Substance Abuse and Mental Health Services Administration (SAMHSA)

Selecting Best-fit Programs and Practices: Guidance for Substance Misuse Prevention Practitioners

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INTRODUCTION

Substance misuse and related behavioral health problems such as injury, addiction, and overdose are pressing personal and public health concerns. To successfully address these problems in states, tribes, jurisdictions, and communities, prevention planners need information about the effectiveness of available programs and practices. They also need to know how to determine which options have the greatest potential to work well in their unique settings and how to proceed if no viable options are available.

To help meet these needs, the Substance Abuse and Mental Health Services Administration (SAMHSA) has developed this guidance document, *Selecting Best-Fit Programs and Practices: Guidance for Substance Misuse Prevention Practitioners*. This resource places the selection of programs and practices within the broader context of evidence-based prevention. Specifically, it explores the following:

- The value of embedding program and practice selection in a strategic planning process
- Where to find information on programs and practices and how to choose among them
- Tips for adopting, adapting, and innovating programs and practices and for supporting their successful implementation and continual improvement at the local level

Supporting materials at the end of this resource provide additional information on these topics.

BEFORE THE SEARCH: LAYING A FOUNDATION THROUGH STRATEGIC PLANNING

Prevention researchers and practitioners have developed many programs and practices that are capable of producing positive changes for individuals, families, and communities struggling with substance use-related problems. Yet in order to work, these programs and practices must be carefully selected and implemented and then continually improved over time. This can be ensured through strategic planning—a systematic process for setting priorities and goals and for determining both *how to achieve* them and *how to know* they are being achieved.

What Are Programs and Practices?

A *program* is a set of predetermined, structured, and coordinated activities. A *practice* is a type of approach, technique, or strategy.

A program can incorporate different practices, and guidance for implementing a specific practice can be developed and distributed as a program.

SAMHSA'S STRATEGIC PREVENTION FRAMEWORK

SAMHSA's Strategic Prevention Framework (SPF) is a proven strategic planning model comprising five steps:

- **Step 1. Assessment** involves gathering and using data to identify a priority problem, factors influencing this problem, and resources and readiness to address it.
- **Step 2. Capacity** involves building resources and readiness to address the priority problem and its associated factors.
- **Step 3. Planning** involves developing a comprehensive plan that details prevention priorities, programs and practices selected to address them, and anticipated outcomes.
- **Step 4. Implementation** involves moving the prevention plan into action by fine-tuning selected programs and practices and delivering them as intended.
- **Step 5. Evaluation** involves examining how programs and practices are working and using lessons learned to improve them and the plan overall.

These five steps are typically presented in circular form (Figure 1) because the SPF process is iterative and dynamic; planners often cycle back to earlier steps and engage in multiple steps simultaneously. For example, they may need to adjust their comprehensive plan if ongoing assessment efforts reveal shifting prevention priorities or build additional capacity to support a specific program or practice once it is underway. In addition, the overall SPF process is guided by two principles that should be integrated into each step:

Figure 1.
SAMHSA's STRATEGIC PREVENTION FRAMEWORK

- **Cultural competence**, which is the ability of an individual or an organization to interact effectively with members of diverse population groups
- **Sustainability**, which is the capacity of a community to produce and maintain positive prevention outcomes after initial funding ends and over time

Together, these principles dictate that all prevention efforts must be informed by and responsive to the unique cultures of those involved, and that individuals, families, and communities should continue to reap the health-related benefits of prevention efforts over time. Successful completion of each step and integration of both principles require the active participation of and collaboration among diverse community stakeholders. These individuals and institutions may change as a prevention initiative evolves, but the need for prevention partners will remain constant.

THE SPF APPROACH TO SELECTING PROGRAMS AND PRACTICES

Successful movement through the early steps of the SPF generates the information that planners need to set prevention priorities, identify intended outcomes, and build a logic model to inform the selection of programs and practices. Each of these functions is described below.

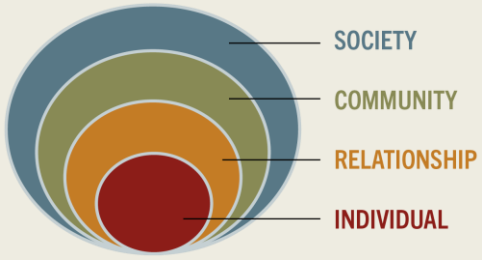
Setting Prevention Priorities

Every community struggles with multiple substance use-related problems, but no community can address them all—at least not all at once. Setting clear priorities requires understanding which problems are most important for a community to address first, and which problems a community is most capable of changing. By engaging in a thorough assessment of local prevention needs and capacity, and in a collaborative prioritization process, planners can identify their community's *priority problem***.** This begins to focus their prevention initiative.

But a community cannot address a substance use-related problem directly; it must work through the underlying factors that influence this problem. For this reason, planners also need to identify the *priority risk and protective factors* they intend to address in order to influence their priority problem. This requires an understanding of which risk and protective factors are present and most urgent at the local level, and which of these factors the community is in a strong position to change.

Multiple Factors, Multiple Levels

Risk factors are associated with an increased likelihood that a person will experience a problem. *Protective factors* are associated with a decreased likelihood. Both types of factors operate at different levels of a person's experience.



For example, an assessment of prevention needs and capacity may reveal a community's priority problem to be the nonmedical use of prescription drugs (NMUPD) among youth. This assessment may further reveal that the best way to address this problem is by *reducing* two priority risk factors: perception among youth that prescription drugs are safer than other drugs and youth access to prescription drugs; and by *strengthening* two priority protective factors: positive familial bonds and parental disapproval of prescription drug misuse.

Identifying Anticipated Outcomes

By setting clear prevention priorities, planners begin to articulate what their community intends to accomplish through its prevention efforts. To inform the selection and evaluation of programs and practices to address these priorities, planners must take this a step further and *specify* what their community intends to

accomplish. This is done by *identifying anticipated outcomes.* There are two types of outcomes: short-term outcomes and long-term outcomes.

- **Short-term outcomes** are the immediate effects of programs and practices, such as changes in people's knowledge, skills, and/or access to substances.
- **Long-term outcomes** are the ultimate effects of programs and practices after they have been in place for a while, such as changes in substance use behaviors and related health problems.

From Short- to Long-Term Outcomes

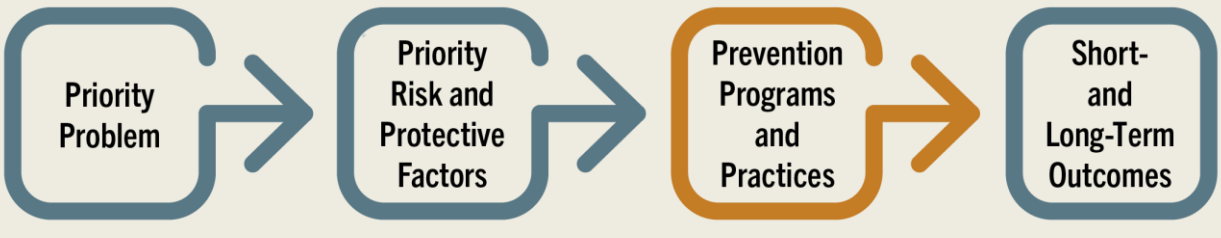
Long-term outcomes, which can take several years to produce, usually result from an accumulation of short-term outcomes. A community can feel confident it is moving in the right direction if it sees anticipated changes in the risk and protective factors associated with its priority problem.

