CPES
Center for Prevention Evaluation and Statistics

Substance Use Primary Prevention Resource Assessment Report

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Statewide Resource Assessment of Primary Prevention for Substance Use

About the Center for Prevention Evaluation and Statistics at UConn Health

The Center for Prevention Evaluation and Statistics (CPES), which conducted this resource assessment, was established to support the Prevention and Health Promotion (PHP) Unit of the Connecticut Department of Mental Health and Addiction Services (DMHAS) in its efforts through the identification, collection, analysis, interpretation and dissemination of data pertaining to substance abuse prevention, mental health, and health disparities. CPES is primarily funded by SAMHSA federal Block Grant and discretionary funds administered by DMHAS.

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Introduction

In Connecticut, substance use remains a significant public health issue. While alcohol and cannabis use among youth and young adults in Connecticut have remained stable or trended downward over the past decade, they have remained consistently higher than the United States over time. Understanding the current landscape of preventive measures is crucial to provide a foundation for strategic planning, enabling policymakers, healthcare providers, and community organizations to allocate resources more efficiently, tailor interventions to specific needs, and ultimately reduce the incidence of substance use disorders.

With funding from the American Rescue Plan Act (ARPA), the Connecticut Department of Mental Health and Addiction Services partnered with Center for Prevention Evaluation and Statistics (CPES) at UConn Health to conduct a comprehensive assessment of alcohol, tobacco, and other drug (ATOD) primary prevention programs and services provided across the state. This initiative led to the creation of a publicly accessible, searchable electronic resource and an interactive, filterable map, which catalogs the findings and lists available substance use primary prevention resources by town. Table 1 outlines the key stakeholders who are the primary intended users of these materials.

Table 1. Intended audience for this resource document and associated filterable map

State Level	Sub State Level	Community Level
• State Agency Planners	• Regional Behavioral Health Action Organizations (RBHAOs)	• Prevention Coalitions • Local Prevention Councils
• Policy Makers (i.e., Legislators)	• Local Health Departments	• Youth Service Bureaus • Local Evaluators • Town/City Government

Methods

A variety of data collection methods and sources were used to assess the availability and scope of primary prevention resources. Surveys were administered to Local Prevention Councils (LPCs) from August to December 2023 and to Regional Behavioral Health Action Organizations (RBHAOs) in October 2023. To address gaps in the survey data, a web scan of state, state agency, and regional prevention services, along with a review of Connecticut's 211 service call resources, was conducted between January and March 2024.

In collaboration with DMHAS and RBHAOs, CPES developed a categorization framework to systematically organize primary prevention services. This framework categorized services by the following constructs:

- **Prevention Strategy:** Types of strategies included information dissemination, material distribution, education, alternative programming, social marketing, program identification and referral, enforcement of laws and policies, public policy efforts, funding of prevention efforts, community assessment/data collection, and community-based processes.
- **Target Population:** Populations served, such as youth (<18 years), emerging adults (18-24 years), adults, and all ages.
- **Service Setting:** Locations where services are provided (community, school, clinic, or online).
- **Funding Source:** Identification of the financial support for services.

Descriptive statistics were used to summarize primary prevention resource availability across regions and by community type (rural, suburban, urban, wealthy) using the Five Connecticuts typology, target population, and service setting. For this report, we have combined urban periphery and urban core communities into one 'urban' category.[1]

Appendix A provides detailed definitions of the prevention strategies and community types used in the analysis.

[1] Levy, Don and DataHaven. (2015): Five Connecticuts 2010 Update. Produced for Siena College Research Institute and DataHaven based on the original method of assigning designations used in Levy, Don, Orlando Rodriguez, and Wayne Villemez. 2004. The Changing Demographics of Connecticut - 1990 to 2000. Part 2: The Five Connecticuts. Storrs, Connecticut: University of Connecticut SDC Series, no. OP 2004-01. Published by DataHaven.

Considerations

The project had several strengths, including a comprehensive, statewide view of Connecticut's prevention landscape, supported by a triangulation of data through multiple methods and sources. A strong partnership between CPES and Connecticut ATOD prevention agencies facilitated high response rates, with 100% of RBHAOs and 81% of LPCs completing the surveys (see Appendix B for LPC response rates by region). Additionally, outreach efforts resulted in the most up-to-date contact information for LPCs, which can be shared with prevention partners.

However, there are some limitations. Some towns, particularly smaller or more isolated communities, may have incomplete data on prevention strategies due to lack of response to the LPC survey, potentially leading to underestimations of available resources or reflecting limited local capacity. Approximately 41% of towns in Region 3 and 40% of rural towns statewide were missing from LPC survey responses (gaps were addressed by web scan of communities).

Additionally, the cross-sectional nature of the survey data provides only a snapshot of prevention programs at a single point in time (Aug-Dec 2023), which may not capture ongoing changes, especially in towns reliant on DMHAS funding through a voluntary application process.

Results

Statewide Prevention Resources

Connecticut's substance use primary prevention infrastructure is managed by the Department of Mental Health and Addiction Services (DMHAS) Prevention and Health Promotion (PHP) division. The DMHAS PHP utilizes federal block grant and discretionary funding to support primary prevention at the state, regional, and local levels. These efforts include state-level initiatives, websites, and social marketing campaigns, Regional Behavioral Health Action Organizations (RBHAOs), and resource links to inform and support the work of DMHAS-funded community prevention initiatives, such as Local Prevention Councils (LPCs) and prevention-focused community coalitions. The primary focus of these initiatives is on youth, but they also target young adults, parents, and the general population. While DMHAS is the primary state agency responsible for substance use primary prevention, other state agencies, including the Department of Children and Families (DCF) and the State Department of Education, engage in related prevention strategies that address substance use prevention, risk factors, and protective/resilience factors.

Table 2 and Table 3 summarize the core functions, target populations, settings, and strategies implemented by key organizations involved in substance misuse prevention in Connecticut.

KEY FINDINGS INCLUDE:

- **Diverse Target Populations:** While the prevention infrastructure primarily focuses on youth, many resources also target young adults and adults, supporting efforts across the lifespan.
- **Community-Based and Online Reach:** Most strategies are implemented across community settings and online platforms, with fewer prevention activities in clinical/provider settings.
- **Comprehensive Strategy Use:** The organizations use a broad range of prevention strategies, from information dissemination and education to community-based processes and social marketing. Program identification and referral, as well as community assessments, are also important components.

