Strategic Prevention Framework:
Regional Training

2010

SANTA ROSA • MODESTO • GARDEN GROVE
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**Acknowledgements**

Thank you to Christina Borbely, Angela Goldberg and Sharon O’Hara.
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This two-day regional event is geared towards County AOD Office representatives who are involved with the adoption and implementation of the Strategic Prevention Framework and Strategic Prevention Plan. This event is designed as a working meeting in which participants will be engaged in a variety of discussion oriented and hands-on application exercises designed to foster both a peer learning environment and work setting. Participants are expected to bring copies of their Strategic Prevention Plans, logic models, evaluation documents and other relevant reference materials. Participants are also encouraged to bring laptops.

Day One:

8:00 - 8:30 a.m. Registration, Networking and Continental Breakfast
8:30 - 8:45 a.m. Welcome, Opening Remarks, and Overview
8:45 - 9:15 a.m. Introductions and Group Check In
9:15 - 12:30 p.m. At the Core: Goals and Objectives
  • Part I. Deepen Our Understanding: An overview presentation on what we’re trying to accomplish in the selection of solid goals and objectives that actually address local conditions.
  • Part II. Learn by Example: Peer case study of such a transformation, with emphasis on challenges, lessons learned and outcomes of the process.
  • Part III. Hands on Application: Working session to re-examine goals and objectives.
  • Part IV. Facilitated Discussion: Share / discuss worksheets. An opportunity to process points of clarity or confusion regarding the hands-on application.
12:30 - 1:30 p.m. LUNCH AND NETWORKING
1:30 - 4:30 p.m. Getting to Outcomes
  • Part I. Deepen Our Understanding: An overview presentation on the alignment between goals, objectives and defining expected outcomes.
  • Part II. Learn by Example: Peer case study of a county that has defined expected outcomes that demonstrate progress toward and accomplishment of corresponding goals and objectives. The focus is on lessons learned on developing meaningful and realistic indicators of change. Describe challenges, including both current barriers and those overcome in the past.
  • Part III. Hands on Application: Working session, building on prior goals and objectives worksheet to confirm outcomes and to refine/develop/choose indicators and related measures.
  • Part IV. Facilitated Discussion: Share / discuss worksheets. An opportunity to process points of clarity and/or confusion regarding the hands-on application.
4:30 p.m. Wrap-up & Preview of Day Two
Day Two

8:00 - 8:30 a.m. Registration, Networking, Continental Breakfast and Welcome

8:30 - 11:30 a.m. Now....Focus on Strategies
- **Part I. Deepen Our Understanding:** An overview presentation with an emphasis on selecting relevant and appropriate evidence-based strategies.
- **Part II. Learn by Example:** Peer case study of how strategies and activities were chosen carefully to “add up” to accomplishing objectives and goals.
- **Part III. Hands on Application:** Working session, building on prior goals and objectives worksheet to identify/assess strategies and activities and how they fit with goals and objectives.
- **Part IV. Facilitated Discussion:** Share / discuss worksheets. Process points of clarity or confusion regarding the hands-on application exercise.

11:30 - 12:30 p.m. LUNCH BREAK

12:30 - 2:30 p.m. Pulling All the Pieces Together
- **Part 1A. Accounting for Strategies:** An overview presentation on the connection of strategies to defining measurable short term and process outcomes.
- **Part 1B. Deepen Our Understanding:** An overview presentation on how all of the components within Strategic Prevention Framework are monitored for ongoing refinement of prevention efforts.
- **Part II. Learn by Example:** Peer case study of a viable evaluation plan and implementation that leverages resources, including CalOMS Pv, and demonstrates how measurement of outcomes reflects changes in the problem/goal/objective.
- **Part III. Hands on Application:** Working session, building on prior goals/objectives/outcomes worksheet to identify/assess methods to implement evaluation.
- **Part IV. Facilitated Discussion:** Share / discuss worksheets. Process points of clarity or confusion regarding the hands-on application exercise.

2:30 - 3:15 p.m. Taking It Home Exercise and Closing

3:15 - 5:00 p.m. Optional Regional Networking Discussion Time
Session 1

At the Core: Goals and Objectives

Identifying Goals and Objectives: First Things First

- What’s the Problem(s)?
- What’s contributing to the problem(s)?
  - Risk Factors
  - Local Conditions
- How do you know?
  - Data, data, data

Problem Analysis

- “Unpacking the problems”
Problem Analysis

1. Problem Statement
2. Risk Factors
3. Local Conditions
   - Specific
   - Identifiable
   - Actionable
4. Supported by Data

How Strong are the Links? Data is the Key

Have we made a clear connection between the problems we are trying to prevent/reduce and the contributing factors that exist in our communities?

Using the Community Assessment

- Do we have the information we need?
- What are the data gaps?
- What are the data questions we will use to find what’s missing?
What are we trying to change?

Can we change it?

How do we know the best way to get there?

How will we know when we're there?

What's the Theory of Change?

If we do ______, then we expect _______ to happen.
Setting Realistic Goals & Objectives
WORKSHEET
<table>
<thead>
<tr>
<th>SRF Regional Training Worksheet</th>
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<tbody>
<tr>
<td><strong>Session I</strong></td>
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<td><strong>Problem</strong></td>
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<td><strong>Contributing Factors</strong></td>
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<td><strong>Local Conditions</strong></td>
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<td><strong>Data:</strong></td>
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<tr>
<td><strong>Goal:</strong></td>
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</tbody>
</table>
REFERENCES & RESOURCES
REFERENCES

- Community Tool Box, University of Kansas. http://ctb.ku.edu


- National Registry of Evidence-based Programs and Practices (NREPP), a service of the Substance Abuse and Mental Health Services Administration (SAMHSA). http://nrepp.samhsa.gov


- Strategic Prevention Overview: Substance Abuse and Mental Health Services Administration (SAMHSA). http://prevention.samhsa.gov
Session 2

Getting to Outcomes

Learning Objectives

- Reflect on underlying theory of change
- Identify measurable and feasible outcomes and indicators aligned with goals and objectives.
- Distinguish between short-term, intermediate, and long-term outcomes.
- Recognize advantages and disadvantages of different measures.

Application Objective

- Complete worksheet section II, resulting in the development of measurable goal and objective statements that determine expected outcomes and indicators.
Goals & Objectives

- Use measurable terms

- By what date will how much of what type of change occur to whom as measured by what?

Measurable

- Targets
  - How much and compared to what?
  - In what increments
  - Who?
- Timelines
- Baseline
- Milestones of progress

Proposed Outcomes

- Goals & Objectives Statements define proposed outcomes
  - If measurable!
Scope of the Outcome

- REALISTIC LEVEL:
  REFLECTIVE OF THE SCOPE OF PREVENTION INTERVENTIONS

Level of Influences

- Progress occurs over time...
  - Short
  - Intermediate
  - Long Term

Break It Down
Links to Outcomes

(Goal) Long term: By June 2012, reduce alcohol consumption among high school youth in XYZ communities by 3%.

(Objective) Intermediate: By June 2011, reduce retail availability of alcohol for underage youth in X community by 5%.

(Activity) Short: By June 2010, implement merchant education in ___ retail outlets in community X.

Links to Outcomes

(Goal) Long term: By June 2012, reduce alcohol consumption among high school youth in XYZ communities by 3%.

(Objective) Intermediate: By June 2011, increase perception of harm by 15% among high risk drinkers in XYZ HS districts.

(Activity) Short: By June 2010, screen all 9th grade students in health education classes at XYZ districts. Short: By June 2010, engage 75% of high risk alcohol users in student assistance programs.

How will we know?

• Indicators
Indicator

- Let's you know that progress is being made?
  - Yard stick
  - Proxy
  - Barometer

Survey Says...

- AOD use:
- Consequences of use:
- Contributing factors:
- Local conditions:

Landscape of Prevention Indicators

- See matrix of common state & national outcomes
- Analyze pros/cons of indicators
### Selecting County Indicators

- Local conditions
- One of a kind outcomes
- Indicators that matter

### Outcomes Link to Indicators

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<thead>
<tr>
<th>PROPOSED OUTCOME</th>
<th>INDICATOR</th>
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<tbody>
<tr>
<td>(Goal) Long term: By June 2012, reduce alcohol consumption among high school youth in XYZ communities by 3%.</td>
<td>11th graders’ self-report 30-day alcohol use rate by survey and interviews.</td>
</tr>
</tbody>
</table>
| (Objective) Intermediate: By June 2011, reduce retail availability of alcohol for underage youth in X community by 5%. | - Sales to minors  
- Compliance checks |
| (Activity) Short: By June 2010, implement merchant education in ___ retail outlets in community X. | - Participation rates |

### Outcomes Link to Indicators

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<td>(Objective) Intermediate: By June 2011, increase perception of harm by 15% among high risk drinkers in XYZ H S districts.</td>
<td>- Youth self-report by survey and interview</td>
</tr>
</tbody>
</table>
| (Activity) Short: By June 2010, screen all 9th grade students in health education classes at XYZ districts. Short: By June 2010, engage 75% of high risk alcohol users in student assistance programs. | - Attendance  
- Screening records  
- SAP participation rates |
What will we know?