For example, prevention planners in a community addressing NMUPD among youth might determine that a 20 percent increase in parents reporting disapproval of prescription drug misuse and a 10 percent decrease in youth reporting NMUPD-related behaviors are realistic short- and long-term outcomes, respectively.

Developing a Logic Model to Inform Selection

Priority problems and factors reflect where a community is; anticipated outcomes indicate where it wants to go. To capture these key decisions, and inform the selection of programs and practices to move a community in the right direction, planners can begin to build a logic model: a graphic planning tool that makes explicit the rationale for selecting programs and practices by presenting the relationship between problems, associated factors, selected programs and practices, and anticipated outcomes (Figure 2).

Figure 2. LOGIC MODEL FOR PREVENTION



When complete, a logic model for prevention reveals a community's plan for addressing its priority substance use-related problem. Some communities may only have the capacity to support a single prevention program or practice; these communities can be strategic about selecting the one that is likely to have the greatest impact. But when and where possible, there is added value in taking a comprehensive approach to prevention. This type of plan includes multiple programs and practices designed to address different risk and protective factors in different community settings—including homes, schools, health care facilities, neighborhoods, and more.

THE SEARCH: FINDING AND SELECTING PREVENTION PROGRAMS AND PRACTICES

The best candidates for inclusion in a community's comprehensive prevention plan are programs and practices with strong conceptual fit, practical fit, and evidence of effectiveness.

- **Conceptual fit** is the degree to which a program or practice is a good match for the job that needs to be done; for example, a saw is a good match for the job of cutting a piece of wood—better than a hammer or screwdriver.
- **Practical fit** is the degree to which a program or practice is a good match for the people involved and the community overall; for example, a handsaw is a good match for someone who wants to cut wood but who cannot afford or comfortably operate a power saw.
- **Evidence of effectiveness** is the proof that a program or practice can (or cannot) do the job that needs to be done; for example, watching someone use a handsaw to cut through wood is evidence of that specific saw's effectiveness.

Figure 3 presents a process for identifying best-fit programs and practices—that is, those with strong conceptual fit, practical fit, and evidence of effectiveness. Each step in this process is described below.

Figure 3. IDENTIFYING BEST-FIT PREVENTION PROGRAMS AND PRACTICES

FINDING OPTIONS

Communities want to establish prevention programs and practices that work. To maximize the chances of this happening, planners should limit their initial search to those for which there is some evidence of potential to produce positive prevention outcomes. By focusing on these *evidence-based programs and practices* (EBPPs), planners will have concrete information to support their decision-making process. They can find this information in systematic reviews of the effectiveness of available EBPPs and, as needed, individual evaluation studies of EBPPs.

Systematic Reviews

Many groups with expertise in and commitment to evidence-based prevention conduct systematic reviews of the effectiveness of available programs and practices. These reviews are excellent sources of information for planners searching for EBPPs that may be a good fit for their communities. Findings from such reviews can be found in searchable online databases and publications from federal agencies, other prevention and public health organizations (e.g., national nonprofits, university-based research centers), and peer-reviewed journals.

Individual Studies

Expertly conducted systematic reviews offer prevention planners a valuable snapshot of information across multiple evaluation studies of EBPPs. However, some planners may not find an option with strong conceptual and practical fit for their communities in these reviews. If this happens, planners may want to look closely at findings from evaluation studies of individual prevention programs and practices. This information can be found in peer-reviewed journals as well as in reports written by those involved in the implementation and evaluation of programs and practices at the local level (e.g., evaluation reports for funding agencies and to support prevention planning, doctoral theses).

CONSIDERING FIT

No matter how much evidence of effectiveness exists for an EBPP, it will only be appropriate for a community if it is actually the right fit. There are two types of fit: conceptual and practical.

Conceptual Fit

To determine conceptual fit, or how well-suited a program or practice is for doing a specific job, planners can look closely at their community's logic model for prevention. An EBPP with strong conceptual fit is one that:

- Directly addresses the community's priority substance use-related problem as well as one or more priority risk and protective factors associated with that problem
- Has been shown to produce positive outcomes among members of the community's focus population(s)

For example, a parenting program that raises awareness of the dangers of prescription drug misuse would have strong conceptual fit for a community that identified parental disapproval of prescription drug misuse as a priority protective factor for addressing NMUPD among youth. In contrast, a responsible beverage server training for alcohol retailers would have weak conceptual fit for this community as it addresses neither NMUPD among youth nor parental attitudes toward substance misuse.

Practical Fit

To determine practical fit, or how well-suited a program or practice is to a community overall, prevention planners can look closely at their community's capacity—that is, its readiness to support new prevention efforts and the resources it has in place, or that could be leveraged, to do so. An EBPP with strong practical fit is one that:

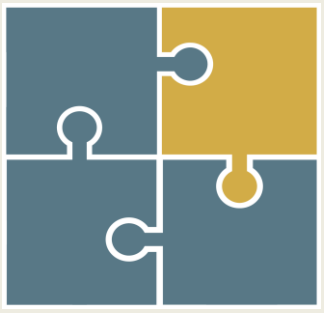
- Is supported by key prevention stakeholders and the broader community
- Is feasible for the organization/community to implement well
- Complements existing prevention efforts in the community

For example, a parenting program to reduce NMUPD among youth would have strong practical fit in a community in which many residents and leaders recognize that NMUPD is a problem; local parents are ready and willing to address it; the program includes content and strategies that are appropriate for these parents; and the program is both affordable for the implementing organization and aligned with its mission and other activities. In contrast, a parenting program would have weak practical fit if key stakeholders are unaware that NMUPD is even a problem and the implementing organization is unwilling or unable to accommodate it.

Does It Fit?

An EBPP with strong conceptual fit will fit neatly into a community's logic model for prevention. One with strong practical fit will fit neatly into the implementing organization and broader community.

There will always be work involved in getting a new program or practice up and running. But if it has strong fit, this work should meet with little resistance—like placing a puzzle piece right where it belongs.



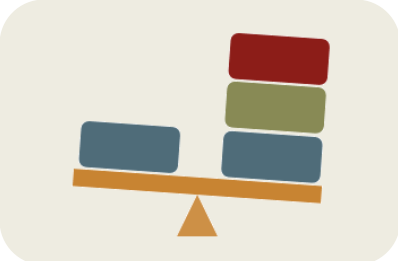
What If Nothing Fits?

Prevention planners who are unable to find any EBPPs with strong conceptual fit and strong practical fit may want to adjust their search criteria and/or process. For example:

- *If there are no EBPPs that directly address their priority problem and factors,* planners may want to consider options that address the same priority factors (e.g., parental disapproval) for a different priority problem (e.g., underage drinking rather than NMUPD).
- *If there are no EBPPs that address their priorities among members of their focus population(s),* planners may want to consider options that address a different priority problem among their focus population(s) (e.g., alcohol misuse rather than opioid misuse among Native American adults).
- *If there are no EBPPs that their community is willing and able to support at this time,* planners may want to work on building capacity for prevention prior to continuing their search.

CONSIDERING STRENGTH OF EVIDENCE

As mentioned earlier, an EBPP with strong conceptual fit is one with evidence that it directly addresses local priorities and can produce intended outcomes. But not all evidence is created equal. Considering the strength of an EBPP's evidence of effectiveness involves closely examining how the evidence was gathered and determining how much confidence it deserves.



Evidence of effectiveness falls along a continuum, from strong to weak. The stronger the evidence, the more confidence it deserves. Strong evidence that an EBPP is, or is *not*, effective comes from strong evaluation studies; the more scientifically rigorous, numerous, and varied the studies, the more compelling the evidence.

