Connecticut Department of Mental Health & Addiction Services
Prevention and Health Promotion Unit

Guidelines for Developing Regional Priority Reports

December 2018 version

Developed by
CPES
Center for Prevention Evaluation and Statistics

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Overview

Pursuant to the Substance Abuse Prevention and Treatment (SABG) and Mental Health Block Grant (MHBG) requirements, states must annually: assess needs, strengths and critical gaps of their service delivery systems; and, identify target populations and the priorities for the populations. As strategic community partners, Regional Behavioral Health Action Organizations (RBHAOs) will assist with this charge by assessing the behavioral health needs of children, adolescents and adults across the regions and developing Regional Strategic Plans to include epidemiological profiles and priority recommendations for prevention, treatment and recovery services.

2018-2019 Timeline

July-October: Development of draft regional prioritization guidelines for discussion with DMHAS and RBHAOs.

November: Release of 2018-2019 Guidelines for Developing Regional Priority Reports.

November/December: Data disseminated to RBHAOs.

Late October: RBHAO workgroup session(s) to understand and unpack the process, with ongoing training and technical assistance available through CPES.

November – May: Constituent surveys and focus groups; data review, analysis and summary; development of epidemiological profiles; selection and ranking of priorities; and plan development.

June: Profiles submitted to DMHAS for review and approval

Purpose

The purpose of this document is to provide a set of guidelines to help RBHAOs create regional epidemiologic profiles and develop strategic reports that identify funding priorities for substance abuse, mental health and problem gambling based on identified needs and gaps. The guidelines includes all the steps in the process, from obtaining, interpreting, and presenting data to the group process of selecting and ranking priorities for regional behavioral health, and development of the Regional Priority Report. The guidelines are also intended to help RBHAOs produce a report that is consistent in content, format, usefulness, and quality, and to promote comparability across regions.

The guidelines provide information about:

- How and where to obtain the core and supplemental epidemiologic data;
- How to interpret and present data;
- The process for developing the regional epidemiological profiles, including what content to include in the profile and how to organize it;
- Techniques for creating user-friendly profiles and reports for a variety of end users;
- How to conduct the regional prioritization process;
- Content, format, and considerations for development of the Regional Priority Report;
- Dissemination and use of the Regional Priority report.

Core Concepts

To increase the effectiveness of the report for end users, RBHAOs should have a common understanding of:

Definitions of Key Terms;
Priority setting and Report goals;
How Regional Priority Reports are used;
Activities involved in Report development.

Definitions

Epidemiology: The study of the distribution and determinants of health, disease, injury, or other health-related event in human populations and the application of this study to the prevention and control of health problems.

Epidemiologic Profile: An epidemiological profile is detailed reports that summarizes the problems affecting a particular community or population. It identifies characteristics of the general population, affected populations, and risk factors and health disparities that place individuals at increased risk for the problem in question. It consists of information gathered to describe the burden of a problem on an area or population in terms of sociodemographic, geographic, behavioral, and clinical characteristics. Epidemiologic profiles can be used to help identify prevention and health promotion needs and set priorities for a given region.

Priority Setting and Report Goals

The RBHAO Regional Priority Report is designed to:

- provide a thorough description of substance use, problem gambling, and mental health problems, including suicide, among the various populations (overall and subpopulations at increased risk) in a region;
- Examine trends over time in substance use, problem gambling, and mental health problems, including suicide, where possible;
- identify characteristics of the general population and of populations who are living with, or at high risk for, substance use and mental health problems, suicide, and problem gambling in the regions and who need primary and secondary prevention or health promotion services;
- provide information required to conduct prevention needs assessments and gap analyses for substance use and mental health problems, suicide, and problem gambling;
- Define regional priorities, resources, and assets, and make recommendations on addressing regional gaps and needs, as well as health disparities.

How Regional Priority Reports Are Used

Regional Priority Reports have many users. The primary users are planning groups, policy makers, service providers, coalitions, foundations, and applicants for funding. As the report is being developed, keep these end users in mind, as well as other end users identified by your stakeholders. *The report should be user-friendly for all users regardless of their experience with statistical data.*

Your region's report may be used to:

- set priorities among populations who need behavioral health prevention, treatment and recovery services;

- provide a basis for determining emerging needs, projecting future needs, and identifying health disparities;
- inform a comprehensive strategic plan;
- increase general community awareness of substance use and other behavioral health problems;
- support leveraging of funding;
- respond to public data needs (e.g., providers, educators, funding agencies, media, policymakers);
- Enhance membership of planning or advisory groups to be more demographically representative and/or more responsive to priority needs of the region.

Activities Involved in Prioritization Process and Report Development

The prioritization and report development process is a collaborative, multi-step process that involves both the RBHAOs and their identified key stakeholders. The process should be approached methodically, with consideration of regional contextual factors (strengths, adverse occurrences, political, social and organizational conditions) and health disparities at every step. Activities involved in this process will require individuals with different skill sets, areas of focus, and perspectives. RBHAO Coordinators should utilize their workgroup and planning resources, as well as the technical assistance resources provided by CPES, as needed to complete this important process.

Activities involved in the process are as follows:

1. Identify regional behavioral health priority setting workgroup (RBHPSW) members;
2. Review and update process and content for focus groups and surveys;
3. Administer surveys and implement focus groups;
4. Review and analyze data (SEOW, CRS, focus groups, survey, treatment, etc.)
5. Prepare epidemiological profiles by priority problem;
6. Identify strengths, services and resources, gaps, and needs;
7. Understand and utilize criteria for selecting priorities;
8. Convene RBHPSW and select priorities (this may take more than one meeting);
9. Prepare comprehensive report, utilizing specified report template;
10. Submit and disseminate report.

