Minnesota's Workbook On Evidence-Based Prevention

A Product of the Minnesota Evidence-Based Practices Workgroup and the Minnesota SPF PFS Project

This workbook is a publication of the Minnesota Department of Human Services, Alcohol and Drug Abuse Division (ADAD).

The contents of the workbook were prepared by the Minnesota Evidence-based Practices Workgroup (EBPW), which consists of a panel of experts from the fields of public health, community prevention, research and evaluation, and training technical assistance. The EBPW was formed in 2010 to support Minnesota's implementation of a statewide grant from the U.S. Substance Abuse and Mental Health Services Administration - the Strategic Prevention Framework State Incentive Grant, also known as SPF SIG and reconvened in 2015 for the implementation Strategic Prevention Framework Partnerships for Success (SPF PFS) grant. As required by the terms of Minnesota's federal grant, the role of the EBPW is to provide ongoing advice and counsel to the SPF Advisory Council and PFS sub-recipients on the selection and implementation of evidence-based prevention programs and practices.

A special thank you to the following authors and EBPW members who greatly contributed to the development of this workbook:

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Part I. Introduction

Most individuals who work in the field of alcohol and drug abuse prevention are at least a little familiar with the concept of "evidence-based" programming. In recent years, it has become more and more common for the public health agencies and foundations that sponsor prevention efforts to state that they will only fund projects that can produce scientific evidence of their effectiveness.

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and the Minnesota Department of Human Services Alcohol and Drug Abuse Division (ADAD) both expect the states and colleges/ universities they fund to implement evidence-based programs, practices, and policies as part of their prevention work.

Such requirements were put in place to help ensure that scarce prevention resources are being used strategically—by supporting programs with a strong likelihood of success. In addition, the evidence-based practice movement has played an important part in educating many communities and prevention professionals about "what really works" in their fields.

At the same time, the growing emphasis on evidence-based practices and programs has created some significant challenges for community-based prevention professionals, who must now struggle to understand different funders' standards of evidence and to find appropriate evidence-based programs that they can adapt and apply to their unique communities. This can be especially challenging for diverse communities with varying needs and minority communities, where relevant research is lacking.

This workbook was created by Minnesota's Evidence-based Practices Workgroup (EBPW) to help local colleges/ universities and prevention professionals answer some of the most common questions that arise about evidence-based programming including:

- What does it mean for a prevention program to be evidence-based?
- Where can I find information about evidence-based prevention programs and practices that meet the State's requirements?
- How do I go about deciding if an evidence-based program is right for my campus community?
- How do I know if a strategy is a good conceptual fit?
- How do I know if a strategy is a good practical fit?
- How much can I alter or modify a program, once I've selected it, without affecting its results?
- How do I know if I have the right mix of prevention strategies?

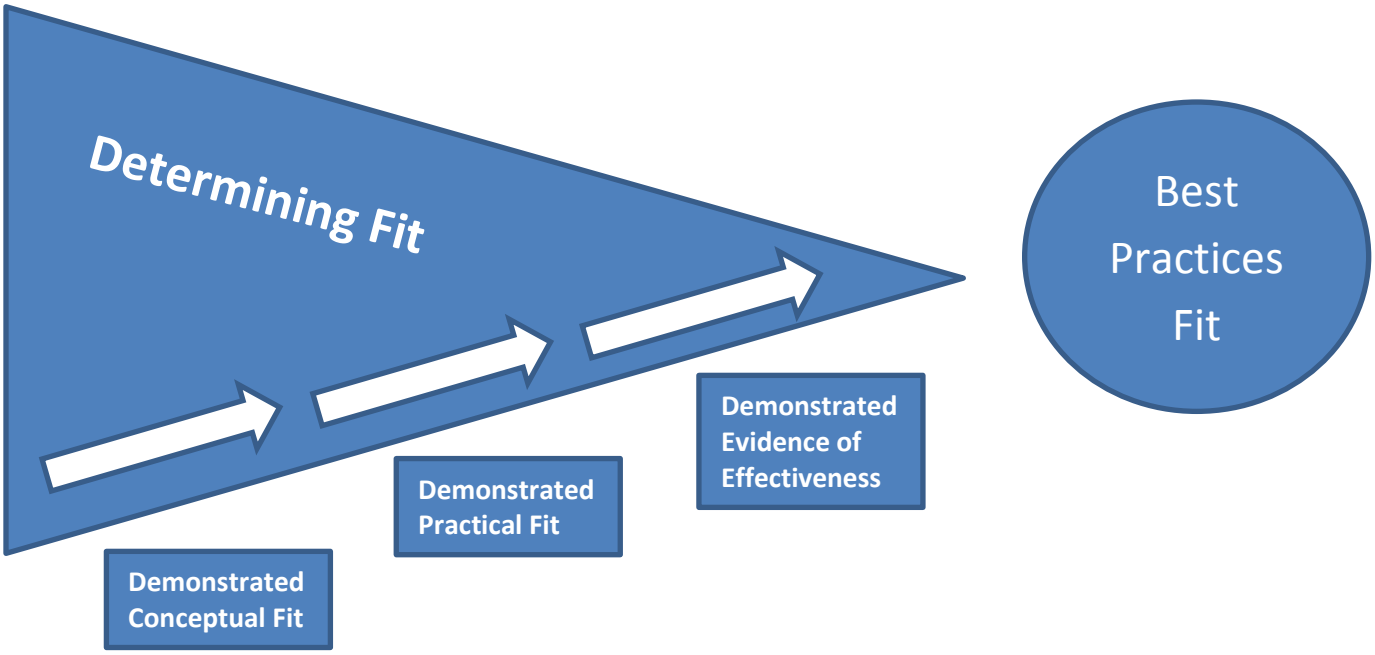
Because Minnesota's EPBW was originally formed in 2010 to help implement a specific prevention grant-SAMHSA's Strategic Prevention Framework State Incentive Grant (SPF SIG) and reconvened in 2015 to implement SAMHSA's Strategic Prevention Framework Partnerships for Success (SPF PFS) grant, many of the recommendations contained here will be particularly relevant for SPF PFS sub-recipients; however, the authors hope that this workbook will also prove useful to other Minnesota communities and individuals interested in evidence-based prevention programming. Indeed, the main purpose of this workbook is to promote a more thorough and consistent understanding of what evidence-based programming really is and when it should be used across all of Minnesota's communities and prevention professionals.

The recommendations and information contained here are based on an extensive review of relevant prevention literature, including guidance documents produced by earlier SAMHSA-funded Evidence-Based Practices Workgroups in other states. However, it is important to note that this document is not intended as a comprehensive guide to prevention, or even a comprehensive guide to all aspects of evidence-based program identification and selection. Individuals and communities interested in continuing their education on these topics will find additional resources and learning materials listed in the appendices to this workbook.

Part II. Determining Best Fit

Evidence of effectiveness is only one of three important criteria to consider in determining if a specific strategy is the best fit for your community. In developing effective prevention programs, it is also essential to consider interventions that represent the best fit for the identified community. Two types of fit should be deliberately evaluated to maintain integrity: conceptual fit and practical fit.

Conceptual and Practical Fit



Conceptual Fit

The conceptual fit of interventions is best defined by their relevance to the identified community needs. While there are many appealing programs available for intervention, not all programs will prove equally effective for all communities. Optimal effectiveness can only be approached when a selected intervention is carefully targeted to the community's specific characteristics, target populations, and local conditions.

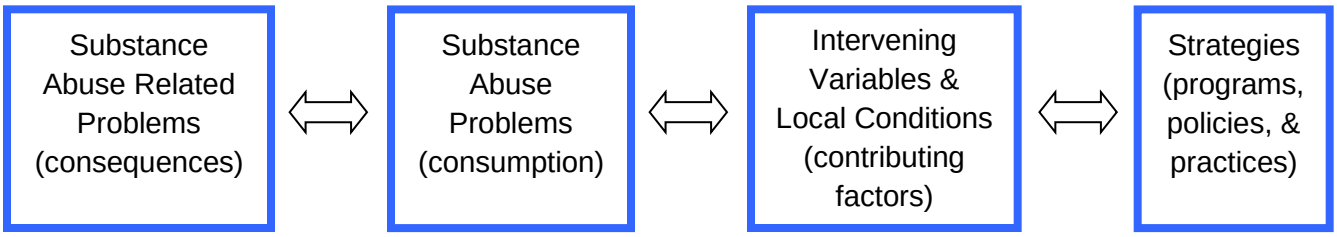
Defining the factors that contribute to substance use: Intervening variables and local conditions

Some of the community- and population-specific characteristics that may need to be considered in selecting an intervention include *"intervening variables."* These are factors that have been identified through research as being strongly related to or influential in the occurrence and magnitude of substance use problems and consequences. *Risk and protective factors* are one type of intervening variable.

Local conditions describe why something is or is not a problem within your community—it is how the intervening variable manifests itself at the local level. For example, a local condition for the retail access/availability intervening variable may be lax carding practices at a particular local bar or liquor store. Local conditions should be identified by analyzing community-specific data.

For instance, if a community has identified a strong correlation between underage drinking and ease in accessing alcohol from retail outlets, interventions that target environmental factors and unique local conditions, such as high retail density or lax carding and training policies, would seem highly relevant. While other interventions such as parent education and social norming might yield impact, they may not be as effective as interventions that specifically target the factors contributing to underage drinking (prevention professionals sometimes refer to these critical contributing factors as intervening variables; see box at left and page 8 for more on intervening variables and local conditions).

Conceptual fit should be contemplated in a comprehensive manner. To ensure that selected strategies lead to the desired outcomes, communities should use a logic model to test if a strategy will address the community's characteristics and local conditions, and if the impact on the intervening variables will lead to expected changes in substance abuse consumption and consequence problems. An example of a simple logic model (using the outcome-based prevention model required for SPF PFS sub-recipients) is provided below.



Beyond intervening variables, other mitigating community characteristics should be considered. Other factors such as religion, education, and culture all interact to form the identity of the community. Consequently, such factors should be considered when judging the potential relevance of a program.

Essentially, a strategy with strong conceptual fit logically leads to change in the desired outcomes.

Practical Fit

Practical fit is best accounted for by the community's technical ability to implement a selected program. Even if a program is determined to be relevant based on the community's needs, it may not be feasible to implement the program due to the limitations of a community. For instance, a community may not be ready for an intervention due to a high level of resistance stemming from particular political views.

Sometimes programs may not be implemented because of a community's inability to collectively mobilize the community members necessary to ensure program success. In other situations, a community may simply not have the resources necessary to implement a desired program (human resources, financial resources, educational resources, etc.). In these situations, additional time may be required in order to first build readiness, political will, capacity, and/or resources. Therefore, it is essential to consider what can be practically implemented based on the dynamics and existing assets of the community, as well as the amount of time and resources currently available.

Comprehensive Program Design

"Best fit" and evidence-base considerations are important criteria, but there are other guidelines and recommendations that can assist communities in developing a well-rounded prevention plan (e.g., NIDA's Prevention Principles, described briefly in the sidebar).

NIDA's Prevention Principles

The National Institute of Drug Addiction's Prevention Principles are based on numerous research studies on the origins of drug abuse behaviors and the common elements found in effective prevention programs. They summarize years of scientific research about the nature of substance use and abuse and how to prevent it and are organized into three areas: Risk and Protective Factors, Prevention Planning, and Prevention Program Delivery.