- Measuring impact through indicators

Check Point

- Once you selected your indicators, how did you measure them?

Measure of a Measure

- Proximity to problem
- Does it reflect progress toward the prevention objective?
- Does it measure county-level prevention?
- Access to the data
- Resource intensity
### Indicators Link to Measures

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<thead>
<tr>
<th>PROPOSED OUTCOME</th>
<th>INDICATOR</th>
<th>MEASURE</th>
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<tbody>
<tr>
<td><strong>(Goal) Long term:</strong> By June 2012, reduce alcohol consumption among high school youth in XYZ communities by 3%.</td>
<td>11th graders’ self-report 30-day alcohol use rate by survey and interviews.</td>
<td>CHKS in XYZ district Youth on Youth interview</td>
</tr>
<tr>
<td><strong>(Objective) Intermediate:</strong> By June 2011, reduce retail availability of alcohol for underage youth in X community by 5%.</td>
<td>- Sales to minors - Compliance checks</td>
<td>for XYZ zip codes: ABC data PD data</td>
</tr>
<tr>
<td><strong>(Activity) Short:</strong> By June 2010, implement merchant education in ____ retail outlets in community X.</td>
<td>- Participation rates</td>
<td>Attendance logs</td>
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</tbody>
</table>

### Indicators Link to Measures

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<tr>
<th>PROPOSED OUTCOME</th>
<th>INDICATOR</th>
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<tr>
<td><strong>(Goal) Long term:</strong> By June 2012, reduce alcohol consumption among 11th grade youth in XYZ communities by 3%.</td>
<td>11th graders’ self-report 30-day alcohol use rate by survey and interviews.</td>
<td>CHKS in XYZ district Youth on Youth interview</td>
</tr>
<tr>
<td><strong>(Objective) Intermediate:</strong> By June 2011, increase perception of harm by 15% among high risk drinkers in XYZ HS districts.</td>
<td>- Youth self-report by survey and interview</td>
<td>SAP Youth Survey Youth on Youth interview</td>
</tr>
<tr>
<td><strong>(Activity) Short:</strong> By June 2010, screen all 9th grade students in health education classes at XYZ districts. Short: By June 2010, engage 75% of high risk alcohol users in student assistance programs.</td>
<td>- Attendance - Screening records - SAP participation rates</td>
<td>Attendance logs Screening results SAP intake records</td>
</tr>
</tbody>
</table>

### Check Point

- In the County’s Strategic Plan, were viable and relevant outcomes of goals and objectives proposed?

- Were the indicators of progress toward outcomes measurable and useful?
Now what?

- Strengthening link of outcomes back to goals and objectives

Check Point

- Have you adjusted or changed your goals, objectives and related outcome measures?

- Have you updated your proposed outcomes in the last year or two?

Contact Information:

- (707) 568-3800
- www.ca-cpi.org

- Christina Borbely, Ph.D.
- cjborbely@sbcglobal.net
From the Field

- Real world application of SPF: Approaches to measurable goals, objectives, and expected outcomes

Application Objective

- Complete worksheet section II, resulting in the development of measurable goal and objective statements that determine expected outcomes and indicators.
Session II: Getting to Outcomes with Measurable Goals and Objectives

- **By what date will how much of what type of change occur to whom as measured by what?**

<table>
<thead>
<tr>
<th>Goal (Long-Term) Outcome</th>
<th>Objective (Intermediate-Term) Outcome</th>
<th>Short Term Objective Outcome</th>
</tr>
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<tbody>
<tr>
<td>(Opposite of problem)</td>
<td>(Opposite of contributing factors)</td>
<td>(Opposite of local conditions)</td>
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| Indicator/Measure of Change: | | |
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| ________________ | | |

| Indicator/Measure of Change: | | |
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| Indicator/Measure of Change: | | |
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| Indicator/Measure of Change: | | |
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REFERENCES & RESOURCES
# Overview of Common Substance Abuse Prevention Outcomes by Federal and State Initiatives

## CONSUMPTION: Use Rates and Patterns of Use

<table>
<thead>
<tr>
<th>Outcome</th>
<th>CSAP</th>
<th>NOMS</th>
<th>DFC</th>
<th>CORE</th>
<th>SSIS</th>
<th>NSDUH</th>
<th>MTF</th>
<th>CDC</th>
<th>YRBS</th>
<th>CHKS</th>
<th>CSS</th>
<th>SIG</th>
<th>SDFSC</th>
<th>CORE</th>
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<tr>
<td>Age of First Use (onset)</td>
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<td>30 Day Use</td>
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<td>Annual/6 month Use</td>
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<td>Ever Use—Lifetime Use</td>
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<td>Intensity/Risk Patterns of Use (i.e. Binge rates, use alone)</td>
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## CONSEQUENCES OF USE

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<td>AOD Related Car Crashes/Injuries</td>
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<td>School Attendance</td>
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<td>AOD Related Incidents/Suspensions/Expulsions</td>
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<td>Self Reported Drinking and Driving (or passenger)</td>
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<td>Self Reported Occurrence of Other Related Problems</td>
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## CONTRIBUTING FACTORS

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<th>Outcome</th>
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<tr>
<td>Attitudes Towards Drug Use Approval/Disapproval</td>
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<td>Perceptions of Risk and Harmful Consequences</td>
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<td>Heavy Use</td>
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<td>Retail Sales to Underage Youth</td>
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<tr>
<td>Social Availability (parents/peers)</td>
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</table>
### OVERVIEW OF COMMON SUBSTANCE ABUSE PREVENTION OUTCOMES BY FEDERAL AND STATE INITIATIVES

<table>
<thead>
<tr>
<th>Outcome</th>
<th>CSAP NOMS</th>
<th>DFC CORE</th>
<th>SSHS</th>
<th>NSDUH</th>
<th>MTF</th>
<th>CDC YRBS</th>
<th>CHKS</th>
<th>CSS</th>
<th>SIG</th>
<th>SDFSC CORE</th>
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<tbody>
<tr>
<td><strong>CONTRIBUTING FACTORS (Continued)</strong></td>
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<tr>
<td>Adult/School/Community Connections</td>
<td>X</td>
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<tr>
<td>Family Communication re drug use</td>
<td>X</td>
<td>X</td>
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<td>Perception of Work Policy</td>
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<td>Perception of School Climate/Environment</td>
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<td><strong>PROCESS OUTCOMES</strong></td>
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<tr>
<td>Number of persons served (by age, gender, race and ethnicity)</td>
<td>X</td>
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<td>Dosage/Participation/Retention Rates</td>
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<tr>
<td># of Coalitions</td>
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<tr>
<td>Coalition Membership/Participation Rates</td>
<td>X</td>
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<tr>
<td><strong>ADDITIONAL OUTCOMES</strong></td>
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<tr>
<td>Evidence-Based Implementation: Number of evidence-based programs and strategies</td>
<td>X</td>
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<tr>
<td>Cost Effectiveness: % of funding spent of evidence-based practices by types</td>
<td>X</td>
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<tr>
<td>Prevention Exposure: Percentage of individuals exposed to prevention messages</td>
<td>X</td>
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</tbody>
</table>

**Notes:**
- CSAP NOMS: Center for Substance Abuse and Prevention, National Outcome Measures for Prevention
- DFC CORE: Drug Free Communities Core Outcome Measures for grantees
- SSHS: Safe Schools Healthy Students Core Outcome Measures for grantees
- NSDUH: National Survey on Drug Use and Health (used to report on CSAP NOMS, so substantial overlap)
- MTF: Monitoring the Future national survey
- CDC YRBS: Center for Disease Control Youth Risk Behavior Survey
- CHKS: California Healthy Kids Survey
- CSS: California Student Survey
- SIG: California State Incentive Grantees—common measures
- SDFSC: California Governor’s Program Safe and Drug Free Schools and Communities Grantees adopted cross-site measures

**SAMPLE**

January 2010
### Checklist for Indicators and Measures

<table>
<thead>
<tr>
<th>Identified Problem</th>
<th>Contributing Factors</th>
<th>Objectives</th>
<th>Short-Term Outcomes</th>
<th>Long-Term Outcomes</th>
<th>Indicators</th>
<th>Measure</th>
<th>Current status of each data source/measure (e.g. in hand; promised; internal task; cancelled)</th>
<th>Specific Population/Scope Measured</th>
<th>When is data collected? With what frequency?</th>
<th>Who/what is the access point for getting the data/information</th>
<th>When is the data transferred to Cty AOD office? By what method? How often?</th>
<th>Rate ease of access: low; medium; high</th>
<th>Rate quality of data: low, medium, high</th>
<th>Rate priority or importance of this data: low, medium, high</th>
<th>How many other data sources on the list overlap with this information source?</th>
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</tbody>
</table>

(This table is designed for MS Excel)
A Focus on Strategies

Angela Goldberg
Center for Community Action & Training (CCAT)

Do You Connect?