The following criteria are often used to assess the strength of evaluation evidence:

- **Research design** describes the approach and structure of the research study. Its purpose is to ensure the study yields information that can answer the research question both meaningfully and unambiguously. As scientific rigor of the research design increases, so too does confidence in the information that is gathered and shared.
- **Internal validity** is the degree to which a program or practice can be considered responsible for producing the outcomes measured in an evaluation study. As scientific rigor of the research design increases, so too does confidence in the internal validity of the results.

- **Independent replication** is the degree to which a program or practice found to produce results with one set of participants consistently produces the same results when rigorously implemented and evaluated by independent practitioners or researchers with other *similar* sets of participants.
- **External and ecological validity** is the degree to which a program or practice found to produce results with one set of participants consistently produces the same results when rigorously implemented and evaluated with other *different* sets of participants (external validity) and under real-world conditions (ecological validity).

What Does Rigor Look Like?

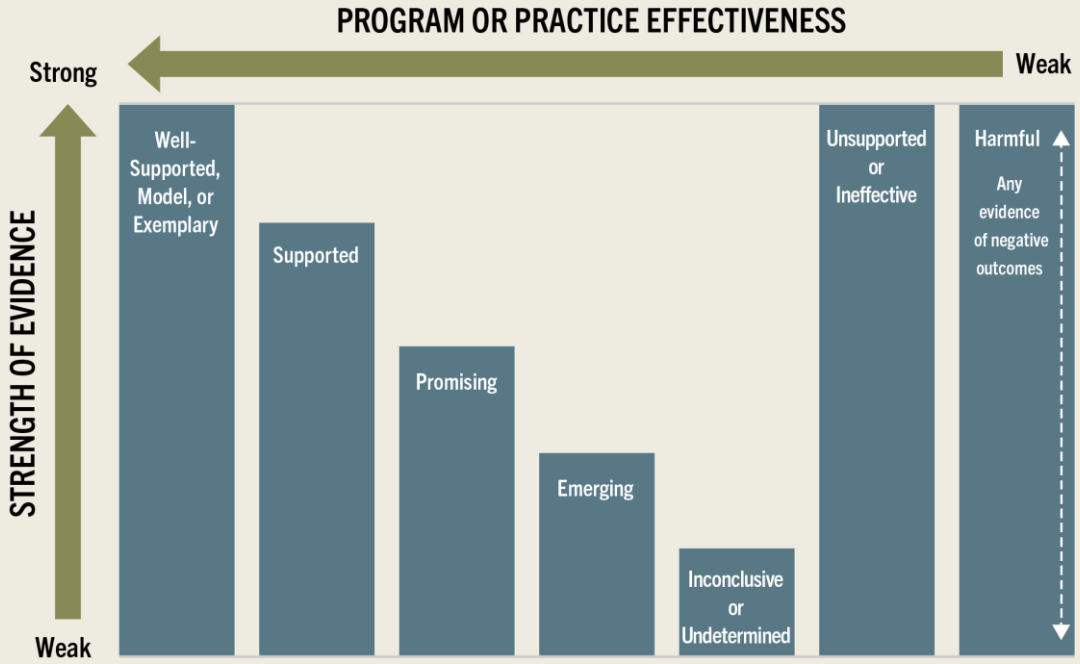
Different research designs possess different degrees of scientific rigor. An experimental design is typically considered the most rigorous. In this design, study participants are randomly assigned to an intervention (i.e., program or practice) group or to a control group. Results from both groups are compared, both before and after the intervention. This ability to compare groups enables the researchers to isolate and identify any effects produced by the intervention and rule out other possible explanations for these effects.

For example, a program for suburban White parents would have very strong evidence of effectiveness for this population if rigorous independent evaluations with members of this population under real-world conditions all demonstrate consistently positive results. However, this program would only have strong evidence of effectiveness for members of a different population—such as rural Latino parents—if it achieved similar results for this population through a similarly rigorous set of evaluation studies.

Prevention planners can use the criteria presented above to understand common categorizations of EBPPs in resources such as federal registries and reports. For example:

- EBPPs with the strongest and most favorable evidence of effectiveness are typically referred to as *well-supported, model,* or *exemplary*.
- EBPPs with weaker yet still favorable evidence of effectiveness are typically referred to as *supported, promising,* or *emerging*.
- EBPPs with insufficient empirical evidence to draw meaningful conclusions about their effectiveness are typically referred to as *inconclusive* or *undetermined*.
- EBPPs with unfavorable evidence of effectiveness are typically referred to as *unsupported* (strong evidence that they do *not* produce desired outcomes) or *harmful* (any evidence, regardless of scientific rigor, that they produce *negative* outcomes).

Figure 4. COMMON CATEGORIES BASED ON STRENGTH OF EVIDENCE SUPPORTING EFFECTIVENESS



Adapted from Puddy, & Wilkins, 2011, p. 8

EBPPs that appear on the far left side of the figure above and also have strong fit should rise to the top of a planner's lists of candidates for inclusion in a community's comprehensive prevention plan. Those on the far right side, which either do not work or can be harmful, should be dismissed outright. Options in the middle categories with strong fit should be carefully considered, particularly when no alternatives are available with stronger evidence of effectiveness. An EBPP with limited evidence of effectiveness may work well in and for a community—and a community can help build its evidence base by evaluating it and sharing the results with others in the prevention field.

AFTER THE SEARCH: MAXIMIZING THE POTENTIAL FOR SUCCESS

When searching for an EBPP, prevention planners may find a best-fit option, a viable but imperfect option, or no viable option at all. Each of these outcomes can set their community on a different path: *adoption, adaptation,* or *innovation.*

READY TO GO: ADOPTING A BEST-FIT OPTION

As described in the previous section, a best-fit EBPP is one with strong evidence of effectiveness in addressing a community's

unique prevention priorities, as well as strong fit for the community overall. A community that finds an EBPP with these ideal characteristics can usually adopt it outright and implement it with fidelity—that is, with strict adherence to its original design. This course of action increases the community's chances of reproducing the positive outcomes this EBPP produced elsewhere.

There are many important ways to promote implementation fidelity and effectiveness. These are described later in this section, in *Maximizing Potential: Building Supports for Successful Implementation*.

Fidelity and Effectiveness

According to Durlak and DuPre (2008), "The difference favoring programs with apparently better as opposed to poorer implementation is profound, and has resulted in mean effect sizes [differences between groups] that are two to three times higher, and, under ideal circumstances, may be up to 12 times higher" (p. 330). These findings underscore the importance of implementation fidelity in prevention.

FROM GOOD TO BEST: ADAPTING A VIABLE BUT IMPERFECT OPTION

While implementation fidelity is strongly associated with effectiveness, some departures from an EBPP's original design and delivery are inevitable. According to Janevic et al. (2016), "The need to modify evidence-based interventions when they are implemented in new practice settings is somewhere between common and universal" (p. 1). Durlak and DuPre (2008) acknowledge this as well; in addition to emphasizing the importance of fidelity, they state that it is unrealistic to expect perfect implementation in real-world settings and that positive outcomes can be achieved even at implementation levels well below 100 percent. In fact, some changes, or adaptations, can even improve the potential of an EBPP to produce positive outcomes—in particular, those adaptations that are carefully planned and executed.

Planned adaptations can help improve an EBPP's potential effectiveness by addressing recognized deficiencies related to fit. For example, if prevention planners find an EBPP that was designed to address their community's priority problem among members of a different focus population, they might consider ways to improve its cultural fit—that is, the relevance of the language, attitudes, beliefs, values, and experiences reflected in the EBPP's design. When planning adaptations of an EBPP, it is important to strive to retain its core components—that is, the specific elements that are required and responsible for producing positive outcomes. The following guidelines can

What Core Components?

