Center for Prevention Evaluation and Statistics (CPES)

Needs Assessment and Strategic Plan

UCONN HEALTH

dmhas

09/2016, rev. 08/2017

Table of Contents

Center for Prevention Evaluation and Statistics (CPES)
Needs Assessment and Strategic Plan

NEEDS ASSESSMENT

In August, 2015, the Department of Mental Health and Addiction Services (DMHAS) funded the Center for Prevention Evaluation and Statistics (CPES) to support the mission of the DMHAS Prevention and Health Promotion Unit (PHP) to promote the overall health and wellness of individuals and communities through the identification, collection, analysis, interpretation and dissemination of data pertaining to substance abuse prevention and mental health promotion.

In accordance with its charge from DMHAS, the CPES is designed to set direction in response to DMHAS' prevention vision, while remaining responsive to emergent needs and issues for prevention at the state, agency, and local levels. One key component of the DMHAS PHP vision is that the Strategic Prevention Framework (SPF) be utilized by all its funded prevention partners and, as such, be infused in all aspects of the state's prevention work. In response to this vision, and utilizing SPF constructs, the CPES undertook a needs assessment process, taking into account Connecticut's prevention infrastructure and stakeholders, as well as its own organizational capacity to meet the needs of DMHAS' PHP. Needs Assessment

Key questions driving CPES needs assessment are:

- *What at the state and community level is driving the need for CPES core functions?*
- *How does each function support the needs of DMHAS' prevention stakeholders?*
- *Are there still gaps, and if so, what are they?*
- *What are the potential challenges in implementing these core functions?*

The results of this needs assessment are summarized in this document. The CPES's needs assessment informed the strategic plan for CPES which is detailed in this document as well.

CPES Advisory Board: Statewide Epidemiological Outcomes Workgroup (SEOW)

One of the initial charges for the CPES upon funding was to re-convene, maintain, and chair the SEOW, the goal of which was to re-assess the changing needs of the state's population, identify emerging problems, broaden the focus of the SEOW to include mental health promotion, re-evaluate the landscape of available prevention resources and services, and review the most recent information about evidence-based practices in prevention of behavioral health problems and behavioral health promotion. In keeping with DMHAS' vision, the SEOW was expected to infuse all steps of the SPF planning process – assessment of needs, resources and readiness; community mobilization and capacity building; strategic planning; implementation of evidence-based practices, programs and policies; and monitoring and evaluation – into the statewide workgroup function and activities. Given this focus and the composition of the SEOW, the SEOW is an ideal advisory body for the CPES, informing the data gathering and prioritization efforts of the CPES, just as the CPES supports the work of the SEOW.

The SEOW, composed of a broad cross-section of state, regional and community level stakeholders, will be active for all five years of the CPES funding period. The SEOW, using a data-driven process, was envisioned as a joint collaborative effort of all state agencies with mandates related to substance abuse and mental health, as well as other key stakeholders, convened to promote cross-systems planning, implementation and monitoring efforts, and ongoing, in-depth exchange of information among members and their constituencies to allow the SEOW partners to more effectively and efficiently utilize prevention resources. The long-term vision for the SEOW is that the data and recommendations of the SEOW will be used to inform not only the DMHAS PHP Unit, the other substance abuse and mental health divisions of DMHAS, as well as other state agency partners, regional planners, and community-based stakeholders. The broad applicability of the SEOW data to multiple users will help insure ongoing engagement by SEOW members and sustainability of the workgroup over time. This expanding focus will also allow the CPES to remain responsive to emergent data needs in the

State.

The SEOW was assembled to include state, regional and local stakeholders who are generators of data and/or users of data for needs assessments, strategic planning, and prevention programming or policy initiatives. In addition to DMHAS PHP staff, the SEOW membership includes representatives from the Connecticut Departments of Public Health (DPH), Education (SDE), Children and Families (DCF), Social Services (DSS), Transportation (DOT), Corrections (DOC), Consumer Protection (DCP), and Emergency Services and Public Protection, Judicial Branch Court Support Services Division (CSSD), Board of Parole, Office of Early Childhood, and Office of Policy and Management (OPM). In addition to state agency representatives, the CPES team, following PHP recommendations, identified and reached out to other stakeholders who are likely to contribute to the SEOW deliberations, such as Regional Action Council (RAC) directors, the Connecticut Hospital Association (CHA), Multicultural Leadership Institute (MLI), Children's Health and Development Institute (CHDI), AIDS CT, Connecticut Youth Services Association, and community representatives responsible for strategic planning and delivery of services for substance use and mental health. A complete list of the current SEOW membership is shown in the table below.

Table 1: 2017 State Epidemiological Outcomes Workgroup Membership

Name	Organization	Title/Role
Diane Aye	DPH	Epidemiologist
Susan Bouffard	DMHAS	Clinical Manager, EQMI
Michelle Devine	Southeast Regional Action Council (SERAC)	Director
Anthony Dias	CT Hospital Association	Vice President, Data Services
Vilmaris Diaz	Board of Pardons and Parole	Associate Research Analyst
David Feillin	Yale School of Medicine	Professor of Medicine and Public Health (and CORE)
Linda Goodman	Office of Early Childhood	Deputy Director
Ajit Gopalakrishnan	SDE	Bureau Chief, Data Collection, Research and Evaluation
David Gregorio	UCONN Health	SEOW Co-Chair
Dawn Grodzki	DMHAS	Behavioral Health Program Manager
Bill Halsey	DSS	Director, Behavioral Health Programs

Name	Organization	Title/Role
Michelle Hamilton	CT Youth Services Association	Member
Adora Harizaj	CHDI	Data Analyst
Robert Heimer	Yale School of Medicine	CORE member
Brian Hill	Judicial, CSSD	Ctr for Research, Prgm Analysis & Quality improvement
Eugene Interlandi	DOT	Transportation Planner
Celeste Jorge	DPH	Epidemiologist
Nana Kittiphane	DCP	Health Program Assistant
Tyler Kleykamp	OPM	Chief Data Officer, Open Data Initiative
Constance Heye	Office of Early Childhood	Epidemiologist, MIECHV Program
Shawn Lang	AIDS CT	Deputy Director
Mary Lansing	DOC	Associate Research Analyst
Mary Lyon	CT Hospital Association	Vice President, Integrated Health Information
Kristin Mabrouk	CT Youth Services Association	Member
Rodrick J. Marriott	DCP	Director, Drug Control Division
Tim Marshall	DCF	Director, Office of Children's Mental Health
Carol Meredith	DMHAS	Director of Prevention Services
Christine Miskell	Southeast Regional Action Council (SERAC)	Evaluator
Stephanie Moran	DMHAS	Primary Prevention Services Coordinator
Mary Painter	DCF	Director of Substance Abuse Services
Robert Palmer	DESPP (Formerly DPS)	State Police Training Academy Commanding Officer
David Rentler	Board of Pardons and Parole	Supervising Psychologist
Julie Revaz	Judicial, CSSD	Administration, Manager
Michelle Riordan-Nold	Connecticut Data Collaborative	Director
Eleni Rodis	DMHAS	Acting Director, Research Division
Melissa Sienna	DCF	Project SAFE Coordinator
Xaviel Soto	DCP	Manager, Rx Monitoring Program
Bonnie Smith	UCONN Health	PFS 2015 Evaluation Coordinator

Name	Organization	Title/Role
Jennifer Sussman	UCONN Health	CPES Project Coordinator
Jane Ungemack	UCONN Health	Evaluator, PFS 2015, CPES Director , SEOW Co-Chair
Jeff Vanderploeg	CHDI	Vice President for Mental Health Initiatives
Smruti Vartak	Connecticut Transportation Safety Research Center, UCONN	Epidemiologist, Research Associate
Sandra Violette	DOC - Health & Addiction Services	Deputy Warden
Faith Vos Winkel	Office of the Child Advocate	Assistant Child Advocate
Sara Wakai	Department of Medicine, UCONN Health	Assistant Professor

Needs Assessment Data Sources

The CPES, through the work of the SEOW and access to other key data sources, accessed qualitative and quantitative data at the State, sub-regional, community and organizational levels, all of which informed its needs assessment and strategic planning process.

The CPES team considered data from a variety of sources in conducting its needs assessment. They reviewed the comments made at SEOW meetings and took into account discussions held with key stakeholders at the state, regional and community levels. In addition, they accessed recent data collected through the 2014 CRS that assessed community use of data, including types of data use, barriers to data use and data applications at the community level. Likewise, findings from the 2014 Community Coalition Survey (CSS) were reviewed to determine what types of data were used by PFS grantees who were well-familiar with the SPF data-driven approach. Data sources consulted appear in the table below.

Table 2: Data Sources Consulted

Stakeholder/ Data Level	Respondent/ Source Affiliation	Type of Data Collected	Data Collection Method	Limitations/ Gaps/ Needs
State	DMHAS Statewide Prevention Enhancement Initiative (SPE)	Results of infrastructure gaps analysis, priorities,	Review of SPE 5 year plan (dev.	Updated data, post plan period

		and plans	2012)	
State	Co-existing data initiatives	Data on relevant indicators, efforts, and availability of data	Review of reports and websites	
State	State agency representatives	Input on substance abuse, mental health, and health disparities indicators	SEOW meetings	Input/representation from DMHAS, CTSAB, and other mental health initiatives
State	State agency representatives	Input on state-level data sharing needs and resources	SEOW meetings	Need survey of SEOW, based on issues identified through needs assessment process
State and sub-regional	Community key informants/ stakeholders	Community attitudes, needs, and readiness	2014 CRS	Need updated results from 2016 CRS
Sub-regional	Community key informants/ stakeholders	Subregional aggregation of community attitudes, needs, and readiness	2014 CRS	Need updated results from 2016 CRS
Sub-regional	Regional Action Council (RAC) Directors	Input on data and data capacity needs	Key informant interviews/ discussions	Need systematic (focus group) data from CPN, and data from RMHBs
Community	DMHAS SPF, PFS, and Best Practice subrecipients (Prevention Coordinators)	Input on data use, capacity, TA needs	2014 Community Coalition Survey (CCS)	Need updated data from PFS 2015, CSC coalitions (others?)
Community	Local evaluators	Input on data use, capacity, resources, needs	Key informant discussions	Will need end user input to inform data repository efforts going forward

The DMHAS Statewide Prevention Enhancement (SPE) Initiative

In 2012, DMHAS was awarded a statewide prevention enhancement grant by the Center for Substance Abuse Prevention (CSAP) that funded a one year planning process resulting in the Statewide Prevention Enhancement (SPE) Five-Year Strategic Prevention Plan to strengthen the statewide Alcohol, Tobacco, and Other Drug prevention infrastructure. The SPE Consortium of diverse partners from state agencies, divisions, departments, Tribal Nations, and others was

convened for this planning process. The planning process included a gaps analysis and a survey of consortium members, and resulted in a comprehensive plan. The gaps analysis and the plan objectives around data and technical assistance were of particular importance in the CPES needs assessment, as well as in support of the core functions laid out for the Center by DMHAS.