Regional Priority Report Development
Steps At-A-Glance

Activity	Steps	Product/Result	Target Date
1.	**Identify Regional Behavioral Health Priority Setting Workgroup (RBHPSW, or Workgroup)**	**RBHPSW/Workgroup**	
	Identify key stakeholders		
	Conduct outreach to identified individuals		
	Include individuals knowledgeable about mental health and substance abuse, including LPC and CAC representatives		
	Assess gaps in knowledge, expertise and perspectives, and conduct outreach to fill those gaps		
	Convene the group to discuss the overall plan and flesh out the process		
	Identify meaningful roles for members at each step of the process		
2.	**Review and update process and content for focus groups and surveys**	**Local Data Collection**	
	Determine the intent/purpose of focus groups and surveys, including target populations		
	Develop or access survey tool(s)		
	Develop focus group protocol and questions		
	Pilot the survey and focus group content with members of the target population(s)		
3.	**Administer surveys and implement focus groups**	**Local Data Collection**	
	Engage RBHPSW members in the survey/focus group implementation process		
	Ensure participation by a sample of all stakeholders		
	If useful data has been collected in the past, pay close attention to fidelity of implementation to ensure comparability		
	Compile and synthesize data for review and analysis		
4.	**Review and analyze data**	**Regional Epidemiological Profiles**	
	Obtain core and supplemental data (including locally collected data)		
	Determine which of these data to include in the analyses (qualitative and quantitative)		
	Conduct analyses, including comparisons with state and national data		
	Identify data gaps and additional data needs		
	Consult data resources provided by CPES, and seek technical assistance as needed		

Activity	Steps	Product/Result	Target Date
5. Prepare epidemiological profiles by priority problem		**Regional Epidemiological Profiles**	
	Focus on magnitude and impact		
	Use local and comparative data (community type, state, national)		
	Include data on risk factors, Mental Health and Substance Abuse Block Grant target and priority populations*, and other subpopulations at increased risk		
6. Identify strengths, services and resources, gaps, and needs			
	Assess regional capacity, strengths, limitations		
	Focus on regional resources and gaps		
	Utilize these elements in your prioritization process		
7. Understand and utilize criteria for selecting priorities		**Prioritization**	
	Criteria include magnitude, impact, changeability		
	Also consider community strengths, resources, gaps, needs		
	Develop a priority ranking matrix based on established criteria		
	Make sure RBHPSW members understand and prioritization criteria and process		
8. Convene RBHPSW and select priorities		**Prioritization**	
	Review prioritization process and criteria with RBHPSW/Workgroup		
	Present data in user-friendly formats		
	Engage the group in discussion of data limitations, gaps, contextual factors, and other questions the data raise		
	Establish plans to fill data gaps and answer questions raised by the group		
	Conduct ranking and prioritization according to established criteria		
	Determine recommendations based on the prioritization process		
	Allow enough time to complete the process (can take more than one session)		
9. Prepare comprehensive report		**Regional Priority Report**	
	Review and follow Regional Priority Report template for report content and organization		
	Integrate epidemiological profile and prioritization process into report		
	Draw overall conclusions and write an effective, useful narrative, paying special attention to shared risk factors and subpopulations at greater risk		
	Develop a clear, user-friendly executive summary		

Activity	Steps	Product/Result	Target Date
10. Submit and disseminate report		**Dissemination Plan**	
	Determine target audiences and areas of influence		
	Determine what aspects of the report should be shared, and in what format(s)		
	Prepare clear presentations for target audiences		
	Create a dissemination plan prior to distribution		

*Mental Health Block Grant (MHBG) target populations include: Children with Serious Emotional Disturbance (SED) and their families; Adults with Serious Mental Illness (SMI); Individuals with SMI or SED in the rural and homeless populations; and individuals who have Early Serious Mental Illness (ESMI) (10% MHBG set aside).

Substance Abuse Block Grant (SABG) priorities and priority populations include: pregnant women and women with dependent children; primary prevention (statutory 20% set aside); HIV early intervention services; Tuberculosis.

The Process

Develop RBHPSW/Workgroup
Develop Process and Content for Focus Groups and Surveys
Administer Surveys and Focus Groups
Review and Analyze Data
Prepare Epidemiological Profiles
Identify Strengths, Services and Resources, Gaps and Needs
Define Criteria for Selecting Priorities
Convene Workgroup and Set Priorities

1. Develop Regional Behavioral Health Priority Setting Workgroup (RBHPSW, or Workgroup)

Steps:

☐ Identify Key Stakeholders

It is important to engage individuals with knowledge and or experience and interest in the subject. Decide whether their role will be advisory or determinant, whether training is needed and whether there are any conflicts of interests or competing interests among them.

☐ Conduct Outreach to Identified Individuals

Some individuals identified for the Workgroup may have participated in prior prioritization processes as part of a Community Needs Assessment Workgroup (CNAW) within the Regional Action Councils, and others may have participated in reporting processes through the Regional Mental Health Board Catchment Area Councils (CACs). These individuals who have been engaged in the process can provide a good foundation for the Workgroup, but RBHAOs should not limit themselves to those individuals. Outreach can be conducted through existing relationships or by forging new ones. Outreach should take advantage of community-level entities such as the Local Prevention Councils (LPCs), Health Districts, and others identified as representative of the region, as well as community members, advocates, and consumers.

For outreach to members new to the planning process, it may be helpful to develop a fact sheet that describes the process in simple terms, its purpose and use, and that defines the role of the Workgroup, and the opportunities for involvement of individual members,

☐ Assess Gaps in Knowledge, Expertise, and Perspectives and Conduct Outreach to Fill Them

Desired Proficiencies

Certain minimum skills and knowledge are needed to ensure development of a valid, useful prioritization process and development of the Regional Priority Report. Additional capabilities and perspectives can only serve to enhance the quality of the process, as well as the report and its utilization. At a minimum, the team should include persons with knowledge and skills in the following areas:

Knowledge of prevention and health promotion programs and policies in the region;
Knowledge of basic data principles including the ability to:

- Interpret data
- Use descriptive statistics (e.g., mean, median, frequency, percentage, statistical relationships)
- Calculate rates
- Assess trends over time
- Determine of the strengths and limitations of the data;

Understanding of the confidential nature of data (e.g., restrictions in reporting small numbers);
Computer skills:

- Word processing skills;
- Use of basic statistical and graphics software (e.g., Microsoft excel, Microsoft PowerPoint);

Writing and speaking skills, including the ability to communicate difficult concepts clearly to a variety of audiences;
Interpersonal skills and ability to work with persons from diverse backgrounds and disciplines.

Once the core group is assembled, the above should be assessed, and additional outreach conducted to fill the gaps in representation, skills, knowledge, and perspectives.

The RBHPSW, or the Workgroup for short, should at a minimum include individuals who are representative of their region. These may include individuals with lived experience, individuals at increased risk for behavioral health problems and those experiencing health disparities or their representatives, family members, potential users of the report, service providers and policy makers. It is up to the RBHAO to determine the mix of members with content expertise and knowledge to inform the process. The RBHAO should also ensure that they have the staff capacity and time to complete the process and prepare the report.

