websites and materials to talk to their children about substance abuse issues and ways to communicate important messages to them. This reporter sent on some resources to the group facilitator afterwards.

Overall though, the parents were very eager to be heard and to share their opinions. They would like to do more of it but their schedule and lives do not allow them to seek out those opportunities. If organizations, policy makers, school personnel or statewide organizations want them to be a part of it, they need to come to the parents. One parent very clearly stated that this reporter got information from the group because I was in the room. They didn't come to the reporter. Face to face works best – fliers are the least effective tool. Using groups such as the ones they were participants in was a good way to reach parents. They in turn tell other parents. Almost all of the parents that participated found their way to these groups through word of mouth. It is also how they get a lot of their other information. Where to find them? Wherever their children are, at the bus stop, at school, and when they aren't with their children, at work. When the reporter mentioned the Parent Advisory Group – many thought it was an interesting idea and it was about time someone asked them for input. Two wanted to become actively involved and others mentioned that they would be interested to learn more as the group began to form.

APPENDIX 5
Behavioral Indicators Provided by SEOW Members

Indicator	Alcohol	Tobacco	Prescription Drugs	Illicit Drugs	Marijuana	Cocaine	Heroin	Suicide	Problem Gambling	Originating Agency	Smallest Geo Area	GradeK-12	Age 12-17	Age 12-20	High School	Age <18	Age 18-25	Age 18+	Age 26+
Current use	✓	✓			✓	✓			✓	DPH	State				✓				
Past month use	✓	✓		✓	✓					Local	Town		✓				✓	✓	✓
Current binge drinking	✓									DPH	State				✓				
Past month binge drinking	✓									Local	Town		✓				✓	✓	✓
Past year use			✓		✓	✓				Local	Town		✓				✓	✓	✓
Lifetime use			✓		✓	✓	✓		✓	DPH	State				✓				
Perception of risk of harm from use	✓	✓			✓					Local	Town		✓				✓	✓	✓
Early onset (first use before age 13)	✓	✓			✓					DPH	State				✓				
School Attendance	✓		✓	✓	✓	✓	✓		✓	SDE	District	✓							
School suspensions/expulsions	✓	✓	✓	✓						SDE	District	✓							
Drove after drinking	✓									DPH	State				✓				
Rode in car when driver had been drinking										DPH	State				✓				
Alcohol-related fatal motor vehicle crashes	✓									DESPP	Town					✓		✓	
Alcohol-related motor vehicle accidents	✓									DESPP	Town					✓		✓	
Alcohol-related motor vehicle deaths	✓									DESPP	Town					✓		✓	
Driving under the influence arrests	✓									DMV	Town			✓		✓		✓	
Liquor law violations	✓									DESPP	Town			✓		✓		✓	
Drug law violations				✓						DESPP	Town			✓		✓		✓	
Alcohol Seller Violation Rate	✓									DCP	Town								
Tobacco Retailer Violation Rate		✓								DMHAS	Town								
Abuse or dependence past year	✓			✓						DMHAS	USR		✓				✓	✓	✓

APPENDIX 5
Behavioral Indicators Provided by SEOW Members

Indicator	Alcohol	Tobacco	Prescription Drugs	Illicit Drugs	Marijuana	Cocaine	Heroin	Suicide	Problem Gambling	Originating Agency	Smallest Geo Area	GradeK-12	Age 12-17	Age 12-20	High School	Age <18	Age 18-25	Age 18+	Age 26+
Calls to gambling helpline									✓	DMHAS	Town					✓		✓	
Needing but not receiving treatment	✓			✓						DMHAS	State		✓				✓	✓	✓
Treatment admissions	✓		✓	✓	✓	✓	✓		✓	DMHAS	Town					✓		✓	
Deaths from lung cancer		✓								DPH	Town					✓		✓	
Alcohol-related suicide deaths	✓									DPH	Town					✓		✓	
So sad or hopeless stopped usual activities								✓		DPH	State				✓				
Suicide seriously considered past 12 months								✓		DPH	State				✓				
Suicide plan past 12 months								✓		DPH	State				✓				
Suicide attempt(s) past 12 months								✓		DPH	State				✓				
Self-injury treated by a doctor or nurse								✓		DPH	State				✓				