A review of the SPE Five Year Strategic Plan revealed the following statewide deficits related to data collection:

- Limitations in the accessibility and meaningful use of the SEOW data repository
- Significant issues with respect to interoperability of state agency data system
- Budget constraints which limit the opportunities to propose major overhauls
- Minor gaps in existing data collection efforts associated with core measures and indicators, for example administration and standardization of student surveys across all high schools, and use of web-based processes to facilitate implementation;
- Specific programmatic gaps in data collection, in content, format, timeliness of data entry and availability;
- Limitations 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.

From the SPE 5 year action plan, SEOW activities in response to the identified goal of "improving ATOD prevention data collection, analysis, and reporting," are as follows:

- streamline data collection and improve quality and access;
- coordinate datasets, planning requirements, and timing of local needs assessments;

- identify common performance measures for ATOD prevention; and
- publish epidemiological data reports.

As part of its strategic plan under the SPE, DMHAS and SPE partners noted the following issues:

"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."

In response to this, DMHAS proposed to 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.

Even though the SPE 5-year plan spanned 2012-2016, the gaps around data remain largely unfilled at the time of this needs assessment, and the SEOW had not undertaken these key activities prior to the funding of CPES. The SEOW, even in a strengthened state, is not in the position to undertake the activities identified by DMHAS in the SPE plan. The CPES, however, with SEOW input, is well-equipped to meet the above needs , including those identified for the proposed Research Analyst, and others identified in the needs assessment that follow. The SPE gaps analysis and strategic plan around ATOD data is a valuable component of the CPES needs assessment, as it provides needs and action steps to drive CPES' strategic planning and implementation.

Information on Data Capacity, Resources, and Gaps through the SEOW process

As part of its needs assessment, the SEOW membership undertook discussion of the state of the data climate, sharing, and collaboration among state agencies and other key

holders and users of data, identifying data resources, gaps, needs and issues. SEOW members identified co-existing data initiatives and a lack of coordination and collaboration between data efforts as the main barriers to data sharing and access at the state agency level. The compartmentalization of publicly available data was cited as a barrier to access and quality assurance of data.

The SEOW agreed that Connecticut's legislative mandate to make state agency data publicly available through OPM's Open Data Portal initiative has both potentially changed Connecticut's data climate and created opportunities for data sharing and increased access at all levels in the state. Consequently, work with OPM and the legislatively supported Open Data Portal seems to be the most efficient way for the SEOW, and CPES, to move forward. The group also agreed that until publicly available data are used, they will not be vetted for reliability and validity in any functional way. To this end, the SEOW set the short-term goal to apply data to a social issue or problem from the perspectives of all SEOW members, and more specifically, to compile and organize data (i.e. use, harm, services) to address the opioid problem in CT.

<u>Data gaps, needs, and opportunities.</u>

Through its experience working through the data application process, the SEOW worked through a list of consumption, consequence, and risk factor indicators compiled by CPES, and identified the following as specific gaps in data held by the CPES. Gaps, needs, and data opportunities include:

- current and trend treatment admissions data;
- hospital (CHIME) data;
- violation of probation data from CSSD and parole remand or revocation data;
- prescriber data;
- juvenile justice GAIN aggregate data;
- EMPS data through A-SBIRT;
- drug-related emergency calls (poison control and 211);
- emergency department visits;
- cost data for opioid misuse;

- drug endangered child data (through DCF and State Police);
- DCF abuse and neglect data;
- adverse childhood experience (ACES) data;
- health disparities data, and
- mental health indicators.

The group also recognized that in the past the SEOW has focused on substance abuse initiatives funded by DMHAS prevention initiative. The SEOW recognized the opportunity, through the CPES, to set a long term goal, using the same epidemiological approach, of focusing on mental health as well, broadening the focus to other health issues and risk factors relevant to both substance abuse and mental health.

Data resource needs.

Through employment of the indicators, and discussion related to data linkage and capacity, the SEOW identified the most immediate data resource needs to enhance data quality, use, and access. These needs include:

- A standardized means of quality assessment and vetting of data in existing public use environments, such as OPM's Open Data Portal and eventually the CPES Prevention Data Repository, through active use of data by key stakeholders (State agencies, the SEOW, RACs, community level grantees, evaluators, and others) and end users and via a standardized feedback process; and
- A strong data sharing and capacity building infrastructure, facilitated by stakeholders at various levels in the State, and mechanized by existing DMHAS infrastructure elements, specifically CPES, TTASC, the SEOW, and the RACs.

Gaps in SEOW membership.

During the needs assessment process, gaps in SEOW representation were identified, as well as, in some cases, potential stakeholders to fill them. Gaps include the following:

- Court Support Services Division (CSSD)

- CT Association of School-based Health Centers
- CT Pharmacists Association
- CT Suicide Advisory Board
- UCONN's CT State Data Center

Representatives from these organizations were identified for participation in the SEOW, as members or consultants. Over time, it is expected that other stakeholders will be identified who either are key holders or users of data related to substance abuse prevention or mental health promotion, who will be invited to participate in the SEOW, as a means of keeping the SEOW responsive to emergent needs and issues.

While the anecdotal data gleaned from the SEOW discussions is useful in identifying important issues related to data needs, resources and capacity among Connecticut's state agencies, more standardized data is needed across stakeholders in the State. To that end, CPES is in discussions with Rachel Leventhal-Weiner, Data Engagement Specialist with the CT Data Collaborative about a collaborative statewide data resource and needs assessment survey of Connecticut's key stakeholders at various levels, the results of which will guide the work of both organizations.

State Resources: Key Initiatives.

Through SEOW discussions and subsequent CPES research, several key initiatives were identified whose missions are relevant to and, in some cases, overlapping with CPES' goals. Data collection, data sharing, and use of data to inform educational, planning and evaluation is a central focus of each of these initiatives. These initiatives relate to the CPES in a variety of ways and represent opportunities for collaboration and coordination to increase the data use capacity of the state, as well as represent potential sources for and users of data generated by CPES. They include:

Alcohol and Drug Policy Council (ADPC): The Connecticut ADPC is a legislatively mandated body comprised of representatives from all three branches of State

government, consumer and advocacy groups, private service providers, individuals in recovery from addictions, and other stakeholders in a coordinated statewide response to alcohol, tobacco and other drug use and abuse in Connecticut. The Council, co-chaired by DMHAS and DCF, is charged with developing recommendations to address substance-use related priorities from all State agencies on behalf of Connecticut's citizens – across the lifespan and from all regions of the state.

Connecticut Opioid Response (CORE) Team: Governor Malloy engaged the Connecticut Opioid Response (CORE) team to supplement and support the work of the ADPC by creating a set of recommendations regarding tactics and methods that could be immediately deployed to have a rapid impact on the number of opioid overdose deaths in Connecticut. The CORE team will continue to work with the ADPC as they lead the state's comprehensive response to the opioid crisis and collaborate on future challenges as they develop (The Connecticut Opioid Response Initiative, October 5, 2016).

CT Data Integration Collaborative: This is an initiative of DCF to identify, collect, share and disseminate data relevant to children's mental health. This initiative brought together various state parties addressing children's behavioral health and well-being, including DCF's mental health, substance use services and juvenile justice divisions, DMHAS, CSSD, CTDC, Beacon Health Options, and various academic partners and advocacy groups that have worked with DCF to collect data on and provide services for children's mental health.

Connecticut Open Data Portal Initiative: Launched by Executive Order No. 39 by Governor Malloy in February, 2016, the Open Data Portal (data.ct.gov) is managed by OPM with the Department of Administrative Services, Bureau of Enterprise Systems and Technology (DAS/BEST) to coordinate implementation, compliance, and expansion of the state's agency open data initiative. The Open Data Portal collects and reports out data from all state agencies and is intended to increase access to state data for use by a broad spectrum of stakeholders at the state and community levels.

Connecticut State Data Center (CTSDC), University of Connecticut: The Connecticut State Data Center (CTSDC) is the State's lead agency in the U.S. Census Bureau's State Data Center Program that makes data available to the public through a network of state agencies, universities, libraries, and regional and local governments. The CTSDC, a collaboration between the University of Connecticut Libraries, Department of Geography, and the OPM, serves as the state's official liaison to the U.S. Census Bureau and seeks to develop a single portal for all socioeconomic datasets for the State of Connecticut and its municipalities. The CTSDC is supported by the State of Connecticut OPM and UCONN Libraries. CTSDC staff organize training programs for Connecticut personnel, organize a network of coordinating and affiliated agencies, and assist with Census data inquiries and processing of custom datasets for Connecticut.

Connecticut Suicide Advisory Board (CTSAB):
The CTSAB is supported and co-chaired by the DCF and DMHAS, and is comprised of volunteers and staff representing a variety of state and community sectors. The Suicide Prevention Plan (PLAN 2020), released December 2014, establishes five goals and 22 objectives for Connecticut to initiate state prevention activities, and is aligned with the National Strategy for Suicide Prevention and Healthy People 2020. As part of this initiative, the CTSAB has identified and collected several indicators relevant to monitoring trends in suicidality and suicide prevalence.

Connecticut Data Collaborative: The Connecticut Data Collaborative, originally a project of the New Connecticut Foundation, a 501I3 nonprofit organization affiliated with the Connecticut Economic Resource Center, is a public-private partnership that advocates for the public availability of open and accessible data to drive planning, policy, budgeting and decision making in Connecticut at the state, regional and local levels. The Ctdata.org data portal contains over 135 datasets curated and processed into a machine-readable structure. Custom data-exploration tools allow users to select data, download raw data in bulk, or browse by topic, search by organization, or search by dataset. This last entity, as described above, is already collaborating in the CPES.

Community-level Data Needs

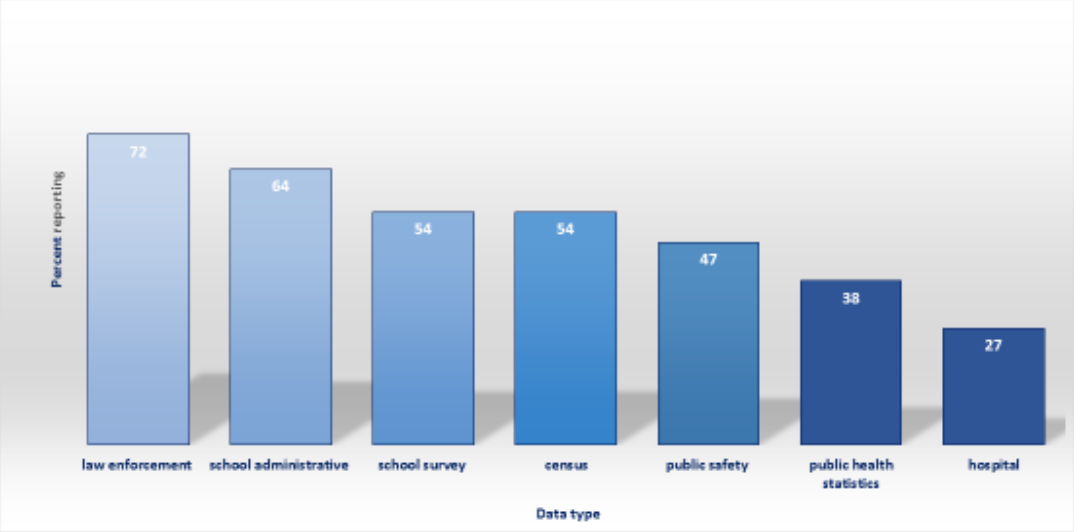
Community Readiness Survey.