☐ Convene the Group to Discuss the Plan and the Process

The work of the Workgroup will require collaboration and consensus, so it is important that the group meet prior to beginning their work, to discuss the overall plan and the steps involved in prioritization and report development, as well as to make sure the group understands the importance of this process, its usefulness, and benefits. Convening the group for these purposes can serve to increase buy-in, commitment, and group cohesion, for a smoother and more efficient process going forward.

☐ Identify Meaningful Roles for Members at Each Step of the Process

One of the keys to a comprehensive and user-friendly report is to ensure that the every step in the development process is a collaborative effort between the RBHAO staff and the Regional Behavioral Health Priority Setting Workgroup (RBHPSW).

A multidisciplinary team approach is recommended, even if one person takes the lead in writing the report. A team can reduce strain on local resources (i.e., one person who prepares the report in addition to other responsibilities), bring multiple skills, and experience, and perspectives to the work.

2. Review and Update Process and Content for Focus Groups and Surveys

Steps:

☐ Re-visit the intent/purpose of focus groups and surveys, including target population(s)

Surveys: in past planning years, a provider survey has been conducted jointly by Regional Mental Health Boards and Regional Action Councils, to assess service substance use and mental health system needs, emerging issues, challenges, and impacts to the system, as well as recommendations for improvement of the service system.

Focus Groups: Engaging stakeholders as key informants in focus groups provides credibility and avoids prioritizing topics that have no relevance to real-world issues. In past planning years, focus groups have been utilized to collect perspectives on service accessibility, quality, needs, strengths of the service system, barriers to service provision, and suggestions for improvement and to strengthen prevention efforts.
An assessment by RBHAOs of the usefulness of these local data to the planning and prioritization process will drive decisions to continue or re-tool these approaches.

☐ Develop or Access Survey Tool(s)

In order to collect the information most vital to the DMHAS report process, DMHAS has developed a set of required questions to be utilized in the regional data collection process, either through surveys or focus groups. A list of these questions are in the Appendix of this document. Decisions about the intent/purpose of surveys and their role in priority setting and other RBHAO work may suggest the need for additional items, or survey administration to a different target population or additional stakeholders.

☐ Develop Focus Group Protocol and Questions

A protocol for conducting focus groups should address the following elements: the proposed size and makeup of the group; focus group logistics (setting and format); confidentiality; the scope, form and process of data collection; as well as how the data will be organized and presented. DMHAS' required questions (found in the Appendix) should be utilized in the survey and focus group components of the local data collection, as deemed most appropriate by the RBHAOs. Decisions about the intent/purpose of the focus groups and their role in the larger RBHAO process may suggest the need for additional questions, or the need to conduct focus groups with additional or different target populations. RESPONSES TO THE REQUIRED ITEMS MUST BE SUBMITTED AS AN APPENDIX TO THE REGIONAL PRIORITY REPORT.

☐ Pilot the Survey and Focus Group Content with the Target Population(s)

Newly developed surveys and protocols, protocols being utilized with new target populations, should be piloted with the members of the target populations,

and feedback solicited, prior to launch or use with the larger target population. Pilot testing allows for refining of the questions or approach for maximum data quality, and to ensure that respondents understand the questions being asked of them and the time needed to complete the survey.

3. Administer Surveys and Implement Focus Groups

Steps:

- ☐ If useful data has been collected in the past, pay close attention to fidelity of implementation to ensure comparability
- ☐ Engage RBHPSW members in the survey/focus group implementation process
- ☐ Compile and synthesize data for review and analysis

4. Review and Analyze Data

Steps:

- ☐ Obtain core and supplemental data

Types and Sources of Data for Epidemiologic Profiles

The table below describes commonly available data and their sources.

Type of Data	Description	Where to Obtain
Demographic data	Demographic data are used to describe social characteristics (e.g., gender, stage of life, and race/ethnicity, income, education, poverty level) of persons in the region.	SEOW Prevention Data Portal

Type of Data	Description	Where to Obtain
Local surveys	Surveys and other data collected from community-based organizations, service organizations, universities, and special studies.	Local evaluators and coalitions
Substance Misuse Data	Substance misuse data are obtained from population-based surveys, medical examiner records, correctional facilities, law enforcement agencies, and state agencies. These sources describe the patterns, prevalence, and consequences of drug use in the general population and specific populations, as well as, in some cases, risk factors.	SEOW Prevention Data Portal
Problem Gambling Data	Problem gambling data is less available, but includes calls to the gambling help line, and information on risk factors, consequences, subpopulations affected, and co-occurring problems.	DMHAS, CPES
Mental Health Data	Mental health data are available from population-based (household and student) surveys (self-reported problems), state agencies such as DMHAS (treatment data), and hospitals, as well as mobile crisis (service requests) and claims data.	SEOW Prevention Data Portal, DMHAS, RMHBs, 211 Counts

Type of Data	Description	Where to Obtain
Suicide data	Vital records contain information, as stipulated by state statutes, on deaths. For example, death records include the cause of death according to the rules of the National Center for Health Statistics and the International Classification of Diseases (ICD-9 or ICD-10) demographics of the deceased. Data on intentional injury may also be available through hospitals, mobile crisis, and Poison Control.	SEOW Prevention Data Portal Hospital data Poison Control
Qualitative Provider and Stakeholder Data	Provider Survey, focus group data, and the DMHAS Community Readiness Survey (CRS) assess systems issues, capacity, local needs and strengths, and consumer experiences (access, etc.)	Collected by RBHAOs CRS data held by CPES

☐ Determine which of these data to include in the analyses

Data Quality and Use Considerations

Below are some considerations for prioritizing data from various sources and in various forms. All data has strengths and limitations, and knowing both will inform inclusion and interpretation of data for the Epidemiological Profiles and the prioritization process that will follow.

Reliability of the data: How well does the data on use or incidence accurately reflect true prevalence? For example, how well does the prevalence of past 30-day use reported in student surveys represent the reality of youth substance use in the region? Are these data consistently reported over time and across reporting units?

Validity of the data: Validity is the accuracy of the data. *How well does a variable measure what it is intended to measure?*

Representativeness of the data: How well do the characteristics of respondents/cases correspond to the characteristics of the overall population? For example, data from a hospital-based sample may not represent all persons in the area covered by the survey.

Comparability of data: Are there comparable data available to track changes over time (trend data), or to compare to similar communities, the State, and nation?

Age of the data: How old are the data that will be used for analysis? For example, a behavioral survey conducted in 2000 might not provide data that are sufficiently up-to-date for current prevention activities.

Timeliness of the data: How long is the reporting delay between data collection and the publication of the report?