Table 2. DMHAS PHP and DMHAS Resource Links - Population and Setting

Organization	Core Functions	Prevention Target Population(s)	Settings
Department of Mental Health and Addiction Services – Prevention and Health Promotion Division (DMHAS PHP)	Substance Use Prevention Health Promotion	Youth Young Adults Adults	Clinic Community Online
DMHAS Center for Prevention Evaluation and Statistics (CPES) at UConn Health	Evaluation Data Collection and Dissemination Data Capacity Building	Young Adults Adults	Community Online
CT Clearinghouse	Information Dissemination Education Social Marketing	Young Adults Adults	Community Online
Governor's Prevention Partnership (GPP)	Youth Empowerment Mentoring	Youth Adults	Community Online
State Education Resource Center (SERC)	Prevention Curriculum DEI/Cultural Competency	Youth Adults	Community School Online
Prevention Training and Technical Assistance Service Center (TTASC)	Training/TA Workforce Development	Adults	Community Online

Table 3. DMHAS PHP and DMHAS Resource Links – Strategies

Organization	Strategy Types									
	Information Dissemination	Education	Community-Based Processes	Alternative Programming	Social Marketing	Program ID and Referral	Community Assessments/ Data Collection	Enforcement of Laws and Policies	Public Policy Efforts	Administer Funding for Prevention Efforts
Department of Mental Health and Addiction Services – Prevention and Health Promotion Division (DMHAS PHP)	✅	✅	✅	✅	✅	✅	✅	✅		✅
DMHAS Center for Prevention Evaluation and Statistics (CPES) at UConn Health	✅	✅	✅				✅			
CT Clearinghouse	✅	✅	✅		✅					✅
Governor's Prevention Partnership (GPP)		✅	✅	✅			✅		✅	✅
State Education Resource Center (SERC)	✅	✅	✅				✅			
Prevention Training and Technical Assistance Service Center (TTASC)	✅	✅	✅				✅			✅

Distribution of Funding Sources for Primary Prevention

Table 4 and Figure 1 present the distribution of funding for primary prevention across Connecticut's 169 towns by region community type.

KEY FINDINGS INCLUDE:

- **LPC Grant Funding Prevalence:** Most towns (92%) receive LPC grant funding for ATOD primary prevention programs and services, and 77% have at least one additional source of funding.
    - LPC funding coverage is complete (100%) in Regions 1 and 4, followed by 94% in Region 2, 88% in Region 5, and 83% in Region 3.
    - LPC funding ranges from 100% in wealthy towns to 85% in rural areas.
- **Diversity of Funding Sources:** A higher proportion of towns in Regions 1, 2, and 4 report having multiple sources of prevention funding compared to Regions 3 and 5.
    - Urban towns are more likely to have multiple funding sources, while rural towns are more dependent on a single source, with 74% relying solely on LPC funding.
- **Funding Gaps:** Five towns (3%) in Connecticut were not supported by any prevention funding as of 2023. Region 3 (7%) and Region 5 (5%) have the highest proportion of towns without primary prevention funding.
    - Rural towns have the highest percentage of towns without funding (5%), followed by suburban towns (3%).

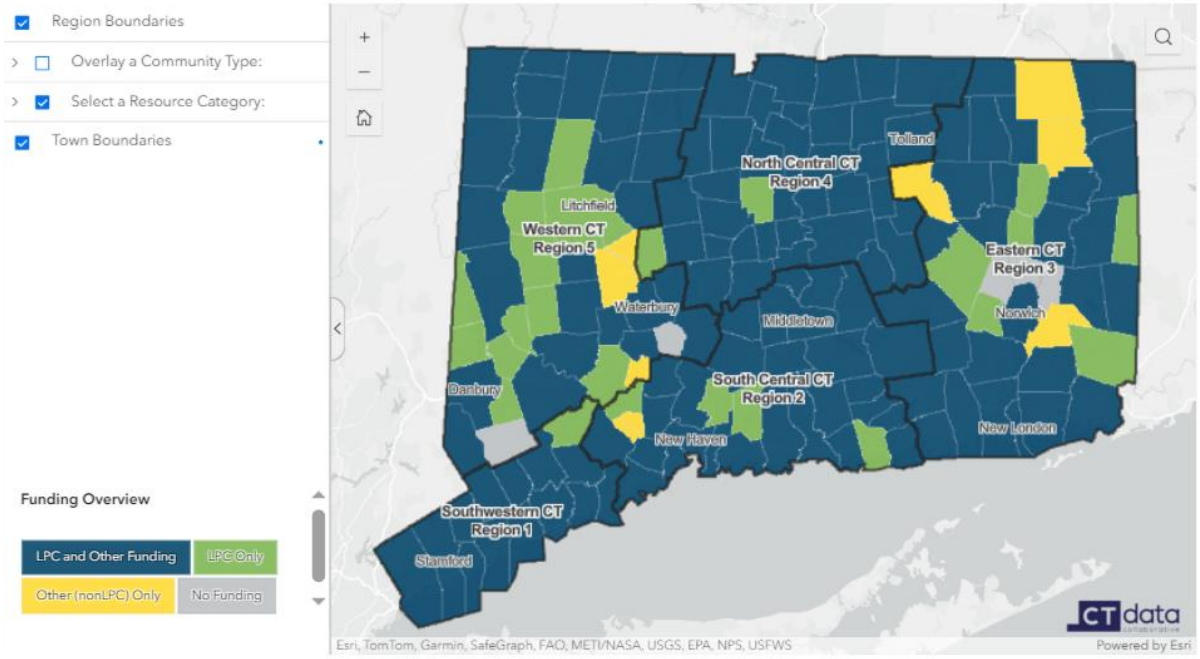
Table 4. Funding Sources* for Primary Prevention Strategies Across Connecticut's 169 Towns – 2023 Data

Funding Source[1]	State	Region					Community Type			
	CT (169)	1 (14)	2 (34)	3 (41)	4 (37)	5 (43)	Rural (60)	Suburban (64)	Urban (36)	Wealthy (9)
LPC	155 (92%)	14 (100%)	32 (94%)	34 (83%)	37 (100%)	38 (88%)	51 (85%)	61 (95%)	34 (94%)	9 (100%)
PCC	12 (7%)	0 (0%)	4 (12%)	3 (7%)	3 (8%)	2 (5%)	2 (3%)	6 (9%)	4 (11%)	0 (0%)
PFS (2022)	12 (7%)	1 (7%)	3 (9%)	3 (7%)	3 (8%)	2 (5%)	5 (8%)	2 (3%)	5 (14%)	0 (0%)
SPF-PFS	5 (3%)	0 (0%)	5 (15%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (3%)	2 (6%)	1 (11%)
STOP	6 (4%)	1 (7%)	4 (12%)	0 (0%)	0 (0%)	1 (2%)	2 (3%)	3 (5%)	1 (3%)	0 (0%)
DFC	24 (14%)	7 (50%)	3 (9%)	5 (12%)	5 (14%)	4 (9%)	1 (2%)	8 (13%)	12 (33%)	3 (33%)
YSB	133 (79%)	12 (86%)	29 (85%)	30 (73%)	34 (92%)	28 (65%)	42 (70%)	49 (77%)	34 (94%)	8 (89%)

Funding Source*	State	Region					Community Type			
	CT (169)	1 (14)	2 (34)	3 (41)	4 (37)	5 (43)	Rural (60)	Suburban (64)	Urban (36)	Wealthy (9)
No funding	5 (3%)	0 (0%)	0 (0%)	3 (7%)	0 (0%)	2 (5%)	3 (5%)	2 (3%)	0 (0%)	0 (0%)
LPC only	25 (15%)	2 (14%)	4 (12%)	6 (15%)	2 (5%)	12 (28%)	13 (22%)	11 (17%)	1 (3%)	1 (11%)
Non-LPC funding only	9 (5%)	0 (0%)	2 (6%)	4 (10%)	0 (0%)	3 (7%)	6 (10%)	1 (2%)	2 (6%)	0 (0%)
LPC + 1 or more other	130 (77%)	12 (86%)	28 (82%)	28 (68%)	35 (95%)	26 (60%)	38 (63%)	50 (78%)	33 (92%)	8 (89%)

*See Appendix C for funding source descriptions.