The principles are intended to help parents, educators, and community leaders think about, plan for, and deliver research-based drug abuse prevention programs at the community level. A copy of the principles is available in the appendix to this workbook and is also available online at: http://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents/prevention-principles

Targeting Multiple Intervening Variables

Generally speaking, the broader the sphere of impact and the more comprehensive programming is, the more effective communities will be in preventing substance abuse. Therefore prevention planners should try to consider selecting a mix of strategies that address the varying factors that contribute to substance use and abuse. It is important that prevention efforts address multiple intervening variables and the local conditions that contribute to your community's problems.

Examples the Minnesota State Epidemiological Outcomes Workgroup (SEOW) identified include broad categories of intervening variables:

- Availability
- Perceived Enforcement
- Promotion/Pricing
- Community Norms
- Individual Factors

The degree to which each of the above categories is a problem varies for each community (and each individual). Communities, therefore, need to consider the local conditions within each of the six intervening variable categories. Every community will have different local conditions for each intervening variable area; additionally, the degree to which each intervening variable contributes to substance abuse problems will also vary for every community.

It is important to understand how these factors contribute to your community's problems prior to identifying the strategies you wish to implement. Selecting a variety of strategies that address multiple local conditions and intervening variables will help ensure comprehensive programming.

Part III: What Exactly are Evidence-based Programs and Practices?

Once you have determined what factors and problems your community is trying to address, and what resources and expertise are available, you still need to consider the "evidence-base" of potential strategies.

Common Definitions of Evidence-based

Although the term "evidence-based" has become common technical jargon in the field of prevention, it is sometimes hard to clearly define exactly what it means, since different funders, communities, and individuals use the term in different ways. Some organizations and individuals will refer to any prevention approach that can be supported by some sort of research as "evidence-based," while others will use the term more strictly to apply only to programs and practices that have repeatedly demonstrated their effectiveness in rigorous evaluation studies.

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) broadly defines the term evidence-based as "signify[ing] that an approach is based in theory and has undergone scientific evaluation. This contrasts with approaches based on tradition, convention, or belief, or anecdotal evidence" (SAMHSA's National Registry of Evidence-based Programs and Practices, 2011).

SAMHSA Definitions of Evidence-based

As part of its SPF SIG grant program, SAMHSA has also provided three more specific definitions of evidence-based programming that grantees and other communities can use to help them identify and select prevention approaches that will meet SAMHSA's standards. For the purposes of this workbook, the Minnesota EBPW has adopted the SAMHSA definitions of evidence-based. A program or practice is considered evidence-based if:

- It has been included in a federal registry of evidence-based interventions (such as SAMHSA's NREPP)
- Its effectiveness in achieving target outcomes has been reported in peer review journals (e.g., *The Journal of Primary Prevention*)
- Its effectiveness has been formally documented in other specific ways in the past (for example, through unpublished outcome evaluations) and the program or practice's effectiveness is supported by the consensus judgment of informed experts.

A more thorough discussion of the three SAMHSA definitions follows.

Definition One: Inclusion in a Federal Registry

Overview of Federal Registries

An intervention is considered evidence-based if "it is included in a federal registry of evidence-based programs." Since the 1990s, several federal agencies have been compiling registries of health and human services programs that they consider to be effective. For example, SAMHSA maintains an extensive registry of effective substance use and mental health programs called NREPP (the National Registry of Evidence-based Programs and Practices), while the U.S. Department of Justice maintains several online directories to effective criminal justice programs.

Most of these federal registries are compiled by teams of federally-funded researchers with years of expertise in program evaluation. They generally feature programs that have achieved positive outcomes and demonstrated their effectiveness in at least one rigorous evaluation. In most cases, they include a brief description of each program's:

- Core elements
- Target populations
- Demonstrated outcomes

Some registries also provide information about the risk and protective factors and community conditions that are addressed by each program, as well as information about the program's costs, published curricula and training materials, and opportunities for replication. Some of the most up-to-date and comprehensive federal registries for substance use prevention and treatment include:

- The Community Guide: The Guide to Community Preventive Services: http://www.thecommunityguide.org/index.html
- Office of Justice Program's Crime Solutions: http://crimesolutions.gov/TopicDetails.aspx?ID=53
- The Agency for Health Research and Quality's Guide to Clinical Preventive Services, 2014: http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html

SAMHSA also maintains an exhaustive list of other, relevant federal registries, which can be found online at: http://www.samhsa.gov/ebpwebguide/ . A directory of federal registries is also included in Appendix A.

Strengths and Limitations of Federal Registries

Because federal registries like NREPP make it easy to find reliable, user-friendly information about effective prevention programs, they are often a good place to start looking for an evidence-based program that might be right for your community. However, it is important to recognize that federal registries have many limitations. Most significantly:

- Different registries use different criteria for deciding whether or not a program or practice is truly evidence-based; as result, consumers may find that a program that they are interested in is considered "effective" or "evidence-based" by one federal agency, but ineffective or merely "promising" by another.
- Most registries focus on interventions that are easy to evaluate using traditional scientific methods; this means they often emphasize school and family-based prevention programs and practices and de-emphasize community, environmental, and policy-oriented strategies.
- Most of the programs that are featured in federal registries have not been tested in diverse settings or with culturally diverse target populations. As a result, even highly recommended programs may not be right for every community or subpopulation.
- Many federal registries are only updated every two to three years, so they may not contain the most up-to-date research and evaluation findings about promising and effective programs.
- No federal registry is truly comprehensive: each one is limited by its areas of focus, its selection criteria, and the resources it has available for identifying and reviewing new programs.

Because of these limitations, it is extremely important that prevention professionals do not rely solely on federal registries for selecting an evidence-based program or practice for their community. **Identifying a potentially appropriate program in a registry should always be just a first step**—one that is followed by further, systematic research about the appropriateness of the intervention for your community. The specific questions you should explore in your follow-up research are outlined in later sections of this community workbook.

Definition Two: Reported in a Peer Reviewed Journal

Overview of Peer Reviewed Journals

SAMHSA also considers a program, practice or approach to be evidence-based if its effectiveness has been reported in a peer reviewed journal. A peer reviewed journal is a scholarly periodical in which the articles have been reviewed by an independent panel of experts (scholarly or scientific peers) before being accepted for publication. Any article that fails to be approved by a majority of the experts on the panel will be rejected.

Some of the leading peer reviewed journals in the field of prevention include:

- The Journal of Primary Prevention
- The American Journal of Public Health
- Journal of Public Health Policy

A more comprehensive list of peer review journals in the fields of public health and substance use prevention is provided in the appendix.

As the box below explains, you may be able to receive some assistance in locating and accessing appropriate peer review journals for your prevention planning.

Tips and Resources: Where to Find Peer Reviewed Articles in Minnesota

There are a number of periodicals that publish articles relevant to substance abuse prevention. While there are many searchable databases of scholarly and peer reviewed journals, most require a subscription. The majority of full-text peer reviewed articles are, therefore, not easily accessed by doing a simple Google search, but there are several options for accessing these databases.

In Minnesota, we are fortunate to have access to libraries and other organizations that may subscribe to prevention-related journals. One resource for prevention professionals in Minnesota is the library maintained by the Minnesota Prevention Resource Center (MPRC). The MPRC Prevention Research Specialist can assist you in searching for such journals or articles and can assist you with literature searches. The Barr Library at the Minnesota Department of Health can also provide access to prevention-related journals and other resources.

Public libraries are another excellent resource. For example, you can use your library card barcode to search databases such as EBSCO for full-text peer reviewed journals that are not available through a standard internet search.

Finally, Minnesota communities participating in the SPF PFS grant process may be able to request literature searches and peer review journal articles from the Wilder Research Library in St. Paul. Grantees should confer with their Wilder Research evaluation consultant about this resource.

Assessing and Applying the Evidence in Peer Review Journal Articles

Unfortunately, using peer reviewed journal articles can sometimes be challenging for community-based prevention specialists, because they are usually written in technical language for specialized audiences. As a result, it may require considerable research expertise to understand the evidence presented. In addition, studies in peer review journal articles often exclude practical aspects of program implementation (e.g., how much training is required to implement a particular model, what are its costs, etc.) To ensure that you make the best possible use of peer review publications, you may want to use the following checklist to review articles:

- Are you certain the publication is peer reviewed (not all scholarly and scientific journals are)?
- Is it clear who funded, implemented, and evaluated the program?
- Does the article include contextual information about the community in which the program was implemented?
- Was there a clear research question identified, or was it clear ahead of time what was being measured?
- Does the article provide a description of the program/approach's conceptual model?
- Does the article clearly spell out its outcomes?
- Does the article address intended and unintended results?
- Does the article clearly define the study population?
- Was a comparison or control group used?
- Are other factors that could have contributed to the outcomes identified and addressed?
- What is the overall quality of the study design?
- Can the evaluation or study design be replicated?
- Are critical assumptions that were made spelled out?
- Was fidelity to the program implementation evaluated?
- Is the difference between causation and correlation honored?
- Could there be alternative interpretations of the data?
- Are the results consistent with other related and well-established information?

These questions may be helpful in evaluating the quality of any research materials. Again, the most important question may be whether or not the reported outcomes are relevant to the local conditions,

intervening variables, and priority problems you have identified for your community. Consideration of the study's community characteristics and target populations is also extremely important in determining whether or not a study's findings are sufficient to support implementation *in your community*.

Definition Three: Other Documented Sources

SAMHSA also allows grantees to identify an appropriate evidence-based intervention for their communities using "other sources of information." However, the process of demonstrating that a program is evidence-based when it does not appear in a federal registry and has not been evaluated in a peer reviewed journal is quite rigorous and demanding.

Guidelines for using other supporting sources

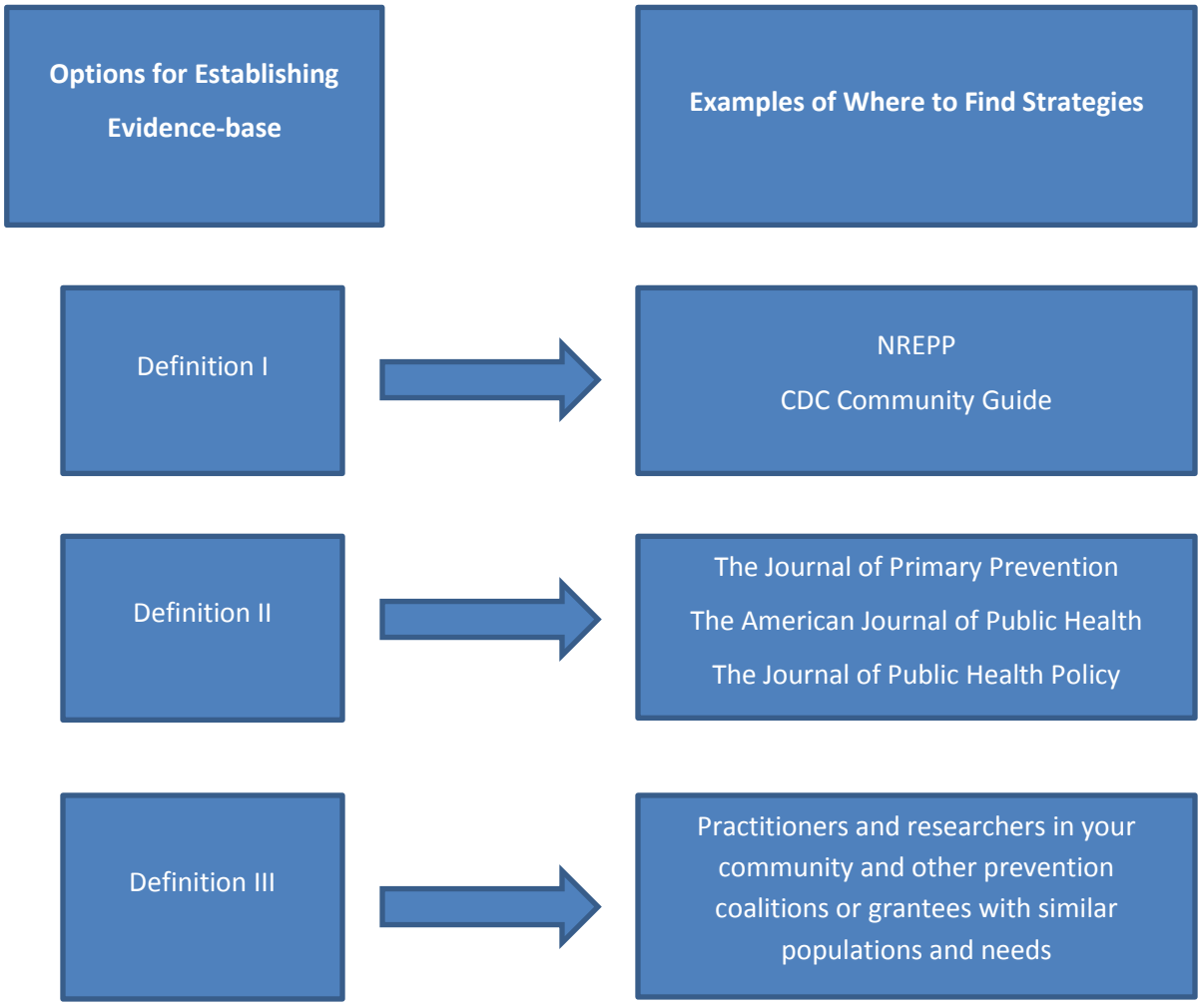
According to SAMHSA's latest guidance, when an intervention is being selected based on other sources of supporting information, ALL FOUR OF THE FOLLOWING GUIDELINES MUST BE MET:

- *Guideline 1: The intervention is based on a theory of change that is documented in a clear logic model or conceptual model.*
- *Guideline 2: The intervention is similar in content and structure to interventions that appear in registries and peer review journal.*
- *Guideline 3: The intervention is supported by documentation that has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects.*
- *Guideline 4: The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes well-qualified prevention researchers who are experienced in evaluating prevention efforts similar to those under review, local prevention practitioners, and key community leaders as appropriate (e.g., officials from law enforcement or the school system or elders from indigenous cultures*).

This third option has been provided to allow communities that cannot identify an appropriate evidence-based prevention approach in federal registries or peer review literature to develop their own prevention strategies. It also provides an opportunity for innovation at the community level.

It is important to note, however, that satisfying the requirements spelled out in SAMHSA's four guidelines can be extremely challenging. For example, even when communities and grantees are able to document their proposed program's theory of change and to demonstrate that similar approaches have been endorsed in federal registries and peer review journals, it can be extremely difficult to produce the documentation to demonstrate a program's past effectiveness. Many communities may also find it difficult to form their own panels of "informed prevention experts" to review and endorse their proposed prevention strategies.

Communities participating in the Minnesota SPF PFS initiative will have the option of having their documentation reviewed and approved by the Minnesota Evidence-based Practices Workgroup rather than a panel of local experts.



Whichever definition and source of information is used to learn about potential evidence-based strategies that may be right for your community, it is important to recognize that identifying potential approaches is only one part of the complex process of selecting and implementing and evidence-based prevention strategies. For many people, the most challenging aspect of this process is actually determining which potential programs offer the best "fit" for their community. These issues of "fit" are discussed in Part II of this workbook.

Part IV. Fidelity and Adaptation Considerations

Once you have identified an evidence-based program or strategy that seems right for your community, it will be important to consider whether or not you can implement the strategy exactly as its original developer intended (this is often referred to in prevention literature as implementing the program model with high "fidelity"). In considering how faithfully you can implement a proposed strategy, it may be helpful to pose the following questions:

- Will you be implementing the strategy with a target population that is the same as, or very similar to, the original target population?
- Will you be working in a similar environmental context with similar local conditions?
- Do you have the required program leadership, staff, and expertise to implement the program or strategy as intended?
- Do you have the necessary resources and infrastructure to implement the strategy with the same intensity and frequency as originally intended?
- Are you certain that you can implement the "core components" of the strategy?
- Are there are other important differences in the way you intend to implement the strategy in your community?

It is important to consider these questions before finalizing your strategy selection, because strategies and practices that are implemented with high fidelity are often more likely to achieve their desired outcomes. At the same time, most practitioners trying to replicate proven strategies find it necessary to adapt these strategies, at least a little bit, to fit their local needs.

Balancing fidelity and adaptation can be tricky—because any time you alter a strategy, you may be compromising outcomes. Yet, implementing a program that requires some adaptation may still be more practical and effective for your community than designing a program from scratch. SAMHSA's Center for Substance Abuse Prevention offers the following basic guidelines for appropriately adapting an evidence-based strategy or intervention to fit your local needs:

- Select programs with the best initial fit to local needs and conditions. This will reduce the likelihood that you will need to make adaptations later on.
- Select programs with the largest effect size. Effect size refers to the magnitude of the effects of an intervention. Policy change interventions generally have larger effect sizes than classroom-based interventions. The smaller an intervention's effect size, the more careful you want to be about changing anything—because you do not want to inadvertently compromise any good you are doing. In general, minor adaptations to programs with large effect sizes are less likely to affect relevant outcomes.
- Change capacity before program. It may be easier to change the program, but changing local capacity to deliver it as it was designed is a safer choice.
- Consult with the experts, including the program developer, an environmental strategies expert, or your evaluator. They may be able to tell you how the intervention has been adapted in the past and how well these adaptations have worked.
- Retain core components. There is a greater likelihood of effectiveness when a program retains the core component of the original intervention. If you are not sure which elements are core, consult the program developer, an environmental strategies expert, or an evaluator.
- Adhere to evidence-based principles. Programs and practices that adhere to evidence-based principles are more likely to be effective, so it is important for adaptations to be consistent with the science.
- Add rather than subtract; doing so will decrease the likelihood that you are eliminating a program element that is important.

For more information, see http://captus.samhsa.gov/access-resources/about-strategic-prevention-framework-spf#Step4

Effective cultural adaptation is especially important when it comes to implementation, but adaptations should be carefully planned. Cultural adaptation refers to program modifications that are culturally sensitive and tailored to a particular group's traditional world views.

Too often, people equate cultural adaptation with translation—but it is much more than that. Effective cultural adaptation considers the values, attitudes, beliefs, and experiences of the target audience. And it depends on strong linkages to cultural leaders and access to culturally competent staff.

http://captus.samhsa.gov/access-resources/about-strategic-prevention-framework-spf#Step4

Part V. Cultural Considerations

In every community, it will also be necessary to consider whether or not the strategy you are proposing is "culturally appropriate" or can be implemented and adapted in a culturally competent way. Unfortunately, many of the best known "evidence-based" prevention strategies have not yet been tested with diverse populations, and it can sometimes be challenging to adapt them sensitively and appropriately for use with new populations.

Part of determining fit involves looking at a community's characteristics and understanding the how substance abuse problems, intervening variables, and local conditions impact different cultural groups. This is easier said than done, but in order to be effective, we need to engage all sub-populations of a community to ensure we identify strategies that reach everyone in a culturally appropriate manner.

In considering the evidence-base of a program, it is crucial that you evaluate whether or not a program will impact your target populations in the same way it impacted the original study population.

Regardless of what types of strategies you decide to implement, you should always strive to be culturally competent in terms of content and delivery of prevention programming.

SAMHSA has identified five core elements of cultural competence:

1. Become aware of, accept, and value cultural differences
2. Become aware of one's own culture and values

3. Understand the range of dynamics that result from the interaction between people of different cultures
4. Develop cultural knowledge of the particular community served or to access cultural brokers who may have that knowledge
5. Adapt individual interventions, programs, and policies to fit the cultural context of the individual, family, or community

Though we often think of cultural competence in terms of an individual's skill set, it is crucial that prevention programs honor these elements as well.

SAMHSA has also produced several helpful guidance documents on developing culturally appropriate programming for specific high-risk populations, which practitioners may wish to consult when attempting to adapt specific strategies to their local populations. A list of some of the resources SAMHSA recommends in this area can be found online at: http://captus.samhsa.gov/access-resources?prevention=96

Part VI: Appendices: Tools & Resources for Applying the SAMHSA Definitions and Criteria

A. Directory of Federal Registries

Complete List of Recommended Substance Use Prevention Registries

- California Healthy Kids Resource Center
- The Campbell Collaboration
- CDC's Community Guide
- Center for the Study and Prevention of Violence
- Child Trends
- Cochrane Collaboration
- College AIM
- County Health Rankings and Roadmaps: What Works for Health
- The SAMHSA Division of Workplace Programs
- Find Youth Info
- Institute for Research, Education, and Training in Addictions
- National Implementation Research Network
- National Institute on Drug Abuse
- Office of Juvenile Justice and Delinquency Prevention
- Oregon Mental Health and Addiction Services
- Promising Practices Network
- SAMHSA's National Registry of Evidence-Based Programs and Practices
- Social Programs That Work
- Strengthening America's Families
- Surgeon General's Office
- Task Force on College Drinking

Complete List of Recommended Substance Use Treatment Registries

- Addiction Technology Transfer Center (ATTC) Network
- California Healthy Kids

- Campbell Collaboration
- Cochrane Collaboration
- Co-Occurring Center for Excellence
- Knowledge Application Programs
- Institute for Research, Education, and Training in Addictions
- National Implementation Research Network
- Office of Juvenile Justice and Delinquency Prevention
- Oregon Mental Health and Addiction Services
- SAMHSA's National Registry of Evidence-Based Programs and Practices
- Strengthening America's Families
- Task Force on College Drinking
- University of Washington Alcohol and Drug Abuse Institute

B. Strategy Selection Process and Tools

To help facilitate the process of identifying, assessing, and selecting prevention strategies, Minnesota's EBPW developed three tools: the **Evidence-Based Practices Strategy Classification & Justification Worksheet**, the **Strategy Selection Worksheet**, and the **Strategy Selection Table**.

Step 1. As you identify relevant strategies using the resources in this workbook, you will need to first determine the level of evidence available for each strategy. The **Evidence-Based Practices Strategy Classification & Justification Worksheet** walks you through this process.

Step 1a. Complete the top portion of the first page to describe the name of the strategy or approach, as well as the priority substance use issue and local condition(s) addressed by the strategy. You will determine which of SAMHSA's definitions of evidence-based programming applies to the strategy by completing the rest of the worksheet, so you will mark that last.

Step 1b. Determine if the strategy is included in a federally approved registry, including those listed on the worksheet. If it is included in a registry, then complete the rest of Section I to indicate if the registry information is sufficient to meet Definition 1, including the following criteria:

- The rating included in the registry explicitly states that the strategy has sufficient evidence of effectiveness. The ratings used vary by registry, but look for ratings such as "evidence-based," "effective," "higher/moderate effectiveness," or "strong evidence." Ratings such as "insufficient evidence," "ineffective," or "too few studies" would not meet this definition.
- Then mark whether the registry includes information on whether or not the strategy is appropriate for your population of focus and your local conditions. If the registry does not include this information, then the strategy may not meet this definition.
- If you determine that the strategy <u>does</u> meet Definition 1, then you are finished with this worksheet for this strategy. If the strategy <u>does not</u> adequately meet this definition, then you will need to move to the next section and test whether it meets Definition 2.

Step 1c. If your strategy does not meet Definition 1, move to Section II to determine if it meets Definition 2. You will do this by gathering all peer review journal articles you can find about this strategy. Enter each article you find in a row of the grid. You can add or delete rows as needed. Then respond to the questions in each column of the grid to determine if the articles provide sufficient evidence to meet Definition 2, as follows:

- There must be more than one article for the strategy, and over half of the articles must demonstrate positive outcomes.
- The journals with the articles must be peer reviewed, using the criteria in column 8. This information is usually readily available on the journal's website.