The Community Readiness Survey (CRS) is a web-based key informant survey that has been administered by DMHAS through the Connecticut Clearinghouse every two years since 2006 to measure state and community readiness and capacity for implementing effective evidence-based substance abuse prevention programs, policies and practices. In 2014, a total of 737 key informants across towns and municipalities in Connecticut participated in the survey, including representatives from local government, law enforcement, schools, social service, public health, substance abuse and mental health agencies, faith-based organizations, youth and parents. Approximately 60% were female, 67% were 46 or older, and 87% were White. While the respondents were not directly representative of the populations of the towns/municipalities they reported on, they were representative of the key prevention workforce and stakeholder agencies addressing substance use problems in those communities.

The CRS was designed to inform and evaluate state and community strategic substance abuse prevention planning and evaluation. The results from the CRS on priority substances, for instance, led to identifying underage alcohol use as a priority for substance abuse prevention in the state. Recent surveys have also increasingly shown that prescription drug misuse is perceived as a problem among all age groups, but especially young adults and those 65 and older. The CRS key informant ratings have also provided evidence that Connecticut's readiness and capacity to address substance abuse problems has increased over the past several years, a major goal of DMHAS' SPF-based prevention initiatives.

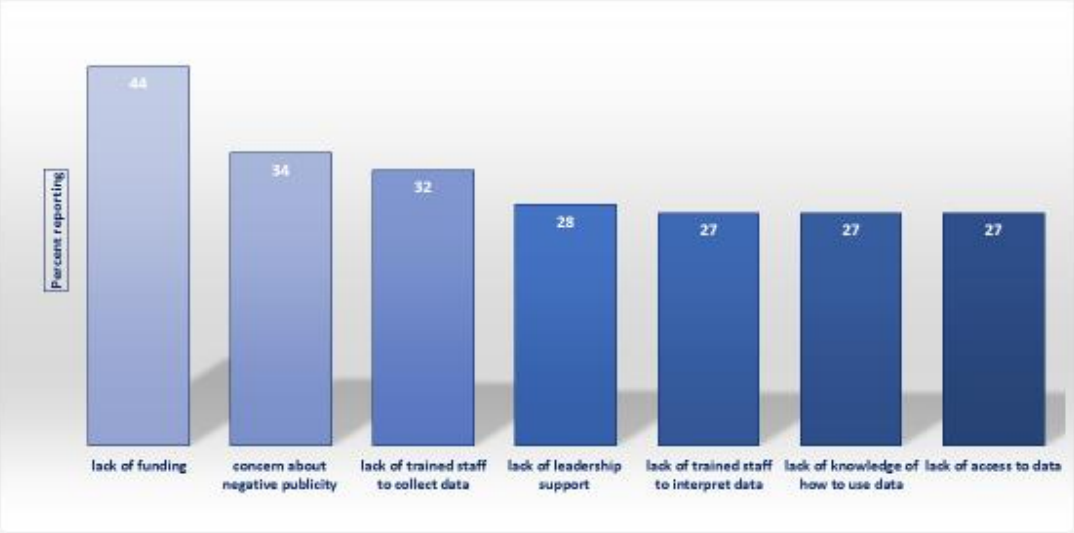
The CRS findings also provide insight into the availability and use of data at the community level to support prevention efforts. Key stakeholders in the 2014 CRS identified the data that they were most likely to access in addressing substance use in their communities (Figure 1, below). The data utilization results indicated that one data focus on CPES should be to build linkages to improve and promote access to public health statistics and hospital data.

Figure 1. Data Most Utilized in Addressing Substance Abuse, Community Readiness Survey 2014



Data on barriers to data use (Figure 2, below) highlighted areas that CPES can help address through training in access and use of data for behavioral health strategic planning and evaluation, the two areas in the SPF process where data are most likely to be utilized.

Figure 2. Barriers to Data Use, Community Readiness Survey 2014



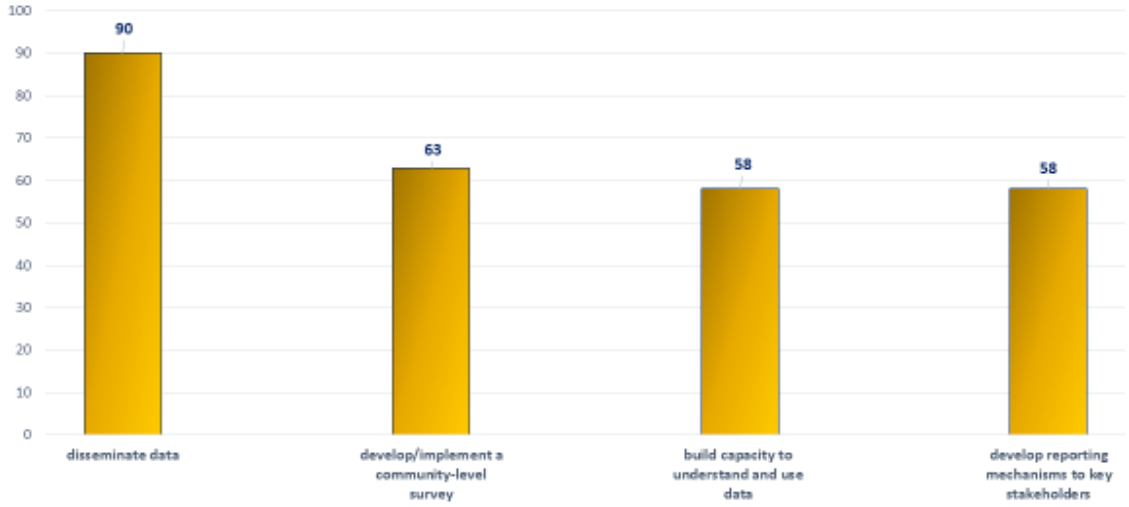
Community Coalition Survey.

The 2014 Community Coalition Survey (CSS), a self-administered survey completed by community-level Prevention Coordinators and their Local Evaluators in conjunction with members of their coalitions for the PFS evaluation, provides additional information about the uses of data for the SPF process. While data from the CSS represent the perspectives of a group of DMHAS-funded community coalitions, the responses illuminate data capacity, use, and needs on the community-level.

The 2014 CCS show that the most common uses of data were for needs assessment, strategic planning, program monitoring and evaluation, and public education. While the types of data used varied across communities, the data accessed included: Census data, student surveys, parent surveys, public meeting data, key informant interviews, law enforcement data, school administrative data, focus groups, and public safety data. Certain types of data were reported as rarely used or unavailable, including public health statistics (53%) and hospital data (41%). These data echoed the CRS data that was collected statewide (Figure 1, above).

The CCS respondents identified mechanisms for enhancing data use capacity at the community level (Figure 3, below).

Figure 3. Mechanisms for Enhancing Community-level Data Use Capacity
Community Coalition Survey, 2014



To ensure sustainability of data-driven planning processes, the 2014 CCS respondents pointed to: establishing program evaluation as a routine part of efforts (68.4%), adopting needs assessment updates as a routine part of efforts (68.4%), and establishing resources for continuation of community data collection (57.9%)**.** These data point to areas where the CPES staff can work to increase access to, use of, and understanding of certain types of data, as well as the applications of data to needs assessment, strategic planning, and program evaluation to inform and maintain support for local prevention efforts.

In assessing community-level needs, the CPES Team also engaged community-level stakeholders through discussions with Local Prevention Coordinators and Evaluators. These discussions were undertaken during the course of CPES' participation in review of the CSC grantee needs assessment and strategic plans. Conversations with local Prevention Coordinators and local evaluators revealed both resources and needs at the community-level. One finding of this process was that, despite the longstanding relationships many of the grantees have had with DMHAS and the Strategic Prevention Framework (SPF), data use capacity and strategic planning, and evaluation expertise varied across grantee community coalitions. Based on discussions around evaluation of their individual plans, a theme emerged: **the desire for increased interaction among community-level grantees, both PCs and Evaluators, with the aim of resource sharing and enhancement of capacity across grantees.** What evolved from these discussions was a vision for a peer mentoring approach to capacity building at the community level, led by a CPES-convened Local Evaluator Workgroup, and supported by CPES, in conjunction with the technical assistance framework and dialogue-based learning model established by the TTASC.

CPES Organizational Resource and Needs Assessment

As part of the needs assessment, CPES assessed its own personnel and data resources to implement CPES core functions. A team of experienced researchers within the UCONN Health Department of Community Medicine and Health Care – Dr. Jane Ungemack (Principal Investigator), Dr. David Gregorio (Co-Investigator), Dr. Bonnie McRee (Co-Investigator), and Jennifer Sussman (Project Director) – are the key staff responsible for implementing the CPES,

in collaboration with Michelle Riordan-Nold and her staff of the Connecticut Data Collaborative. All four of the key Uconn Health staff have a long history of working in collaboration with DMHAS in conducting substance abuse needs assessments and/or evaluations of statewide substance abuse initiatives. Their experience in collecting, managing, analyzing and disseminating data to support these and other DMHAS initiatives has given them an in-depth understanding of the landscape of substance abuse-relevant data in the state, including the agencies that collect and generate the data, data quality issues, and the applications of various datasets for prevention planning, especially at the state level. Dr. Ungemack and Ms. Sussman in particular have worked with the DMHAS PHP for over 15 years to provide needs assessment data to inform and evaluate its CSAP-funded and data-driven Strategic Prevention Framework – State Incentive Grant (SPF-SIG) and Partnership for Success (PFS) (initial and current) initiatives, all of which utilized the SPF approach to reduce underage drinking and other substance use in the state. Their experience in collecting, managing, analyzing and disseminating data to support these and other DMHAS initiatives has given them an in-depth understanding of the landscape of substance abuse-relevant data in the state, including the agencies that collect and generate the data, data quality issues, and the applications of various datasets for prevention planning, especially at the state level.