Making meaningful changes while retaining core components seems like an ideal way to balance the need for real-world fit *and* high fidelity—but core components are not always readily apparent. If you are unsure about the core components of your selected EBPP, seek guidance from the original developer(s) and/or others who have used and evaluated it.

help communities make adaptations that retain core components and boost, rather than compromise, effectiveness:

- **Preserve the setting.** It may be unrealistic or impossible to make an EBPP designed for one setting (e.g., schools) appropriate for a different setting (e.g., health clinics).
- **Maintain the dosage,** including the number, length, and spacing of sessions. Sufficient participant exposure may be essential for effectiveness.
- **Add new content** if the need for content changes arise, rather than subtract existing content. This will prevent the removal of core content.
- **Make any design or delivery changes with intention and care.** Work closely with the original developers (if implementing a program), members of and leaders from your community's focus population, and other experts in prevention and program evaluation to execute adaptations—including the addition of new content.

For example, in one American Indian community looking to offer a parenting program to prevent youth substance use, community members worked with university researchers to culturally adapt an evidence-based program that was originally developed for Latino parents. They selected this program because it reflected many of the risk and protective factors prioritized by all involved, including supporting youth in different cultural environments. Together, they incorporated American Indian cultural values, worldviews on parenting, and family challenges specific to Native experience as well as cultural elements like storytelling that are common across diverse tribal communities. Participants in the adapted program reported increases in their parenting skills and Native cultural identity and decreases in negative behaviors among their children (Kulis, Ayers, & Baker, 2015).

WHY WAIT? INNOVATE! DEVELOPING A NEW PROGRAM OR PRACTICE

Sometimes the most thorough search for EBPPs fails to generate a single best-fit option or even a solid starting point for adaptation. This tends to occur when looking for programs or practices that address priority problems with emerging rather than extensive evidence—for example, opioid overdose as compared with underage drinking. This may also be the case when looking for programs or practices designed for and/or evaluated with traditionally underserved focus populations—for example, people with disabilities.

In the absence of viable EBPPs, prevention planners might choose to expand or delay their search. Or they may choose to innovate—that is, develop a new or "home-grown" program or practice. Through innovation, communities can address their unique prevention needs in a uniquely appropriate manner. By documenting and evaluating these innovations, they can also help the prevention field evolve and benefit others in similar situations.

Innovation, like any other prevention-related decision and effort, should be grounded in evidence. While a new program or practice cannot be deemed evidence-*based* until after it has been evaluated for effectiveness, it can and should be evidence-*informed*. Valuable sources of expertise and insights that can support an evidence-informed innovation process include relevant:

- **Research:** This may include studies of how other groups and communities have tried to address problems and/or serve populations of interest, including what did and did *not* work well—and why. It may also include more general theories and studies of behavior change; the starting point for many effective programs and practices is a broad but substantiated theory of change, and no program or practice can be considered evidence-based without this foundation.

- **Practice:** Prevention planners can look to practices that are currently being used in diverse community settings to address problems and/or serve populations of interest. These may include culture-based practices, which are informed and guided by the social structures, values, and beliefs of specific cultural groups. Many effective prevention programs and practices have grown out of real-world approaches to promoting health and well-being that communities agree are working well—that is, practice-based evidence.

- **EBPPs:** Even when no EBPPs are the right fit for a community, prevention planners can still benefit from looking closely at those with some relevance to their community's priority problem and/or focus population(s). Doing so can help them understand the wide range of options, explore varied best practices, and crystalize their thinking about what will—or will *not*—work well for their community.

- **Associations:** Prevention planners can also consult with groups at the local, state, regional, and national levels dedicated to advancing best practices in addressing substance use-related problems and/or supporting specific cultural populations. These groups include professional associations focused on specific prevention strategies, such as the National Association of Drug Court Professionals, and/or specific disciplines, such as the National Association of Addiction Treatment Providers. These groups also include diverse cultural centers and associations.

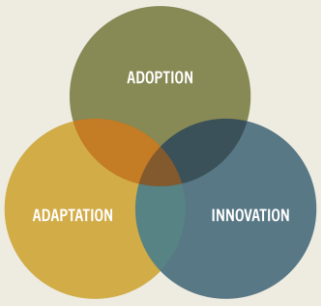
Virtual Communities

Prevention planners can also consult with fellow planners working in other communities to develop innovative prevention and public health interventions. Virtual communities of practice, such as *NNEDshare* from the National Network to Eliminate Disparities in Behavioral Health, offer valuable opportunities for information-sharing and support.

For example, members of a university-tribal partnership in the Pacific Northwest developed an innovation to promote cultural identity and prevent substance misuse among tribal youth based on a cultural practice known as the Canoe Journey. This intertribal tradition, which has included nearly 100 tribes in a given year, includes the formation of Canoe Families within each tribe comprised of youth, their families and extended families, and other tribal and nontribal community members. Each Canoe Family meets throughout the year, participating in drug-free cultural events and fundraising efforts to support the annual Canoe Journey. Many tribal youth and Canoe Family participants refer to the Canoe Journey as their most highly valued cultural best practice for prevention (Hawkins, Cummins, & Marlatt, 2004).

Adoption, Adaptation, and Innovation: Distinct Yet Overlapping Paths

It is important to keep in mind that adoption, adaptation, and innovation are not mutually exclusive. For example, minor adaptations are common when adopting an EBPP; adaptations can turn an EBPP into something new and innovative; and developers of a new program or practice want their innovation to be adopted.



MAXIMIZING POTENTIAL: BUILDING SUPPORTS FOR SUCCESSFUL IMPLEMENTATION

The most carefully selected or crafted prevention effort will only work well if it is implemented, from the very start and over time, with the same degree of care. So whether adopting, adapting, or innovating a new program or practice, prevention planners and communities will need to invest in its implementation and continual improvement to ensure its success. Specifically, they can consider important factors and take decisive actions in each of the following areas:

- **Provider selection:** The providers responsible for implementing a new program or practice should be committed to its delivery, qualified and confident in their ability to implement it, a good cultural match for the focus population, and willing to learn—before and throughout its implementation.

- **Provider preparation and support:** Essential learning opportunities for providers include pre- and in-service trainings to promote the knowledge and skills needed to implement the program or practice as intended, as well as ongoing consultation and coaching to provide on-the-job support and assistance.

- **Process and outcome evaluation:** By closely monitoring the delivery of a program or practice, communities can make sure it is being implemented as intended and improved as needed. By assessing program or practice outcomes, communities can determine whether it is working as intended and worth investing in and continuing over time. By sharing this information, communities can help build the evidence base for programs and practices—thereby contributing to the prevention literature and giving other communities more valuable information to support prevention planning.

- **Organizational leadership and prevention champions:** Strong, dedicated leaders can foster an organizational culture supportive of change, including the use of new prevention programs and practices; help keep all involved coordinated and energized; and proactively remove on-site implementation barriers. These leaders, along with other prevention champions, can also work with systems beyond the implementation site to ensure the continuation of policies, funding, and other supports conducive to implementation and continual improvement.

- **Implementation guidance:** According to the Centers for Disease Control and Prevention (as cited in Puddy, & Wilkins, 2011, p. 19), “Implementation guidance includes any and all services and/or materials that aid in the implementation of a prevention strategy in a different setting, including but not limited to: training, coaching, technical assistance, support materials, organization/system change

consultation, and manuals/guides." Such guidance from program or practice developers, and/or others with relevant skills and experience, can support a community's efforts in each of the areas presented above.