- The study design must be rigorous enough to reliably demonstrate effectiveness for your community. This includes a population that is similar to your population of focus and a setting similar to your setting. In addition, it is important that there are enough people included in the study to be able to adequately document a change. Finally, studies with a comparison group or participants tracked over time tend to be more rigorous, but it is not essential.
- There must be key outcomes that demonstrate positive changes in your local conditions or related substance use consumption or consequences. Designate if these key outcomes are statistically significant by underlining them.
- Then mark whether the article includes information on whether or not the strategy is appropriate for your population of focus and your local conditions. If none of the articles include this information, then the strategy may not meet this definition.
- Document the limitations of the article. This includes the limitations specified by the article authors (usually found at the end of the article), as well as any limitations that pertain to this article's relevance for your community. Be sure to consider here whether the study includes a similar population, setting, and goals to what you are planning to have for the strategy.
- If you determine that the strategy <u>does</u> meet Definition 2, then you are finished with this worksheet for this strategy. If the strategy <u>does not</u> adequately meet this definition, then you will need to move to the next section and test whether it meets Definition 3.

Step 1d. If your strategy does not meet Definition 2, move to Section III to determine if it meets Definition 3. In order to meet this definition, the strategy must meet the following criteria:

- The strategy must have a program logic model or theory of change that lays out how the strategy logically links to target problems and local conditions similar to yours. If there is not a pre-existing logic model or theory of change, you can create one, but it must include logical, research-based links between the strategy and its expected outcomes. You should also plan to include multiple stakeholders in the development and review of the logic model or theory of change to ensure that the logic is defensible. Be sure to attach your logic model to the worksheet if you're sharing it with others, submitting it to an expert panel, or providing it to a funder.
- The strategy must be similar to other interventions that meet either Definition 1 or Definition 2 of evidence-based. Consider the structure, setting, and goals of the strategies to identify similarities and differences. It is important that this similar strategy has evidence of outcomes that align with your population of focus and local conditions.
- The strategy must have some documented evidence of effectiveness in an evaluation. Gather all evaluation results that have been compiled for this strategy, including reports from journals that are not peer reviewed and from local evaluators or program staff

who have implemented it before. Similar to the criteria for Definition 2, it is important that the evaluations for Definition 3 are rigorous enough to reliably demonstrate effectiveness, and that they align with your population of focus and local conditions.

- Finally, the strategy must be reviewed by a panel of informed prevention experts. This can include experts in substance use prevention, research, evidence-based strategies, or cultural or community groups that you are hoping to reach. The SPF Evidence-Based Practices Workgroup could serve as this expert panel. If you use a local panel of experts, document who is included on this panel to demonstrate that your panel has a variety of experts and roles.

Step 1e. Go back to the first page of the worksheet to mark which definition the strategy meets. Remember, if the strategy does not meet any of these definitions, but does have some evidence of effectiveness, then it may be considered a Promising Practice. If there is no evidence of effectiveness available, then be sure to mark that option on the worksheet.

Step 2.The next step involves assessing both the conceptual fit and practical fit of each strategy for your specific community and local conditions. To do this, use the **Strategy Selection Worksheet**for each strategy being considered.

Step 2a.Complete the fields at the bottom of page 1. This information will help you keep the worksheet organized, and will help later with completion of the Strategy Selection Table.

Step 2b. For the strategy you are assessing, rate your response to questions 1a to 1e on a scale of 1 to 5, with a 5 indicating the best fit. For item 1c, consider all aspects of reach. One you're finished, sum your responses for 1a to 1e and then divide by five. This will give you an average score for conceptual fit.

Step 2c. Follow this same process to respond to questions 2a to 2f to assess practical fit. Again for items 2a and 2b consider all questions posed in the worksheet. This time, divide the total score by six.

Step 2d. Using your completed **Evidence-Based Practices Strategy Classification & Justification Worksheet**, note whether the strategy being assessed: meets Definition 1, 2, or 3. If it does not meet one of these definitions, enter a "4" for promising practices that show some evidence of effectiveness, or a "5" for strategies that have no evidence of effectiveness.

Step 3.Finally, enter information from each of your Strategy Selection Worksheets into the **Strategy Selection Table**. The template provided includes multiple rows for each intervening variable type; add or delete rows as needed, depending on the number of strategies being considered.

Step 3a. In column B, note which substance the strategy addresses. If a particular strategy addresses both or all of the substances your community has prioritized, simple note "both" or "all."

Step 3b. In column C, list the prioritized local condition a particular strategy addresses. Local conditions describe why something is or is not a problem in your community--how the intervening variable manifests itself at the local level.

Step 3c. In column D, list the particular strategy being considered.

Step 3d. From your **Strategy Selection Worksheet**, enter the average conceptual fit score in column E and the average practical fit score in column F. For column G, simply add the two averages together for a total fit score.

Step 3e. From your **Strategy Selection Worksheet**, note which level of evidence the particular strategy meets.

Step 3f. Once the table is complete and all strategies under consideration have been entered, answer the questions listed above the table. These will help your community stakeholders select the right mix of prevention strategies for a comprehensive approach. Ultimately, the number of strategies your community is able to implement will depend on available resources.

Evidence-Based Practices Strategy Classification & Justification Worksheet

Community: Coordinator name:

Complete this form for each strategy you are considering implementing to determine the level of evidence supporting it using the Substance Abuse and Mental Health Services Administration (SAMHSA) definitions of evidence-based.

Program Name and Classification

What is the name of the strategy or approach?

What priority substance use issue would this strategy address?

What local condition(s) would this strategy address?

After completing the worksheet, which of SAMHSA's definitions of evidence-based programming applies to this particular program?

☐ Definition 1: It appears in a federal registry of evidence-based programs (Section Iof this form)
☐ Definition 2: It has been positively evaluated in a peer reviewed journal (Section II of this form)
☐ Definition 3: It is evidence-based according to "other documented sources" (Section III of this form)
☐ Promising practices: It does not meet any of the above definitions, but there is preliminary evidence of effectiveness available.
☐ No evidence: There is no evidence of this strategy's effectiveness available.

Section I: Criteria for Definition 1 programs

1. Is this strategy in a registry? ☐ Yes ☐ No (SKIP TO SECTION II)

2. Which of the following federally approved registries include your program or practice?

- SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) ☐
- Centers for Disease Control and Prevention's Guide to Community Preventive Services ☐
- Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide ☐
- AHRQ's2014 Guide to Clinical Preventive Services ☐
- County Health Rankings and Roadmap for What Works ☐
- College AIM ☐
- Other (Please describe)

3. What specific rating did your selected strategy receive in this registry (e.g. promising, effective, evidence-based, not evidence-based, etc.)?

4. Does the registry include information on whether or not this strategy is appropriate for your population of focus? ☐ Yes ☐ No

5. Does the registry include information on whether or not this strategy is appropriate for your local conditions? ☐ Yes ☐ No

If you cannot successfully document that your strategy is endorsed by a federal registry of evidence-based programs, move to Section II of this worksheet.

Section II: Criteria for Definition 2 programs

6. Is this strategy in at least two peer-reviewed journal articles? ☐Yes ☐No (SKIP TO SECTION III)

Complete this table for all articles found for this strategy, even if the article does not demonstrate the outcomes you were seeking. You should review at least two articles per strategy to meet Definition 2. You can remove or add rows to this chart as needed.

7. Article citation	8. Documentation of peer review	9. Study design	10. Key outcomes (underline statistically significant outcomes)	11. Article relevance	12. Study limitations (including lack of article relevance in column 9)
	☐ The peer review process is clearly stated in the journal or on its web site ☐ It is listed as a peer reviewed journal in the appendices to your Community Workbook ☐ Other(Please describe)	Describe population studied: Setting of the study: Size of group receiving strategy/treatment: Size of comparison group (if any): Were participants tracked over time? ☐ Yes ☐ No		Check if the article includes: ☐Information about your population of focus ☐Information about your local conditions	
	☐ The peer review process is clearly stated in the journal or on its web site ☐ It is listed as a peer reviewed journal in the appendices to your Community Workbook ☐ Other(Please describe)	Describe population studied: Setting of the study: Size of group receiving strategy/treatment: Size of comparison group (if any): Were participants tracked over time? ☐ Yes ☐ No		Check if the article includes: ☐ Information about your population of focus ☐ Information about your local conditions	

7. Article citation	8. Documentation of peer review	9. Study design	10. Key outcomes (underline statistically significant outcomes)	11. Article relevance	12. Study limitations (including lack of article relevance in column 9)
	☐ The peer review process is clearly stated in the journal or on its web site ☐ It is listed as a peer reviewed journal in the appendices to your Community Workbook ☐ Other(Please describe)	Describe population studied: Setting of the study: Size of group receiving strategy/treatment: Size of comparison group (if any): Were participants tracked over time? ☐ Yes ☐ No		Check if the article includes: ☐ Information about your population of focus ☐ Information about your local conditions	
	☐ The peer review process is clearly stated in the journal or on its web site ☐ It is listed as a peer reviewed journal in the appendices to your Community Workbook ☐ Other(Please describe)	Describe population studied: Setting of the study: Size of group receiving strategy/treatment: Size of comparison group (if any): Were participants tracked over time? ☐ Yes ☐ No		Check if the article includes: ☐ Information about your population of focus ☐ Information about your local conditions	
	☐ The peer review process is clearly stated in the journal or on its web site ☐ It is listed as a peer reviewed journal in the appendices to your Community Workbook ☐ Other(Please describe)	Describe population studied: Setting of the study: Size of group receiving strategy/treatment: Size of comparison group (if any): Were participants tracked over time? ☐ Yes ☐ No		Check if the article includes: ☐ Information about your population of focus ☐ Information about your local conditions	

If you cannot successfully document that your strategy has demonstrated strong outcomes in more than one peer review journal, move to Section III.

Section III: Criteria for definition 3

According to SAMHSA's latest guidance, when an intervention is being selected based on "other sources of supporting information," ALL FOUR OF THE FOLLOWING GUIDELINES MUST BE MET:

1. *The intervention must be based on a theory of change that is documented in a clear logic model or conceptual model.*
2. *The intervention must be similar in content and structure to interventions that appear in registries and peer review journals.*
3. *The intervention must be supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects.*
4. *The intervention must be reviewed and deemed appropriate by a panel of informed prevention experts that includes well-qualified prevention researchers who are experienced in evaluating prevention efforts similar to those under review, local prevention practitioners, and key community leaders as appropriate (e.g., officials from law enforcement or the school system or elders from indigenous cultures*).

11. Does the strategy have a program logic model that clearly lays out your target problems and local conditions and links them logically to your selected strategy and expected results?

☐Yes (Attach the logic model to this form) ☐No ☐Not sure

12. Is your selected strategy similar to other interventions that have been positively evaluated in peer review journals and online registries?

☐Yes ☐No (Skip to Q13) ☐Not sure

12a. What strategy is it similar to?

12b. What is the level of evidence for the similar strategy? ☐ Definition 1 ☐ Definition 2

12c. How is it similar?

12d. How does it differ?

12e. What positive outcomes have been documented for the similar strategy?