Limitations of the data source or variable of interest: Consider the limitations of the data source or variable, such as lack of granularity or generalizability, and suppression of data.

Surrogate, or proxy, markers: A proxy variable is used as a marker for other variables when what we really want to measure is too difficult to measure directly.

Small numbers: Data based on small numbers should generally be avoided. Rates calculated from numerators smaller than 20 should be denoted in a footnote as potentially unreliable.

☐ Conduct analyses, including comparisons with state and national data

Understanding Basic Analytic Concepts

Compilation of epidemiological data is only part of the prioritization and report development process. To be useful to RBHRDWs and other planning groups, the data must be analyzed and interpreted. Analysis is the application of logic in order to understand and find meaning in the data. It involves identifying consistent patterns and summarizing the relevant details. The purposes of analysis and interpretation in an epidemiologic profile are to:

- Identify populations in a region that are affected by substance misuse, problem gambling, mental health issues, or suicide and describe their key characteristics;
- Identify risk factors and subpopulations at greater risk for health disparities;
- Understand the impact of these problems in a region;
- Identify emerging trends and needs.

Descriptive Analyses

Descriptive analysis is concerned with organizing and summarizing data according to time, place, and person. To carry out an effective descriptive analysis, become familiar with the data before applying analytic techniques. This initial examination should progress to summarizing the data with descriptive statistics, such as frequencies and percentages, in a table to explain the distribution of the substance use, problem gambling, and suicide in the region.

As the data are analyzed and interpreted, keep the following cautions in mind:

- Be aware of the strengths and limitations of the data source. *Is the data of high quality? What precisely does it measure? Are any data missing or suppressed? What questions does it leave unanswered?*
- Confidentiality of public health data is a special concern when dealing with small numbers of cases because of the potential that a person can be identified. This is especially true with suicide data.
- Concerns about lack of reliability mean that caution must be taken in interpreting large percent changes (increases or decreases) based on small numbers.

☐ Identify data gaps and additional data needs

☐ Consult data resources provided by CPES, and seek technical assistance from CPES as needed.

The Center for Prevention Evaluations and Statistics (CPES), staffed by Jane Ungemack, Dr. PH., Principal Investigator, and Jennifer Sussman, Coordinator, was established to support DMHAS in its prevention and health promotion efforts through the identification, collection, analysis, interpretation and dissemination of data pertaining to substance abuse prevention, mental health, and health disparities. The CPES supports the RBHAOs by identifying indicators, accessing and assessing indicator data including but not limited to those identified for the priority substances; providing research and statistical expertise and support, as well as training and technical assistance on evaluation and data use; tracking behavioral health indicators, and developing and maintaining the SEOW Prevention Data Portal: https://ctdata.shinyapps.io/cpes/

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

5. Prepare Epidemiological Profiles by Priority Problem

As part of the priority setting and report development process, RBHAOs should develop brief (1-3 page) epidemiological profiles for all major problems/substances listed in the tables below. Epidemiological profiles may also be developed for emerging issues as well.

Steps:

☐ Focus on Magnitude and Impact

Magnitude

1. Describe the data for people affected, including data for various age groups and subpopulations;
2. Describe the range of prevalence across towns;
3. Indicate any trends over the last 3 to 5 years;
4. Compare town-level prevalence rates to regional and/or state rates if possible;
5. Include anecdotal information from key stakeholders that gives life to data.

The table below represents a sample of available indicators. For a more complete list of available indicators, contact the Center for Prevention Evaluation and Statistics (CPES). Additional indicator data may also be available locally.

MAGNITUDE Indicators	Alcohol	Tobacco	Prescription Drugs	Illicit Drugs	Marijuana	Cocaine	Heroin	Mental Health Issues	Suicide	Problem Gambling
Past month use	✓	✓	✓	✓	✓					✓
Past month binge drinking	✓									
Past year or lifetime use			✓	✓	✓	✓	✓			
Past year gambling										✓
Perception of risk of harm of use	✓	✓	✓	✓	✓					✓
Age of initiation	✓	✓	✓	✓	✓	✓	✓			✓
Calls to gambling helpline/use of problem gambling chat/text lines										✓
Sad or hopeless, stopped activities								✓	✓	
Mental illness/SMI past year								✓		
Seriously considered suicide/ suicide plan								✓	✓	
Self-inflicted injury								✓	✓	
Suicide deaths								✓	✓	

Impact

1. Describe the data in terms of the impact across populations and towns, indicating the greatest and least impacted towns;
2. Describe the severity of social, health, economic, and criminal justice costs in the region;
3. Indicate trends over the last 3 to 5 years;
4. Compare town-level rates to regional, and/or state rates if possible;
5. Include anecdotal information from key stakeholders that gives life to data.

The table below represents a sample of available indicators. For a more complete list of available indicators, contact the Center for Prevention Evaluation and Statistics (CPES). Additional indicator data may also be available locally.

IMPACT/BURDEN Indicators	Alcohol	Tobacco	Prescription Drugs	Illicit Drugs	Marijuana	Cocaine	Heroin		Mental Health Issues	Suicide	Problem Gambling
School attendance	✓		✓	✓	✓	✓	✓		✓		✓
School suspensions/expulsions	✓	✓	✓	✓					✓		✓
Drove after drinking	✓										✓
Alcohol-related fatal MV crashes	✓										
Alcohol-related MV accidents	✓										
Alcohol-related MV deaths	✓										
Driving under the influence arrests	✓										✓
Liquor law violations	✓										
Drug law offenses				✓	✓	✓	✓				✓
Treatment admissions	✓		✓	✓	✓	✓	✓		✓	✓	✓
Property and violent crime	✓		✓	✓	✓	✓	✓		✓		✓
Deaths from lung cancer		✓									
Suicide attempts									✓	✓	✓
Suicide deaths									✓	✓	✓
Self-injury treated by doctor/nurse									✓	✓	✓

☐ Use Local and Comparative Data

Local and comparative data provide both context and specificity when used in concert with the data previously discussed.

☐ Include Data on Risk Factors, Mental Health and Substance Abuse Block Grant Target and Priority Populations, and Other Subpopulations at Increased Risk

The table below represents a sample of available indicators. For a more complete list of available indicators, contact the Center for Prevention Evaluation and Statistics (CPES). Additional indicator data may also be available locally.