Figure 1. Funding Sources* for ATOD Primary Prevention Programs and Services – 2023 Data



*See Appendix C for funding source descriptions.

Regional Behavioral Health Action Organizations: Prevention Strategies

To optimize resources and enhance integration across the planning, training, advocacy, and development of mental health and substance use programs, the RBHAOs are funded to fulfill their statutory roles as strategic community partners throughout the behavioral healthcare continuum. Operating within one of DMHAS' Uniform Regions, each RBHAO oversees a variety of planning, instruction, and advocacy tasks related to behavioral health needs and services for community members across the lifespan.

Table 5 summarizes the prevention strategies being implemented by each RBHAO. [2]

KEY FINDINGS INCLUDE:

- **Universal Prevention Strategies:** All five RBHAOs report implementing core ATOD primary prevention strategies, including Information Dissemination, Material Distribution, Education, Social Marketing, Public Policy Efforts, Funding of Prevention Efforts, Community-Based Processes, and Community Assessment.
    - These strategies are implemented across a range of settings, such as clinics/providers, schools, online platforms, and communities, with community-based settings being the most prevalent.
- **Enforcement of Laws and Policies:** Regions 1, 2, and 4 report additional engagement in the Enforcement of Laws and Policies as part of their prevention efforts.
    - These enforcement activities target youth (<18 years) and young adults (18-25 years) and are predominantly implemented in community settings.
    - Region 2 also implements enforcement strategies in school environments.
- **Program Identification and Referral:** Region 2 is uniquely involved in Program Identification and Referral, primarily targeting youth in school settings.
- **Gaps in Alternative Programming:** None of the RBHAOs report the implementation of Alternative Programming, indicating a potential gap or unmet need in the range of prevention strategies being offered.

[2] Detailed data on populations served and settings for each implementation strategy are available upon request.

Table 5. Prevention Strategies Implemented by the RBHAOs

Region	Prevention Strategy RBHAO Survey Reporting										
	Information Dissemination	Material Distribution	Education	Alternative Programming	Social Marketing	Program ID & Referral	Law Enforcement	Public Policy Efforts	Funding of Prevention Efforts*	Community-Based Processes*	Community Assessments*
1	✓	✓	✓		✓		✓	✓	✓	✓	✓
2	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
3	✓	✓	✓		✓			✓	✓	✓	✓
4	✓	✓	✓		✓		✓	✓	✓	✓	✓
5	✓	✓	✓		✓			✓	✓	✓	✓

*Indirect Service

Local Prevention Councils and Community-Based Prevention Initiatives

LPCs work at the local level to promote the development and implementation of community-based prevention initiatives mostly directed towards youth and raise public knowledge of ATOD prevention. In their community programs, LPCs employ a minimum of two of the six preventative techniques specified by CSAP, which include program identification and referral, education, community-based procedures, alternative programming, environmental, and information dissemination.

Appendix B presents the LPC survey response rates by region. The LPC survey had a strong overall response rate, with 81% of LPCs participating statewide, covering 78% of Connecticut towns. Regionally, the Southwest (Region 1) and South Central (Region 2) had the highest LPC participation, with 93% and 89% of LPCs responding, representing 93% and 91% of towns, respectively. The Eastern region (Region 3) had the lowest response rate, with only 68% of LPCs and 59% of towns represented. Web scan and Connecticut 211 service call data were used to confirm and supplement LPC survey findings.

Table 6 and Figures 2 and 3 show the proportion of towns implementing each prevention strategy by region and community type.

KEY FINDINGS INCLUDE:

- **Top ATOD Prevention Strategies:** The most commonly implemented primary prevention strategies across Connecticut towns are Information Dissemination (85%), Education (80%), and Social Marketing (64%).
    - Indirect service types like Community-Based Processes (79%) and Community Assessments (61%) are also widely used.
- **Alternative Programming:** Approximately 53% of towns implement Alternative Programming, with Region 4 and urban areas having the highest participation rates.
- **Regional Disparities:** There is significant regional variation in the implementation of prevention strategies.
    - Region 1 shows the highest reported implementation across most strategies, while Region 3 has the lowest implementation rates.
- **Community Type Disparities:** Rural towns report the lowest levels of implementation across all prevention strategies compared to suburban, urban, and wealthy towns. Lower response rates to the LPC survey in rural towns and in Region 3 may also reflect capacity or resource issues in those areas.

Table 6. Proportion of Towns Implementing Each Prevention Strategy by Region and Community Type

	State	Region					Community Type			
	CT	1	2	3	4	5	Rural	Suburban	Urban	Wealthy
Total towns	169	14	34	41	37	43	60	64	36	9
Information Dissemination	144 (85%)	14 (100%)	30 (88%)	30 (73%)	33 (89%)	37 (86%)	44 (73%)	58 (91%)	33 (92%)	9 (100%)
Education	135 (80%)	13 (93%)	28 (82%)	26 (63%)	33 (89%)	35 (81%)	39 (65%)	56 (88%)	31 (86%)	9 (100%)
Alternative Programming	89 (53%)	5 (36%)	18 (53%)	17 (41%)	26 (70%)	23 (53%)	25 (42%)	36 (56%)	23 (64%)	5 (56%)
Social Marketing	109 (64%)	11 (79%)	27 (79%)	20 (49%)	21 (57%)	30 (70%)	30 (50%)	44 (69%)	28 (77%)	7 (78%)
Program ID & Referral	39 (23%)	5 (36%)	6 (18%)	6 (15%)	15 (41%)	7 (16%)	8 (13%)	17 (27%)	12 (33%)	2 (22%)

	State	Region					Community Type			
	CT	1	2	3	4	5	Rural	Suburban	Urban	Wealthy
Law Enforcement	69 (41%)	8 (57%)	15 (44%)	18 (44%)	12 (32%)	16 (37%)	21 (35%)	27 (42%)	18 (50%)	3 (33%)
Public Policy Efforts	31 (18%)	6 (43%)	8 (24%)	6 (15%)	6 (16%)	5 (12%)	6 (10%)	18 (28%)	5 (14%)	2 (22%)
Community Assessments*	103 (61%)	11 (79%)	27 (79%)	13 (32%)	24 (65%)	28 (65%)	22 (37%)	45 (70%)	28 (77%)	6 (67%)
Community-Based Processes*	133 (79%)	13 (93%)	28 (82%)	26 (63%)	30 (81%)	36 (84%)	37 (62%)	55 (86%)	34 (94%)	8 (89%)