13. Has this strategy been evaluated?

☐Yes ☐No (Skip to Q14) ☐Not sure

13a. Describe population studied:

13b. Setting of the study:

13c. Size of group receiving strategy/treatment:

13d. Size of comparison group (if any):

13e. Were the participants tracked over time? ☐Yes ☐No

13f. What were the key outcomes? (underline statistically significant outcomes)

14. Has this strategy been reviewed and deemed appropriate by a panel of informed prevention experts? (Note: the Minnesota SPF Evidence Based Practices Workgroup may serve as the body of experts)

☐ Yes, by a panel in our community ☐ Yes, by the SPF EBPW (end worksheet) ☐ No (end worksheet) ☐ Not sure (end worksheet)

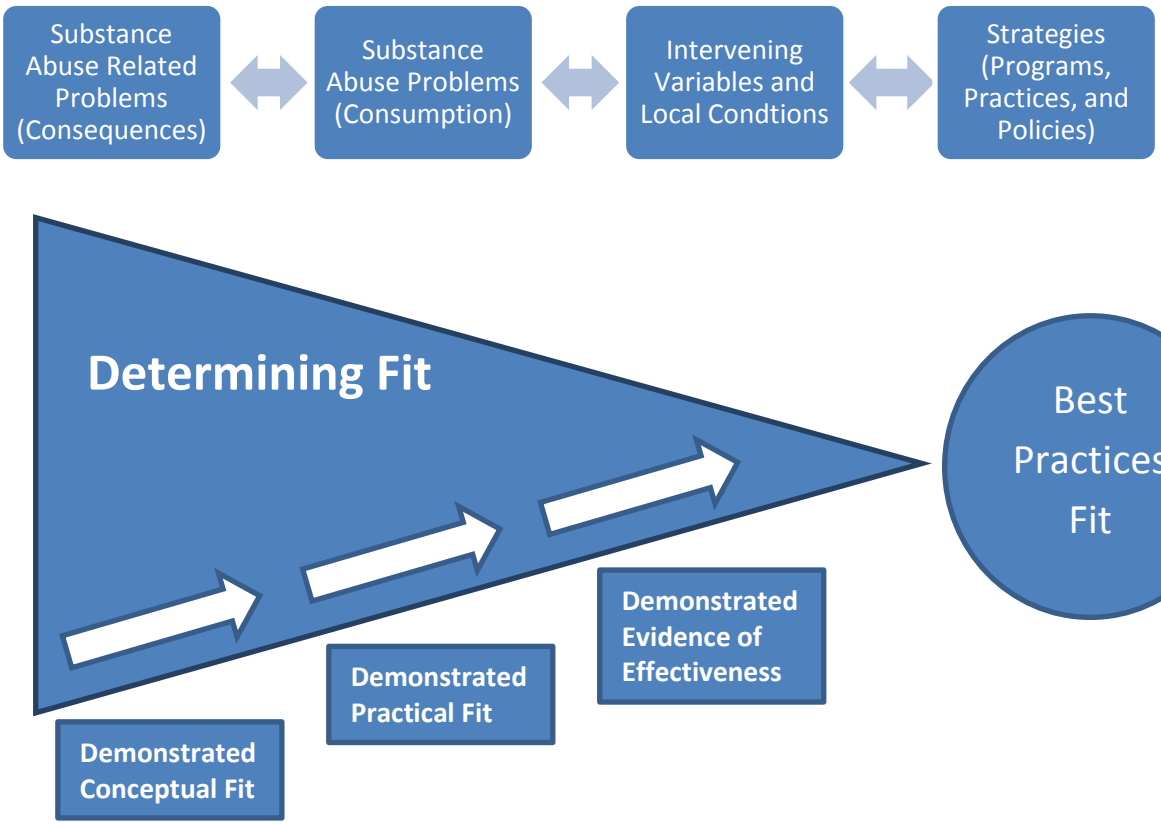
14a. Complete this grid for all members of the expert panel (if not using SPF EBPW)

Name	Position or role	Organization or agency	Area(s) of expertise
			☐ Substance use prevention ☐ Research ☐ Evidence-based practices ☐ Cultural or community knowledge
			☐ Substance use prevention ☐ Research ☐ Evidence-based practices ☐ Cultural or community knowledge
			☐ Substance use prevention ☐ Research ☐ Evidence-based practices ☐ Cultural or community knowledge
			☐ Substance use prevention ☐ Research ☐ Evidence-based practices ☐ Cultural or community knowledge
			☐ Substance use prevention ☐ Research ☐ Evidence-based practices ☐ Cultural or community knowledge
			☐ Substance use prevention ☐ Research ☐ Evidence-based practices ☐ Cultural or community knowledge
			☐ Substance use prevention ☐ Research ☐ Evidence-based practices ☐ Cultural or community knowledge

Please note if you cannot successfully document that your strategy fits all four of the criteria for Definition 3, but there is some evidence of effectiveness for your strategy, it may be considered a Promising Practice.

Strategy Selection Worksheet

Complete this worksheet for <u>each</u> strategy being considered for inclusion in your Community Strategic Plan. Consider exploring more than one strategy for each identified Local Condition.



Grantee/Coalition:

Priority Substance Abuse Problem Being Addressed:

Intervening Variable:

Local Condition:

Strategy Being Evaluated:

Other Strategies Being Considered for This Local Condition:

Conceptual Fit	1	2	3	4	5
1a. Referring to the Outcome-Based Prevention Model, how likely is it that the strategy will change the priority substance abuse problem being addressed (1 = not at all likely; 5 = very likely)	☐	☐	☐	☐	☐
1b. Does the strategy align with your local condition (1 = doesn't align at all; 5 = aligns exactly)?	☐	☐	☐	☐	☐
1c. Will the strategy have sufficient reach to impact the local condition (1 = reach not at all sufficient; 5 = reach very sufficient)? Consider the following: ▪ Does the strategy reach across multiple sectors in the community? ▪ Does it reach people who have the ability to change the condition)? ▪ Does the strategy reach enough people from the population of focus?	☐	☐	☐	☐	☐
1d. How relevant is the evidence behind the strategy given your community's characteristics--i.e., size, location, demographics (1 = not at all relevant; 5 = very relevant)?	☐	☐	☐	☐	☐
1e. How similar are your community's cultural attributes to those of the study communities where the strategy has shown positive results (1 = very different cultural attributes; 5 = very similar cultural attributes)?	☐	☐	☐	☐	☐
TOTAL: add up scores from 1a-1e					
AVERAGE CONCEPTUAL FIT SCORE: divide the total score by five					
Practical Fit	**1**	**2**	**3**	**4**	**5**
2a. How feasible is implementing the strategy given the community's capacity--i.e., skills, knowledge, partnerships, funding, resources (1 = not at all feasible; 5 = extremely feasible)? Consider the following: ▪ Do the individuals responsible for implementing the strategy currently have the necessary capacity? ▪ If not, is it feasible to ensure that adequate capacity is built?	☐	☐	☐	☐	☐
2b. To what extent does the coalition have the necessary stakeholder buy-in to implement this strategy (1 = no stakeholder buy-in; 5 = all necessary stakeholder buy-in)? Consider the following: ▪ Is implementation of the strategy feasible given the community's current readiness--willingness to act and support the project goals? ▪ Do coalition members support the implementation of this strategy?	☐	☐	☐	☐	☐
2c. How likely is it that you can make any necessary cultural adaptations without compromising fidelity (1 = not at all likely; 5 = very likely)?	☐	☐	☐	☐	☐
2d. How feasible is it for you to implement this strategy before the end of the grant (1 = not at all feasible; 5 = extremely feasible)?	☐	☐	☐	☐	☐
2e. How sustainable is this strategy--can it continue to be effective beyond the funding period (1 = not at all sustainable; 5 = very sustainable)?	☐	☐	☐	☐	☐
2f. To what extent does the strategy build on prevention work already in place (1 = it starts from scratch; 5 = it expands greatly on existing effective work)?	☐	☐	☐	☐	☐
TOTAL: add up scores from 2a-2f					
AVERAGE PRACTICAL FIT SCORE: divide the total score by six					
Evidence-Based	**1**	**2**	**3**	**4**	**5**
3a. Which of the definitions of evidence-based does the strategy meet (1 = definition one; 2 = definition two; 3 = definition three; 4 = promising practice; 5 = none)?	☐	☐	☐	☐	☐

Strategy Selection Table

Complete this table by detailing all strategies being considered. You may be considering multiple local conditions under each intervening variable category; add and delete rows as needed. From your Strategy Selection Worksheets, use the average conceptual fit and practical fit scores, and evidence-based definition. When comparing strategies for each local condition, consider both the total score as well as the following guiding questions:

- To what extent do you have the right mix of strategies to fully engage interested stakeholders?
- To what extent do you have the right mix of strategies to effectively intervene with your population of focus?
- To what extent do you have the right mix of strategies to provide a comprehensive approach to your "highest priority" problems?
- Including existing prevention efforts, will you have at least three strategies for each priority substance abuse problem being addressed?

Grantee/coalition:

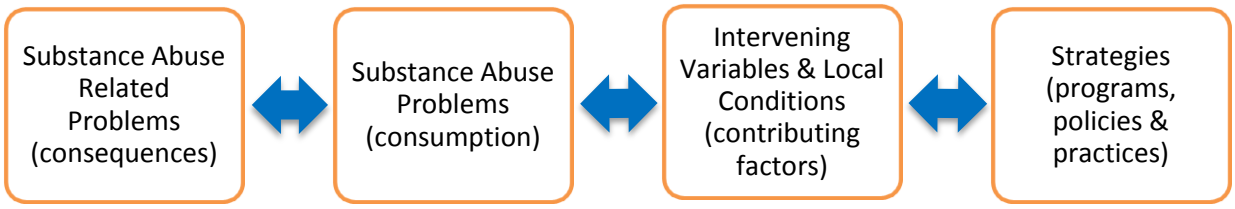
A. Intervening Variable	B. Substance	C. Prioritized Local Condition	D. Strategy	E. Average Conceptual Fit Score	F. Average Practical Fit Score	G. Total Score (sum columns E and F)	H. Evidence of Effectiveness (Definition 1-5)
Access/ Availability							
Perceived Enforcement							
Pricing and Promotion							
Community Norms							
Individual Factors							

C. Strategies Lacking Evidence: Not Likely to be Effective

Prevention science has developed a great deal over the last 30 years. We have learned a lot about what will likely be effective and what will not. Many of the types of strategies listed below have been implemented across the nation and in Minnesota; however, research show that on their own, these strategies are not effective at reducing substance abuse, or in some cases, may even be harmful.

There is a subtle difference between simply being ineffective versus being *ineffective at reducing substance use.* Some programs designed to reduce substance abuse, such as the old DARE program, may have been effective at things like building relationships between law enforcement and schools or building morale among police officers, but they have not achieved a decrease in youth substance abuse. These types of programs are not always bad; sometimes they simply are not the best way to utilize limited resources when the ultimate goal is to decrease substance abuse.

Utilizing a strategic planning process that incudes consideration of the SPF outcome-based prevention model (see below) can help ensure that prevention strategies will have a direct impact on the desired outcomes communities are hoping to achieve.



This is not a complete and exhaustive list of all less effective strategies. It should not be assumed that strategies not included in this table is therefore considered effective. Each community should "dig deeper" into the actual research to gain a better understanding of study findings.

Lastly, it is important to note that some of the types of activities listed below may be appropriate if they are one *component* of another evidence-based strategy and are not sending a message that is inconsistent with other prevention messages. Strategies that may cause harm or may undermine other efforts will neither be effective or beneficial to ATOD prevention efforts.