Population/Risk Factor Indicators	Alcohol	Tobacco	Prescription Drugs	Illicit Drugs	Marijuana	Cocaine	Heroin	Mental Health Issues	Suicide	Problem Gambling
Gender	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Race/ethnicity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Income level	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Single parent households	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Community type	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Poverty status	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4 year cohort graduation rate	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chronic absenteeism	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Disengaged youth	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bullying	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Homelessness/housing status	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Reported HIV/Hepatitis Cases			✓	✓			✓			
Substance use/misuse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mental health issues (SED, SMI, ESMI)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Social/Emotional Support (lack of)								✓	✓	

The epidemiological profiles comprise individual synopses of data on alcohol, tobacco, prescription drugs, marijuana, heroin, illicit opioids, cocaine, problem gambling, mental health problems such as anxiety and depression, and suicide. Each synopsis should contain all relevant indicators and should be no more than two to three pages long.

The profiles should be able to stand alone and be used individually or as a group in the work of the RBHAOs and their community partners. Data in these profiles will also be utilized in the regional prioritization process which is outlined later in this guidance document. An example layout of the Epidemiological Profile can be found in the Appendix.

6. Identify strengths, services and resources, gaps, and needs

Steps:

☐ Assess Regional Capacity, Strengths, and Limitations

Describing capacity means taking a close look at the assessment data for substance misuse, problem gambling, mental health problems, and suicide, identifying readiness and existing resources, finding the gaps that lie therein, and developing recommendations to address those gaps and improve capacity.

Of course, resources and readiness often go hand-in-hand: building resources also contributes to greater readiness. For example, when key stakeholders are engaged in solving problems, they often mobilize others to get involved. This leads to more people recognizing the value of prevention.

A key facet in prioritizing the six substances, mental health issues, problem gambling, and suicide is describing both the capacity within the community and changes to the community environment that will reduce problems related to substances, gambling, and suicide.

Describe the level of awareness, concern, and action across the region as it pertains to the problem. Look critically at the community readiness data to identify areas in which community members are not yet ready to undertake prevention or mental health promotion, and ways in which their capacity and readiness can be increased to address substance issues, mental health problems, problem gambling, or suicide.

Recommended Considerations:

- Describe the findings from the Community Readiness Survey, the web-based key informant survey conducted bi-ennially since 2006, and most recently in 2018, to measure state and community readiness and capacity for implementing effective evidence-based substance abuse prevention programs, policies and practices. RBHAO and state results will be disseminated in early October, 2018.
- Describe existing prevention, treatment, and recovery resources in the community related to the substance, mental health issue, problem gambling, and suicide. *Are a range of partners engaged and involved - to share resources and information and to ensure that that the community is able to reach multiple populations with multiple*

strategies, in multiple settings? Are important champions for prevention found in the local media, and in the legislature, faith, or business communities?

- Indicate evidence based services, system changes, collaboration that might improve readiness to address the problem. *Are there broad cultural representation and a wide base of support? Are there systems to support prevention and health promotion workforce development activities?*

The table below represents a sample of available indicators. For a more complete list of available indicators, contact the Center for Prevention Evaluation and Statistics (CPES). Additional indicator data may also be available locally.

Capacity and Strength Indicators	Alcohol	Tobacco	Prescription Drugs	Illicit Drugs	Marijuana	Cocaine	Heroin	Mental Health Issues	Suicide	Problem Gambling
Community readiness	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Community concern	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Community attitudes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Perceived effectiveness of services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Provider data	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Focus group results	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Services/programs in place (MH, SA, Suicide, problem gambling)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medication Assisted Treatment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Evidence-based practices	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Naloxone distribution	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Homelessness services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Access to services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Existing infrastructure for prevention, treatment recovery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

☐ Focus on regional resources and gaps

Focus group and provider survey data will inform this assessment, as will service system information, treatment utilization data, and other sources of local information. Specifically, focus group and provider survey data are important elements in the prioritization process, providing systems and stakeholder insights that can inform the assessment of gaps, strengths, needs, and the resulting regional recommendations.

☐ Utilize these elements in your prioritization process

7. Understand and utilize criteria for selecting priorities

Steps:

☐ Consider Magnitude, Impact and Changeability, and Readiness

Magnitude – the burden and breadth of the problem
***Consider:* How many people are affected directly and indirectly?**
How serious are the consequences?
Impact – the depth of the problem across the various dimensions including the impact on the healthcare system, economy and criminal justice resources.
Changeability – whether the problem can be reversed or changed within a specified period, and whether evidence-based strategies are available or sufficient to effect change.
Capacity/readiness – whether there is community capacity and readiness to address the problem. Is there buy-in? Are others in the area doing similar work? Consequence of Inaction – What may be the changes in the problem? What may be changes in consequences to individuals and the community?

☐ Also Consider Community Strengths, Resources, Gaps, and Needs

Focus group and provider survey data as well as insights from stakeholders in the Workgroup, and RBHAO staff, should come together in the identification of strengths, resources, gaps and needs. In this, as in all steps of the process, consideration should be given to gaps related to health disparities and health access for subpopulations at increased risk.

☐ Utilize a Priority Ranking Matrix Based on Established Criteria

The SEOW has developed a process for systematically collecting rankings of the substance misuse and behavioral problems with the highest prevalence in and impact on the region. This process, which has been widely used and is described below, is recommended for use with the RBHPSWs:

- After preparing the Regional Epidemiological Profiles, the RBHAO will convene its Regional Behavioral Health Priority Setting Workgroup (RBHPSW) to review the data and information contained in the profiles.

- Using a Priority Rating Matrix (Appendix), each Workgroup member scores each problem on a scale of one to five (low to high priority) using the following criteria:

  Magnitude (Burden and breadth of problem)
  - A relatively large number of people are affected
  - 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
  - Resources and evidence-based strategies (EBPs) are available to affect change in the indicator
  - Can outcomes/impact be demonstrated in 2 (or 3) years?

  Capacity/Readiness (Resources and buy-in related to the problem)
  - Are there adequate human and financial resources to address the problem?
  - Is there community-buy in regarding the problem?
  - Are there others in the region addressing this? Is it identified in strategic plans?

  Consequence of Inaction (What happens if this problem is not addressed?)
  - What may be the changes in the problem?
  - What may be changes in consequences to individuals and the community?

- RBHAOs then add the scores to determine the priority ranking for each problem.

- It is recommended that RBHAO add scores and create an average or mean score so that all substances and problems are ranked on a 5 point scale.

☐ Make Sure RBHPSW Members Understand and Are On Board with Prioritization Criteria and Process

Ensure that the goals for priority setting are aligned within the strategic purpose of DMHAS. RBHAOs cannot by themselves undertake activities to address all behavioral health needs, so priority-setting decisions must flow from their overall mission and strategic purpose.