Goals
Objectives
Strategies
Contributing
Factors

Does your action address the why?

If the lack of knowledge about consequences contributes to the problem, then…….

If the environment contributes to high-risk use, then…….

Characteristics of Good Strategies

• They Work
  Build Community
• Build Community
• Strengthen Partner Organizations & Individuals
Now...Focus on Strategies

A Focus on Strategies

Angela Goldberg
Center for Community Action & Training (CCAT)

Do You Connect?

Does your action address the why?

If the lack of knowledge about consequences contributes to the problem, then.....

If the environment contributes to high-risk use, then ......

Characteristics of Good Strategies

• They Work
• Build Community
• Strengthen Partner Organizations & Individuals
Change

Rarely the result of a single action

Making the Right Choice

- The Strategy (ies) Directly Affect The Risk Factor
- Actionable
- Logic Makes Sense
- Part Of A Comprehensive Plan

Choosing Strategies

Three Levels of Context

- Relevant to your goals and objectives
- Appropriate for your community needs and capacity
- Effective
Strategies: Fundamental Ways to Foster Change
- Provide Information & Build Skills
- Provide Support
- Modify Barriers & Access
- Change Consequences
- Change Physical Design of Environment
- Modify Policy

The “CSAP 6”, or the What
1. Problem ID & Referral
2. Community-Based Process
3. Environmental
4. Education
5. Information Dissemination
6. Alternatives

IOM, or the Who
Who is the target, in terms of the level of risk:
- Universal
- Selected
- Indicated
Choosing Strategies

- Inventory What Others Have Done
- What Does Science Suggest?
  - Peer Reviewed
  - Tried and Tested
  - Model Programs: Strategies that stand up to scrutiny

NREPP Revamped

FROM
- Picking off lists
- Categorical labels
- Rely on evidence alone
- Single bullet interventions

TO
- Thinking critically about needs
- Ratings on a continuum
- Evidence in context
- Program, Policies & Practice

http://www.nrepp.samhsa.gov/index.asp
Fidelity

- How to modify or adapt without resources
- Can you afford consultation?

Adaptation

- Different population or setting?
- Get help
- Design for success

Do What Works

- Avoid what doesn't work
- Use evidence to help advocate for the right action
- Build capacity for making good choices
Change

Rarely the result of a single action

Levels of Change

- County Objectives
  - Change (Outcome) at County level

- Short Term Objectives
  - Still focused on outcome
  - Work may occur at provider level

- Strategy
  - Change as a result of the intervention, which involves multiple actions

Short Term Outcomes

- Indicators Look Like Process Outcomes
  - Did They Attend? More? Fewer?
  - What Happened?
  - Data May Be In CalOMS Pv

- Measures Look Like:
  - Attendance Logs
  - Pre-Post Evaluations

- Still Link to Intermediate Outcomes
  - Knowledge Influenced Behavior
WORKSHEET
### Session III: Now Strategies

<table>
<thead>
<tr>
<th>Goal (Opposite of problem)</th>
<th>Objectives (Opposite of contributing factors)</th>
<th>Short Term Objectives (Opposite of local conditions)</th>
<th>Strategies (Which set of strategies address the risk/conditions?) List at least three:</th>
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<td>1. __________________________________________________________________________</td>
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<td><strong>Expected Outcome(s):</strong> __________________________________________________________________________</td>
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<td><strong>Expected Outcome(s):</strong> __________________________________________________________________________</td>
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</table>

Data Already Cited Throughout….Now Focus on Data on a) Choice/Fit of Strategy and b) What is Expected Outcome in the Short Term
REFERENCES & RESOURCES
RESOURCES AND WEB LINKS


- Community Tool Box: www.ctb.ku.edu


- www.pathwaystoutcomes.org

INTERNET RESOURCES

- http://www.bestpractices.org
  UNCHS (Habitat) and the Togetherson Foundation. A catalogue of good and best practices in a number of health, human service, and development areas.

- http://www.cdc.gov/ncipc/dvp/bestpractices.htm
  A downloadable 216-page sourcebook on youth violence prevention from the Centers for Disease Control.

- http://www.cdc.gov/tobacco/bestprac.htm
  A paper entitled "Best Practices for Comprehensive Tobacco Control Programs " from the Centers for Disease Control.

- http://www.ed.gov/
  Best practices in state and local education from the U.S. Dept. of Education.

  Best practices in community health from the U.S. Dept. of Health and Human Services.


- http://www.stedwards.edu/educ/eanes/ganghome.html
  Best practices in Gang Prevention and Intervention.
PREVENTION BASICS:  
MAKING INFORMED CHOICES

Last year, the Department of Alcohol and Drug Programs (ADP) posted a document on CalOMS Prevention that helps counties understand the Institute of Medicine’s (IOM) Universal, Selective and Indicated risk-levels. That document offered guidelines for making correct categorizations when entering CalOMS Prevention data.

This document offers additional information about primary prevention, the Strategic Prevention Framework (SPF), IOM risk populations, and selecting strategies to meet your locally assessed needs. Counties should explain these choices in their County Strategic Prevention Plans, based on a good assessment of needs and resources.

Below are brief descriptions of primary prevention, CalOMS Prevention, and the SPF process, as well as a reminder of the WHO, the HOW, and the WHY involved in planning effective services.

**PRIMARY PREVENTION**

Primary prevention, as defined by the Substance Abuse Prevention and Treatment (SAPT) Block Grant, are programs directed at “individuals who have not been determined to require treatment for substance abuse.” Primary prevention does not include any services for an individual in need of treatment, assessing whether an individual meets the criteria for treatment, or any kind of relapse prevention. Primary prevention does include strategies, programs and initiatives which reduce both direct and indirect adverse personal, social, health, and economic consequences resulting from problematic alcohol and other drug availability, manufacture, distribution, promotion, sales, and use.

The majority of ADP funding for primary prevention comes from the SAPT Block Grant. A minimum of 20% of the total grant must be spent on primary prevention or the entire block grant is at risk. The SAPT funds are disbursed via the Net Negotiated Amount (NNA) Contract through monthly allocations to all counties.

**CALIFORNIA OUTCOME MEASUREMENT SERVICE FOR PREVENTION (CalOMS Prevention or CalOMS Pv)**

Understanding the difference between CalOMS Treatment (Tx) and CalOMS Prevention (Pv):

- **CalOMS Tx** is a system developed and supported by ADP for collecting client treatment data
- **CalOMS Pv** is a web-based service hosted by KIT Solutions, LLC, an ADP contractor, for collecting primary prevention service/activity data from counties (and their contracted/funded providers). Statewide data is necessary for the annual application for SAPT Block Grant funds.
  - Many times both are referred to as just CalOMS. Be specific to avoid confusion.

**The STRATEGIC PREVENTION FRAMEWORK**

The SPF, developed by SAMHSA, consists of five steps designed for effective and sustainable prevention. (NOTE: Although called “steps”, these are actually processes that should be ongoing efforts and some occur concurrently.)
• **Assessment:** Identify, acquire and analyze relevant consumption and consequence data to profile population needs, resources, and readiness to address problems and gaps in service delivery
• **Capacity:** Mobilize and/or build capacity to address need
• **Planning:** Develop a comprehensive logic model, plan, and measures
• **Implementation:** Implement evidence-based programs and infrastructure activities
• **Evaluation:** Monitor, evaluate, and apply data to improve approaches and sustain desired results

Beginning July 2007, counties were required to have conducted a prevention needs assessment and, based on the assessment, prioritize the identified needs, identify available resources, develop a strategic prevention plan to meet the unique needs of their county, and structure their SAPT-funded services around their plan. These plans identified the populations to be served and the strategies proposed to serve those populations.