Dr. Gregorio, a medical sociologist and epidemiologist, worked on one of DMHAS' previous family of studies to assess statewide needs for substance abuse treatment, as well as served on the SEOW committee that developed the criteria for selection and prioritization of reliable, valid indicators of substance abuse problems that informed development and implementation of the SPF-SIG and its selection of underage drinking as Connecticut's priority substance abuse problem. His role within CPES is to chair the SEOW and guide the deliberations of that workgroup to identify, share and disseminate data for Dr. McRee is an experienced public health researcher who has collaborated with DMHAS to implement and evaluate the State's Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiatives. She is also an experienced trainer in addiction sciences and evaluation research and will have a key role in providing training to PFS-2015 grantees and other stakeholders. In addition, the

UCONN team includes a data analyst and research assistance staff who help with data collection, management and analysis functions of the CPES.

Although the CPES staff at UCONN Health are experienced and knowledgeable in substance abuse research and have access to the considerable facilities and resources of the UCONN Health School of Medicine campus in Farmington for data collection and analysis, they have identified other additional resources that will be needed to fully meet the objectives of CPES. Most importantly, at the application stage for the CPES, the UCONN staff recognized that although they had previously developed and maintained a central repository of substance abuse data for DMHAS' prevention initiatives, it had had limited use, primarily by DMHAS itself, its RACs and DMHAS grantees for the SPF-SIG and first PFS initiative. The goal for the CPES was to have a repository more easily accessible to a broad range of stakeholders from the state, regional and local levels and one that would enable more interactive manipulation of the data for strategic planning, proposal development, education, and monitoring and evaluation purposes. The UCONN staff were aware of the CTDC which was already functioning as a statewide data repository with ties to numerous state and university entities. Under the new leadership of Michelle Riordan-Nold, the CTDC was beginning to become more widely recognized within the state and was connected to other data-driven behavioral health initiatives such as DCF's Data Integration Workgroup convened to identify, collect and share data relevant to children's mental health. Because the CTDC was already serving as a data repository, including several years of data relevant to underage drinking that UCONN staff had collected through 2010 to support DMHAS' SPF-SIG and PFS initiatives, the UCONN Health researchers collaborated with CTDC to serve as the data repository for CPES.

Another gap in the UCONN team's capacity is in the area of mental health. Although Dr. Ungemack has post-doctoral training in mental health services, has worked within mental health settings, and conducted evaluation research with mental health providers, she and her UCONN collaborators did not have experience in identifying, collecting and assessing indicators for mental health promotion. As a result, the CPES budget included a set-aside for consultants with mental health expertise who could inform that component of the CPES.

Data Resources

As mentioned above, the UCONN Health investigators had significant experience in identifying, collecting, managing, analyzing and disseminating data for previous DMHAS prevention initiatives. In particular, they had extensive knowledge of and access to consumption, risk and protective factor, and consequence indicators for underage drinking. In all cases, the UCONN researchers sought to secure data that could be used at the state, regional and local community levels. This means accessing data available at the town and municipality level. Unfortunately, that is a challenge.

With respect to consumption data of alcohol and other drugs, Connecticut must rely upon statewide data from SAMHSA's National Survey of Drug Use and Health (NSDUH) and the CDC's Behavioral Risk Factor Surveillance Survey (BRFS) and the Youth Risk Factor Behavior Surveillance Survey (YRBS). The NSDUH provides statewide and regional estimates for the population 12 and older reported in limited age groups (i.e., 12-17, 18-25, 26 and older) based on two-year combined data. Because of the limited number of respondents included in the annual survey, the estimates are based on 2-year combined data and many substances (e.g., heroin use, subtypes of prescription drugs) are not reported for the state, much less subgroups of the population relevant to addressing health disparities (e.g., race, ethnicity, gender). The BRFS is an annual survey conducted by DPH for adults 18 and older, but again the numbers in the statewide sample are limited and subgroup estimates can be unreliable. The YRBS, conducted by DPH every two years, samples high schools statewide and does provide sufficient numbers for subgroup analyses. None of these data sets, however, can be used to estimate the prevalence of alcohol or other drug use at the community level.

Unlike many other states, Connecticut has no mandated statewide school survey that could provide district/community level data to monitor community-level prevention efforts or changes over time. Many towns and cities in Connecticut have implemented their own surveys, but they have limited utility for monitoring and evaluating a statewide initiative because they are administered to different samples of students, at different time intervals, and using different instruments. They cannot be used for comparative or aggregate analyses.

Many risk and protective factor variables are measured at the individual level within these broader surveys, but beyond basic demographic data (e.g., age, gender, race, Hispanic ethnicity), different measures are collected in each. Again, individual-level information about risk and protective factors are rarely available at the town level. Conclusions about health disparities require triangulating data from each of the surveys and any publically available social indicators (e.g., opioid-related deaths, arrest data) that might include demographic data and census data for the entire community.

Survey data regarding consequences (e.g., getting into fights or sexual risk behavior (YRBS)) are sometimes available, but they are not consistently measured across surveys and are rarely available at the town-level. The UCONN Health team has expended considerable effort to identify and compile consequence data from state agencies that is reported or can be calculated at the town level. These data can then be collapsed up for state and regional use. Those data are being compiled into Needs Assessment Workbooks that are being distributed to RACs and PFS-2015 grantees to start and then will be available through CTDC for statewide use. There is a caveat to use of some types of data, especially when issues of individual privacy and confidentiality are of concern, such as with substance abuse, mental health or emergency department (ED) treatment data. In those cases, data at the town level may be censored to protect the possible identity of the persons receiving those services, which then limits the use of those data, especially for communities with small population sizes.

Through its participation in the evaluations of several state agency initiatives, the UCONN researchers have been able to access both qualitative and quantitative information about the availability and use of data by stakeholders at the state and community levels. It has become clear over the years that there is little data sharing across agencies and access to data can be limited by a variety of factors. This very conclusion was cited in the recent report to Governor Malloy about steps to take to address the opioid epidemic in Connecticut where the authors recommended: “Support the use of key datasets from various stakeholders to answer key questions regarding opioid prescribing, non-fatal and fatal overdoses, and treatment of opioid disorder.” This same need extends to most public health problems, including substance

abuse and mental health problems. In many cases, there is limited knowledge among state personnel and the general public about the data collected and generated within and by agencies. Many agencies are wary of sharing data beyond what they are mandated to report, often data required by federal agencies for national reporting (e.g., substance abuse treatment data for TEDS, fatal accident date reported to FARS). Issues about confidentiality have limited lead agencies to be unwilling to share data, especially treatment data. For many agencies and organizations, a lack of sufficient dedicated staff with data management and analysis expertise pose a challenge for meeting data requests beyond the mandated reporting. In addition, differences in reporting formats and level of reporting have limited the use of many datasets. Delays in reporting data and preparing clean datasets means that most data are not available until one or two years after they were collected, meaning that are not available in real time. Data collection protocols and data definitions can change over time, which can then limit their utility for trend analyses. However, despite these limitations, state agency-reported data are typically valuable for monitoring trends and evaluation precisely because they are standardly reported, routinely collected on an annual basis, and are submitted to cleaning procedures which increase the quality of the data.

Table 3: Summary of Needs Assessment

Core Function	Need/Justification	Gaps	Resources	Challenges/Needs
Establish evaluation services that support DMHAS PHP providers, contractors, and stakeholders	DMHAS' PHP infrastructure has expanded and solidified. This expansion provides an opportunity as well as a need for efficient interface between the various elements of DMHAS PHP infrastructure. CPES as a comprehensive prevention data center stands to be responsive to the evolving needs of a growing prevention system.	Expertise and data linkages in prevention areas beyond underage drinking,		
Re-establish and maintain the SEOW	There is a need for a State Agency driven approach to data interpretation and sharing. SPE Initiative and Alcohol and Drug Policy Council (ADPC) rely on the SEOW process for epidemiological data. Partnership for Success 2015 (PFS 2015) requires a SEOW be integrated into the statewide process.	Court Support Services Division (CSSD), CT Association of School-based Health Centers, CT Pharmacists Association, CT Suicide Advisory Board, and UCONN's CT State Data Center. Gaps in membership will also be monitored over time, and plans made to outreach to key partners.	DCF, DPH data integration and sharing initiatives; CT Data Collaborative and OPM Open Data initiative	Overlap in membership with other data-driven initiatives and bodies. Potential supplication of efforts, and limited time resources.

Core Function	Need/Justification	Gaps	Resources	Challenges/Needs
Design and implement prevention data collection and management	SPE 5-year plan: "*Specific programmatic gaps in data collection, in content, format, timeliness of data entry and availability.*"	Current and trend treatment admissions data; hospital (CHIME) data; violation of probation data from CSSD and parole remand or revocation data; prescriber data; juvenile justice GAIN aggregate data; EMPS data through A-SBIRT; drug-related emergency calls (poison control and 211); emergency department visits; cost data for opioid misuse; drug endangered child data (through DCF and State Police); DCF abuse and neglect data; adverse childhood experience (ACES) data; health disparities data, and mental health indicators. Expertise in Mental Health Indicators.	UCONN Health experts; Center for Public Health and Health Policy; Consultation Center	Convene a mental health indicator workgroup to interface with the SEOW
Disseminate and utilize epidemiological data for decision-making	SEOW role; State and subregional priority setting process; use of SPF across DMHAS partners	High level in-house expertise in data visualization, media graphics; linkages to additional data (see above)	SEOW; ADPC; CT Data Collaborative; Regional Action Councils; OPM Open Data Initiative	Increased CPES capacity for data visualization; additional data linkages need to be fostered

Core Function	Need/Justification	Gaps	Resources	Challenges/Needs
Develop and maintain the Prevention Data Repository	SPE 5-year plan ID'ed gap; "*Limitations in the accessibility and meaningful use of the SEOW data repository*" RAC Subregional Priority Setting Process; Community-level coalition needs; support of funding opportunities and grant writing	Linkages to key data not already accessed by the SEOW, and to lowest level data in dataset form, for some indicators.	CT Data Collaborative staff expertise and existing interactive data visualization website (ctdata.org)	Delays in data availability; Access to lowest level data in a timely fashion
Provide technical assistance and training on evaluation tasks and topics	Needs of DMHAS community-level grantees (PFS, CSC, etc.); SPE 5-year plan objective: *"Work collaboratively to maximize training and capacity building from ATOD infrastructure"*	High level expertise in data visualization, mapping, evaluation of social media analytics	UCONN PFS 2015 Evaluation Team; TTASC; RACs; NECAPT; Local Evaluator Workgroup; consultants/experts	Content expertise to bolster CPES internal expertise
Develop and disseminate statewide behavioral health profiles and products	Existing DMHAS and State efforts (STR, SPF Rx, ADPC Prevention Subcommittee, Legislature, Regional Action Councils) would benefit from compilation and distillation of consumption, consequence, risk factor and health disparities data from multiple sources, in a usable format	Graphic design expertise, support and infrastructure to provide high level products	UCONN Health departmental resources; CPES consulting funds to engage professionals on development of products	Enhanced expertise for CPES staff