*Indirect Service

Figure 2. Proportion of Towns Implementing Each Prevention Strategy by Region

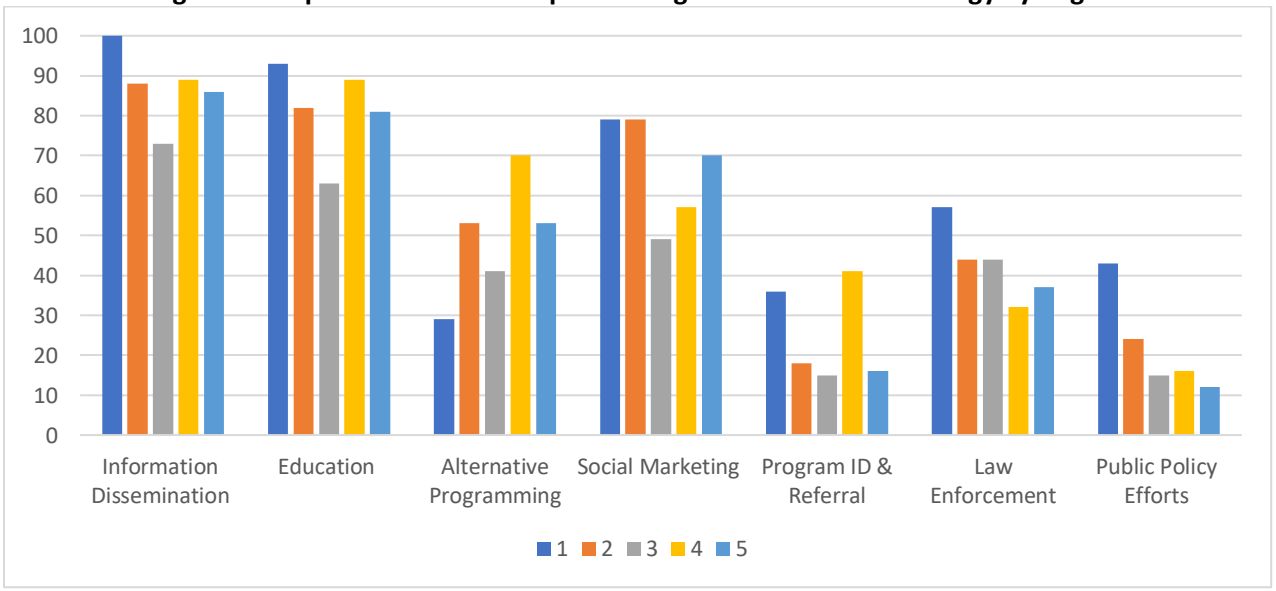


Figure 3. Proportion of Towns Implementing Each Prevention Strategy by Community Type

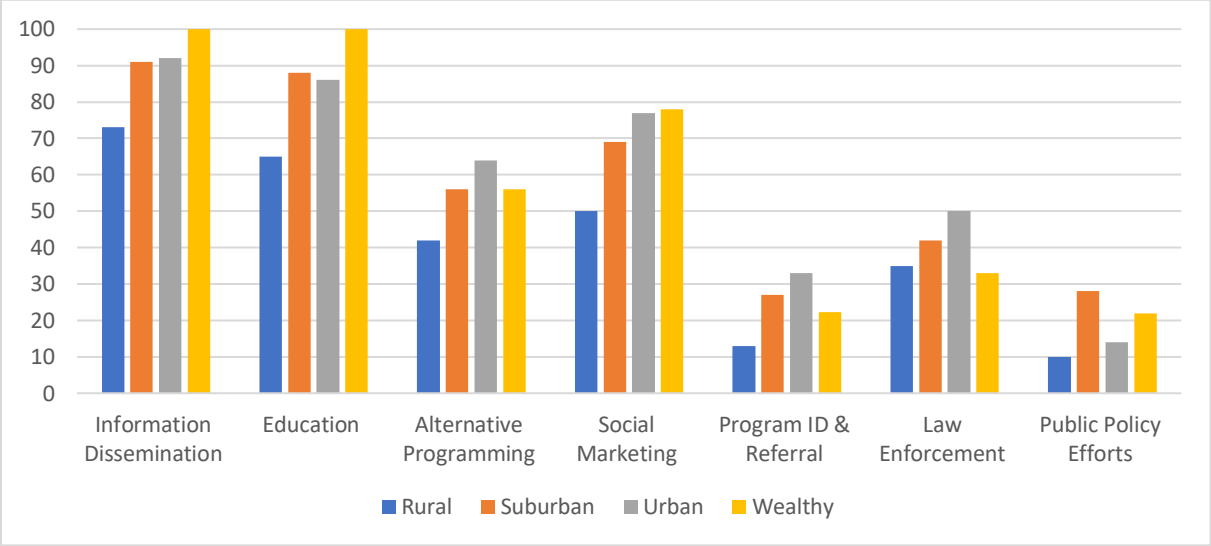


Table 7 and Figures 4 and 5 depict the populations served by various prevention strategies and the settings in which where these strategies are implemented.

KEY FINDINGS INCLUDE:

- **Youth-Centered Focus:** Connecticut's primary substance use prevention infrastructure is focused on youth populations, although there is some inclusion of other age groups across the lifespan.
    - Information dissemination, education, social marketing, community-based processed exhibit the broadest reach across all age groups.
- **Predominant Settings:** Most prevention strategies occur within community and school settings, except for social marketing, which is primarily implemented online.
- **Multiple Settings for Most Strategies:** Most prevention strategies are implemented in more than one setting, although the degree of implementation varies.
- **Limited Use in Clinical Settings:** Few prevention strategies are taking place in clinical or provider-based settings, indicating an area for potential expansion.

Table 7. Populations Served by the Prevention Strategies and Settings in Which They Occur (N=169 towns)

Prevention Strategy	Population Served				Setting			
	Youth	18-24	Adult	All Ages	Clinic/provider	Community	Online	School
Information Dissemination	109 (65%)	74 (44%)	83 (49%)	89 (53%)	18 (11%)	130 (77%)	112 (66%)	112 (66%)
Education	94 (56%)	52 (31%)	71 (42%)	73 (43%)	10 (6%)	113 (67%)	84 (50%)	104 (62%)
Alternative Programming	72 (43%)	26 (15%)	17 (10%)	19 (11%)	5 (3%)	72 (43%)	13 (8%)	50 (30%)
Social Marketing	54 (32%)	34 (20%)	42 (25%)	78 (46%)	3 (1.8%)	61 (36%)	91 (54%)	36 (21%)
Program ID & Referral	28 (17%)	8 (5%)	9 (5%)	9 (5%)	13 (7.7%)	19 (11%)	5 (3%)	18 (11%)
Law Enforcement	38 (23%)	28 (17%)	22 (13%)	18 (11%)	2 (1.2%)	56 (33%)	8 (5%)	13 (8%)
Public Policy Efforts	7 (4%)	4 (2%)	8 (5%)	16 (10%)	0 (0%)	22 (13%)	2 (1%)	4 (2%)
Community Assessments*	78 (46%)	26 (15%)	27 (16%)	23 (14%)	4 (2%)	58 (34%)	34 (20%)	75 (44%)
Community-Based Processes*	76 (45%)	47 (28%)	66 (39%)	79 (47%)	9 (5%)	114 (68%)	68 (40%)	56 (33%)