**MAKING INFORMED PREVENTION CHOICES**
the Who, the How, and the Why

**The WHO, according to the Institute of Medicine (IOM)**

The IOM tiered approach organizes level of risk for substance abuse, into three levels:

**Universal:** The entire population shares the same general risk for substance abuse. The goal of delivering services to a universal audience is to prevent, reduce, or delay substance abuse. Examples of services/activities targeting this audience are the dissemination of printed materials, media campaigns, public service announcements, community service activities, recreational activities, classroom educational services, and environmental strategies focusing on policy change, regulations, ordinances and community development.

**Selective:** Subsets of the population considered to be at risk for substance abuse. The goal of delivering services to a selective audience is to address subsets of the population who share a higher than average risk for substance abuse compared to the entire population (e.g., children of alcoholics, school drop-outs, students who are failing academically). Examples of services/activities targeting this audience are the dissemination of printed materials, youth/adult/family groups aimed specifically at this audience, mentoring, peer leader/helper programs, and youth/adult leadership activities.

**Indicated:** Individuals who are showing early sign of substance abuse and problem behaviors but have not been identified to be in need of treatment. The goal of delivering services to an indicated audience is to identify these individuals and serve them with special prevention programs intended to reverse the behavior. Examples of services/activities targeting this audience are parenting/family management services, topical small group sessions, prevention screenings, and employee/student assistance programs.

**The HOW, or strategies, according to the Center for Substance Abuse Prevention (CSAP)**

CSAP organizes primary prevention into six strategies, each of which has associated services. ([Refer to the Demographic and Non-Demographic Services Matrix located in the Library on the CalOMS Pw website for a more comprehensive list of services that fall under each strategy](#)): 

- Demographic: Focus on specific groups within the population (e.g., youth, adults, families)
- Non-Demographic: Focus on population-wide interventions (e.g., media campaigns, school-based programs)
- Primary: Focus on preventing substance use and abuse among individuals who have not yet used substances (e.g., early childhood prevention programs)
- Secondary: Focus on reducing substance use and abuse among individuals who are at risk (e.g., youth who are experimenting with substances)
- Tertiary: Focus on reducing substance use and abuse among individuals who have already used substances (e.g., treatment and recovery programs)
- Strategic: Focus on creating a comprehensive framework for prevention (e.g., grants and funding programs)
<table>
<thead>
<tr>
<th>CSAP Strategy</th>
<th>Example</th>
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<tbody>
<tr>
<td>Problem ID &amp; Referral</td>
<td>Student /Employee Assistance Programs; prevention screening to determine whether an individual can benefit from prevention education or whether s/he needs to be referred for a treatment assessment; referral to a primary prevention service</td>
</tr>
<tr>
<td>Community-Based Process</td>
<td>Youth and adult allies organize coalitions to develop campaigns /other strategies to address alcohol promotion/products (the youth would also be counted under the Alternatives strategy, Youth/Adult Leadership); community needs assessment; systematic planning; training and technical assistance</td>
</tr>
<tr>
<td>Environmental</td>
<td>Policy changes to reduce availability / access of alcohol to minors; ordinances; media strategies; retailer compliance; community development; efforts to ensure policy implementation, enforcement and sustainability</td>
</tr>
<tr>
<td>Education</td>
<td>Delivering school-based curriculum in classrooms or as part of after school activities; mentoring; small group sessions on prevention</td>
</tr>
<tr>
<td>Information Dissemination</td>
<td>Distributing educational and informational materials; maintaining a video library/ clearinghouse/ website; telephone information services; developing and airing public service announcements</td>
</tr>
<tr>
<td>Alternatives</td>
<td>Alcohol-free community events; youth-driven events; involving youth in coalitions/ environmental strategies</td>
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</tbody>
</table>

It is important to make informed choices about use of your prevention resources.

**Resources May Be Limited**

Few counties receive what they may think is sufficient federal SAPT Block Grant funding for prevention. But this cannot stop you from designing prevention approaches that best meet the greatest needs identified in your local communities. The Strategic Prevention Framework process has helped many County AOD offices establish partnerships across other systems that have increased available resources. Find the common ground with Education, Probation, Mental Health, Public Safety and other systems, and identify ways to share resources to meet common goals related to how AOD impacts their work.

**The WHY…. or What Criteria to Use in Your Choices**

You are often required to make choices between the priority needs identified during the needs assessment, and what strategies to employ to best meet these needs. Your County Prevention Plan should be a living document that periodically reexamines these questions. As you consider matching “Who” (risk level) is best served by “What” (strategy and service), keep in mind these criteria:

- **Local data tells you this specific issue is a priority**
  Your assessment should draw on multiple data sources that ideally confirm your conclusions from different angles on the problems related to use and consequences of use. No County is exactly like another, even if you share features or size or demographics. Your chosen goals should reflect this local data.

- **Research suggests the strategy that will effectively address the problem**
  In choosing strategies, rely on evidence-based practices, policies and procedures that have been supported by research. While local adaptations are typically needed, it is important to keep fidelity in mind. A critical part of making informed choices includes discontinuing strategies that have been demonstrated to yield little or no benefit.
• **The strategy fits your “culture” in terms of participant groups, local values and geography**
  Local values and local needs must be reflected in your choices about which strategies to use. There may be demographic, political or regional considerations that should not be ignored.

• **Resources match dosage, along with your expectations for change**
  Align your expectations for outcomes with your investments. You’ll need to identify whether you have sufficient resources available to attain the desired result. When too many objectives are undertaken, resources may not be adequate to effectively attain any of them. Prioritization of problems, goals, and objectives is critical. Few counties can provide enough resources to cover their entire population or address all their identified problems. Consider tiered or stepped investments as a means to incrementally reach your goals. For example, Counties may decide to concentrate an effort in one local community, and in another town promote early preparation for later expansion of services.

**Informed Choices Lead to Desired Results**

The following logic model provides an overview of the how local data collection should inform the prioritization of problem statements. This includes identification of populations and communities to receive services, which in turn should inform the selection and implementation of strategies, ideally achieving the desired results.

**Overview of Process for Informed Choices Leading to Desired Results**

1. Identification, collection and analysis of local data
2. Identification and prioritization of needs and problem statements
3. Selection and implementation of relevant and evidence-based strategies to address problems and achieve desired outcomes
4. Achievement of desired short-term, intermediate, and sustainable long term outcomes

**Questions?** Contact your ADP County Analyst, CADPACC Prevention Committee Chair Connie Moreno-Peraza, or an ADP technical assistance provider. Remember that your Prevention Coordinator has access to no cost technical assistance services across this spectrum.
Institute of Medicine (IOM) for Prevention

The following IOM categories and definitions are an excerpt from "Drug Abuse Prevention: What Works", National Institute of Drug Abuse, 1997, p. 10-15 and have been approved by the Center for Substance Abuse Prevention (CSAP). This information can also be obtained at the following link: http://casat.unr.edu/bestpractices/bptype.htm.

In a 1994 report on prevention research, the Institute of Medicine (IOM 1994) proposed a new framework for classifying prevention based on Gordon's (1987) operational classification of disease prevention. The IOM model divides the continuum of services into three parts: prevention, treatment, and maintenance. The prevention category is divided into three classifications--universal, selective and indicated prevention.

Universal

A Universal prevention strategy addresses the entire population (national, local community, school, and neighborhood) with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. For example, it would include the general population and subgroups such as pregnant women, children, adolescents, and the elderly. The mission of universal prevention is to prevent the problem. All members of the population share the same general risk for substance abuse, although the risk may vary greatly among individuals. Universal prevention programs are delivered to large groups without any prior screening for substance abuse risk. The entire population is assessed as at-risk for substance abuse and capable of benefiting from prevention programs.