8. Convene Workgroup and Select Priorities

Steps:

☐ Review Prioritization Process and Criteria with the Workgroup

Make sure all members of the Workgroup are clear on the criteria being used to prioritize and the steps in the process. Allow members to ask questions regarding the process and have them adequately addressed.

☐ Present Data in User-Friendly Formats

Summarizing the data and presenting them in tables or figures are critical to an effective prioritization, because raw data are difficult to understand, visualize, aggregate, and use in detecting trends. However, poorly designed or executed tables and figures can mislead users or distract them from the message.

Tables may be the only presentation format needed when the data are few and relationships are straightforward (tables are the best choice when the display of exact values is important). Figures (e.g., line and bar graphs, pie charts) make more sense for trends and for comparing populations, especially with populations broken into subsets, such as males and females or age groups. The key points of tables and figures should always be explained in the accompanying narrative.

While developing the profile and determining which kind of display to use, consider these questions:

- Can the Workgroup determine what data are being conveyed by looking at this type of display, or would another type be better?
- Given the needs of the Workgroup, is this presentation of the data logical?

☐ Engage the Workgroup in Discussion of Data Limitations, Gaps, Contextual Factors, and Other Questions the Data Raise

Contextual factors: Has something occurred in the region or the state in terms of policy, media approaches, events or occurrences that have impacted quantitative data or partners' perceptions of a problem or local condition negatively or positively?

☐ Establish Plans to Fill Data Gaps and Answer Questions Raised by the Workgroup

Address any questions that arose from the process, and make note of data limitations and contextual factors. Make a list of data gaps and brainstorm potential sources and linkages to fill those gaps. A list of action steps can be generated from this information, if so desired, to guide coalition efforts going forward.

☐ Conduct Ranking and Prioritization According to Established Criteria

Please refer to the process, criteria, and considerations describe in the previous pages, and utilize the Ranking and Priority Recommendation matrices in the Appendix to organize your information.

Identifying priorities:
When the number of priorities is large, multiple rounds of prioritization, as well as consideration of feasibility and resources, may be needed to narrow the number. Priorities may also be combined, utilizing the information recorded in the Priority Recommendation Matrix in the Appendix.

☐ Determine recommendations based on the prioritization process

Once priorities are determined, the Workgroup should utilize the information gathered on resources/strengths/assets and resource gaps/needs to identify recommendations for the region in the realms of prevention, treatment, and recovery for substance abuse/misuse, mental health, and problem gambling. These recommendations will be distilled and summarized in the Recommendations/Conclusion section of the Regional Priority Report (refer to the Report section of this document for more information on structuring regional recommendations).

☐ Allow Enough Time to Complete the Process

The data review and prioritization process can take more than one session, if needed. One approach is to convene two Workgroup sessions, the first focused on data presentation and discussion, identification of gaps and limitations, and the second focused on the prioritization ranking. This is not the only approach, however, and RBHAOs and their RBHPSW should determine the approach that best suits their needs and capabilities.

The Report

Prepare the Regional Priority Report
Submit and Disseminate Report
Dissemination and Use

9. Prepare the Regional Priority Profile Report

Steps:

- ☐ Review and follow Regional Priority Report format (see Content and Organization) and template (separate document, to be distributed)
- ☐ Integrate epidemiological profiles and prioritization process into report
- ☐ Draw overall conclusions and write an effective, useful narrative, paying special attention to shared risk factors and subpopulations at greater risk
- ☐ Develop a clear, user-friendly executive summary.

Scope of the Report

To be useful, the regional priority report should answer several core epidemiological questions:

1. What are the sociodemographic characteristics of the general population in the region?
2. What is the scope - magnitude and impact - of substance use, mental health issues, suicide, problem gambling, and related problems in the region?
3. What are the relevant risk factors associated with these problems in the region?
4. What subpopulations are at greater risk of substance use and mental health problems, suicide, problem gambling, and related problems in the area?

It should also answer questions specific to planning needs, such as:

What services are available for affected persons in the area, and what services are being done well, meeting a priority need, or showing positive results?
What evidence-based services, system changes, or collaboration might increase the region's capacity to address the problem?

Content and Organization

As is true of any good document, a well-organized profile is divided into logical sections:

- Front Matter
- Introduction
- Body
- Recommendations/Conclusions
- Appendices

Front matter

The front matter should consist of the following:

Contributors: a list that includes the names of writers and others who worked on the regional priority report, including those who gathered or synthesized data for the profiles, and those who contributed to the prioritization process as part of the Regional Behavioral Health Priority Setting Workgroup (RBHPSW);
Abbreviations: a list of the shortened names for terms and organizations that appear in the profile;
Executive Summary: a synopsis of the report's content including a brief description of priority ranking process and results;
Table of Contents and Figures: a listing, with page numbers, of topics, tables, charts, and figures. The table of figures can be integrated into the Table of Contents or exist as a separate Table.

Introduction

The introduction should include the following:

Background about the history and purpose of the report;
General description of data sources including surveys and focus groups and their strengths and limitations to ensure that users understand what the report can and cannot explain;
Overall description of the report's *strengths and limitations*;
A brief description of how the report was developed, and by whom, including a description of the priority setting process.

Body

The body of the report includes:

- *Brief description of the region*, including demographic characteristics of the population, and any relevant geographic, governmental, or other characteristics, including existing or emerging subpopulations in the region.
- *Regional epidemiological profiles by substance/problem* (data that answer the core epidemiologic questions). Data are typically presented in tables, graphs, pie charts, or maps, accompanied by a narrative that explains and expands upon the data. Profiles should be completed for: Alcohol; Tobacco/ENDS; Marijuana; Cocaine; Heroin and Other Illicit Opioids (such as Fentanyl); Prescription Drugs; Mental Health issues, including Depression and Anxiety; Suicide, and Gambling.
- Discussion of *emerging issues* in the region, including issues and substances that should be monitored over time for significance.
- Discussion of *resources, strengths, assets in the region*, including a description of services that are available for affected persons in the area, and what services are being done well, meeting a priority need, or showing positive results.
- Discussion of *resource gaps and needs in the region*, including consideration of evidence-based services, system changes, or collaboration that might increase the region's capacity to address the priority problems.

Utilize the information your Workgroup has compiled in the *Priority Recommendation Matrix* (in Appendix) to organize your discussion of resources/strengths/assets and resource gaps/needs.

Recommendations/Conclusion

The Conclusion summarizes the data and trends and highlights key findings, and lays out the main recommendations as result of the prioritization process.