Each of these implementation supports is necessary and essential, but it is through a combination of these supports that a community can truly maximize the potential for individual program or practice success—just as it is through a combination of prevention programs and practices that a community can truly move the needle on its priority substance use-related problem.

No matter how well any single program or practice fits or is implemented within a given organization and community, its power is strengthened exponentially by being part of a strategically planned and comprehensive prevention initiative. In fact, many of the anticipated outcomes identified in a community's logic model for prevention, in particular long-term changes in substance use behaviors and related consequences, rely on the comprehensive plan as a whole. At the same time, each program and practice within that plan must be carefully selected, implemented, and continually improved if it—or the plan as a whole—is to be successful.

APPENDIX 1: PROGRAM AND PRACTICE REVIEW CHECKLIST

Best-fit prevention programs and practices are those with strong conceptual fit, practical fit, and evidence of effectiveness. This checklist includes some key considerations in each of these areas. While not exhaustive, this checklist can help prevention planners create useful snapshots of program and practice viability for their communities. Planners can complete one checklist for each program or practice they review, then compare strength of fit and evidence of effectiveness across multiple programs and practices.

Name of program/practice:

Source(s) of information used to complete this checklist:

CONCEPTUAL FIT

- ☐ **Alignment with priority problem:** This program/practice is designed to address the specific substance use-related problem our community has prioritized.
- ☐ **Alignment with priority factor(s):** This program/practice directly addresses one or more of the specific risk or protective factors our community has prioritized.
- ☐ **Alignment with focus population(s):** This program/practice is designed for use with our community's focus population(s) for prevention efforts.
- ☐ **Evidence of outcome(s) of interest:** This program/practice has been formally evaluated to determine its impact on our community's anticipated short- and/or long-term prevention outcome(s).

PRACTICAL FIT

- ☐ **Implementation guidance:** Program/practice materials (e.g., facilitator guide) and/or services (e.g., training and technical assistance) are available that detail its content, specify its requirements, and can aid in its implementation. *Please note: This guidance can help you consider the items below.*
- ☐ **Support of key stakeholders:** This program/practice is likely to be supported by those it will serve, those who will be responsible for its implementation, and others with relevant decision-making power in our community.
- ☐ **Support of the broader community:** This program/practice is likely to be supported by others in our community, including those who may not be directly involved in or affected by its implementation but are invested in our priority problem and/or focus population(s).

PRACTICAL FIT (continued)

- ☐ **Feasibility of implementation:** It is likely that the implementation site will have sufficient capacity to meet this program's/practice's requirements for use—including funds for materials and training, time and space, and access to qualified staff and evaluators as well as intended participants.

- ☐ **Synergy with other prevention efforts:** This program/practice aligns well with the mission of the implementation site and supports/enhances other prevention efforts at this site and in the broader community.

EVIDENCE OF EFFECTIVENESS

If your information sources include a systematic review of multiple evaluation studies, complete this item. If not, skip to the next set of items.

Systematic review designation: Based on the strength of evidence supporting its effectiveness in producing intended outcomes, the following best describes the reviewers' categorization of this program/practice:

- ☐ Well-supported, model, or exemplary (strongest and most favorable evidence of effectiveness)
- ☐ Supported, promising, or emerging (weaker yet still favorable evidence of effectiveness)
- ☐ Inconclusive or undetermined (insufficient empirical evidence to draw meaningful conclusions about effectiveness)
- ☐ Unsupported (strong evidence that it does *not* produce intended outcomes)
- ☐ Harmful (any evidence that it produces *negative* outcomes)

If your information sources include one or more evaluation studies, complete the following items.

- ☐ **Implementation fidelity:** This program/practice was implemented with strict adherence to its original design. *Please note: This can increase confidence that the program/practice evaluated is the one you are considering.*

- ☐ **Study design:** This program/practice was evaluated using a scientifically rigorous research design. *Please note: This can increase confidence that the program/practice itself was responsible for producing outcomes of interest (i.e., internal validity).*

- ☐ **Study outcomes:** This program/practice produced positive outcomes similar to our community's anticipated short- and/or long-term prevention outcomes.

- ☐ **Study participants:** The study participants are similar to our community's focus population(s).

EVIDENCE OF EFFECTIVENESS (continued)

- ☐ **Independent replication:** This program/practice has produced consistently positive outcomes across multiple rigorous studies with *similar* sets of participants.
- ☐ **External validity:** This program/practice has produced consistently positive outcomes across multiple rigorous studies with *different* sets of participants.
- ☐ **Ecological validity:** This program/practice has produced positive outcomes under real-world conditions (e.g., staff turnover, cancelled sessions).

SUMMARY OF FINDINGS AND NEXT STEPS

Based on this checklist, this program/practice appears to have strong:

- ☐ **Conceptual fit**
- ☐ **Practical fit**
- ☐ **Evidence of effectiveness**

If a meaningful conclusion in each of these areas is not possible at this time, some ways to learn more about this program/practice include the following:

APPENDIX 2: SUPPORTING MATERIALS

The following resources are intended to help prevention planners dig deeper into some of the important topics and concepts introduced in this guidance document:

1. Collaboration Across the Strategic Prevention Framework
2. Criteria for Setting Prevention Priorities
3. Key Features of Risk and Protective Factors
4. Logic Models for Prevention
5. Characteristics of a Comprehensive Approach
6. Finding Evidence-Based Programs and Practices
7. Types of Evaluation

1. COLLABORATION ACROSS THE STRATEGIC PREVENTION FRAMEWORK

No single individual or agency can provide the resources or reach needed to effectively address a community's prevention needs. This is why collaboration is such an integral part of SAMHSA's Strategic Prevention Framework (SPF). To influence complex social problems, practitioners must tap the skills and resources of a broad spectrum of community stakeholders throughout the prevention planning process. Following are examples of opportunities for collaboration at each step of the SPF:

SPF Step	Opportunities for Collaboration	Example
Step 1: Assessment: Communities use data to explore local prevention needs and capacity and identify a priority problem	• Obtain and manage data on local substance use problems and related behaviors • Identify a priority problem • Obtain and manage data on the risk and protective factors associated with and local capacity to address the priority problem • Share and receive feedback on assessment findings	Engage evaluators and/or graduate students from a local university to help collect, analyze, and interpret assessment data
Step 2: Capacity: Communities build local resources and readiness to address the priority problem	• Develop and/or strengthen a prevention team (e.g., add new members to fill gaps in expertise and increase access to resources) • Raise community awareness of the priority problem • Promote community support for and participation in prevention efforts	Work with the editor of a local newspaper to highlight community prevention efforts in a monthly news column
Step 3: Planning: Communities develop a comprehensive plan for addressing the priority problem	• Identify specific risk and protective factors to address in order to influence the priority problem • Select appropriate prevention programs and practices to address these priority factors • Combine programs and practices to ensure a comprehensive prevention approach • Build a logic model for prevention with stakeholders	Share and discuss the logic model with prevention partners, including those who will play a key role in selected programs and practices, to ensure that the model clearly communicates what they hope to accomplish and how

SPF Step	Opportunities for Collaboration	Example
Step 4: Implementation: Communities deliver and fine-tune selected prevention programs and practices	• Adapt selected programs and practices as needed to increase their cultural relevance • Establish infrastructure supports for the implementation of programs and practices • Monitor programs and practices to ensure they are being implemented as intended	Meet with leaders in implementation sites to work out the logistics of program/practice delivery, including identifying and training appropriate providers
Step 5: Evaluation: Communities examine the process and outcomes of their programs and practices	• Identify evaluation stakeholders • Plan and conduct a culturally appropriate and technically sound evaluation that will meet diverse stakeholder needs • Determine how well each program and practice is working and why • Share lessons learned and ensure use of evaluation findings	Involve members of your focus population in the development of evaluation tools

WANT TO LEARN MORE?