Core Function	Need/Justification	Gaps	Resources	Challenges/Needs
Understand and utilize the prevention data collection system (IMPACT) and recommend content and enhancements	SPE 5-year plan id'ed gap: "*Significant issues with respect to interoperability of state agency data system and budget constraints which limit the opportunities to propose major overhauls"*	N/A	Knowledge of and experience with DMHAS' prior data systems and the reporting needs of other DMHAS initiatives; PFS2015 evaluation team	Delays in accessing the system due to delays in strategic plan development; Need staff time to become immersed in the system
Track indicators from PHP unit's IMPACT prevention database to determine program outcomes	Continuation of SPE 5-year plan objective to "*increase efforts to monitor and evaluate ATOD prevention program performance."* Need for performance-based accountability for prevention partners, as element of SPF.	Access to IMPACT data as system is designed; Relevant report formats to facilitate outcomes monitoring	DMHAS staff; MOSAIX developers and liaison;	Access to MOSAIX staff as needed, through DMHAS liaison; additional expertise in IMPACT data access and report capabilities
Develop and disseminate an annual report card that evaluates progress of each prevention initiative	Continuity with SPE 5-year plan objective to "*increase efforts to monitor and evaluate ATOD prevention program performance."* Need for performance-based accountability for prevention partners, as element of SPF.	N/A	SPE scorecard format and 5-year plan content as a base template	Need input from DMHAS, CSAP, and key prevention initiatives

Core Function	Need/Justification	Gaps	Resources	Challenges/Needs
Assist in the implementation and maintenance of substance use related surveys identified by the PHP	SPE 5-year plan: "*Minor gaps in existing data collection efforts associated with core measures and indicators, for example administration and standardization of student surveys across all high schools, and use of web-based processes to facilitate implementation.*"	Lack of a standardized statewide student survey; multiple local data collection efforts with differing methodologies and content; Limited and decreasing resources for implementation of surveys (e.g. CRS)	UCHC experience and expertise with development and implementation of surveys (e.g. GPIY); SERAC; DPH YRBS survey staff; CT Clearinghouse	Standardization of efforts across initiatives; buy-in from key informants and respondents
Convene Local Evaluator Workgroup	SPE 5-year plan identified gap: "*Limitations in terms of sampling methodology and the cultural sensitivity of instruments for specific populations*"; Local stakeholder desire/need to establish best practices and support for local evaluation; Need for workforce development to increase evaluation resources and expertise for prevention	Limited number of local evaluators stretched across projects and initiatives	PFS 2015 and CSC local evaluators; DFC grantee evaluators; PFS Evidence-based Workgroup	Time commitment and buy in from local evaluators; concensus on evaluation best practices and approaches

STRATEGIC PLAN

Based on the identified needs, and the existing capacity in Connecticut's prevention system and stakeholders, the CPES established goals, objectives, organizational strategies and an implementation plan for undertaking its core functions. Measurable objectives and performance measures were also established, as well as plans for mid-course corrections and sustainability. Contextual elements of this work were also examined in the process of putting together the plan, which is detailed below.

Goals and Objectives

DMHAS' prevention system is designed to promote the overall health and wellness of individuals and communities by preventing or delaying substance use. Prevention services are comprised of six key strategies including information dissemination, education, alternative activities, strengthening communities, promoting positive values, and problem identification and referral to services. The CPES, by design, supports DMHAS' prevention objectives, while remaining responsive to emergent needs and issues for prevention at the state and local levels. Its primary role is to be a prevention data center for DMHAS responsible for the identification, collection, assessment, analysis, and dissemination of data that can be used to support substance abuse prevention and mental health promotion initiatives. The goals of CPES are to increase access to and use of data, increase capacity among state and local stakeholders to use data, and provide technical expertise in data collection, analysis and interpretation of data.

Objective 1: Conduct data gathering, prioritization, interpretation, and management, and develop a user-friendly data repository for DMHAS prevention partners and stakeholders.

Objective 2: Re-convene, maintain, provide logistical support for, and chair the SEOW.

Objective 3: Establish evaluation services to support DHMAS PHP, Unit, providers, subcontractors, and other related entities, as needed. In order to address this objective, the UCHC CPES team will establish a logic model template to be used statewide throughout DMHAS-funded programs, and provide training on the logic model template to local-level

evaluators and DMHAS-funded programs to build capacity for tracking outcomes and meeting evaluation needs.

Objective 4: Provide training, technical assistance and consultation through the CPES on developing evaluation plans and reports, interpreting data and making data-informed choices. Training will be conducted in conjunction with the DMHAS funded TTASC and other applicable entities designated by the PHP Unit.

Objective 5: To promote data capacity on the state, regional and community levels, the CPES will make itself available to assist in the implementation of substance use-related surveys, as well as the maintenance of existing surveys. The CPES will also track indicators from the PHP Unit's existing prevention databases to determine program outcomes.

CPES core functions in relation to these services are as follows:

- Design and implement prevention data collection and management
- Disseminate and utilize epidemiological data for decision-making
- Provide technical assistance and training on evaluation tasks and topics.
- Re-establish, maintain, provide logistical support for, and chair the SEOW.
    - Reconvene the SEOW to continue to integrate data on substance abuse and related consequences into the SPF planning framework steps (State and community level)
    - Determine data needs by conducting key informant interviews w stakeholders and end users, and conducting state and community level scan to identify data availability, format, and areas of duplication
    - Establish indicator inclusion criteria for evaluating old indicators and deciding on new ones
    - Build epidemiological capacity and links based in identified needs
    - Clean, collect, analyze, interpret, and disseminate data
    - Monitor the prevention data system
    - Maintain web-based SEOW data repository

        - Provide training and technical assistance on repository
        - Assist in troubleshooting/responding to end-user questions
        - Facilitate and promote access to system

- Develop and disseminate statewide behavioral health profiles and products
- Establish evaluation services that support DMHAS PHP providers, subcontractors, and stakeholders
- Establish a logic model template
- Provide training, technical assistance and consultation to build capacity to track outcomes and evaluate efforts
- Understand and utilize the prevention data collection system (IMPACT) and recommend content and enhancements as needed.
- Track indicators from PHP unit's existing prevention databases to :
    - determine program outcomes
    - Develop and disseminate an annual report card that evaluates progress of each prevention initiative
    - Assist in the implementation and maintenance of substance use related surveys identified by the PHP unit

State Epidemiological Outcomes Workgroup (SEOW)

The SEOW's role will be to systematically review and analyze data related to behavioral health problems and make recommendations regarding state priorities for substance use prevention and mental health promotion and particular target groups for State prevention efforts. An update of the needs assessment data will be collected by the CPES and presented to the SEOW annually for review. The SEOW, using a data-driven process, will be able to promote cross-systems planning, implementation and monitoring efforts, in addition to promoting an ongoing, in-depth exchange of information among members and their constituencies and allow the SEOW partners to more effectively and efficiently utilize prevention resources. It is intended that the data and recommendations of the SEOW be used to inform not only the

DMHAS PHP Unit, but also the other substance abuse and mental health divisions of DMHAS, as well as the other state agency partners and community stakeholders. The broad applicability of the SEOW data to multiple users will help insure ongoing engagement by SEOW members and sustainability of the workgroup over time. The SEOW, in turn, will be informed by other existing state and local epidemiological workgroups, including those supported by the DPH, DCF, local health departments and community coalitions.

The SEOW has begun by identifying priority indicators and data focus for the CPES, through discussion of existing data (UCONN Health Indicator Lists) and moving to identification of social indicator data related to prescription drug use and opioid-related deaths. The SEOW will move forward by sharing and vetting data brought to the table by its various members, and identifying and prioritizing data sources, formats, and quality indicators for use with the Data Prevention Repository.

Table 4. SEOW Tasks According to the Strategic Prevention Framework Steps

SPF Step	SEOW Activities
NEEDS ASSESSMENT	Determine data needs; Identify, collect and analyze data to identify problems; Interpret data findings to determine priority needs; Create state level epidemiological profiles;
CAPACITY BUILDING	Assist in the identification, collection, analysis, and interpretation of capacity data; Provide data and information to key stakeholders to mobilize and enhance state and community resources to address prevention priorities. Support local epidemiological workgroups and coalitions
PLANNING	Establish links between assessment findings and priorities for resource allocations; Identify gaps and/or duplication in State services Use data to recommend targets for State Strategic Prevention Plan (places, populations, behaviors);
IMPLEMENTATION OF EVIDENCE-BASED PRACTICES	Determine strategies that effectively address priorities in the State Strategic Prevention Plan; Play a role in establishing link among: behavioral health problems, causal factors that contribute to identified problems, and evidence-based strategies to address causal factors and problems;
MONITORING AND EVALUATION	Assist in developing data monitoring plan based on data priorities that emerge; Contribute to ongoing data collection and analysis to examine changes over time in substance and mental health-related risk factors and problems; Contribute data to the CTDC; Based on trends, recommend adjustments to prevention initiatives.

Identifying Priority Indicators: Assessment of Substance Abuse Risk Factors

Decades of targeted federal and block grant finding, DMHAS' efforts have resulted in a firm grounding in alcohol indicators, dating back to the Governor's Prevention Initiative for Youth (GPIY). This broad database provides a strong foundation for the data expansion needs that face the DMHAS PHP and specifically the CPES. Increased public awareness and funding around the emergent problem of prescription drug misuse and opioid-related deaths have resulted in the need for data around the consumption, consequences and risk factors related to these substances. CPES and the SEOW are responding to this need by prioritizing indicators related to non-medical use of prescription drugs, with a focus on opioids. As a step in this process, the SEOW will review the Connecticut Opioids Response (CORE) Strategic Plan and ADPC goals and objectives, to ensure its efforts are aligned with, and supportive of, the key initiatives in the State addressing this issue.