*Indirect Service

Figure 4. Populations Served by Towns Implementing Each Prevention Strategy

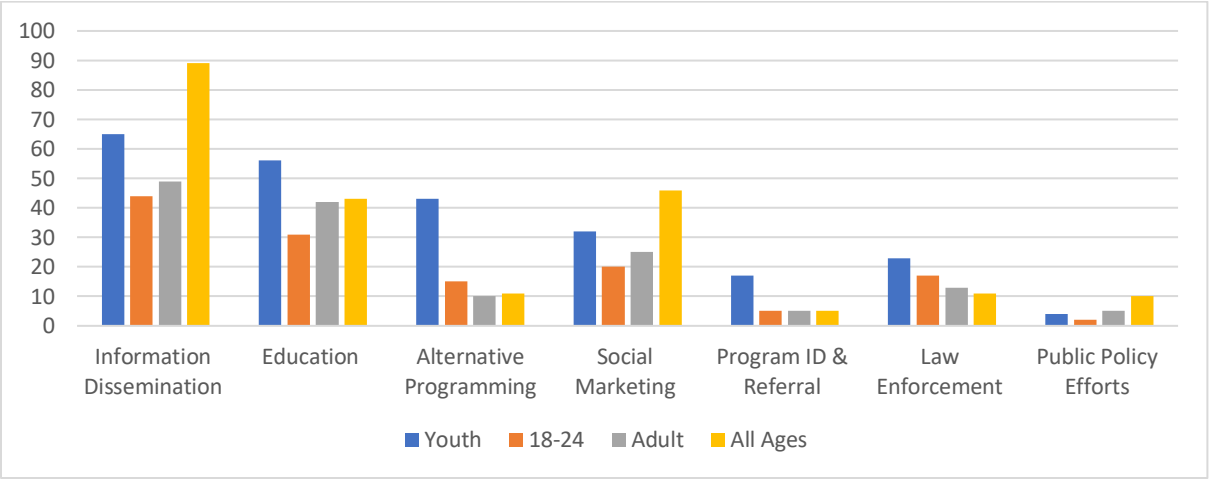
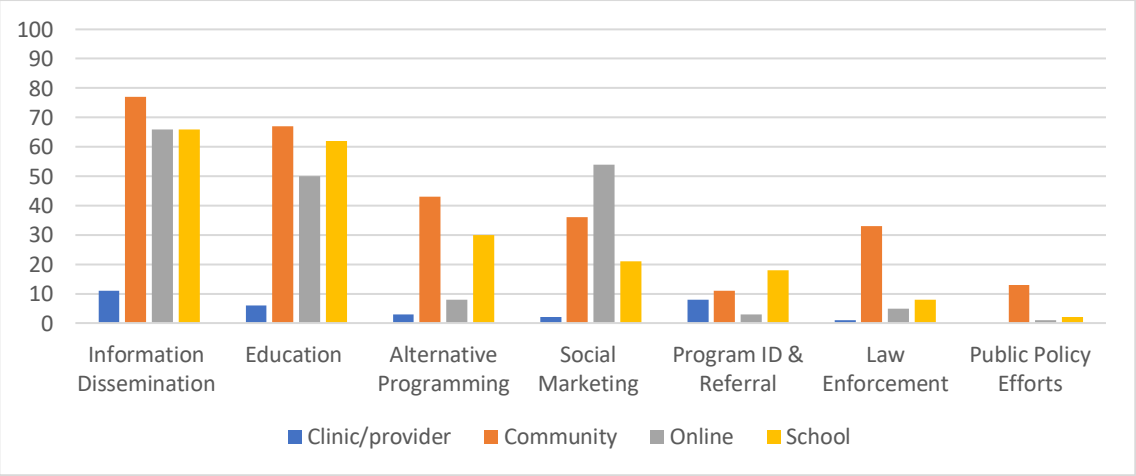


Figure 5. Settings in Which Towns are Implementing Each Prevention Strategy



Appendix D provides a detailed breakdown of prevention strategies, populations served, and settings, by region and community type.

Conclusion

Connecticut's substance use primary prevention efforts demonstrate several strengths that can be leveraged and expanded. The state employs a comprehensive, multi-strategy approach, utilizing information dissemination, education, social marketing, and community-based processes, with broad outreach across community and school settings, particularly targeting youth. Many initiatives also extend to young adults and adults, promoting a lifespan approach to prevention. The strong engagement of RBHAOS and LPCs, with statewide prevention support, ensures that prevention efforts are tailored to regional needs and grounded in local community contexts.

However, the findings also highlight several gaps that must be addressed to improve the effectiveness and equity of prevention efforts statewide. Disparities in funding and strategy implementation are evident across regions and community types, with a few towns lacking funding altogether and others relying on a single source to support their efforts. Community capacity and readiness to address substance use prevention is a key factor in these disparities, with communities at various levels in their ability to consider, document, gather support, plan, and then address substance misuse at the community level. Targeted capacity building in these underserved communities is a necessary step in preparing these communities to seek and receive funding. Increased investment in underserved regions, particularly rural areas and Eastern Connecticut (Region 3), alongside efforts to diversify funding sources, will reduce dependence on single funding streams, expand prevention efforts, and improve sustainability.

Additionally, the limited integration of clinical settings in primary prevention represents a missed opportunity. Expanding the role of healthcare providers in primary prevention efforts could help reach populations who may not engage with community or school-based programs. Finally, while DMHAS PHP coordinates statewide efforts, greater integration of resources across state-level agencies is essential for creating a more unified and comprehensive approach to substance use prevention.

By building on its existing strengths and addressing existing gaps, Connecticut can further enhance its substance use prevention infrastructure, ensuring that prevention efforts are equitable, comprehensive, and effective across the entire state.