Selective

Selective prevention strategies target subsets of the total population that are deemed to be at risk for substance abuse by virtue of their membership in a particular population segment—for example, children of adult alcoholics, dropouts, or students who are failing academically. Risk groups may be identified on the basis of biological, psychological, social, or environmental risk factors known to be associated with substance abuse (IOM 1994), and targeted subgroups may be defined by age, gender, family history, place of residence such as high drug-use or low-income neighborhoods, and victimization by physical and/or sexual abuse. Selective prevention targets the entire subgroup regardless of the degree of risk of any individual within the group. One individual in the subgroup may not be at personal risk for substance abuse, while another person in the same subgroup may be abusing substances. The selective prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for substance abuse than the general population. An individual's personal risk is not specifically assessed or identified and is based solely on a presumption given his or her membership in the at-risk subgroup.
**Indicated**

Indicated prevention strategies are designed to prevent the onset of substance abuse in individuals who do not meet DSM-IV criteria for addiction, but who are showing early danger signs, such as falling grades and consumption of alcohol and other gateway drugs. The mission of indicated prevention is to identify individuals who are exhibiting early signs of substance abuse and other problem behaviors associated with substance abuse and to target them with special programs. The individuals are exhibiting substance abuse-like behavior, but at a sub-clinical level (IOM 1994). Indicated prevention approaches are used for individuals who may or may not be abusing substances, but exhibit risk factors that increase their chances of developing a drug abuse problem. Indicated prevention programs address risk factors associated with the individual, such as conduct disorders, and alienation from parents, school, and positive peer groups. Less emphasis is placed on assessing or addressing environmental influences, such as community values. The aim of indicated prevention programs is not only the reduction in first-time substance abuse, but also reduction in the length of time the signs continue, delay of onset of substance abuse, and/or reduction in the severity of substance abuse. Individuals can be referred to indicated prevention programs by parents, teachers, school counselors, school nurses, youth workers, friends, or the courts. Young people may volunteer to participate in indicated prevention programs.

NOTE: In the majority of cases, indicated strategies would be the most appropriate strategies for youth already involved with the juvenile justice system.
**CSAP’s Prevention Strategies**

The Substance Abuse Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP), has classified prevention strategies into six categories. The definition of each strategy as taken from the Federal Register, Volume 58, Number 60, March 31, 1993, are provided below along with practical examples of the application of each strategy.

**Information Dissemination Strategy**

“This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco, and drug use, abuse, and addiction and the effects on individuals, families, and communities. . . (and) . . . increases knowledge and provides awareness of available prevention programs and services.”

The CSAP characterizes information dissemination as “one-way” communication from the source to the audience. A message is delivered, but there is little opportunity for an exchange of information with those who receive the message. Examples of this strategy include print and electronic media, speaking engagements, resource directories, clearinghouses, or health fairs/promotions.

In an effort to collect the best possible prevention related data, California does not collect demographics for Information Dissemination type services/activities as they are generally estimated figures with no documented basis.

The following are definitions for the services/activities within this strategy:

**Clearinghouse/Information Resource Centers**: A central repository of and dissemination point for current, factual, and culturally relevant written and audiovisual information and materials concerning substance use and abuse. Examples are: information resource centers, resource libraries, electronic bulletin boards, prevention resource centers, and Regional Alcohol and Drug Awareness Resource (RADAR) network centers.

**Conferences/Fairs**: A gathering to discuss matters of common concern, or a gathering of buyers, sellers, and competitive exhibitions with accompanying entertainment and amusements. These events may be general in nature and may not necessarily be school- or prevention-based activities; however, they offer the opportunity to disseminate materials and information intended to educate individuals, schools, families, and communities about specific substance abuse and health-related risks, risk reduction activities, and other activities to promote positive and healthy lifestyles. Examples are: presentations at conferences, or booths or tables set up to display informational materials at county/state fairs, etc.

**Health Fair/Promotions**: A school- or community-focused gathering or a wide array of services and methods to disseminate materials and information intended to educate individuals, schools, families, and communities about specific substance abuse and health-related risks, risk reduction activities, and other activities to promote positive and healthy lifestyles. Examples are: school health promotion gatherings, health screening programs in shopping malls, church fairs or
carnivals, and public health or health education fairs where health education materials, screening services and the showing of substance abuse prevention videotapes are available.

Materials Development: The creation of original documents and other educational materials for use in information dissemination activities related to substance abuse and its effects on individuals, schools, families, and communities. Included are:
- Audiovisual Material - prevention material involving both hearing and sight; e.g., videotapes and films.
- Brochures/Pamphlets – unbound written material containing program, service and/or subject information.
- Printed Material - written materials designed to inform individuals, schools, families, and communities about the effects of substance abuse and available prevention approaches and services; e.g., flyers, fact sheets, posters, prevention plans.
- Curriculum - a course of study in prevention.
- Newsletter - a report giving prevention news or information of interest to a particular group. Electronic newsletters, e-mail, and broadcast faxes may be included.
- Resource Directories – a list of substance abuse and related programs and services in a particular community, county, or state.

Materials Dissemination: Distribution of the written and audiovisual prevention information as listed above in the Materials Development category. Examples are: providing handouts for a speaking engagement or providing materials for health fairs.

Media Campaigns: Structured activities that use print and broadcast media to deliver prevention information or health promotion messages relative to substance abuse. In contrast to PSAs, campaign messages are usually more than five minutes long. Examples are: media promotion of Red Ribbon, Project Graduation, or other similar events, printing of ads with “no-use” messages, distribution of signs to stores and businesses, distribution of bumper stickers, posters, etc., use of national substance abuse prevention media materials tailored to the state or community (Partnership for a Drug-Free America).

Public Service Announcements (PSAs): a media message, or campaign, usually less than five minutes long, broadcast at no charge, that is designed to inform and educate audiences concerning substance abuse and its effects on individuals, schools, families, and communities; e.g., television PSAs, radio PSAs, no charge newspaper advertisements and announcements.

Speaking Engagements: A wide range of prevention activities intended to convey information about substance abuse issues to general and/or specific audiences. Examples are: speeches, talks, news conferences, briefings, one-time classroom presentations, one-time assembly presentations, hearings, volunteer speakers’ bureaus.

Telephone Information Services: Telephone services intended to provide information about substance abuse prevention and treatment issues and services. Examples are: toll-free telephone number services, information and referral lines, hotlines, crisis lines.

Web Sites: A provider operated web site used to deliver prevention information, education, and/or materials.
**Education Strategy**

“This strategy involves two-way communication and is distinguished from the Information Dissemination Strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its activities.”

The Education Strategy has two basic characteristics that distinguish it from other prevention efforts. First, the strategy depends on the interaction between an instructor and/or facilitator and an audience. Second, the services under this strategy aim to “improve critical life and social skills,” which includes “decision making, refusal skills, critical analysis, and systematic judgment abilities.” Approaches used in this strategy involve some form of a teaching to enhance individual efforts to remain alcohol and drug free. However, this transference of information does not need to be conducted by teaching or in an educational setting.

The following are definitions for the services/activities within this strategy.

**Children of Substance Abusers (COSA) Groups:** Substance abuse prevention educational services targeted to youth and adults who are children of substance abusers. Examples are: COSA programs, short-term educational groups, risk and protective factor programs, Adult Children of Alchoholics (ACOA) meetings.

**Classroom Educational Services:** Prevention lessons, seminars, or workshops that are recurring and are presented primarily in a school or college classroom. Examples are: delivery of recognized prevention curricula, regular and recurring health education presentations to students.

**Educational Services for Youth Groups:** Structured substance abuse prevention lessons, seminars, or workshops directed to a variety of youth groups (children, teens, young adults) and youth organizations. Examples are: substance abuse education for youth groups such as Boys & Girls Clubs and Scouts, general substance abuse prevention education for other groups or organizations serving youth.

**Educational Services for Adult Groups:** Structured substance abuse prevention lessons, seminars, or workshops directed to a variety of adult groups.

**Mentoring:** A relationship over a prolonged period of time between two or more people in which the older, wiser, more experienced individual(s) provides stable, as-needed support, guidance, and concrete help to the young, at-risk person(s).

**Parenting/Family Management Services:** Structured classes and programs intended to assist parents and families in addressing substance abuse risk factors, implementing protective factors, and learning about the effects of substance abuse on individuals and families. Topics typically include parenting skills, family communications, decision-making skills, conflict resolution, family substance abuse risk factors, family protective factors, and related topics. Examples are: parent effectiveness training, parenting and family management classes, prevention programs targeting the family, programs designed to strengthen families.

**Peer Leader/Helper Programs:** Structured, recurring prevention services that utilize peers (people of the same rank, ability, or standing) to provide guidance, support, and other risk
reduction activities for youth or adults. Examples are: peer-resistance development, peer-cross-age tutoring programs, student non-using groups (“Just Say No”), teen leadership institutes, peer support activities (clubs, church groups).

Preschool Alcohol and Other Drug (AOD) Prevention Programs: Structured substance abuse prevention lessons directed to preschool youth.