Table 5. ATOD Indicators Collected/Proposed by the SEOW

Indicator	Alcohol	Tobacco	Marijuana	Prescription Drugs		Heroin	Cocaine	Other Illicit Drugs	Suicide	Problem Gambling	Source	Smallest Geo Area	Ages 12-17	Ages 18-25	Ages 26+	Other	Gender	Race/Ethnicity
Current use	✓	✓	✓				✓			✓	YRBS	State				Grade 9-12	✓	✓
Past month use	✓	✓	✓					✓			NSDUH YRBS	State	✓	✓	✓	12+, 18+ Grade 9-12	✓	✓
Current binge drinking	✓										YRBS	State				Grade 9-12	✓	✓
Past month binge drinking	✓										NSDUH YRBS	State	✓	✓	✓	12+, 18+ Grade 9-12	✓	✓
Past year use			✓	✓			✓				NSDUH	State	✓	✓	✓			
Lifetime use			✓	✓		✓	✓			✓	YRBS	State				Grade 9-12	✓	✓
Perception of risk of harm from use	✓	✓	✓								NSDUH	State	✓	✓	✓	12+, 18+		
Early onset (first use before age 13)	✓		✓								NSDUH YRBS	State	✓	✓	✓	12+, 18+ Grade 9-12	✓	✓
School Attendance	✓		✓	✓		✓	✓	✓		✓	SDE	Town/ District				Grade K-12		
School drop out rate											SDE	Town/ District				Grade 9-12	✓	✓
School suspensions/ expulsions	✓	✓		✓				✓			SDE	Town/ District				Grade K-12		
Drove after drinking	✓										YRBS	State				Grade 9-12	✓	✓
Rode in car when driver had been drinking											YRBS	State				Grade 9-12	✓	✓
Alcohol-related fatal MV crashes	✓										Crash repository DESPP	Individual Town	✓	✓	✓	Age <18 Age 18+	✓	✓
Alcohol-related MV accidents	✓										Crash repository DESPP	Individual Town	✓	✓	✓	Age <18 Age 18+	✓	✓
Alcohol-related MV deaths	✓										Crash repository DOT DESPP	Individual Town	✓	✓	✓	Age <18 Age 18+	✓	✓
Driving under the influence arrests	✓										UCR DMV	Town	✓	✓	✓	Age <18 Age 18+ Age 12-20	✓	✓
Liquor law violations	✓										UCR DESPP	Town	✓	✓	✓	Age <18 Age 18+ Age 12-20	✓	✓
Drug abuse			✓			✓	✓	✓			UCR	Town	✓	✓	✓	Age <18	✓	✓

violations (drug law violations)											DESPP					Age 18+ Age 12-20		
Alcohol Seller Violation Rate	✓										DCP	Town						
Tobacco Retailer Violation Rate		✓									DMHAS	Town						
Abuse or dependence past year	✓							✓			NSDUH	Town	✓	✓	✓	12+, 18+		
Calls to gambling helpline										✓	DMHAS	Town				Age <18 Age 18+		
Treatment admissions	✓		✓	✓		✓	✓	✓		✓	TEDS	State	✓	✓	✓	31-35, 36-40, 41-45, 46-50, 51-55, 56-60, 61-65, 66+	✓	✓
Deaths from lung cancer		✓									DPH	Town				Age <18 Age 18+		
Alcohol-related suicide deaths	✓										DPH	Town				Age <18 Age 18+		
So sad or hopeless stopped usual activities											YRBS	State				Grade 9-12	✓	✓
Suicide seriously considered past 12 months									✓		YRBS	State				Grade 9-12	✓	✓
Suicide plan past 12 months									✓		YRBS	National				Grade 9-12	✓	✓
Suicide attempt(s) past 12 months									✓		YRBS	State				Grade 9-12	✓	✓
Self-injury treated by doctor/nurse									✓		YRBS	National				Grade 9-12	✓	✓
Property Crime	✓		✓	✓		✓	✓	✓		✓	UCR	Town	✓	✓	✓	<10, 10-12, 13-14, 15, 16, 17, tot <18, 18, 19, 20, 21, 22, 23, 24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65+, tot 18+	✓	✓
Violent Crime	✓		✓	✓		✓	✓	✓		✓	UCR	Town	✓	✓	✓	<10, 10-12, 13-14, 15, 16, 17, tot <18, 18, 19, 20, 21, 22, 23, 24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65+, tot 18+	✓	✓
Prescription Drug Monitoring Program				✓								State						

Teen births	✓		✓	✓		✓	✓	✓			DPH	Town					
Overdose deaths	✓			✓		✓	✓	✓			OCME	Individual	✓	✓	✓	Any age based on individual cases	✓	✓
Embezzlement										✓	UCR	Town	✓	✓	✓	<10, 10-12, 13-14, 15, 16, 17, tot <18, 18, 19, 20, 21, 22, 23, 24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65+, tot 18+	✓	✓
Offense vs Family	✓		✓	✓		✓	✓	✓		✓	UCR	Town	✓	✓	✓	<10, 10-12, 13-14, 15, 16, 17, tot <18, 18, 19, 20, 21, 22, 23, 24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65+, tot 18+	✓	✓
Neonatal Abstinence Syndrome				✓		✓	✓	✓			DPH	State						
Accidental overdose deaths				✓		✓	✓	✓			OCME	Individual	✓	✓	✓	Any age based on individual cases	✓	✓
HIV/AIDS						✓					AIDS CT	Town						
Hepatitis						✓					DPH	Town						
COPD deaths		✓									DPH	State						
Cardiac disease deaths											DPH							
Needing but not receiving treatment in past year	✓							✓			NSDUH	Town	✓	✓	✓	12+, 18+		
Serious mental illness in past year											NSDUH	Town	✓	✓	✓	12+, 18+		
Any mental illness in past year											NSDUH	Town	✓	✓	✓	12+, 18+		
Had at least one major depressive episode in past year											NSDUH	Town	✓	✓	✓	12+, 18+		
Datahaven Community Wellbeing Survey		✓										State				18-34, 35-49, 50-64, 65+ Education Income	✓	✓
Community Readiness Survey	✓	✓	✓	✓		✓	✓		✓	✓	UConn	RAC	✓	✓	✓			

Youth Tobacco Survey		✓									DPH	State				Middle School High School	✓	✓
Monitoring the Future Survey	✓	✓	✓			✓	✓	✓				National				Grades 8, 10, 12		
Ever tried vape pens		✓									Datahaven Community Wellbeing Survey YRBS	State				18-34, 35-49, 50-64, 65+ Education Income Grade 9-12	✓ ✓	✓ ✓
Any opioid related death				✓		✓					OCME	Individual	✓	✓	✓	Any age based on individual cases	✓	✓
Heroin related deaths						✓					OCME	Individual	✓	✓	✓	Any age based on individual cases	✓	✓
Density liquor permits	✓										CT DCP	Town						
Educational Attainment											CT Data Collaborative	Town						
Population											Census	Town						
Gender											Census	Town					✓	
Race											Census	Town						✓
Ethnicity: Hispanic or Latino											Census	Town						✓
Age											Census	Town				<5, 5-9, 10-14, 15-19, 20-24, 25-34, 35-44, 45-54, 55-59, 60-64, 65-74, 75-84, ≥85 18 and older 21 and older 62 and older 65 and older	✓	
Median Household Income											CT Data Collaborative	Town						
Poverty Rate											CT Data Collaborative	Town						
Owner Occupied Dwellings											CT Data Collaborative	Town						
Single parent family											National Kids Count	State						
Chronic absenteeism											SDE	Town				Grade K-12		
Graduation rates											SDE	Town				Grade 9-12	✓	

Unemployment rate											CT Data Collabor-ative	Town					
Total Housing Units											Census	Town					
Enrollment rate											SDE	Town				Grade PK-12		
Emergency room visits											DPH						
BRFSS	✓	✓									CDC	State				18-24, 25-34, 35-44, 45-54, 55-64, 65+ Other demographics	✓	✓

Identifying Priority Indicators: Assessment of Mental Health Risk Factors

CPES' needs assessment revealed a gap in CPES resources relevant to mental health. The CPES will use its allocated resources to contract with one or more consultants to work with the SEOW on identification of indicators relevant to mental health promotion. One resource in the identification of mental health indicators is the Suicide Advisory Board CTSAB), led jointly by DMHAS and DCF. Review of the State of Connecticut Suicide Prevention Plan 2020, developed by the CTSAB, will drive the subsequent focus of the SEOW data prioritization of mental health indicators. A representative of the CTSAB will be invited to the SEOW to participate in prioritization of mental health indicators, once the prioritization of NMUPD and opioid indicators is complete.

Selection of behavioral health indicators – whether for substance abuse prevention or mental health promotion – will be guided by a set of criteria developed initially for the SPF-SIG. These criteria were based on established epidemiological principles for measurement quality, reliability, validity and utility.

Table 6: Recommended Selection Criteria for Behavioral Health Indicators

Domain	Indicator	Criteria
Data Quality	Ability to analyze at the town level	Data are available at the town level that can be used to establish community-level needs Town-level data can be aggregated up to sub-state and state levels

Domain	Indicator	Criteria
Nature of Relationship	Availability over time (Reproducibility)	Data are historically available for two or more years to assess need and trends Data will continue to be routinely available through the project period to assess change
	Accessibility (Timeliness)	Multi-year data are currently available for needs assessment The lag time to obtaining the data for longitudinal analysis is reasonable to support monitoring and evaluation (i.e. 12-month lag or less)
	Capacity of subgroup analysis/application to different subgroups	Level of information for population subgroups (i.e., gender, age, race/ethnicity)
	Data completeness	Complete coverage across the state Acceptable validity/accuracy Consistently reported over time and across reporting units
	Clarity of relationship with behavioral health problem	Scientific evidence shows strong association (Temporality/Specificity/Strength) Relationship is well-understood by a broad spectrum of stakeholders
	Sensitivity to change in problem (Dose response)	Change/reduction in the factors contributing to the problem behavior or the problem would lead to change in the indicator rate
	Magnitude (Burden/breadth of problem)	A relatively large number of people are affected Health disparities are evident for certain subgroups of the population The number affected is sufficient to assess statistically significant change over time, settings and sub-groups
	Impact (Depth of problem across dimensions)	The social (i.e., health, economic, criminal justice) costs are high
	Changeability (Reversibility)	The indicator is amenable to change Evidence-based strategies are available to affect change in indicator
Readiness	Readiness	Broad-based consensus that the issue is important Resources are available to implement identified strategies Identified strategies are acceptable to key stakeholders Cost/benefit ratio of identified strategies is reasonable

Prioritization of Indicators

Data needs of DMHAS and other State identified initiatives will drive the prioritization of indicators. The Governor's charge to the ADPC to address Connecticut's opioid crisis, DMHAS' PFS 2015 and the SPF Rx initiatives have moved CPES and the SEOW to focus on prescription drug indicators, opioids and heroin, as well as alcohol indicators, of which the CPES has the most complete compilation. Risk factors and health disparities are another emergent focus that has been driven by recently funded federal initiatives. What is most easily available will also be sought and compiled as connections present themselves. Data quality is another prioritization focus, and focus on risk factors and consequences shared across substances for maximum benefit.

Two other areas of focus that will follow include mental health, as discussed above, and marijuana use. With increasing legislation to legalize marijuana use nationally, it is likely that marijuana use will increase among adults and youth. The State would be well-advised to monitor any emerging growth in marijuana consumption and any consequences.

Subgroup Differences and Health Disparities

One of the key responsibilities of the CPES and SEOW will be to review available data on subgroup differences in substance use/mental health problems to assess and address health disparities in Connecticut. The CPES needs assessment shows that many datasets do not provide sufficient information on subgroups of the population, often those that are especially vulnerable to health disparities. With respect to investigation of health inequities, ethnic and racial group analyses for Connecticut are likely to be limited to Caucasian, African American, and Hispanic subgroups due to the small population sizes of other groups in the state. However, special studies and reports relevant to smaller population groups that may be at elevated risk of substance use, such as young adults, criminal justice-involved populations, Native Americans, Asians, and LGBT populations will be sought to supplement the survey data.