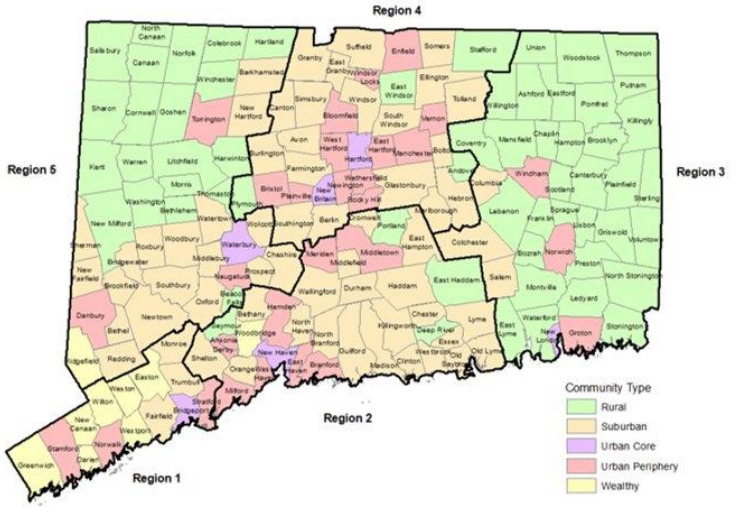
Appendices

Appendix A. Prevention Strategy and Community Type Definitions

Prevention Strategy	Definition
Information Dissemination	Printed or electronic materials dissemination, health fairs
Material Distribution	Narcan, lock boxes, drug disposal, etc. Does NOT include promotional merchandise. (RBHAO survey only)
Education	Speaking engagements, educational events, info sessions, PSAs
Alternative Programming	ATOD free-social/recreational events, community service activities
Social Marketing	Media campaigns
Program Identification and Referral	Student assistance programs, ASBIRT/SBIRT
Enforcement of Laws and Policies/Preventing Sales to Underage Youth	Compliance checks, zoning enforcement
Public Policy Efforts	Advocacy to change laws and policies
Funding of Prevention Efforts	Providing funding to other agencies/organizations for prevention strategies and activities (RBHAO survey only)
Community Assessment/Data Collection*	Needs assessment, community surveys, school surveys (Indirect Service Type)
Community-Based Processes*	Coalition meetings, workgroups, community team meetings/activities (Indirect Service Type)

*Indirect Service

Community Type[1]	Characteristics (Average)
Rural	Median income = $89,317 Poverty Rate = 6% Population Density = 246.4
Suburban	Median Income = $112,991 Poverty Rate = 4% Population Density = 569.9
Urban (Urban Core & Urban Periphery)	Median Income = $74,028 Poverty Rate = 13% Population Density = 2,818.8
Wealthy	Median Income = $194,848 Poverty Rate = 3% Population Density = 865.2



APPENDIX B. Local Prevention Council (LPC) Survey Response by Region

Region	LPC Responses	Total LPCs	LPC %	Towns Represented[1]	Total Towns	Town %
1 (Southwest)	13	14	93%	13	14	93%
2 (South Central)	25	28	89%	31	34	91%
3 (Eastern)	19	28	68%	24	41	59%
4 (North Central)	28	35	80%	30	37	81%
5 (Western)	17	21	81%	34	43	79%
TOTAL	**102**	**126**	**81%**	**132**	**169**	**78%**

[1]Some LPCs represent multiple towns.

APPENDIX C. Descriptions of Funding Types

Funding Type	Funding Acronym	Funding Description
Local Prevention Council	LPC	Funded by the Department of Mental Health and Addiction Services (DMHAS) Prevention and Health Promotion Division (PHP), administered through the Regional Behavioral Health Action Organizations (RBHAO). This initiative supports over 150 local, municipal-based alcohol, tobacco and other drug (ATOD) use prevention councils focused on implementation of local prevention activities primarily focused on youth, with the support of the Chief Elected Officials. The current primary funded focus issue is vaping.
Prevention in Connecticut Communities	PCC	Funded by the DMHAS PHP utilizing federal Substance Use Prevention Treatment and Recovery Support (SUPTRS) Block Grant funds, the Prevention in CT Communities (PCC) community coalitions utilized the SAMHSA strategic prevention framework (SPF) data-driven needs assessment and strategic planning approach to select a priority substance for which to implement evidence-based prevention approaches focused on youth 12-17.
Partnerships for Success	PFS - 2022	Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP) through the DMHAS PHP, PFS 2022 are charged with selection and implementation of evidence-based prevention approaches, including targeted capacity building, for/with pre-selected high need communities to reduced underage drinking and related behaviors for youth 12-17. This initiative has a specific focus on addressing address health disparities for subpopulations at increased risk in those communities.
Strategic Prevention Framework – Partnerships for Success	SPF - PFS	Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP), SPF-PFS focuses on preventing substance use initiation and reducing the progression of substance use (and related problems) among youth and young adults through implementation of comprehensive, evidence-based prevention strategies and community coalition capacity building.
Sober Truth on Preventing Underage Drinking Act	STOP	Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of this funding is to prevent and reduce alcohol use among youth and young adults ages 12 to 20 in communities throughout the United States through implementation of evidence-based strategies and community and coalition capacity building.
Drug Free Communities	DFC	Funded by the Office of National Drug Control Policy (ONDCP), DFC-funded coalitions engage multiple community sectors and employ various environmental strategies to address local substance use problems. DFCs involve local communities in finding solutions and help youth at risk recognize that most of our nation's youth choose not to use substances.
Youth Service Bureau	YSB	Youth Service Bureaus are funded by the Department of Children and Families (DCF) with matching funds from communities. Local communities began to develop YSBs in the 1960's as a response to a growing number of issues affecting youth. The role of the YSBs has been expanded to include both advocacy and coordination of a comprehensive service delivery system for youth, including administrative services, needs assessment, and coordination of services.

Appendix D. Detailed distribution of prevention strategies, populations served, and settings, by region and community type

	State	Region					Community Type			
	CT	1	2	3	4	5	Rural	Suburban	Urban	Wealthy
Total towns	169	14	34	41	37	43	60	64	36	9
Strategy:										
Information Dissemination	144 (85%)	14 (100%)	30 (88%)	30 (73%)	33 (89%)	37 (86%)	44 (73%)	58 (91%)	33 (92%)	9 (100%)
Population Served:										
<18	109 (65%)	11 (79%)	21 (62%)	26 (63%)	27 (73%)	24 (56%)	38 (63%)	39 (61%)	25 (69%)	7 (78%)
18-24	74 (44%)	5 (36%)	15 (44%)	16 (39%)	18 (49%)	20 (47%)	25 (42%)	32 (50%)	14 (39%)	3 (33%)
Adult	83 (49%)	8 (57%)	21 (62%)	22 (54%)	19 (51%)	13 (30%)	25 (42%)	1 (2%)	18 (50%)	5 (55%)
All Ages	89 (53%)	6 (43%)	24 (77%)	17 (41%)	17 (46%)	25 (58%)	24 (40%)	2 (3%)	18 (50%)	4 (44%)
Setting:										
Clinic/Provider	18 (11%)	3 (21%)	4 (12%)	4 (10%)	4 (11%)	3 (7%)	2 (3%)	7 (11%)	7 (19%)	2 (22%)
Community	130 (77%)	13 (93%)	29 (85%)	25 (61%)	30 (81%)	33 (77%)	36 (60%)	55 (86%)	31 (86%)	8 (89%)
Online	112 (66%)	12 (86%)	25 (74%)	19 (46%)	24 (65%)	32 (74%)	30 (50%)	47 (73%)	27 (75%)	8 (89%)
School	112 (66%)	12 (86%)	23 (68%)	22 (54%)	26 (70%)	29 (67%)	32 (53%)	45 (70%)	28 (78%)	7 (78%)
Strategy:										
Education	135 (80%)	13 (93%)	28 (82%)	26 (63%)	33 (89%)	35 (81%)	39 (65%)	56 (88%)	31 (86%)	9 (100%)
Population Served:										
<18	94 (56%)	11 (79%)	18 (53%)	22 (54%)	27 (73%)	24 (56%)	34 (57%)	39 (61%)	22 (61%)	7 (78%)
18-24	52 (31%)	5 (36%)	14 (41%)	16 (39%)	18 (49%)	20 (47%)	25 (42%)	32 (50%)	13 (20%))	3 (33%)
Adult	71 (42%)	8 (57%)	19 (56%)	18 (44%)	19 (51%)	13 (30%)	21 (35%)	35 (55%)	16 (44%)	5 (55%)
All Ages	73 (43%)	5 (36%)	22 (65%)	16 (39%	16 (43%)	23 (53%)	23 (38%)	40 (63%	15 (42%)	4 (44%)
Setting:										
Clinic/Provider	10 (6%)	3 (21%)	4 (12%)	4 (10%)	4 (11%)	3 (7%)	2 (3%)	7 (11%)	7 (19%)	2 (22%)
Community	113 (67%)	12 (86%)	27 (79%)	24 (59%)	29 (78%)	32 (74%)	35 (58%)	53 (83%)	28 (78%)	8 (89%)
Online	84 (50%)	11 (79%)	23 (68%)	15 (37%)	23 (62%)	32 (74%)	26 (43%)	46 (72%)	24 (67%)	8 (89%)
School	104 (62%)	12 (86%)	21 (62%)	18 (44%)	25 (68%)	28 (65%)	28 (47%)	43 (67%)	26 (72%)	7 (78%)