Small Group Sessions: Provision of educational services to youth or adults in groups of not more than 30 members. Examples are: substance abuse education groups, short-term education groups, youth education groups, parent education groups, business education groups, and church education groups.

Theatrical Troupes: theatrical performances that deliver an alcohol and other drug (AOD) free message.
Alternative Strategy

“This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use. The assumption is that constructive and healthy activities offset the attraction to or otherwise meet the needs usually filled by alcohol, tobacco, and other drugs and would, therefore, minimize or remove the need to use these substances.”

Alternative programs and activities redirect individuals from potentially problematic settings and activities to situations free from the influence of alcohol and other drugs.

The following are definitions for the services/activities within this strategy.

Alcohol and Other Drug (AOD) Free Social/Recreational Events: Social and recreational events for youth and adults that specifically exclude the use of alcohol and other drugs. Examples are: Project (Sober) Graduation and similar events, after-prom parties, alcohol and other drug-free school events, alcohol and other drug-free community events, etc.

Community Drop-In Centers Operating: Centers that provide community facilities and structured prevention services that do not permit alcohol or other drug use on their premises. This refers to the facility and is not an activity per se. Examples of community-drop-in centers include teen centers, community centers, recreation centers, or senior citizen centers.

Community Drop-In Center Activities: Substance abuse prevention activities and events held at community drop-in centers that offer social, recreational, and learning environments free of alcohol and other drugs. See examples above of where these activities would take place.

Community Service Activities: Functions intended to prevent substance abuse by involving youth and adults in providing a variety of community services. Examples are: community clean-up activities, events to repair or rebuild neighborhoods, fundraising for charitable causes, and support to the elderly, handicapped, ill, etc.

Outward Bound: Outdoor wilderness experiences that build confidence, leadership skills and teamwork.

Recreational Activities: Activities, as compared to events, that youth and adults would participate in that specifically exclude the use of alcohol and other drugs. The key words are “active participation” rather than attendance. Examples are: participation on sports teams, participation in theatrical or musical productions, etc.

Youth/Adult Leadership Activities: Services through which youth/adult role models work with youth to help prevent substance abuse. Examples are: tutoring programs, coaching activities, adult-mentoring programs, adult-led youth groups, youth/peer mentoring programs. A mentoring program is defined as a relationship over a prolonged period of time between two or more people in which the older, wiser, more experienced individual(s) provides stable, as-needed support, guidance, and concrete help to the younger, at-risk person(s).
Problem Identification and Referral Strategy

“This strategy aims at identification of those individuals who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs and to assess whether their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.”

Of the six CSAP primary prevention strategies, this one causes the most discussion and controversy because it appears to crossover from primary prevention into intervention and treatment. The CSAP definition clearly precludes services “designed to determine if a person is in need of treatment”; however, an assessment to determine if behavior can be reversed through education is allowed. After all, it may not be possible to know if a person’s need is education or treatment until after an initial assessment.

A key aspect of the strategy is that the service is educational for behavioral change, not therapeutic for AOD abuse or dependency treatment. We recognize that some of the services within this strategy have the potential to bridge into treatment. It is important that providers note that administration of addiction severity instruments, case screening, and/or preparation for intervention are not a component of this strategy.

The following are definitions for the services/activities within this strategy.

Employee Assistance Programs: Services intended to provide substance abuse information for individuals whose substance abuse-related problems may be interfering with work performance. Examples are: workplace prevention education programs, risk reduction education for work-related problems involving substance abuse, health education and health promotion programs for employees, supervisor training, workplace policy development, screening for referral.

DUI/DWI/MIP Programs (Driving Under the Influence, Driving While Intoxicated, Minors in Possession): Structured prevention education programs intended to change the behavior of youth and adults. Examples of programs are: alcohol-related highway traffic safety classes and alcohol and other drug awareness seminars or education programs. In California, the court system mandates that individuals attend DUI/DWI programs as a result of an arrest and requires that each individual pay for the program. Substance Abuse Prevention and Treatment (SAPT) block grant funds are not utilized for DUI/DWI court-mandated programs; therefore, the individuals that attend them should not be reported in CalOMS Prevention.

Mens/Womens Alternative to Violence Programs: The inclusion of violence programs reflects the correlation between violence and AOD affected behavior. The inclusion of either men’s or women’s alternative to violence programs must satisfy two criteria; (1) it must be a program receiving prevention dollars, and (2) it must offer, as part of its overall service, specific information about AOD issues. A counseling service or a facility that primarily provides temporary safe refuge for individuals is not AOD primary prevention and is not reported in CalOMS Prevention.
**Prevention Assessment and Referral Services:** Those activities intended to provide risk screening, assessment, and referral to prevention service populations for placement in prevention or other appropriate services.

**Student Assistance Programs:** Structured prevention programs intended to provide substance abuse information for students whose substance abuse may be interfering with their school performance. Examples are: early identification of student problems, referral to designated helpers, follow-up services, in-school services (e.g., support groups), screening for referral, referral to outside agencies, school policy development.
**Community-Based Process Strategy**

“This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco, and drug abuse disorders. Activities in this strategy include organizing, planning, and enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking.”

The past decade has seen an increased use of community-based processes for supporting prevention outcomes. The nationally funded community partnerships and later community collaboration grants are evidence of the heightened awareness of the importance of community approaches in addressing alcohol and other drug problems. This strategy area includes a broad range of activities including assessing community needs, developing community teams, providing technical support and training, and organizing community efforts. For many California communities there will be a close link between community organizing efforts and their use of Environmental Strategy approaches.

The following are definitions for the services/activities within this strategy.

**Assessing Community Needs/Assets**: Implementing prevention-focused tasks to determine the needs for prevention services, identify at-risk populations, or determine priority prevention populations for service delivery. Examples are: conducting/participating in statewide prevention needs assessments, conducting community prevention needs assessments, neighborhood needs assessments.

**Accessing/Monitoring Services and Funding**: Assisting communities in increasing or improving their prevention service capacity by developing resources to support those services. Examples are: developing and maintaining a resource listing of federal, state, and local funding programs, accessing, coordinating and monitoring federal, state, and local prevention grants/contracts, developing program budgets.

**Community Team Activities**: Activities or services conducted with or sponsored by formalized community teams for the purpose of fostering, supporting, or enhancing community prevention services. Examples are: community mobilization events, development or implementation of action plans, civic advocacy, development of interagency or multi-agency cooperative agreements to provide prevention services.

**Community/Volunteer Services or Training**: Structured prevention activities intended to impart information and teach organizational development skills to individuals or community groups. Examples are: community volunteer services, action planning for community decision makers, multicultural leadership mobilization activities, and neighborhood action services.

**Evaluation Services**: Activities or services conducted to evaluate progress towards meeting goals and/or objectives and eventually, program success.

**Formal Community Teams**: Formalized community organizations concerned with fostering common interests and advocacy for prevention services. Formal Community Teams are counted only one time once the formal community team is formed. (Activities that teams conduct or
engage in are reported under Community Team Activities). Examples are: regular and ongoing participation in interagency councils or multi-agency task forces, alliances, coalitions, groupings of citizens, including youth, who promote healthy communities, families, schools, and activities.

**Multi-Agency Coordination/Collaboration**: joint planning or programming between two or more agencies or organizations.

**Systematic Planning**: Structured services that help communities to identify prevention needs, assess existing prevention services, set priorities, and allocate prevention resources systematically, based on objective needs assessments. Examples are: agency/provider strategic plan, community team/organization plan, block grant plan, and state prevention plan.

**Technical Assistance (TA)**: Services provided by professional prevention staff intended to provide technical guidance to prevention programs, community organization, and individuals to conduct, strengthen, or enhance activities to promote prevention. Services recorded under this service should be viable technical assistance that will lead to a final product. Examples are: addressing cultural competence, developing an action plan/capacity building, quality assurance and improvement, conducting evaluations, adding programs and services, developing funding and resources, providing professional expertise, organizational development.

**Training Services**: Structured substance abuse prevention training events intended to develop proficiency in prevention program design, development, and delivery skills. Examples are: conducting prevention training programs, training of trainers, and other formal skill-building activities.
**Environmental Strategy**

“This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general populations. This strategy is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those which relate to the service and action-oriented initiatives.”

The Environmental Strategy is the last of the six CSAP strategies. The first five strategies primarily focus on who was served and the services they received. The Environmental Strategy focuses on places and specific problems, with an emphasis on public policy. A growing body of research and practice supports the environmental approach to prevention. The results can be wide-ranging and sustained, although specific recipients are not identifiable.