Ineffective and Potentially Harmful ATOD Prevention Strategies

Type of Strategy & Examples	Why the Strategy May Not be Effective in Preventing Substance Abuse	References for More Information (links to other lit reviews and research
1. Alternative Activities ▪Drug-free dances ▪Recreational activities	●These types of activities bring members of the focus population together, they are often expensive and have no evidence that they impact identified intervening variables. ●These activities alone do not provide essential social and critical thinking skills. ●Activities that promote healthy messages and "social skills development and mental health promotion" are much more effective than programs that simply offer a drug-free environment.	CSAP Tech Report 13: A review of alternative activities and alternative programs in Youth-Oriented Prevention http://vvv.dmhas.state.ct.us/sig/pdf/CSAPTechReport13.pdf Alternative Activities as a Prevention Strategy http://rpstrainings.omni.org/pdf/rps_installment6_alternative_activities.pdf
2. Instructional programs that focus on Scare Tactics or Fear Arousal ▪Mock Car Crashes ▪Fatal Vision Goggles ▪Scared Straight Programs	●Scare tactics can be counter-productive when exaggerated danger, false information, or biased presentations are delivered. Teens tend to disbelieve the message and discredit the messenger, especially when youth have access to contrary information and experience. ●Students tend to remember the destruction, sadness or horror of the experience without relating it to their future behavior. Reflection or intention-impact may be strongest on those who have already committed to not using. ●Studies show that the effects on attitudes towards drinking and driving of fatal vision goggles disappear after four weeks and do not result in a decrease in actual drunken driving behaviors.	Prevention First (2008). Ineffectiveness of fear appeals in youth alcohol, tobacco and other drug (ATOD) prevention. Asper, K. (2015). Scared straight? Why to avoid scare tactics. Prevention Forum. Hastings, G. (2004). Fear appeals in social marketing: Strategic and ethnical reasons for concern. *Psychology & Marketing*, 21 (11), 961-986. Jewell, J. and Hupp, S. (2002). Examining the Effects of Fatal Vision Goggles on Changing Attitudes and Behaviors Related to Drinking and Driving. *Journal of Primary Prevention* (26) 6, 553-565. Block, L. (2005). Self-referenced fear and guilt appeals: The moderating role of self-construal. Journal of Applied Social Psychology, 35(11), 2290-2309.
4. Awareness Days or Assemblies for Student Audiences ▪Motivational or Cautionary Speakers and Assemblies	One-time events demonstrate little or no impact, and any impact is short-lived. These assemblies are often referred to as "powerful," however the emotional effects observed are not only temporary, but they don't translated to changes in behavior.	Don't Do It! Ineffective Prevention Strategies http://www.cde.state.co.us/cdeprevention/download/pdf/Ineffective

Type of Strategy & Examples	Why the Strategy May Not be Effective in Preventing Substance Abuse	References for More Information (links to other lit reviews and research
5. Instructional Programs that Focus Only on Social Influence ▪Some Peer-to-Peer Programs ▪Stand-alone Social Norms Campaigns	Social marketing and public awareness campaigns can enhance prevention programming, but information dissemination as a stand-alone strategy has not demonstrated effectiveness. This type of program will not be considered if in conjunction with other evidence-based practices it may support.	Youth Violence: A Report of the Surgeon General http://www.ncbi.nlm.nih.gov/books/NBK44294 Guidelines and Benchmarks for Prevention Programming http://vvv.dmhas.state.ct.us/sig/pdf/GuidelinesBenchmarks.pdf Dishion, T., McCord, J., & Poulin, F. (1999). When interventions harm. Peer groups and problem behavior. *The American Psychologist, 54*(9), 755-764. **Not available from MPRC**.
6. Extremely Harsh Deterrent Punishment	Parents and youth are likely to remain silent in order to protect the offender from punitive policies. Observers fear only the associated consequence of the offender. Placing youth offenders with other, perhaps more delinquent offenders can have significantly harmful effects. Underlying problems are often never addressed; therefore, the behavior continues.	Youth Violence: A Report of the Surgeon General http://www.ncbi.nlm.nih.gov/books/NBK44294 Don't Do It! Ineffective Prevention Strategies http://www.cde.state.co.us/cdeprevention/download/pdf/Ineffective Malignant Neglect: Substance Abuse and America's Schools http://www.casacolumbia.org/addiction-research/reports/malignant-neglect-substance-abuse-americas-schools

Type of Strategy & Examples	Why the Strategy May Not be Effective in Preventing Substance Abuse	References for More Information (links to other lit reviews and research
7. Some Harm Reduction Models ▪Designated Driver and Sober Ride Services	Harm reduction programs can send mixed messages and have mixed results on participants. Designated driver programs may increase the number of people reporting that they always use a designated driver and, in some cases, may prevent extremely intoxicated individuals from driving after drinking, but this model gives permission to non-drivers to drink more. Several studies have found that non-drivers actually consume more alcohol when a designated driver has been identified. Additionally, designated drivers often still drink – just less than others. More research is needed to determine if such harm reduction programs decrease other alcohol-related problems, such as alcohol-related crashes.	Babor, Thomas F., et al. Alcohol: No Ordinary Commodity. Oxford: Oxford University Press, (2003). Effectiveness of Designated Driver Programs for Reducing Alcohol-Impaired Driving: A systematic Review http://www.thecommunityguide.org/mvoi/mvoi-AJPM-evrev-d-driver.pdf
8. Instructional Programs that focus only on dissemination of information about drugs ▪Curricula solely focused on Drug Facts ▪Health Fairs ▪One-time Drug facts presentations	When used alone, knowledge-oriented interventions designed to supply information about the negative consequences of substance use do not produce measurable and long-lasting changes in substance use-related behaviors or attitudes. These programs are considered among the least effective educational strategies.	How Effective is Drug Abuse Resistance Education? A Meta-Analysis of DARE Outcome Evaluations http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1615171/ Community Prevention Initiative (2013). Effective substance abuse prevention: Why it matters, what works, and what the experts see for the future. *Center for Applied Research Solutions*. Gandhi, A., Murphy-Graham, E., Petrosino, A., Chrismer, S., & Weiss, C. (2007). The devil is in the details: examining the evidence for "proven" school-based drug abuse prevention programs. *Evaluation Review, 31*(1), 43-74. **Not available from MPRC**.

D. Peer Reviewed Journals: Public Health/Substance Abuse & Prevention

"Open Access" refers to material that is provided free of charge. Some journals provide all of their articles as open access, while other journals provide only certain articles as open access. Those that provide ALL open access are labeled in the following list.

Public Health

American Journal of Public Health
http://ajph.aphapublications.org/
The *American Journal of Public Health*® (*AJPH*®) is dedicated to the publication of original work in research, research methods, and program evaluation in the field of public health. The mission of the journal is to advance public health research, policy, practice, and education.

The Journal of the American Medical Association
http://jama.ama-assn.org/
JAMA, published continuously since 1883, is an international peer reviewed general medical journal published 48 times per year.

Journal of Public Health
http://jpubhealth.oxfordjournals.org/
The *Journal of Public Health* invites submission of papers on any aspect of public health research and practice. We welcome papers on the theory and practice of the whole spectrum of public health across the domains of health improvement, health protection and service improvement, with a particular focus on the translation of science into action.

Journal of Public Health Policy
http://www.palgrave-journals.com/jphp/index.html
The *Journal of Public Health Policy* is committed to providing an accessible source of scholarly articles on the epidemiologic and social foundations of public health policy, rigorously edited, and progressive.
The Journal publishes articles from all over the world that can inform policy in other communities, countries or regions. Our aim is to provide a platform to inform debates about public health policy globally.

Public Health
http://www.publichealthjrnl.com/
Public Health is an international, multidisciplinary peer reviewed journal. It publishes original papers, reviews and short reports on all aspects of the science, philosophy, and practice of public health.

It is aimed at all public health practitioners and researchers and those who manage public health services and systems. This includes public health doctors, nurses, dentists, pharmacists, demographers, epidemiologists, health education and promotion specialists, environmental health specialists, and other specialists and scientists in the field of public health. It will also be of interest to anyone involved in provision of public health programs, the care of populations or communities and those who contribute to public health systems in any way.

Social Science and Medicine
http://www.sciencedirect.com/science/journal/02779536
Social Science & Medicine provides an international and interdisciplinary forum for the dissemination of social science research on health. We publish original research articles (both empirical and theoretical), reviews, position papers and commentaries on health issues, to inform current research, policy and practice in all areas of common interest to social scientists, health practitioners, and policy makers. The journal publishes material relevant to any aspect of health from a wide range of social science disciplines (anthropology, economics, epidemiology, geography, policy, psychology, and sociology), and material relevant to the social sciences from any of the professions concerned with physical and mental health, health care, clinical practice, and health policy and organization.

Substance Abuse/Prevention with Public Health Component

Addiction
http://www.addictionjournal.org/
Published on behalf of the Society for the Study of Addiction, *Addiction*, a peer reviewed journal, publishes international research offering a forum for debate with editorials, commentaries, interviews with leading figures in the field, and a comprehensive book review section.

Journal of Behavioral Health Services & Research
http://link.springer.com/journal/volumesAndIssues/11414
The Journal of Behavioral Health Services & Research (JBHS&R) is a peer reviewed, multidisciplinary journal that publishes articles on the organization, financing, delivery, and outcomes of behavioral health services, including mental health, alcohol, and substance abuse. JBHS&R provides practical and empirical contributions and explains the implications of each research article. Each issue includes an overview of contemporary concerns and recent developments in behavioral health policy and management through research articles, policy perspectives, commentaries, brief reports, and book reviews.

Harm Reduction Journal *(*Open Access)*
http://www.harmreductionjournal.com
This is a peer reviewed, online journal whose focus is on prevalent patterns of psychoactive drug use, the public policies meant to control them, and the search for effective methods of reducing the adverse medical, public health, and social consequences associated with both drugs and drug policies.

Mental Health and Substance Abuse: Dual Diagnosis
http://www.informaworld.com/smpp/title~db=all~content=g790361739~tab=summary
This peer reviewed journal focuses on concerns specifically related to coexisting mental health and substance use, referred to by some as 'dual diagnosis.' It covers assessment, intervention, treatment, prevention, innovation, opinion, conceptual exploration and analysis, service delivery, service development, policy and procedure, research and debate.

Prevention Science
http://link.springer.com/journal/volumesAndIssues/11121
Prevention Science serves as an interdisciplinary forum designed to disseminate new developments in the theory, research and practice of prevention. Prevention sciences encompassing etiology, epidemiology and intervention are represented through peer reviewed original research articles on a variety of health and social problems, including but not limited to substance abuse, mental health, HIV/AIDS, violence, accidents, teenage pregnancy, suicide, delinquency, STD's, obesity, diet/nutrition, exercise, and chronic illness.

Substance Abuse Treatment, Prevention, and Policy *(*Open Access)*
http://www.substanceabusepolicy.com
This is an open access, peer reviewed online journal that encompasses various aspects of research concerning substance abuse, with a focus on policy issues. The journal aims to provide an environment for the exchange of ideas, new research, consensus papers, and critical reviews, to bridge the established fields that share a mutual goal of reducing substance abuse. These fields include: legislation pertaining to substance abuse; correctional supervision of substance abusers; medical treatment and screening; mental health services; research; and evaluation of substance abuse programs.

Other Related Journals

Alcohol Research: Current Reviews (*Open Access)
http://www.arcr.niaaa.nih.gov/arcr/default.html
Alcohol Research: Current Reviews is the peer-reviewed journal of the National Institute on Alcohol Abuse and Alcoholism. Each issue presents an in-depth review of an important area of alcohol research. Topics cover a wide range of disciplines in both the biomedical and social sciences.

Health Education & Behavior
http://heb.sagepub.com/
Health Education & Behavior (HEB) is a peer-reviewed bi-monthly journal that provides empirical research, case studies, program evaluations, literature reviews, and discussions of theories of health behavior and health status, as well as strategies to improve social and behavioral health. HEB also examines the processes of planning, implementing, managing, and assessing health education and social-behavioral interventions.