	State	Region					Community Type			
	CT	1	2	3	4	5	Rural	Suburban	Urban	Wealthy
Strategy:										
Alternative Programming	89 (53%)	5 (29%)	18 (53%)	17 (41%)	26 (70%)	23 (53%)	25 (42%)	36 (56%)	23 (64%)	5 (56%)
Population Served:										
<18	72 (43%)	5 (36%)	13 (38%)	16 (39%)	20 (54%)	16 (37%)	23 (38%)	27 (42%)	16 (44%)	4 (44%)
18-24	26 (15%)	1 (7%)	10 (29%)	13 (32%)	14 (38%)	12 (28%)	18 (30%)	20 (31%)	11 (31%)	1 (11%)
Adult	17 (10%)	5 (36%)	12 (35%)	14 (34%)	14 (38%)	9 (21%)	15 (25%)	22 (34%)	13 (36%)	4 (44%)
All Ages	19 (11%)	1 (7%)	15 (44%)	12 (29%)	14 (38%)	13 (30%)	14 (23%)	25 (39%)	14 (39%)	2 (22%)
Setting:										
Clinic/Provider	5 (3%)	2 (14%)	3 (9%)	3 (7%)	4 (11%)	2 (5%)	2 (3%)	5 (8%)	5 (14%)	2 (22%)
Community	72 (43%)	5 (36%)	16 (47%)	17 (41%)	23 (62%)	21 (49%)	24 (40%)	34 (53%)	19 (53%)	5 (55%)
Online	13 (8%)	5 (36%)	13 (38%)	10 (24%)	18 (49%)	20 (47%)	16 (27%)	28 (44%)	17 (47%)	5 (55%)
School	50 (30%)	4 (29%)	17 (50%)	11 (27%)	20 (54%)	18 (42%)	17 (28%)	29 (45%)	21 (58%)	3 (33%)
Strategy:										
Social Marketing	109 (65%)	11 (79%)	27 (79%)	20 (49%)	21 (57%)	30 (70%)	30 (50%)	44 (69%)	28 (78%)	7 (78%)
Population Served:										
<18	54 (32%)	8 (57%)	17 (50%)	18 (44%)	18 (49%)	19 (44%)	26 (43%)	28 (44%)	21 (58%)	5 (55%)
18-24	34 (20%)	4 (29%)	14 (41%)	14 (34%)	14 (38%)	20 (47%)	23 (38%)	26 (41%)	14 (39%)	3 (33%)
Adult	42 (25%)	6 (43%)	17 (50%)	15 (37%)	12 (32%)	8 (19%)	15 (25%)	24 (38%)	15 (42%)	4 (44%)
All Ages	78 (46%)	5 (36%)	23 (68%)	13 (32%)	12 (32%)	20 (47%)	19 (32%)	33 (52%)	17 (47%)	4 (44%)
Setting:										
Clinic/Provider	3 (1.8%)	3 (21%)	4 (12%)	2 (5%)	3 (8%)	3 (7%)	1 (2%)	5 (8%)	7 (19%)	2 (22%)
Community	61 (36%)	11 (79%)	25 (74%)	20 (49%)	21 (57%)	29 (67%)	30 (50%)	43 (67%)	26 (72%)	7 (78%(
Online	91 (54%)	10 (71%)	23 (68%)	12 (29%)	16 (43%)	27 (63%	20 (33%)	38 (59%)	23 (64%)	7 (78%)
School	36 (21%)	9 (64%)	21 (62%)	14 (34%)	19 (51%)	27 (63%	23 (38%)	37 (58%)	25 (69%)	5 (55%)

	State	Region					Community Type			
	CT	1	2	3	4	5	Rural	Suburban	Urban	Wealthy
Strategy:										
Program Identification & Referral	39 (23%)	5 (36%)	6 (18%)	6 (15%)	15 (41%)	7 (16%)	8 (13%)	17 (27%)	12 (33%)	2 (22%)
Population Served:										
<18	28 (17%)	5 (36%)	6 (18%)	5 (12%)	8 (22%)	5 (12%)	7 (12%)	13 (20%)	7 (19%)	2 (22%)
18-24	8 (5%)	2 (14%)	4 (12%)	3 (7%)	7 (19%)	5 (12%)	5 (8%)	11 (17%)	4 (11%)	1 (11%)
Adult	9 (5%)	5 (36%)	5 (15%)	3 (7%)	8 (22%)	4 (9%)	5 (8%)	12 (19%)	6 (17%)	2 (22%)
All Ages	9 (5%)	2 (14%)	5 (15%)	3 (7%)	9 (24%)	4 (9%)	5 (8%)	11 (17%)	6 (17%)	1 (11%)
Setting:										
Clinic/Provider	13 (7.7%)	3 (21%)	0 (0%)	1 (2%)	3 (8%)	0 (0%)	1 (2%)	3 (5%)	2 (6%)	1 (11%)
Community	19 (11%)	5 (36%)	2 (6%)	5 (12%)	12 (32%)	6 (14%)	7 (12%)	16 (25%)	8 (22%)	2 (22%)
Online	5 (3%)	5 (36%)	3 (9%)	4 (10%)	10 (27%)	5 (12%)	4 (7%)	12 (19%)	9 (25%)	2 (22%)
School	18 (11%)	4 (29%)	6 (18%)	6 (15%)	9 (24%)	7 (16%)	8 (13%)	13 (20%)	10 (28%)	1 (11%)
Strategy:										
Law Enforcement	69 (41%)	8 (57%)	15 (44%)	18 (44%)	12 (32%)	16 (37%)	21 (35%)	27 (42%)	18 (50%)	3 (33%)
Population Served:										
<18	38 (23%)	7 (50%)	8 (24%)	17 (41%)	11 (30%)	8 (19%)	18 (30%)	17 (27%)	14 (39%)	2 (22%)
18-24	28 (17%)	4 (29%)	4 (12%)	15 (37%)	10 (27%)	9 (21%)	15 (25%)	17 (27%)	9 (25%)	1 (11%)
Adult	22 (13%)	6 (43%)	8 (24%)	16 (39%)	9 (24%)	4 (9%)	15 (25%)	15 (23%)	11 (31%)	2 (22%)
All Ages	18 (11%)	4 (29%)	11 (32%)	14 (34%)	9 (24%)	16 (37%)	18 (30%)	24 (38%)	10 (28%)	2 (22%)
Setting:										
Clinic/Provider	2 (1.2%)	3 (21%)	3 (9%)	3 (7%)	3 (8%)	3 (7%)	1 (2%)	7 (11%)	5 (14%)	2 (22%)
Community	56 (33%)	8 (57%)	15 (44%)	17 (41%)	11 (30%)	16 (37%)	19 (32%)	27 (42%)	18 (50%)	3 (33%)
Online	8 (5%)	7 (50%)	13 (38%)	11 (27%)	10 (27%)	16 (37%)	14 (23%)	24 (38%)	16 (44%)	3 (33%)
School	13 (8%)	6 (43%)	10 (29%)	11 (27%)	9 (24%)	13 (30%)	12 (20%)	21 (33%)	15 (42%)	1 (11%)