Following are additional resources on the SPF and collaboration in prevention:

- **Applying the Strategic Prevention Framework (SPF):** This section of the SAMHSA website offers detailed information on each SPF step and guiding principle, as well as many additional resources to guide and support effective prevention planning.
- **Grantee Stories:** This section of the SAMHSA website includes stories of real-world experiences and strategies shared by recipients of SAMHSA grants and services. These stories illustrate how applying the SPF to prevention planning led to successful efforts in their states and communities. Many of these stories focus specifically on collaboration among diverse prevention stakeholders.

2. CRITERIA FOR SETTING PREVENTION PRIORITIES

A comprehensive assessment of local substance use-related problems and contributing factors will typically yield information about more issues than a community can address at any given point in time. To focus and maximize the impact of local prevention efforts, planners need to make thoughtful and reasoned decisions about which problem(s) and factors to address first. Doing so requires clear prioritization criteria.

IDENTIFYING THE PRIORITY PROBLEM

The following criteria can help prevention planners examine and understand local assessment data with an eye toward identifying their community's priority substance use-related problem:

- **Magnitude:** This describes the prevalence of different problems. Prevention planners considering this criterion will try to answer the question*: Which problem is affecting the greatest number of people in our community?*
- **Severity:** This describes how large an impact different problems are having on individuals and/or the community overall. Prevention planners considering this criterion will try to answer the question: *Which problem is most serious?*
- **Trend:** This describes whether and how different problems seem to be changing over time within a community. Prevention planners considering this criterion will try to answer the question: *Which problem, if any, is getting worse?*
- **Changeability:** This describes how likely it is that a community will be able to modify different problems. Prevention planners considering this criterion will try to answer the question: *Which problem are we in the strongest position to favorably influence through prevention efforts?*

The most straightforward decision-making process is one in which careful consideration of all four criteria point to the same substance use-related problem—but this does not always happen. For example, prevention planners considering the severity of underage drinking as compared with youth prescription drug misuse in their community may find that alcohol is involved in *more injuries, hospitalizations, and arrests* among local youth than prescription drugs—but *more young people may have died* from overdosing on prescription drugs than from misusing alcohol. Prevention planners, together with key community stakeholders, must carefully consider and critically discuss their assessment data in relation to each of these criteria when weighing the relative burdens of different problems and when trying to understand their community's capacity to reduce those burdens.

IDENTIFYING PRIORITY RISK AND PROTECTIVE FACTORS

After identifying a priority problem, prevention planners will need to identify which associated risk and protective factors their community should address in order to influence that problem (see *3. Key Features of Risk and Protective Factors* for more information). To identify priority risk and protective factors at the local level, it is helpful to consider their relative importance and changeability.

- **Importance:** This describes the role of a specific risk or protective factor in reducing a problem. Prevention planners considering this criterion will try to answer the following questions:
  - *To what degree is this factor contributing to our community's priority problem?*
  - *Is this factor relevant to our focus population (e.g., based on developmental stage, culture)?*
  - *Is this factor associated with other pressing behavioral health problems in our community?*

- **Changeability:** This describes a community's capacity to influence a specific risk or protective factor. Prevention planners considering this criterion will try to answer the following questions:
  - *Does our community have sufficient resources and readiness to address this factor?*
  - *Does a suitable prevention program or practice exist to address this factor?*
  - *Will our community be able to produce positive outcomes within a reasonable time frame?*

When setting local prevention priorities, it is best for a community to prioritize risk and protective factors that are *high for both importance and changeability*. If no factors are high for both, the next best option is to prioritize factors with *high importance and low changeability*. Since factors with high importance contribute significantly to priority problems, addressing these factors is more likely to make a significant difference—and it is easier to increase the changeability of a factor (e.g., by boosting prevention capacity) than its importance. However, sometimes a community will choose to address a factor with *low importance and high changeability*. Doing so can give a community a quick "win," help raise awareness of and support for prevention, and increase the community's capacity to address more important factors in the future.

3. KEY FEATURES OF RISK AND PROTECTIVE FACTORS

Since a community cannot change substance use-related problems directly, prevention practitioners must work through the underlying risk and protective factors that influence these problems. ***Risk factors*** precede, and are associated with a higher likelihood that a person will experience, a problem. ***Protective factors*** are associated with a lower likelihood that a person will experience a problem or that reduce the impact of one or more risk factors. Risk and protective factors:

- **Operate in multiple contexts**
- **Are correlated and cumulative**
- **Can be associated with multiple outcomes**
- **Are influential across contexts and over time**

Each of these features is described below.

RISK AND PROTECTIVE FACTORS OPERATE IN MULTIPLE CONTEXTS

Many different factors can make a person vulnerable to, or resilient in the face of, potential substance use-related problems. At the **individual level**, these factors may include a person's prenatal exposure to substances; genetic predisposition to addiction; substance-related knowledge, attitudes, and experiences; self-image; and social and emotional competence.

But individuals do not exist in isolation; they are also influenced by numerous risk and protective factors operating at the relationship, community, and societal levels. For example:

- At the **relationship level**, risk factors can include having parents and/or friends who use or misuse substances; protective factors can include having strong familial bonds and parents who disapprove of substance misuse and closely monitor youth behavior.
- At the **community level,** risk factors can include social norms favorable to substance use or misuse and neighborhood poverty or violence; protective factors can include availability of after-school activities and health-related resources.
- At the **societal level**, risk factors can include limited economic opportunity and substance use-related stigma; protective factors can include laws and policies that limit the number of alcohol retailers and prohibit sales to minors.

RISK AND PROTECTIVE FACTORS ARE CORRELATED AND CUMULATIVE

Risk factors tend to be positively correlated with one another and negatively correlated with protective factors. In other words, a person who already has some risk factors is more likely than a person who does not have risk factors to experience *even more* risk factors—and *less likely* to experience protective factors.

Risk and protective factors also tend to have a cumulative effect on the development, or prevention, of substance use and other behavioral health problems. Someone with multiple risk factors is more likely than someone with fewer risk factors to experience a problem; in contrast, someone with multiple protective factors will have greater protection against problems than someone with fewer protective factors.

These correlations underscore the importance of intervening *early* and implementing prevention programs and practices that target *multiple* risk and protective factors.

RISK AND PROTECTIVE FACTORS CAN BE ASSOCIATED WITH MULTIPLE OUTCOMES

Although prevention programs and practices are often designed to produce a single outcome, both risk and protective factors can be associated with multiple outcomes. For example, adverse life experiences, such as abuse and homelessness, are associated with substance use-related problems as well as with anxiety, depression, and other behavioral health issues. Prevention efforts that target risk and protective factors common across multiple health-related problems have the potential to produce positive effects in many different areas of a person's and community's well-being.

RISK AND PROTECTIVE FACTORS ARE INFLUENTIAL ACROSS CONTEXTS AND OVER TIME

Risk and protective factors in one context, such as relationships, may also influence or be influenced by factors in another context, such as the community. For example, effective parenting has been shown to mediate the effects of multiple risk factors, including poverty. Risk and protective factors can also have power throughout a person's entire life span. For example, risk factors such as early poverty and family dysfunction can contribute to the development of mental and/or substance use disorders later in life.

WANT TO LEARN MORE?