Health Promotion Practice
http://hpp.sagepub.com/
Health Promotion Practice (HPP) is a peer-reviewed bi-monthly journal devoted to the practical application of health promotion and education. HPP focuses on critical and strategic information for professionals engaged in the practice of developing, implementing, and evaluating health promotion and disease prevention programs.

Journal of Adolescent Health
http://www.jahonline.org/
The *Journal of Adolescent Health* is a multidisciplinary scientific Journal, which seeks to publish new research findings in the field of Adolescent Medicine and Health ranging from the basic biological and behavioral sciences to public health and policy.

Journal of Drug Education
http://dre.sagepub.com/
The *Journal of Drug Education: Substance Abuse Research and Prevention (DRE)* covers psychosocial, pharmacological, legal, and social aspects of drugs. This journal serves as a medium for the discussion of all aspects of drug education.

Journal of Research on Adolescence
http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1532-7795
Multidisciplinary in scope, this compelling journal is designed to significantly advance knowledge about the second decade of life. Employing a diverse array of methodologies, it publishes original research that includes intensive measurement, multivariate-longitudinal, and animal comparative studies; demographic and ethnographic analyses; and laboratory experiments. Articles pertinent to the variety of developmental patterns inherent throughout adolescence are featured including cross-national and cross-cultural studies, systematic studies of psychopathology, as well as those pertinent to gender, ethnic, and racial diversity.

Journal of Studies on Alcohol and Drugs

www.jsad.com

The *Journal of Studies on Alcohol and Drugs* (2007–present) is the oldest substance-related journal published in the United States, formerly the *Journal of Studies on Alcohol* (1975–2006) and the*Quarterly Journal of Studies on Alcohol* (1940–1974). It is published by Alcohol Research Documentation, Inc., based at the Center of Alcohol Studies at Rutgers, The State University of New Jersey.

JSAD is a multidisciplinary journal, publishing research on all aspects of the use of, abuse of, and dependence on alcohol, illicit substances, and inhalants; tobacco use and dependence; and the misuse of prescription medication. The range of topics includes, but is not limited to, the biological, medical, epidemiological, psychiatric, social, psychological, legal, public health, socioeconomic, genetic, and neuroscientific aspects of substance use.

E. SAMHSA's Strategic Prevention Framework

Assessment

Profile population needs (including the review and collection of epidemiological data and data regarding intervening variables), capacity, resources, and readiness to address needs and gaps

Capacity

Mobilize and/or build capacity to address needs

Planning

Develop a comprehensive strategic plan

Implementation

Implement evidence-based prevention programs, practices, and policies

Evaluation

Monitor, evaluate, sustain, and improve or replace those that fail

Sustainability

The process of ensuring an adaptive and effective substance abuse prevention system that achieves long-term results and outcomes

Cultural Competence

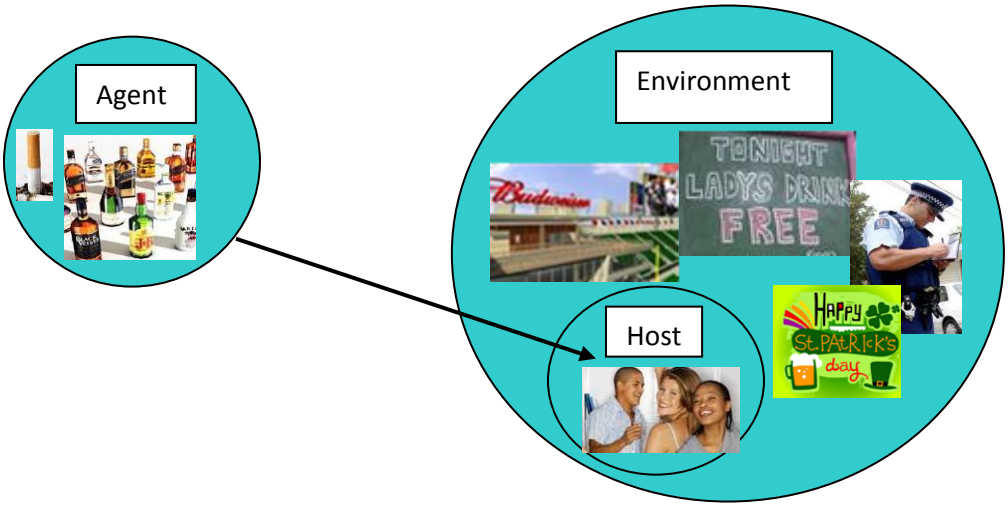
A set of congruent behaviors, attitudes and policies that come together in system, agency or among professionals and enable that system, agency or those professionals to work effectively with ALL people, and in cross-cultural situations

Key Principles of the SPF

- The SPF takes a **public health approach** to *prevent* substance abuse and related problems.
- The SPF is a **data-driven** process; data are used throughout all five steps to inform decisions.
- The SPF supports **collaborative leadership**.
- The SPF is **a strategic planning process** that helps communities ensure that selected prevention strategies *logically* impact the underlying causes of substance abuse problems to create change.
- The SPF utilizes **outcome-based prevention.**

Public Health Approach

In a public health model, we are interested in learning about the relationship between three elements: the agent (ATOD), the host (the ATOD user), and the environment (climate that encourages, discourages, or sustains substance use). The goal is to determine where we can best intervene. Throughout history, we tend to have focused on the host, but the SPF requires us to look at the broader environment, in which the host lives and consumes ATOD.



Elements of a Public Health Approach:

- Multidisciplinary
- Entire population vs. individual
- Community = the "patient" and instrument of change
- Proactive & preventive vs. treatment
- Focus on the environment

Data-Driven

Like any decision making process, we need to make sure we have the right data needed to make informed decisions in every step of the SPF. These data include:

- Epidemiological data

    - Population survey data such as: MSS, CSHS, NCHA
    - Consequence of abuse data
    - Indirect indicator data
- Data regarding readiness, resources, capacity, and gaps in services
- Data reflecting the effectiveness of strategies implemented in other communities that we are considering
- Implementation data (process data)
- Other outcome evaluation data, as appropriate

Collaborative Leadership

The SPF requires a commitment to collaboration from a broad group of community stakeholders. Two national experts on the topic of collaborative leadership, David Chrislip & Carl Larson, have stated, "If you bring the appropriate people together in constructive ways with good information, they will create authentic visions and strategies for addressing shared concerns of their organizations or community." This illustrates the process the SPF model supports in addressing substance abuse problems.

Strategic Planning Process

Intentional planning gives us the best chance at being successful the first time around. If you think about the SPF being a roadmap, it is extremely important to have an *understanding of where Point A and Point B are*. When time and money are limited, it is absolutely crucial to *plan your route* before you take off. Knowing up front *what resources* you have and *what roadblocks* you may encounter will help you identify the best route.

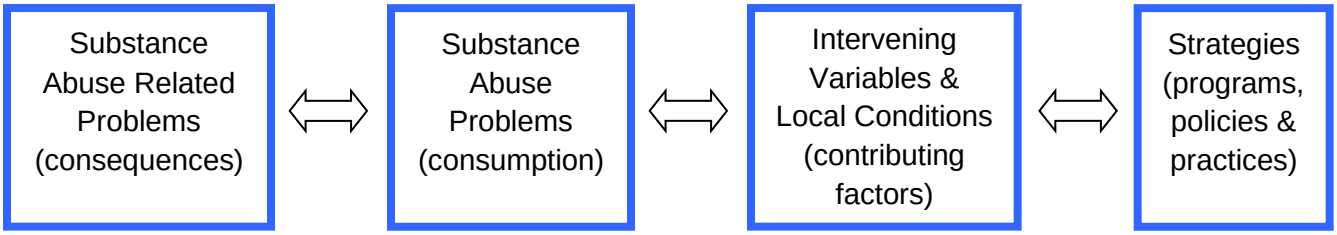
The SPF walks us through a planning process of identifying a starting point and destination, understanding your environment and existing and needed resources, anticipating roadblocks, knowing when and how to take detours, and how you'll know when you've arrived.

Outcome-based Prevention

Requires a clear understanding of:

1. The problem (substance abuse patterns and related consequences)
2. Why the problem exists (intervening variables and local conditions)
3. What change you hope to create (desired outcomes) across a population
4. What needs to be in place in order for change can occur
5. How certain programs, policies, and practices will address the local conditions and intervening variables and will affect change in the identified problems
6. How you will know when change has occurred

A logic model, such as the SPF model below, helps you map out all of these steps and can help a community avoid implementing strategies that won't lead to desired change.



F. Glossary of Terms

Below are definitions of some of the terms commonly used in the **P**artnership **F**or **S**uccess Program.

ADAD: Acronym referring to the Minnesota Department of Human Services Alcohol and Drug Abuse Division. ADAD administers the Minnesota PFS funding, houses the project staff, and oversees all activities of the PFS.

Adaptation: Modification made to a chosen intervention; changes in audience, setting, and/or intensity of program delivery. Research indicates that adaptations are more effective when (a) underlying program theory is understood; (b) core program components have been identified; and (c) both the community and needs of a population of interest have been carefully defined. Research also indicates that success improves when adaptations are handled as additions to, rather than deletions of, program components.

Age of Onset: In substance abuse prevention, the age of first use of alcohol, drugs or tobacco.

Anecdotal Evidence: Information derived from a subjective report, observation, or example that may or may not be reliable but cannot be considered scientifically valid or representative of a larger group or of conditions in another location.

Assessment: Assessment involves the collection of data to profile population needs, resources, and readiness to address needs and gaps within a geographic area. The assessment identifies, analyzes, and depicts the nature and extent of a problem in the community. Based on these data, a subset of modifiable factors or conditions are selected as the focus of the coalition's prevention strategies.

Asset Mapping: The process of cataloging the resources of a community.

ATOD: Acronym for alcohol, tobacco, and other drugs.

Baseline Data: The initial information collected prior to the implementation of an intervention, against which outcomes can be compared at strategic points during and at completion of an intervention.

Capacity: Generally refers to the skills, infrastructure, and resources of organizations and communities that are necessary to effect and maintain behavior change.

Capacity Building: Increasing the ability and skills of individuals, groups, and organizations to plan, undertake, and manage initiatives. It involves the attainment of necessary relationships and knowledge and the mobilization of resources within a community. It also enhances the capacity of the individuals, groups, and organizations to deal with future issues or problems.

Coalition: A union of people and organizations working for a common cause.

Collaboration: The act of working jointly or in partnership with groups or organizations, often ones with whom no previous connections had existed, toward a common goal. Collaboration is an important concept in prevention, community development, technology transfer, and all social change activities.

Community: The intended area of focus for a coalition's work. For the Minnesota PFS Project, community is defined by the geographical area the coalition intends to impact.

Community-level Change: Change that occurs across the population of focus in a community.

Community Readiness: The community's level of awareness of, interest in, and ability and willingness to support substance abuse prevention initiatives. More broadly, connotes readiness for changes in community knowledge, attitudes, motives, policies, and actions.

Consequences: The social, economic and health problems associated with the use of alcohol and illicit drugs e.g., illnesses related to alcohol (cirrhosis, fetal effects), drug overdose deaths, crime, and car crashes or suicides related to alcohol or drugs.

Consumption Patterns: The way in which people drink, smoke and use drugs. Consumption includes overall consumption, acute or heavy consumption, consumption in risky situations (e.g., drinking and driving) and consumption by high-risk groups (e.g., pregnant women).

CSAP: Acronym for the Center for Substance Abuse Prevention, part of the (Federal) Substance Abuse and Mental Health Services Administration (also see SAMHSA). CSAP administers the PFS program and oversees the work of Minnesota's project.