The Recommendations section should include a summary of the main recommendations generated by the Workgroup, and can be summarized in the *Priority Recommendations* table, which follows. Recommendations should be specific to substance, problem or issue and realistic in scope, and be organized according to the realms of prevention, treatment, and recovery for substance abuse/misuse, mental health, and problem gambling. Systems or access recommendations can also be summarized in this section.

Priority Recommendations: Region X

Problem/Issue	Prevention	Treatment	Recovery
Substance Abuse/ Misuse			
Mental Health			
Problem Gambling			
Systems/Other *(optional)*			

At least <u>one</u> recommendation should be made relevant to substance abuse/misuse, mental health (including suicide), and problem gambling, in the realms of prevention, treatment, and recovery.

Using the above table format, all non-optional cells should be populated. Different substance/problems/issues can be addressed in each of these realms (e.g. suicide could be the focus of the recommendation in the prevention realm/cell, while depression/anxiety could be the focus of the recommendation in the treatment realm/cell).

Recommendations can also span priority substances/problems as applicable, in cases in which risk factors and/or subpopulations are shared.

<u>Appendices</u>

Appendices can contain additional information on data sources, instruments/approaches (such as surveys and focus group questions and content), and any other pertinent supporting documentation.

Answers to the **DMHAS Required Stakeholder Questions for Regional Priority Reports** <u>must be included</u> in the report Appendices.

10. Submit and Disseminate Report

Steps:

In order for your prioritization and report to forward the work in your region, it must be shared with key stakeholders, funders, and others you identify as end users of the report.

☐ Determine target audiences and areas of influence

Consider stakeholders across the spectrum of substance abuse, mental health, gambling and suicide, and those at the state, regional and community levels.

☐ Determine what aspects of the report should be shared, and in what format(s)

Before sharing your Regional Priority Report beyond DMHAS and your Workgroup, it is important to strategize and plan dissemination of the report and/or its components for maximum impact and effectiveness.

The contents of the report can be broken out and shared separately. Components designed specifically for this purpose are the Executive Summary and the Epidemiological Profiles, but other elements of the report can also be highlighted through print, electronic, in person, website posting, and multimedia approaches, such as:

- Info Briefs
- Infographics
- PowerPoint presentations
- Press releases

☐ Prepare Clear Presentations for Target Audiences

When preparing presentations, the goals of and target audiences for the presentations should drive the content, which may be different for each presentation and audience. Some key questions to ask in preparing a presentation are:

- Who is my audience?
- What is their capacity to understand data?
- Why are they here?
- What do they need to know?
- What do we need them to know?
- How will this information be utilized? (potentially and in practice)
- How can we best get our points across?

☐ Create a Dissemination Plan Prior to Distribution

One process of conceptualizing dissemination is to create a dissemination plan. This should be done with your Workgroup, once your report has been finalized. Questions to be answered in your dissemination plan include:

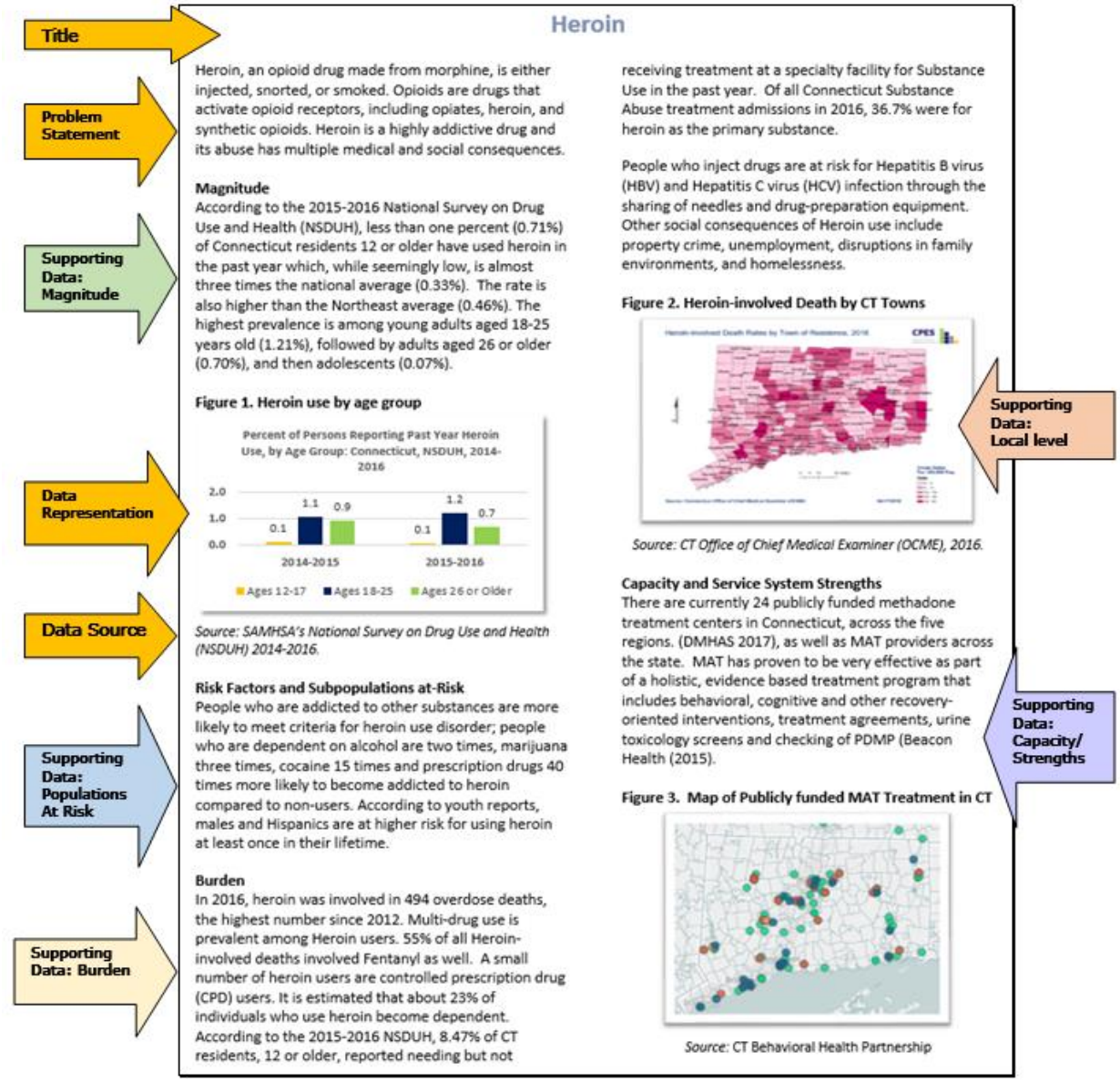
- Who is the audience for this report or report elements? Are there multiple audiences that can best be reached by different approaches?
- Do priorities and recommendations resonate with funders and policy makers? How about key stakeholders and community members?
- What are the best ways (formats, vehicles, and approaches) to communicate these findings to the public, funders, and others?