Following are additional resources on risk and protective factors associated with substance use-related problems:

- **Preventing Prescription Drug Misuse: Understanding Who Is at Risk**: This tool provides information from cross-sectional and longitudinal studies on factors that have been shown to increase risk of or protect against the nonmedical use of prescription drugs.

- **Preventing Youth Marijuana Use: Factors Associated with Use:** This tool offers a summary of research findings on risk and protective factors associated with youth marijuana use.
- **Ensuring the Well-being of Boys and Young Men of Color: Factors that Promote Success and Protect Against Substance Use and Misuse:** This tool distills research on substance use and misuse in boys and young men of color as well as on factors promoting positive youth development.
- **Risk and Protective Factors Associated with Binge or Heavy Episodic Drinking Among Adolescents and Young Adults: Using Prevention Research to Guide Prevention Practice**: This tool provides an overview of prevention research on risk and protective factors associated with binge and heavy episodic drinking among adolescents and young adults.

4. LOGIC MODELS FOR PREVENTION

Prevention planners use logic models to visualize how the pieces of a prevention plan fit together to produce change. As shown in the graphic below, key elements of a logic model typically include the following:

- **Priority problem** a community has identified and intends to address through prevention efforts
- **Priority risk and protective factors** a community intends to address in order to influence this problem
- **Prevention programs and practices** selected to address these risk and protective factors
- **Short- and long-term outcomes** a community expects to produce by implementing these programs and practices

Like a road map, a logic model can help prevention planners and communities see where they are, where they are going, and how they will get there.

WHY DEVELOP A LOGIC MODEL?

Developing a logic model is a crucial step in strategic prevention planning that can help prevention planners and communities do the following:

- **Document key lessons learned and decisions made.** A great deal of information-gathering and processing must occur before planners are ready to build a logic model of their community's prevention plan. Logic models offer a concrete way to record, and create a snapshot of, key findings and decisions.

- **Identify any holes that need to be filled**. The pieces of a logic model should fit together seamlessly. The act of building one can reveal any flaws in reasoning or planning gaps. For example, prevention planners might notice a priority factor with no program or practice to address it or an anticipated outcome with no program or practice to produce it. The sooner mistakes are discovered, the easier they are to correct.

- **Communicate how prevention efforts will work**. A complete and hole-free logic model provides prevention planners with a valuable tool for clearly communicating with diverse stakeholders about

how their community intends to address its priority problem and the solid rationale behind this plan that makes it likely to succeed.

- **Assess and improve how well prevention efforts are working**. By developing a logic model *before* implementing prevention programs and practices, planners build a solid foundation for evaluation. This model details the specific and measurable outcomes these prevention efforts are expected to produce in both the short and the long term, which helps planners and their evaluation colleagues monitor the progress of and continually improve these efforts—and, in the end, determine which efforts are worth continuing.

LOGIC MODEL VARIATION

There are many different ways to structure a logic model. For example, the logic model in this resource includes four elements, but others include a greater number of more detailed elements. Prevention planners should explore different approaches to building a logic model in order to identify the one that will best meet their needs. In some cases, they may want to build multiple logic models to serve different strategic planning purposes. For example, a detailed logic model may be needed to support evaluation efforts while a simple one may be more helpful when communicating with the public.

WANT TO LEARN MORE?

Following are additional resources on developing and using logic models in prevention:

- **CDC Evaluation Documents, Workbooks and Tools: Logic Models:** This section of the Centers for Disease Control and Prevention's (CDC) website offers links to several useful resources on understanding, developing, and using logic models to support the strategic planning and evaluation of health-related initiatives.
- **Developing a Logic Model to Guide Program Evaluation:** This presentation from SAMHSA describes how logic models can be used to support prevention planning, implementation, and evaluation.
- Examples of logic models from SAMHSA:
    - **Examples of Community-level Logic Models for Reducing the Non-Medical Use of Opioid Prescription Drugs**
    - **Examples of Community- and State-level Logic Models for Addressing Opioid-related Overdose Deaths**
    - **Examples of Local-level Logic Models for Addressing Behavioral Health Disparities**

5. CHARACTERISTICS OF A COMPREHENSIVE APPROACH

When prevention programs and practices are planned and implemented in a strategic, coordinated, and comprehensive manner, they can support and reinforce one another and produce stronger health-related outcomes for individuals, families, and communities. In fact, the greatest evidence of effectiveness in addressing substance misuse and related behavioral health problems comes from studies of prevention programs and practices working in concert with one another—making a strong case for taking a comprehensive approach to prevention when and where possible. A comprehensive approach to the prevention of substance misuse and related behavioral health problems comprises multiple programs and practices that:

- **Address different levels of risk**
- **Operate at different levels of influence**
- **Require the support and participation of diverse stakeholders**

Each of these characteristics is described below.

ADDRESSING DIFFERENT LEVELS OF RISK

Community-based efforts to address substance use-related problems are most effective when matched to their audience's level of risk. Prevention programs and practices can be grouped according to three levels of risk: universal, selective, and indicated.

- **Universal** prevention efforts focus on general audiences who have not been identified based on substance use-related risk.
- **Selective** prevention efforts focus on audiences with known risk factors for a substance use-related problem.
- **Indicated** prevention efforts focus on audiences who are already experiencing a substance use-related problem.

A community's comprehensive approach to prevention should include strategies at all three levels. For example, a comprehensive plan for addressing the nonmedical use of prescription drugs among youth might include a school-based substance misuse prevention curriculum for all middle school students (universal), support groups for youth with a family history of substance misuse disorders (selective), and counseling and referral to other services, as needed, for youth who are currently misusing prescription drugs (indicated).

OPERATING AT DIFFERENT LEVELS OF INFLUENCE

In addition to addressing different levels of risk, the programs and practices that make up a community's comprehensive prevention approach should reduce the specific risk factors and strengthen the specific protective factors that are known to influence a substance use-related problem at the local level. Because these factors operate at different levels of a person's experience (see *3. Key Features of Risk and Protective Factors* for more information), so too should the programs and practices selected to address them. Specifically, a community's comprehensive approach should include programs and practices that operate at the individual, relationship, and community levels.

- To reduce risk at the **individual** level, programs and practices would address such factors as a person's knowledge, attitudes, perceptions, and behaviors related to the substance use-related problem. For example, a school-based curriculum could boost participants' knowledge of the risks and promote accurate perceptions of the harm associated with prescription drug misuse.

- To reduce risk at the **relationship** level, programs and practices would address factors within a person's closest social circle, such as the knowledge, attitudes, perceptions, and behaviors of family members, friends, and trusted service providers. For example, schools might supplement a prevention curriculum for students with a complementary program for parents that increases their understanding of the risks associated with prescription drug misuse and promotes effective communication with their children about these risks.

- To reduce risk at the **community** level, programs and practices would address factors within a person's broader social and physical environment, such as substance use-related social norms and access to substances. For example, a community might adopt prescriber and pharmacy guidelines designed to reduce medically inappropriate access to prescription drugs among youth.

REQUIRING SUPPORT AND PARTCIPATION FROM DIVERSE STAKEHOLDERS

A comprehensive approach to prevention is only possible with the support and participation of a broad range of community stakeholders. Stakeholders who can play an important role in addressing substance-use related problems include those with:

- **Access to and insights about relevant data**—such as public health, health care, law enforcement, and education professionals

- **Expertise in gathering and using data**—such as research and evaluation professionals

- **Capacity to raise awareness of prevention needs and build support for efforts to address them**—such as media professionals and public opinion leaders

- **Authority to allocate resources to prevention efforts**—such as government officials, business/organizational leaders, and philanthropic organizations
- **Commitment and connections to focus population members**—such as schools, workplaces, health clinics, community centers, non-profit agencies, and faith-based organizations

Every community will have a unique comprehensive prevention approach because every community has a unique set of prevention priorities and resources. What will be similar across communities is the need for support and participation from diverse stakeholders to fully understand and establish those priorities, determine how best to address them, and leverage the resources required to do so successfully. In addition, the communication channels and working relationships fostered when diverse stakeholders collaborate to address current prevention needs also serve to strengthen their communities' capacity to recognize and respond effectively as those needs evolve over time.