Cultural Competence: (1) A set of congruent behaviors, attitudes and policies that come together in system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations. (2) The attainment of knowledge, skills, and attitudes to enable administrators and practitioners to provide for diverse populations. This includes an understanding of that group's or members' language, beliefs, norms, and values, as well as socioeconomic and political factors that may have a significant impact on their well-being, and incorporating those variables into programs.

Cultural Diversity: The existence of multiple cultural groups at all levels of a community or organization; also the deliberate inclusion of diverse cultural groups in community or organizational planning and development.

Culturally Specific Services: Services targeted to comprehensively address the needs of an individual cultural group and foster positive cultural identity development. Services intentionally allow for culture to affect and guide, to ensure that the services are responsive to the unique needs of the populations receiving them.

Data-driven: A process whereby decisions are informed by and tested against systematically gathered and analyzed information.

Demographics: The statistical characteristics of human populations.

DFC: Acronym referring to SAMHSA's Drug Free Communities Program. There are multiple DFC grantees throughout Minnesota, and SPF SIG sub-recipients are expected to collaborate with these communities.

DHS: Acronym referring to the Minnesota Department of Human Services, the statewide department that houses the Alcohol and Drug Abuse Division (also see ADAD).

Domain: Sphere of activity or affiliation within which people live, work, and socialize (e.g., self, peer, school, workplace, community).

Environmental Factors: Those factors that are external or perceived to be external to an individual, but that may nonetheless affect his or her behavior. At the broader level, these refer to social norms and expectations as well as policies and their implementation.

Environmental Strategies: Prevention efforts that aim to change the context in which substances are used or influence community standards, institutions, structures, and attitudes that shape individuals' behaviors.

EBPW: Acronym for the Minnesota Evidence-Based Practices Workgroup. This workgroup was established under the PFS and is responsible for adopting definitions, tools, and guidance around appropriate strategy selection. The EBPW will also be reviewing the PFS sub-recipient Strategic Plans for approval.

Epidemiology: Epidemiology is the study of the distribution and determinants of disease within a population, and/or the study of health data.

Evaluation: A systematic, data-driven examination of coalition development, functioning, outcomes, and effectiveness, or the examination of changes occurring as a result of a program, strategy, or intervention.

Evidence-based Program, Practices, and Polices: Prevention strategies that are proven to have produced positive change. SAMHSA/CSAP presents three definitions of "evidence-based," which the EBPW has adopted for use in Minnesota.

Fidelity: Fidelity is the degree to which a specific implementation of a program or practice resembles, adheres to, or is faithful to the model on which it is based.

Goal: A broad statement of what the coalition intends to accomplish. For PFS, goals are related to the changes sub-recipients hope to make in the three PFS Priority Problems.

High-risk (aka "At-risk"): The condition of being more likely than average to develop an illness or condition, such as substance abuse, because of some predisposing factor such as family history or the display of other problem behaviors.

High-risk Sub-populations: For PFS, specific groups of students under age 21 who are at higher risk for drinking alcohol, and specific groups of students ages 18-25 year-olds who are at higher risk for using marijuana.

Incidence: The number of new cases of a disease or occurrences of an event in a particular time period, usually expressed as a rate, with the number of cases as the numerator and the population at risk as the denominator. Incidence rates are often presented in standard terms, such as the number of new cases per 100,000 population.

Implementation: Taking action guided by a strategic plan. Progress toward achieving objectives related to the goal of changing behavior is made through the implementation of related activities.

Intervening Variables: Factors that have been identified through research as being strongly related to and influential in the occurrence and magnitude of substance use problems and consequences. The Minnesota PFS Project has adopted the following six categories of intervening variables: retail access/availability, social access/availability, enforcement, pricing and promotion, community norms, and individual factors. Also see *Local Conditions*.

Intervention: An activity or set of activities to which a group is exposed in order to change the group's behavior. In substance abuse prevention, interventions may be used to prevent or lower the rate of substance abuse or substance abuse-related problems.

IOM Categories: Institute of Medicine's characterization of prevention interventions into three categories: Universal, Selected, and Indicated.

- **Universal** interventions target general populations without regard to individual risk factors.
- **Selective** interventions target sub-groups of the general population that are determined to be at higher risk for substance abuse. People are recruited to participate because of the subgroup's profile of high risk, not because of an individual's assessment as being at high risk.
- **Indicated** intervention programs target individuals identified as experiencing early signs of substance abuse and other related problem behaviors, but who do not meet the criteria for addiction. They are designed to address multiple risk factors in individuals/families. People are recruited to participate because of their individual profile of being at high risk and their display of risky behavior.

Local Conditions: Local manifestations of intervening variables that describe why something is or is not a problem in each unique community.

Local Condition Indicator: Specific measures of local conditions or data that describe a local condition.

Logic Model: A graphic depiction or map of the relationships between the local substance abuse problem, the risk/protective factors (intervening variables) and local conditions that contribute to it, and the interventions known to be effective in altering those underlying factors and conditions. An evaluation logic model is a tool for describing the relationships between resources, activities, and expected outcomes. An evaluation logic model illustrates the underlying program theory and serves as framework for the evaluation.

Methodology: A procedure for collecting data.

Mobilization: The process of bringing together and putting into action volunteers, community stakeholders, staff, and/or other resources in support of one or more prevention initiatives.

Morbidity: The presence of a condition, illness, or disease.

Mortality: A fatal outcome, or death.

Norms: A behavior or belief of a community that represents the majority.

Objectives: What is to be accomplished during a specific period of time to move toward achievement of a goal, expressed in specific, measureable terms. For SPF SIG, objectives describe the desired changes in local conditions (local condition indicators) and intervening variables.

Outcomes: The extent of change in targeted attitudes, values, behaviors, or conditions between baseline measurement and subsequent points of measurement. Depending on the nature of the intervention and the theory of change guiding it, changes can be short-term, intermediate, or long-term.

Outcome Measures: Assessments that gauge the effect or results of services provided to a defined population. Outcomes measures include the consumers' level of knowledge or skills and perception of quality of life, as well as objective measures of mortality, morbidity, and health status.

Peer-reviewed: Articles written by recognized authorities in their field and assessed by an unnamed panel of additional experts prior to publication for the purposes of ensuring the quality and validity of its research conclusions.

Population of focus: The specific population of people whom a particular program or practice is designed to serve or reach. A program, practice, or policy may have direct and indirect target populations. Target populations also include high-risk sub-populations and populations requiring culturally specific efforts.

Populations Requiring Culturally Specific Programming: Sub-groups of the community or groups of individuals who require culturally specific or tailored services in order for prevention messages or programming to be effective. This may involve adaptations such as changing the language of the prevention message, changing the delivery method, or adding cultural information to the content to make it more relevant. These sub-groups may or may not be at higher risk.

Prevalence: The number of all new and old cases of a disease or occurrences of an event during a particular time period, usually expressed as a rate, with the number of cases or events as the numerator and the population at risk as the denominator. Prevalence rates are often presented in standard terms, such as the number of cases per 100,000.

Prevention: Prevention is a proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles. The goal of substance abuse prevention is the fostering of a climate in which (a) alcohol use is acceptable only for those of legal age and only when the risk of adverse consequences is minimal; (b) prescription and over-the-counter drugs are used only

for the purposes for which they were intended; (c) other substances of abuse (e.g., aerosols) are used only for their intended purposes; and (d) illegal drugs and tobacco are not used at all.

Process Measures/Indicators: Measures of participation, "dosage," staffing, and other factors related to implementation. Process measures are not outcomes, because they describe events that are inputs to the delivery of an intervention.

Program: A coordinated set of activities designed to achieve specific objectives over a period of time.

Protective Factors: Factors that increase an individual's ability to resist the use of drugs (e.g., strong family bonds, external support systems, problem solving skills).

Qualitative Data: Qualitative data are records of thoughts, observations, opinions, or words. Qualitative data typically come from asking open-ended questions to which the answers are not limited by a set of choices or a scale. Examples of qualitative data include answers to questions and are used only if the user is not restricted by a pre-selected set of answers. Qualitative data are best used to gain answers to questions that produce too many possible answers to list them all or for answers that you would like in the participant's own words.

Quantitative Data: Quantitative data are numeric information that includes things like personal income, amount of time, or a rating of an opinion on a scale. Even things that you do not think of as quantitative, like feelings, can be collected using numbers if you create scales to measure them. Quantitative data are used with closed-ended questions, where users are given a limited set of possible answers to a question. They are for responses that fall into a relatively narrow range of possible answers.

Resilience: Resilience is either (1) the capacity to recover from traumatically adverse life events and other types of adversity and achieve eventual restoration or improvement of competent functioning or (2) the capability to withstand chronic stress and sustain competent functioning despite ongoing stressful and adverse life conditions.

Resources: Anything that can be used to improve the quality of community life—the things that can help close the gap between what is and what ought to be. There are many types of resources, including human resources, technical resources, financial resources, etc.

Risk Factors: Individual characteristics and environmental influences associated with an increased vulnerability to the initiation, continuation, or escalation of substance use.

SAMHSA: Acronym for the Substance Abuse and Mental Health Services Administration, the federal agency charged with focusing attention, programs, and funding on improving the lives of people with or at risk for mental and substance abuse disorders. SAMHSA houses the Center for Substance Abuse Prevention, the agency responsible for administering the PFS Program (also see CSAP).

SEOW: Acronym for State Epidemiological Outcomes Workgroups. The SEOW is a group that has been compiling and monitoring substance abuse data since 2006. The SEOW has contributed significantly other prevention activities and to the PFS project. SEOW and collaborates with the PFS Advisory Council and staff on data-related activities, including the identification of PFS priorities, the development of the 18-25 year old survey (Young Adult Alcohol Survey), the development of the Local Epidemiologic Profile Template, and the evaluation of community data sources.

Stakeholder: An individual, organization, constituent group, or other entity that will be affected by prevention activities or has an interest in the activities or outcomes of a substance abuse intervention.

Statistically significant: a result or outcome in research that's not attributed to chance. In technical statistical terms, it refers to the outcome of a hypothesis test that tests the validity of a claim made about a population. The difference is referred to as the Null Hypothesis. If the Null Hypothesis is true (or that there really is no difference), there's a low probability of getting a result that large or larger. Researchers would resolve that the difference seen is not as a result of chance.

Strategic Planning: A deliberate set of steps that consider needs and resources; define target audiences and a set of goals and objectives; plan and design coordinated strategies with evidence of success; logically connect these strategies to needs, assets, and desired outcomes; and measure and evaluate the process and outcomes.

Strategy: The overarching approach of a coalition to achieve intended results, including programs, practices, or policies.

Sub-recipient Communities: The entities that receive funds from the State of Minnesota to carry out PFS activities or prevention interventions. The term *sub-recipients* is often used interchangeably with the term *grantee*.

Substance Abuse: Abuse of or dependency on alcohol, tobacco and other drugs. The DSM-IV definition is: The maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following occurring within a 12-month period: recurrent substance use resulting in a failure to fulfill major role obligations; recurrent substance use in situations in which it is physically hazardous; recurrent substance- related legal problems; and continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of the substance.

Sustainability: (1) The process through which a prevention system becomes a norm and is integrated into ongoing operations. Sustainability is vital to ensuring that prevention values and processes are firmly established, that partnerships are strengthened, and that financial and other resources are secured over the long term. (2) The process of ensuring an adaptive and effective substance abuse prevention system that achieves long-term results that benefit a focus population.

Young Adults: For the purposes of the PFS, the term *young adults* refers to persons are who between the ages of 18 and 25.