Prevention Data Repository

UCONN Health has subcontracted with the CTDC in Rocky Hill, CT to develop and maintain the SEOW Data Repository. The CTDC will help identify, collect, clean, process, and maintain the data for the Repository. In addition, they will help build a user-friendly, web-based interface for viewing community epidemiologic profiles. To support data curation and development, CTDC staff will work with UCONN partners, the PHP Unit, and state agency and community representatives to identify and gather relevant publically available data for the Repository. The repository will provide users with what data is available; metadata for the datasets; the most recent year available in the repository; the geographic level of the data (for example if it is at the town level, regional level, or statewide); the ability to view the data through interactive web-visualizations; and also the ability to download the raw data.

Data Curation and Development

- The Collaborative will work with project partners and state agencies to gather the relevant public data.
- Data will be cleaned and processed into the necessary format for uploading into the data repository.
- Development and creation of metadata for the data set in consultation with data sources. The Collaborative current uses the international DublinCore standard for metadata.
- Maintain and update datasets as new ones are released.

- The repository will provide users with what data is available; metadata for the datasets; the most recent year available in the repository; the geographic level of the data (for example if it is at the town level, regional level, or statewide); the ability to view the data through interactive web-visualizations; and also the ability to download the raw data.

- In consultation with project partners, the Collaborative will design a web-based, user-friendly interface for viewing interactive community profiles displaying community epidemiologic profiles.

Data Products and Dissemination

Beyond the collection and analysis of behavioral health data, the purpose of the CPES is to make sure that these data are accessible and can be used by a variety of stakeholders at the state and community levels. There are different ways to accomplish that goal, including the production of epidemiological profiles at the state and regional levels, technical reports on specific areas of interest (e.g., trends in prescription drug misuse or marijuana use), information briefs, webinars, presentations to state and local stakeholders, and testimony at the State Legislature. The CPES would produce epidemiological profiles for the State and RACs on substance use and a similar mental health report tailored for use by the LMHAs or RMHBs. Those reports can sent directly to the targeted users, but they also can be posted on the website for access by other interested users of needs assessment data. Links to such reports could be available through the CTDC website, as well as through DMHAS and UCONN to increase access and use of the SEOW data. Once the Data Repository is running in Year 2, the data would be available on an ongoing basis.

Epidemiologic Profiles

The CPES will create and update epidemiologic profiles of prioritized problems (use of substances, mental health issues, health disparities) as guided by the SEOW. Currently epidemiologic profiles have been created for prescription drug misuse, heroin, alcohol, and profiles for marijuana and tobacco are in the process of being updated to reflect the evolving contextual and subcultural landscape with regard to these substances. A separate profile will be developed for electronic nicotine delivery systems (ENDS), as "vaping" is an emergent issue for youth and young adults in Connecticut. The profiles developed by the CPES will be vetted by the SEOW and revised or expanded accordingly, based on data sources brought forth through the SEOW process. These profiles will be made available electronically and in paper formats for

dissemination and use by stakeholders and constituents at the state, regional, and community levels.

Logic Model

The UCHC CPES team will provide training on the logic model template to local-level evaluators and DMHAS-funded programs to build capacity for tracking outcomes and meeting evaluation needs. The CPES team will utilize the logic model template developed for the SPF-SIG initiative. The logic model for underage drinking prevention will be utilized as the basic template but updated based on the SEOW's priority setting process. The CPES team will work with the SEOW to develop an applicable logic model for each of the State's established prevention priorities, based on review of available data and the literature.

Technical Assistance and Capacity Building

Short-term training and technical assistance needs will be prioritized on a quarterly basis, with regular planning meetings with the DMHAS prevention teams driving determination of key needs over time. Results of the proposed State data resource and needs assessment will identify training and technical needs relative to prevention and health promotion outside of DMHAS' specific funded initiatives, in order to ensure that the work of CPES is aligned with DMHAS substance abuse prevention and mental health promotion vision statewide.

The Local Evaluator Workgroup, comprised of local evaluators across DMHAS PHP initiatives, will also inform CPES prioritization of evaluation services (data provision, training, and technical assistance). This Workgroup will meet biannually, based on the needs and activities of the funded initiatives and CPES. The Workgroup will function as a means to share evaluation expertise and broaden data capacity, but also as a resource to set and evaluate CPES course when it comes to community-level data capacity and resources.

The CPES will conduct ongoing data collection from key stakeholders at State, regional, and community levels to evaluate CPES provision of services and feed data to the SEOW to identify emergent needs and a strategic direction going forward.

Capacity Building of and by CPES

In order to solidify itself as a key element of DMHAS' prevention infrastructure, the CPES must establish a visible presence and create a "brand" for itself that reflects its role, based on its core functions and key objectives. Capacity building of the CPES will also increase sustainability over time. CPES will do this through the following:

- Develop a website that will include news and products of and by CPES, a webpage for the SEOW, and links to data resources, including the Prevention Data Repository at ctdata.org, the CT Open Data Portal, the CT Suicide Advisory Board, and other identified resources;
- Develop a logo that will be used on all CPES materials and the website, for ease of recognition of the Center;
- Regularly feed data back to Connecticut PHP stakeholders, through the SEOW, ADPC prevention subcommittee, Connecticut Prevention Network, info briefs, and products on behalf of DMHAS/CPES;
- Participate in presentations and panels at State and national prevention and public health-related meetings and conferences on behalf of CPES and DMHAS;
- Work closely with community-level prevention practitioners, coalitions, and Regional Action Councils in order to enhance data and evaluation capacity of local entities;
- Develop and regularly convene a Local Evaluator Workgroup, with evaluators across DMHAS PHP initiatives and later expanded to related initiatives (Drug Free Communities, etc.) to enhance evaluation capacity in Connecticut;
- Establish best practices, standards, and vetted tools for local evaluation, and disseminate those tools and standards to the community-level evaluation workforce, in order to enhance workforce development in Connecticut.

Evaluation and Monitoring

In order to assess progress in fulfilling its core functions, measure and demonstrate success, and respond to the need or mid-course corrections, CPES will collect process and outcomes data, including re-assessment of evolving data and evaluation needs over the course of its contract period. Ongoing data will be collected from key stakeholders at State, subregional, and community levels to evaluate CPES provision of services and feed data to the SEOW to identify emergent needs and a strategic direction going forward. Progress toward the following short and long term outcomes will also be assessed, and achievement will be defined by their fulfillment.

Table 7: CPES Benchmarks and Outcomes

Objective	**Benchmark/Outcome**	**How/when Measured**
Establish evaluation services to support DHMAS PHP Unit, providers, subcontractors, and other related entities, as needed.	Establishment of SEOW as CPES Advisory Group; full staffing of CPES; CPES website launch; completion and results of state data resource needs assessment	Quarterly according to project timeline; Annually via IMPACT reporting and DMHAS progress reports.
Conduct data gathering, prioritization, interpretation, and management, and develop a user-friendly data repository for DMHAS prevention partners and stakeholders.	Expanded indicator list; launch of prevention data repository, dashboard, and interactive epi profile functionality	Quarterly according to project timeline; Annually via IMPACT reporting and DMHAS progress reports.
Re-convene, maintain, provide logistical support for, and chair the SEOW.	SEOW vitality; Expanded indicator list; State Epidemiological Profile;	Quarterly via SEOW attendance, agendas, minutes and products;

	SEOW Prioritization; SEOW webpage launch	Annually via IMPACT reporting and DMHAS progress reports
Provide training, technical assistance, and consultation on developing evaluation plans and reports, interpreting data, and making data informed choices.	Completed guidance documents for CSC and PFS 2015 SPF process; Successful completion of CSC, PFS 2015 planning steps and products and RAC prioritization; presentation materials and content from Learning Communities and workgroup meetings.	Quarterly according to project timeline; Annually via IMPACT reporting and DMHAS progress reports.
Promote data capacity on the state, regional, and community levels.	Bi-annual Community Readiness Survey (CRS) State and Subregional reports; vitality of Local Evaluator Workgroup (LEW);	Quarterly via LEW attendance, agendas, minutes and products and adherence to project timeline; annually via IMPACT reporting and DMHAS progress report

Table 8: CPES Timeline, Years 2-5

Activity	2016 Y2, Q1 (Jul-Sep)	2016 Y2, Q2 (Oct-Dec)	2017 Y2, Q3 (Jan-Mar)	2017 Y2, Q4 (Apr-Jun)	2017 Y3, Q1 (Jul-Sep)	2017 Y3, Q2 (Oct-Dec)	2018 Y3, Q3 (Jan-Mar)	2018 Y3, Q4 (Apr-Jun)	2018 Y4, Q1 (Jul-Sep)	2018 Y4, Q2 (Oct-Dec)	2019 Y4, Q3 (Jan-Mar)	2019 Y4, Q4 (Apr-Jun)	2019 Y5, Q1 (Jul-Sep)	2019 Y5, Q2 (Oct-Dec)	2020 Y5, Q3 (Jan-Mar)	2020 Y5, Q4 (Apr-Jun)
Needs Assessment and Data																
Convene the SEOW	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Develop State Epidemiologic Profiles	X	X	X	X	X											
Share CPES Strategic Plan and CPES progress w SEOW				X		X		X		X		X		X		
Conduct priority setting process with the SEOW	X	X	X		X	X	X									
Identify and prioritize data needs and sources	X	X	X	X	X	X										
Disseminate epidemiological data to DMHAS, SEOW, and key stakeholders				X	X			X	X			X	X			X
Develop Prevention Data Repository	X	X	X	X	X	X	X	X								
Develop template for community epidemiologic profiles (data repository)							X	X	X	X						
Compile/update data package for RAC subregional priority setting process					X	X							X	X		
Conduct a data resource and needs assessment w CTDC						X	X									