The following are definitions for the services/activities within this strategy.

**Compliance** – *Activities geared toward improving compliance with existing laws and policies that have been shown to reduce substance availability and consumption.*

**Compliance Checks – Retailers (off-site):** The use of underage buyers to test retailers’ compliance with laws regarding the sale of alcohol to minors.

**Compliance Checks – ID Checks at Bars/Taverns (on-site):** The use of underage buyers to test retailers’ compliance with laws regarding the sale of alcohol to minors at bars, taverns, restaurants, etc.

**Drug Sale Surveillance:** Community members monitor an area that is known for illegal drug sales and then inform law enforcement of illegal activities.

**DUI Checkpoints:** collaborate with local law enforcement in DUI Checkpoint events.

**Law Enforcement Education:** Training designed to assist in the prevention and/or reduction of the sale of alcoholic beverages to minors.

**Party Patrols:** Community members monitor underage parties and inform local law enforcement of underage drinking and/or possible illegal drug activity.

**Retailer/Vendor Education:** Training designed to assist in the prevention and/or reduction of the sale of alcoholic beverages to minors.

**Shoulder Tap Surveillance:** The use of underage youth to test adults willingness to purchase alcohol for underage youth outside an alcohol retailer outlet.

**Training – Commercial Host and Management:** Responsible beverage service programs for ABC licensees (retailers and distributors of alcoholic beverages).
Training – Social Host and Management: Approved responsible beverage service programs for those who serve alcoholic beverages in settings or circumstances under the servers’ control where the drinker does not pay for his/her drink (weddings, private house party, event caterers, etc.).

**Environmental Consultation** – Consultation and technical assistance provided to support the development and implementation of environmental strategies in the community.

Technical Assistance (TA) to Communities – Other

Technical Assistance (TA) to Develop Drug Free School Zones

Technical Assistance (TA) to Develop Drug Free Work Places

Technical Assistance (TA) to Monitor Enforcement of Sales to Minors Laws

Training for Media Advocacy

**Media Strategies** – Structured activities that use print, broadcast or web media to deliver messages to the target population with the intent to change norms and behaviors around alcohol and/or illegal drugs.

Counter-Advertising: Disseminating information about the hazards of a product, the legal and social consequences of use, and/or the methods that the industry uses to promote the products in order to change the public’s acceptance of the misuse of the product.

Informational/AOD Warning Posters, Notices & Signs: Displaying notices/signs in alcohol retail outlets that give information about the legal, social and health effects of AOD use and to discourage the purchase of illegal substances by minors.

Media Advocacy: A strategy that uses the power of the media to advance an environmental prevention agenda. This strategy requires news story development that clearly presents specific AOD problems and the policies and social change required to resolve them.

Retail Outlet Recognition: Publicly acknowledging retail outlets, using the media, who do not sell to minors.

Social Norms Marketing: Changing community norms regarding substance abuse and/or underage drinking through targeted media campaigns.

**Policies and Regulations** – Creation/passage of local policy, regulation, legislation or ordinance that reduces AOD availability and/or changes norms and behavior surrounding AOD use.

Advertising Restrictions: Policies that control the density and acceptable placement of product advertising (billboards, store fronts, product placement, etc).
Alcohol Sponsorship Restrictions: Regulations that reduce or prohibit alcohol retailers, wholesalers and distributors from sponsoring public community events where children, families, and/or young adults under the age of 21 are present.

Drinking in Public Ordinances: Local ordinances that regulate the consumption of alcohol in public places and/or at public events. Regulation may be prohibition (no drinking allowed) or conditional (permits may be required, drinking may be permitted only in restricted areas, only at certain times, only in certain circumstances, etc.).

Drug Paraphernalia Ordinances: Local ordinance regulating the sales, displaying, furnishing, supplying, giving or otherwise dispensing of drug paraphernalia.

One Day Event Requirements: Permits provided by state and local governments for time-limited activities/events. Usually these activities/events run for a period of one to two days.

Product Pricing Policies: Policies or regulations intended to control economic availability through pricing strategies, which can include taxation, and insuring the real cost of alcohol remains consistent with the cost of other consumer goods.

Public Use Restrictions: Regulations that control availability of alcohol in public places and/or community events (restrictions/bans in parks and recreational areas, open container laws, controlling hours of sale, etc.).

School Policies (college): Prevention policies of the school administration to eliminate settings or circumstances for alcohol/drug use and/or availability on or about the premises. It is expected that students and faculty will participate with school administrators in the formation and implementation of the policies.

School Policies (K-12): Prevention policies of the school administration to eliminate settings or circumstances for alcohol/drug use and/or availability on or about the premises. It is expected that students and faculty will participate with school administrators in the formation and implementation of the policies.

Social Host Ordinance: Local ordinance that makes it an infraction or misdemeanor for social hosts who knowingly allow minors to obtain, posses, or consume alcoholic beverages at parties held at private residences or private premises.

Sporting Event Policies: Policies that place limits on alcohol sales at sporting events (number of drinks sold to a single individual, no drinks sold after a set time, alcohol free seating areas, etc.).

State Alcohol Beverage Control (ABC) Regulations: Participation in activities to create or expand public policy for the prevention of alcohol/drug problems specifically through legislation and regulations administered by the State ABC.

Workplace Policies: Prevention policies of the workplace administration to eliminate settings or circumstances for alcohol/drug use and/or availability on or about the workplace premises. It is expected that workers will participate with workplace management in the formation and implementation of the policies.
**Zoning Ordinance – Retail Alcohol Outlet Density:** Local ordinances that restrict the location and density of retail alcohol outlets.

**Zoning Ordinance – Abate Existing Outlets:** Local ordinances that use planning land-use regulations to control alcohol outlets currently in operation under an ABC license. This definition includes “deemed approved” ordinances and nuisance abatement actions.

**Zoning Ordinance – New Alcohol Outlets:** Local ordinances that use planning and land-use regulations to control future alcohol outlets. This definition includes all establishments that seek original licenses from the State Department of Alcohol Beverage Control (ABC) and all establishments that seek to transfer an existing ABC licenses to a new location.
Welcome to the National Registry of Evidence-based Programs and Practices (NREPP), a service of the Substance Abuse and Mental Health Services Administration (SAMHSA).

NREPP is a searchable database of interventions for the prevention and treatment of mental and substance use disorders. SAMHSA has developed this resource to help people, agencies, and organizations implement programs and practices in their communities.
Questions You Might Want To Ask a Developer
As You Explore the Possible Use of an Intervention

Implementations
☐ Where has this intervention been implemented? In what settings? With what populations?
☐ What are the particular challenges to effective implementation? How might these challenges be overcome?
☐ What common mistakes have been made, and how can we avoid them?
☐ Can you provide contact information for two or three directors of implementation sites that are currently in the process of implementing the intervention?

Notes:

Adaptations
☐ Has your intervention been adapted in any ways that might be relevant to its implementation in a setting like mine (describe your setting) or with a population like mine (describe your population)?
☐ Have you been able to identify whether there are any “core components” of the intervention—parts of the intervention that must be implemented and/or should not be adapted?

Notes:

Staffing
☐ What are the staffing requirements (number and type)?
☐ What are the minimum staff qualifications (degree, experience)?
☐ What methods are used to select the best candidates (philosophy, skills)?
☐ Is there a recommended practitioner-to-client ratio?
☐ Is there a recommended supervisor-to-practitioner ratio?

Notes:
### Quality Assurance Mechanisms

- What are the core components that define the essence of the intervention?
- How are supervisors prepared to provide effective support for practitioners?
- What is the supervision protocol for providing effective support for practitioners?
- What practical instruments are available to assess adherence and competence of the practitioner’s use of the intervention’s core components?
- What tests have been done to ensure the validity and reliability of the fidelity instruments?

### Training and Technical Assistance

- Is training required before a site can implement this intervention?
- Who conducts the training, and where is it conducted?
- Can staff at implementation sites be certified to conduct the training?
- Who is typically trained (practitioners, staff selection interviewers, staff trainers, staff supervisors/coaches, agency administrators)?
- What is the duration of the training (hours, days)?
- Is retraining required/available?
- What on-site assistance is provided by the developer, if any?
- How long does it usually take for a new implementation site to become a high-fidelity user of the intervention?

### Costs

- How much does it cost to secure the services of the developer?
- What is included in that cost?
- If the intervention costs more than my budget allows, is there a way to implement only part of the intervention?
- Do costs include salaried positions? In-kind costs? Special equipment?