Example of Regional Epidemiological Profile Layout
Priority Ranking Matrix
Priority Recommendation Matrix
Suggested Stakeholder Questions

Appendices

Example of Regional Epidemiological Profile Layout

The example below illustrates the content requirements of the regional epidemiological profile, which comprises individual synopses of data on alcohol, tobacco, prescription drugs, marijuana, heroin, illicit opioids, cocaine, problem gambling, mental health problems such as anxiety and depression, and suicide. Each synopsis should contain all relevant indicators and should be no more than **two to three** pages long.



RBHPSW (Workgroup) Priority Ranking Matrix

SCALE: 1=Lowest 2=Low 3=Medium 4=High 5=Highest

PROBLEM	MAGNITUDE	IMPACT	CHANGEABILITY	CAPACITY/ READINESS	CONSEQUENCE OF INACTION	TOTAL	Mean Ranking Score:
Alcohol							
Tobacco							
Electronic Nicotine Delivery Systems (ENDS), vaping, juuling							
Marijuana							
Prescription Drug Misuse							
Heroin							
Cocaine							
Problem Gambling							
Mental Health Issues (specify as applicable)							
Suicide							

Priority Recommendation Matrix

Assess each identified substance or behavior based on your prioritization (magnitude, impact, changeability, and readiness/capacity for change).

Document who is being directly and indirectly impacted or harmed, and where (subpopulations), based on an assessment of why (risk factors).

Consider what resources and assets are available (i.e. public education; staff training; evidence-based /environmental approaches to prevention, treatment, and recovery; and data availability), and what local strengths exist (what is being done well).

PRIORITY PROBLEM	Risk Factor(s)	Subpopulation(s) of Increased Risk	Community Strengths, Resources and Assets	Challenges, Gaps, and Needs		
Substance Misuse/Abuse				Prevention	Treatment	Recovery/ Maintenance
Alcohol						
Tobacco						
Electronic Nicotine Delivery Systems (ENDS), vaping, juuling						
Marijuana						
Prescription Drug Misuse						
Heroin						
Cocaine						

PRIORITY	Risk Factor(s)	Subpopulation(s) of Increased Risk	Community Strengths, Resources and Assets	Challenges, Gaps, and Needs		
Problem Gambling and Mental Health Issues				Prevention	Treatment	Recovery/ Maintenance
Problem Gambling						
Depression, Anxiety, PTSD, Trauma, etc.						
Serious Emotional Disturbance						
Early Serious Mental Illness						
Serious Mental Illness						
Suicide						
Other Priorities (Specify below)						

Required Stakeholder Questions for Regional Priority Reports

Instructions: *RBHAOs must obtain feedback from a broad array of stakeholders about the needs and strengths of, and opportunities for, the DMHAS funded and operated substance use, mental health and problem gambling systems. Following are the questions that must be asked, analyzed and incorporated in the Regional Priority Report. RBHAOs are free to determine the best format for obtaining the feedback.*

A summary of the answers to these questions must be included in the Appendices to the RBHAO Regional Priority Report. *An answer grid, which follows this list of questions, has been developed to aid in this process.*

1. How appropriate are available services to meet the needs of:
   - substance use prevention, treatment and recovery?
   - mental health promotion, treatment and recovery?
   - problem gambling prevention, treatment and recovery?

2. What prevention program, strategy or policy would you like to most see accomplished related to:
   - substance use?
   - mental health?
   - problem gambling?

3. What treatment levels of care do you feel are unavailable or inadequately provided:
   - related to substance use?
   - related to mental health?
   - related to problem gambling?

4. What adjunct services/support services/recovery supports are most needed to assist persons with:
   - substance use issues?
   - mental health issues?
   - problem gambling?

5. What would you say is the greatest strength/asset of the:
   - substance use prevention, treatment and recovery service system?
   - mental health promotion, treatment and recovery service system?
   - problem gambling prevention, treatment and recovery service system?

6. Are there particular subpopulations (for example, veterans, LGBTQ, Latinos, etc.) that aren't being adequately served by the:
   - substance use service system?
   - mental health service system?
   - problem gambling service system?

7. What are the emerging prevention, treatment or recovery issues that you are seeing or hearing about:
   - substance use issues?
   - mental health issues?
   - problem gambling?

8. Are there opportunities for the DMHAS service system that aren't being taken advantage of (technology, integration, partnerships, etc.)?

Answer Summary Grid for DMHAS Required Stakeholder Questions

1. How appropriate are available services to meet the needs of:								
Of Substance Use?			**Of Mental Health?**			**Of Problem Gambling?**		
Prevention	**Treatment**	**Recovery**	**Prevention**	**Treatment**	**Recovery**	**Prevention**	**Treatment**	**Recovery**

2. What Prevention Program, strategy, or policy would you like most to see accomplished:		
Related to Substance Use?	**Related to Mental Health?**	**Related to Problem Gambling?**

3. What treatment levels of care do you feel are unavailable or inadequately provided related to:		
Related to Substance Use?	**Related to Mental Health?**	**Related to Problem Gambling?**

4. What adjunct services/support services/recovery supports are most needed to assist persons:		
With substance use issues?	**With mental health issues?**	**With problem gambling issues?**

Answer Summary Grid for DMHAS Required Stakeholder Questions (continued)

5. What would you say is the greatest strength/asset of:		
Substance use prevention, treatment and recovery service system?	**Mental health promotion, treatment and recovery service system?**	**Problem gambling prevention, treatment and recovery service system?**
6. Are there particular subpopulations(for example veterans, LGBTQ, Latinos, etc.) that aren't being adequately served by the:		
Substance use service system?	**Mental health service system?**	**Problem gambling service system?**
7. What are emerging prevention, treatment or recovery issues that you are seeing or hearing about regarding:		
Substance use issues?	**Mental health issues?**	**Problem gambling issues?**
8. Are there opportunities for the DMHAS service system that aren't being taken advantage of? (technology, integration, partnerships, etc.)		