Activity	2016 Y2, Q1 (Jul-Sep)	2016 Y2, Q2 (Oct-Dec)	2017 Y2, Q3 (Jan-Mar)	2017 Y2, Q4 (Apr-Jun)	2017 Y3, Q1 (Jul-Sep)	2017 Y3, Q2 (Oct-Dec)	2018 Y3, Q3 (Jan-Mar)	2018 Y3, Q4 (Apr-Jun)	2018 Y4, Q1 (Jul-Sep)	2018 Y4, Q2 (Oct-Dec)	2019 Y4, Q3 (Jan-Mar)	2019 Y4, Q4 (Apr-Jun)	2019 Y5, Q1 (Jul-Sep)	2019 Y5, Q2 (Oct-Dec)	2020 Y5, Q3 (Jan-Mar)	2020 Y5, Q4 (Apr-Jun)
Needs Assessment and Data (cont'd)																
Regularly assess TA needs of DMHAS PHP initiatives	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Identify and contract with mental health experts and					X	X	X	X								
Convene mental health indicator workgroup						X	X	X								
Support Community Readiness Survey implementation and analysis							X	X							X	X
Planning and Management																
Participate in planning meetings w/ DMHAS PHP (including Resource Links and TTASC)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Conduct CPES management team mtgs	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Participate in PFS 2015 Implementation Team planning meetings	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Activity	2016 Y2, Q1 (Jul-Sep)	2016 Y2, Q2 (Oct-Dec)	2017 Y2, Q3 (Jan-Mar)	2017 Y2, Q4 (Apr-Jun)	2017 Y3, Q1 (Jul-Sep)	2017 Y3, Q2 (Oct-Dec)	2018 Y3, Q3 (Jan-Mar)	2018 Y3, Q4 (Apr-Jun)	2018 Y4, Q1 (Jul-Sep)	2018 Y4, Q2 (Oct-Dec)	2019 Y4, Q3 (Jan-Mar)	2019 Y4, Q4 (Apr-Jun)	2019 Y5, Q1 (Jul-Sep)	2019 Y5, Q2 (Oct-Dec)	2020 Y5, Q3 (Jan-Mar)	2020 Y5, Q4 (Apr-Jun)
Technical Assistance/ Capacity Building																
Develop and maintain CPES Website and SEOW webpage					X	X	X	X	X	X	X	X	X	X	X	X
Provide TA on data/epi issues and evaluation	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Provide TA on logic model development and use	X			X			X									
Participate in Learning Communities (w TTASC)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Convene Local Evaluator Workgroup				X		X		X		X		X		X		X
Data Dissemination and Product Development																
Support development and dissemination of State and RAC-level CRS reports								X	X						X	X
Develop info briefs on CRS, priority and emerging PHP issues	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Maintain active links and post relevant data, products, and news items to CPES website						X	X	X	X	X	X	X	X	X	X	X
Develop and update annual report card for DMHAS PHP						X	X				X				X	

Activity	2016 Y2, Q1 (Jul-Sep)	2016 Y2, Q2 (Oct-Dec)	2017 Y2, Q3 (Jan-Mar)	2017 Y2, Q4 (Apr-Jun)	2017 Y3, Q1 (Jul-Sep)	2017 Y3, Q2 (Oct-Dec)	2018 Y3, Q3 (Jan-Mar)	2018 Y3, Q4 (Apr-Jun)	2018 Y4, Q1 (Jul-Sep)	2018 Y4, Q2 (Oct-Dec)	2019 Y4, Q3 (Jan-Mar)	2019 Y4, Q4 (Apr-Jun)	2019 Y5, Q1 (Jul-Sep)	2019 Y5, Q2 (Oct-Dec)	2020 Y5, Q3 (Jan-Mar)	2020 Y5, Q4 (Apr-Jun)
Evaluation and Reporting																
Attend, participate, and observe CPES-relevant mtgs	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Collect and review archival records (agendas, minutes)				X	X			X	X			X	X			X
Monitor, compile and analyze relevant IMPACT data							X				X				X	
Conduct key informant survey	X							X	X						X	X
Monitor, assess and report on CPES/SEOW performance				X	X			X	X			X	X			X
Report CPES implementation data into IMPACT system as required by DMHAS					X	X	X	X	X	X	X	X	X	X	X	X

Figure 4. CPES as Part of the DMHAS Prevention System

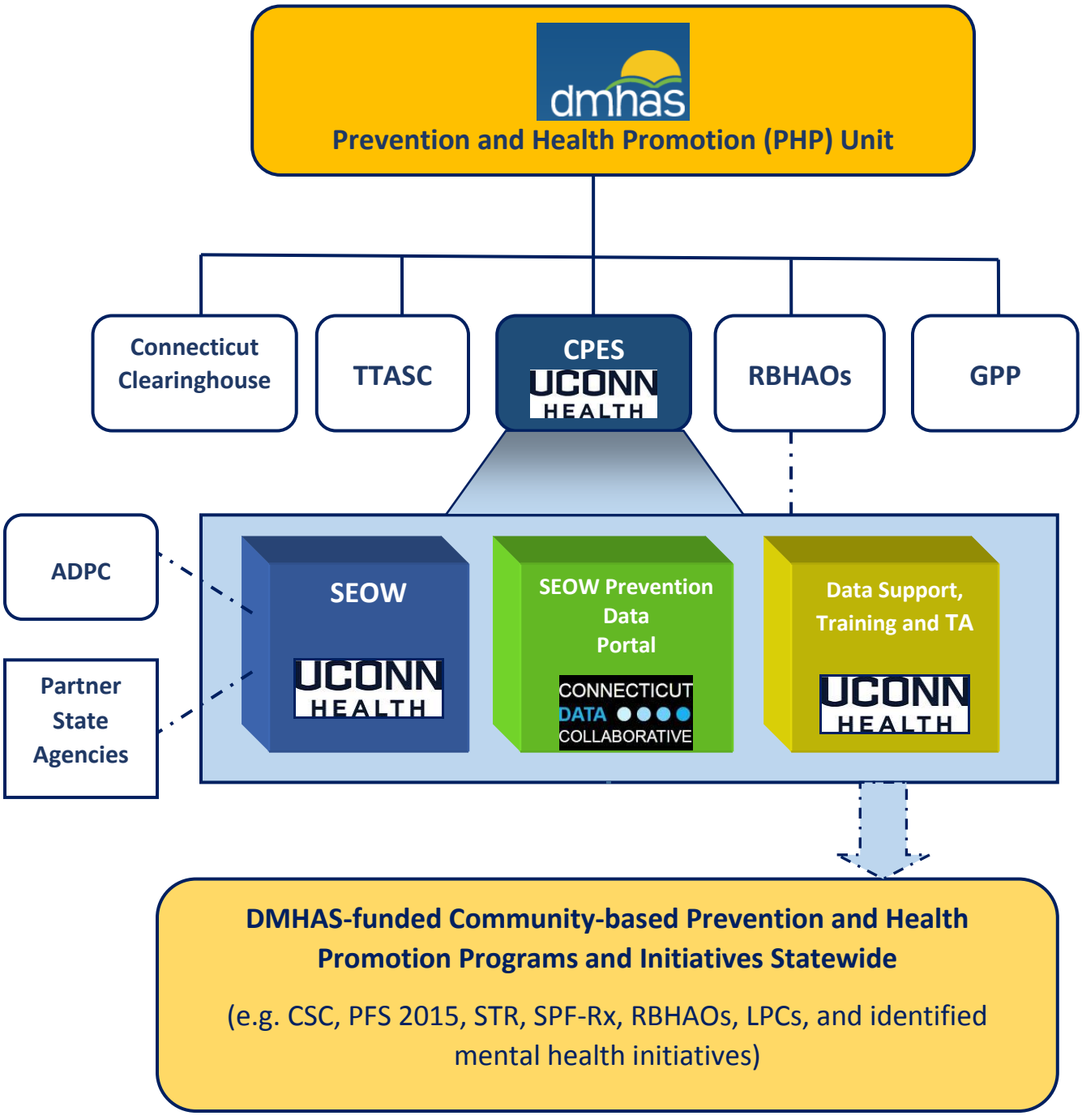


Figure 5. CPES Organizational Structure

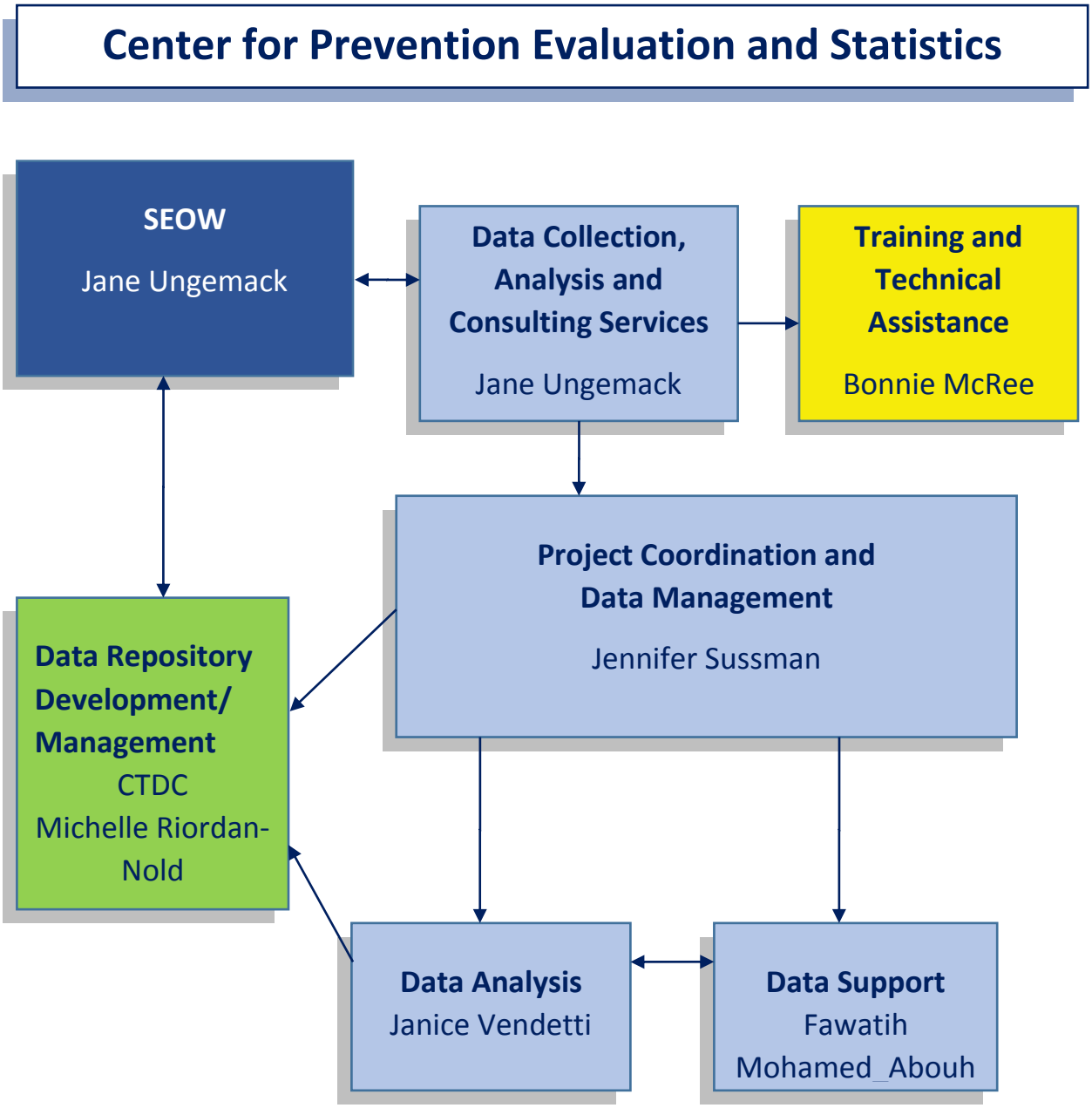


Figure 6: CPES Logic Model