	State	Region					Community Type			
	CT	1	2	3	4	5	Rural	Suburban	Urban	Wealthy
Strategy:										
Public Policy Efforts	31 (18%)	6 (43%)	8 (24%)	6 (15%)	6 (16%)	5 (12%)	6 (10%)	18 (28%)	5 (14%)	2 (22%)
Population Served:										
<18	7 (4%)	6 (43%)	6 (18%)	6 (15%)	6 (16%)	1 (2%)	5 (8%)	13 (20%)	5 (14%)	2 (22%)
18-24	4 (2%)	3 (21%)	5 (15%)	5 (12%)	5 (14%)	1 (2%)	3 (5%)	11 (17%)	4 (11%)	1 (11%)
Adult	8 (5%)	5 (36%)	6 (18%)	5 (12%)	6 (16%)	1 (2%)	5 (8%)	13 (20%)	3 (8%)	2 (22%)
All Ages	16 (10%)	2 (14%)	7 (21%)	4 (10%)	4 (11%)	4 (9%)	3 (5%)	15 (23%)	2 (6%)	1 (11%)
Setting:										
Clinic/Provider	0 (0%)	3 (21%)	2 (6%)	1 (2%)	1 (3%)	1 (2%)	0 (0%)	5 (8%)	2 (6%)	1 (11%)
Community	22 (13%)	6 (43%)	8 (24%)	5 (12%)	6 (16%)	5 (12%)	5 (8%)	18 (28%)	5 (14%)	2 (22%)
Online	2 (1%)	5 (36%)	7 (21%)	6 (15%)	4 (11%)	5 (12%)	6 (10%)	15 (23%)	4 (11%)	2 (22%)
School	4 (2%)	5 (36%)	8 (24%)	5 (12%)	6 (16%)	5 (12%)	5 (8%)	18 (28%)	5 (14%)	1 (11%)
Strategy:										
Community Assessments*	103 (61%)	11 (9%)	27 (79%)	13 (32%)	24 (65%)	28 (65%)	22 (37%)	45 (70%)	28 (77%)	6 (67%)
Population Served:										
<18	78 (46%)	9 (64%)	18 (53%)	13 (32%)	19 (51%)	17 (40%)	22 (37%)	29 (45%)	20 (56%)	5 (55%)
18-24	26 (15%)	5 (36%	13 (38%)	7 (17%)	14 (38%)	16 (37%)	16 (27%)	24 (38%)	12 (33%)	3 (33%)
Adult	27 (16%)	7 (50%)	17 (50%)	9 (22%)	13 (35%)	4 (9%)	9 (15%)	22 (34%	15 (42%)	4 (44%)
All Ages	23 (14%)	5 (36%)	22 (65%)	4 (10%)	13 (35%)	20 (47%)	11 (18%)	33 (52%)	17 (47%)	3 (33%)
Setting:										
Clinic/Provider	4 (2%)	3 (21%)	4 (12%)	3 (7%)	4 (11%)	3 (7%)	1 (2%)	7 (11%)	7 (19%)	2 (22%)
Community	58 (34%	11 (79%)	25 (74%)	12 (29%)	23 (62%)	26 (60%)	23 (38%)	42 (66%)	26 (72%)	6 (67%)
Online	34 (20%)	10 (71%)	23 (68%)	11 (27%)	19 (51%)	24 (56%)	19 (32%)	38 (59%)	24 (67%)	6 (67%)
School	75 (44%)	9 (54%)	21 (62%)	13 (32%)	20 (54%)	26 (60%)	23 (38%)	37 (58%)	25 (69%)	4 (44%)

	State	Region					Community Type			
	CT	1	2	3	4	5	Rural	Suburban	Urban	Wealthy
Strategy:										
Community-Based Processes*	133 (79%)	13 (93%)	28 (82%)	26 (63%)	30 (81%)	36 (84%)	37 (62%)	55 (86%)	34 (94%)	8 (89%)
Population Served:										
<18	76 (45%)	10 (71%)	18 (53%)	22 (54%)	24 (65%)	23 (53%)	31 (52%)	37 (58%)	23 (64%)	6 (67%)
18-24	47 (28%)	5 (36%)	14 (41%)	16 (39%)	16 (43%)	20 (47%)	24 (40%)	30 (47%)	14 (39%)	3 (33%)
Adult	66 (39%)	7 (50%)	18 (53%)	18 (44%)	16 (43%)	12 (28%)	19 (32%)	32 (50%)	16 (42%)	4 (44%)
All Ages	79 (47%)	6 (43%)	23 (68%)	16 (39%)	16 (43%)	24 (56%)	22 (37%)	41 (64%)	18 (50%)	4 (44%)
Setting:										
Clinic/Provider	9 (5%)	3 (21%)	4 (12%)	4 (10%)	4 (11%)	3 (7%)	2 (3%)	7 (11%)	7 (19%)	2 (22%)
Community	114 (68%)	12 (86%)	26 (76%	24 (59%)	28 (76%)	32 (74%)	34 (57%)	52 (81%)	29 (81%)	7 (78%)
Online	68 (40%)	11 (79%)	24 (71%)	15 (37%)	22 (59%)	31 (72%)	24 (40%)	46 (72%)	26 (72%)	7 (78%)
School	56 (33%)	11 (79%)	21 (62%)	19 (46%)	24 (65%)	28 (65%)	27 (45%)	43 (67%)	27 (75%)	6 (67%)

*Indirect Service