6. FINDING EVIDENCE-BASED PROGRAMS AND PRACTICES

Following are resources that prevention planners can use to find evidence-based programs and practices (EBPPs) designed to help address substance misuse and related behavioral health problems in their communities. These resources from the Substance Abuse and Mental Health Services Administration (SAMHSA), other federal agencies, and nongovernmental organizations include searchable databases, reports, and sets of links to other sources of information. Please note that this is not an exhaustive list.

RESOURCES FROM SAMHSA

- **Evidence-Based Practices Resource Center:** This searchable database offers information about evidence-based practices related to substance use and mental health disorder prevention, treatment, and recovery.

- **Finding Evidence-based Programs:** This resources contains links to numerous federal and nongovernmental sources of information on evidence-based programs and practices in substance misuse prevention and behavioral health promotion.

RESOURCES FROM OTHER FEDERAL AGENCIES

- **CrimeSolutions.gov:** This searchable database from the National Institute of Justice offers information about the strength of evidence supporting the effectiveness of programs and practices in such areas as substance abuse, juvenile delinquency, and crime prevention.

- **Evidence-Based Practices & Programs:** This section of the National Institutes of Health's website includes information from federal agencies, nonprofit organizations, and private-sector organizations on evidence-based public health services, programs, and practices.

- **The Community Guide:** This online guide includes evidence-based findings and recommendations of the Community Preventive Services Task Force—an independent group established in 1996 by the U.S. Department of Health and Human Services comprising public health and prevention experts appointed by the director of the Centers for Disease Control and Prevention. Topics include adolescent health, alcohol, and mental health.

- **Healthy People 2020 Evidence-Based Resources:** This searchable database from the U.S. Department of Health and Human Services offers resources on various topics related to Healthy People's science-based, 10-year national objectives for improving health. Topics include access to health services, educational and community-based programs, and substance abuse.

- **Model Programs Guide:** This searchable database from the Office of Juvenile Justice and Delinquency Prevention contains information about evidence-based juvenile justice and youth prevention, intervention, and reentry programs.

- **youth.gov:** Created by the Interagency Working Group on Youth Programs, this website includes a searchable program directory of evidence-based programs to address delinquency and other problem behaviors in young people as well as the Evidence-Based Program Directories, a set of links to other federal resources.

RESOURCES FROM NONGOVERNMENTAL ORGANIZATIONS

- **Blueprints for Healthy Youth Development:** This searchable database from the Center for the Study and Prevention of Violence at the University of Colorado Boulder offers information about evidence-based positive youth development programs, including those to prevent substance use and misuse and to promote positive relationships and academic achievement.
- **Resources and Programs:** This searchable database from the Suicide Prevention Resource Center offers information on evidence-based programs, practices, and strategic planning.
- **CASEL Program Guides: Effective Social and Emotional Learning Programs:** These resources from the Collaborative for Academic, Social, and Emotional Learning (CASEL) offer findings from systematic reviews of school-based (preschool through high school) social and emotional learning programs.
- **Top Tier Evidence:** This resource from the Laura and John Arnold Foundation's Evidence-Based Policy Initiative offers findings from a systematic review of interventions in such areas as early childhood, education (K-12), youth development, crime/violence prevention, substance abuse prevention and treatment, and housing/homelessness.
- **What Works:** This searchable database from Child Trends offers information on programs that promote outcomes related to education, life skills, and social/emotional, mental, physical, or reproductive health.

7. TYPES OF EVALUATION

Evaluation is the systematic collection and analysis of information about prevention efforts to reduce uncertainty, improve effectiveness, and make decisions. According to Michael Quinn Patton (2002), an expert in evaluation, research seeks to *prove* while evaluation seeks to *improve*. In other words, evaluation is all about enhancing prevention efforts. Two important types of evaluation in prevention are *process evaluation* and *outcome evaluation.*

PROCESS EVALUATION

Process evaluation documents the implementation of prevention programs and practices. This type of evaluation can be used to continually improve prevention efforts as they are occurring and to enhance stakeholder understanding of the outcomes ultimately produced by these efforts. Specifically, process evaluation can help communities answer the following questions:

- *To what extent was the program or practice implemented as originally designed?*
- *What, if any, adaptations were made to the program or practice?*
- *How many people participated in the program or were affected by the practice?*
- *Were these participants the intended audience?*

Approaches to gathering data to answer these and other process evaluation questions include interviews and focus groups with providers and/or participants, attendance records, feedback forms, photography and video, implementation checklists, and journal entries/field notes.

OUTCOME EVALUATION

Outcome evaluation measures the effects of prevention programs and practices following their implementation. This type of evaluation can be used to determine whether, and to what degree, prevention efforts are producing the short- and long-term outcomes a community wants to bring about. Specifically, outcome evaluation can help communities answer the following questions:

- *Did any changes occur among participants and/or within the community?*
- *If changes did occur, what were they?*
- *Can these changes be attributed to the program and/or practice itself?*
- *How do these changes compare to those anticipated by the community?*

Because outcome evaluation seeks to capture and understand any changes that occur from before to after the implementation of prevention programs and practices, it is important to gather data from participants at both points in time. Two approaches to designing outcome evaluation studies to gather these data are *experimental* and *quasi-experimental.*

- **Experimental evaluation design:** In this design, which offers the highest level of scientific rigor, participants are randomly assigned to a program/practice group or to a control group. Those in the program/practice group participate in the intervention being evaluated while those in the control group do not. Data are gathered from both groups before and after the intervention using such methods as surveys, interviews, focus groups, and/or observations. Results are then compared to identify any differences between groups.

- **Quasi-experimental evaluation design:** This design is similar to the experimental design in that there is a program/practice group and a control group; however, it does not rely on random assignment. Pure randomization is easier to achieve in laboratories where potentially influential variables can be controlled than in the complex, real-world settings where prevention efforts typically occur. In quasi-experimental evaluations of prevention efforts, existing groups are used rather than randomly assigning individuals to groups. Because there is no random assignment, the program/practice group and the control group will differ not only in terms of the intervention experience but also in other potentially important ways. Evaluators using quasi-experimental designs must try to identify, and explore the potential impact of, as many of these between-group differences as possible to understand their results—including whether the intervention or other variables can be considered responsible.

If a community can credibly demonstrate that existing prevention programs and practices are working well and favorably influencing community health and well-being, this can go a long way toward building confidence in and ongoing support for these—and future—prevention efforts.

WANT TO LEARN MORE?

Following are additional resources on evaluating prevention programs and practices:

- **Evaluation Organizations:** This section of the SAMHSA website offers a list of federal and nongovernmental organizations (NGOs) that provide evaluation-related training, technical assistance, and resources for prevention practitioners.
- **Evaluation Tools and Resources:** This section of the SAMHSA website offers a set of practical tools, tip sheets, and other resources from federal organizations and NGOs with evaluation and prevention expertise.
- **Step 5: Evaluate:** This section of the SAMHSA website is dedicated to the fifth step of the Strategic Prevention Framework (SPF) and includes detailed information on such topics as evaluating prevention processes and outcomes and communicating evaluation results.

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