### Notes:

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**Stategic Prevention Framework**
NREPP Frequently Asked Questions  
(Extracted from NREPP Website)

What is NREPP?

The National Registry of Evidence-based Programs and Practices (NREPP), formerly the National Registry of Effective Programs, is a voluntary rating and classification system for mental health and substance abuse prevention and treatment interventions. The system is designed to identify, review, and disseminate information about interventions.

How has the NREPP program been revised and expanded?

NREPP originated as a program to promote model substance abuse prevention interventions that have a strong scientific evidence base. NREPP has expanded to include mental health promotion and treatment as well as substance abuse treatment interventions. As part of this expansion, SAMHSA has revised the review process and review criteria. Interventions are reviewed and classified based on the Quality of Research for specific outcomes achieved, rather than for a global assessment of the intervention. In addition, NREPP also includes a new dimension called Readiness for Dissemination, which is a measure of the availability and quality of training and implementation materials.

Why was NREPP expanded?

Increasingly, Federal agencies are recognizing the value to the public and to science of a voluntary classification system that summarizes the best current evidence about the effectiveness and utility of interventions. NREPP promises to be a transparent system to promote the dissemination of information on evidence-based interventions to prevent and treat mental and substance use disorders.

Can I still access content from SAMHSA's Model Programs Web site (the old NREPP)?

Programs from the Model Programs Web site that have been re-reviewed under the current NREPP will be listed in this site's Find Interventions section.

Most Effective and Promising Programs from the Model Programs Web site have consented to be posted in this site's Legacy Programs section.
Many documents from the Model Programs Web site are now available in this site’s Legacy Documents section.

Can I appeal a rating?

If applicants have reason to doubt the validity or the accuracy of an NREPP review, they will have an opportunity to initiate a formal appeals process. In these rare cases, NREPP will provide instructions to the applicant on how to proceed with a formal appeal.

Why aren't prevention and treatment interventions considered under separate criteria?

The developers and Federal sponsors of NREPP believe that the scientific standards for evidence-based practice assessments contained within NREPP apply equally to the prevention and treatment components of behavioral health care.

Where can I get help if I want to submit my intervention to NREPP, or if I just want more information about NREPP?

Please contact NREPP at 1-866-43NREPP (1-866-436-7377) or e-mail us at NREPP@samhsa.hhs.gov with your questions.

Will environmental interventions/community-level interventions be included in NREPP?

Yes.

How do I find out if my project qualifies for submission?

Minimum review requirements and other submission details will be published in the Federal Register and posted on the NREPP Web site in summer 2010 before the next open submission period.

Will every intervention that is submitted be reviewed?

No. Each application undergoes a preliminary assessment to determine whether the intervention meets the minimum requirements for submission. From those meeting the minimum requirements, SAMHSA accepts interventions for review based on current funding available. SAMHSA may choose to give special consideration to interventions that meet one or more conditions, as outlined in the Federal Register notice published the summer before each submission period.
Can interventions emanating from outside the United States be considered by NREPP?

Yes, if they meet all the NREPP requirements and if they have implementation materials that can be disseminated in the United States.

Will there be another application cycle?

Yes. The next open submission period - to begin October 1, 2010 - will be published in the Federal Register and posted on the NREPP Web site in summer 2010.

Is there any cost to apply to NREPP?

There is no cost to apply. However, applicants must be prepared to send all relevant intervention materials as well as three copies of all dissemination materials at their own expense.

What are Legacy Programs?

All programs that received Effective or Promising status under the previous NREPP system were offered the opportunity to be listed on this site as Legacy Programs. Legacy Programs have not been reviewed using the current NREPP criteria and rating system and are intended to be used for historical reference only.

Once my intervention is accepted for review by NREPP, am I required to post the results on the NREPP Web site?

While NREPP is a voluntary registry, each NREPP review represents a considerable investment of time and public funds. Any individual or organization that applies for an NREPP review is expected to authorize publication of the results in the form of an intervention summary (See Find Interventions). In rare cases, a program developer may choose to decline posting of a summary. To provide full disclosure to all users of this site, NREPP will publish the names of these reviewed but unlisted interventions on the NREPP Web site with a notation that the developers declined posting.

Is there a recommended format for citing information from intervention summaries listed on this site?

NREPP recommends the following citation format:
What is comparative effectiveness research?

The Federal Coordinating Council on Comparative Effectiveness Research defines comparative effectiveness research as follows:

Comparative effectiveness research is the conduct and synthesis of research comparing the benefits and harms of different interventions and strategies to prevent, diagnose, treat, and monitor health conditions in "real world" settings. The purpose of this research is to improve health outcomes by developing and disseminating evidence-based information to patients, clinicians, and other decision-makers, responding to their expressed needs, about which interventions are most effective for which patients under specific circumstances.

To provide this information, comparative effectiveness research must assess a comprehensive array of health-related outcomes for diverse patient populations and subgroups. Defined interventions compared may include medications, procedures, medical and assistive devices and technologies, diagnostic testing, behavioral change, and delivery system strategies. This research necessitates the development, expansion, and use of a variety of data sources and methods to assess comparative effectiveness and actively disseminate the results.

This definition was published in the Federal Coordinating Council's June 30, 2009, Report to the President and the Congress on Comparative Effectiveness Research. NREPP's Find Interventions page allows users to search for interventions that have been evaluated in comparative effectiveness research studies. For each intervention identified by the search, at least one of the studies included in the NREPP review must meet the definition of comparative effectiveness research above.
Session 4
Pulling All the Pieces Together

Pulling All The Pieces Together
Christina Borbely, PhD

Learning Objectives
- Define short-term outcomes in terms of interventions
- Actively reflect theory of change: cohesion of goals, objectives and outcomes
- Plan and implement evaluation of progress and success
- Identify opportunities to refine monitoring and evaluation

Application Objective
- Complete the final section of worksheet section II, resulting in defined short-term outcomes associated with interventions (strategies/activities)
- Complete worksheet section IV, resulting in the identification of outcome indicators, measures, and logistics for implementation
Connecting the Dots

- Goals/Objectives
- Outcomes/Indicators
- Interventions

Interventions Link to Short-Term Outcomes

<table>
<thead>
<tr>
<th>PROPOSED OUTCOME</th>
<th>INDICATOR</th>
<th>MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>By June 2012, reduce alcohol consumption among high school youth in XYZ communities by 3%</td>
<td>11th graders' self-report 30-day alcohol use rate by survey and interviews.</td>
<td>CHKS in XYZ district Youth on Youth interview</td>
</tr>
<tr>
<td>By June 2011, reduce retail availability of alcohol for underage youth in X community by 5%</td>
<td>Sales to minors</td>
<td>Compliance checks for XYZ zip codes: ABC data PD data</td>
</tr>
<tr>
<td>By June 2010, implement merchant education in __ retail outlets in community X.</td>
<td>Participation rates</td>
<td>Attendance logs</td>
</tr>
</tbody>
</table>

PROPOSED OUTCOME

(Goal) Long-term: By June 2012, reduce alcohol consumption among high school youth in XYZ communities by 3%.

(Objective) Intermediate: By June 2011, increase perception of harm by 15% among high risk drinkers in XYZ HS districts.

(Activity) Short: By June 2010, screen all 9th grade students in health education classes at XYZ districts. By June 2010, engage 75% of high risk alcohol users in student assistance programs.

- Attendance
- Screening records
- SAP participation rates
- SAP intake records

PROPOSED OUTCOME

(11th graders' self-report 30-day alcohol use rate by survey and interviews. CHKS in XYZ district Youth on Youth interview

Youth self-report by survey and interview | SAP Youth Survey Youth on Youth interview

Attendance logs Screening results SAP intake records
Big Picture

- Step back to reflect
- Refer to theory of change
- Examine logic model
- Confirm

Evaluating Progress

- Process
- Outcome

Viable Evaluation

- Taking stock of resources
- Integrating efforts
Evaluation Plan

- Roles
- Responsibilities
- Timelines

Check Point

- How are you currently tracking the County’s prevention progress?
- Does the County have an SPF evaluation plan?

Building It In

- Expanding capacity
- Trainings
- Technical Assistance
- RFP process
- Partners
Check Point

How do you use these findings to inform your efforts?

CalOMS Pv – SPF Map

<table>
<thead>
<tr>
<th></th>
<th>PLANNING</th>
<th>IMPLEMENTATION</th>
<th>EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CalOMS Pv</td>
<td>Goal</td>
<td>Objective</td>
<td>Input Activity</td>
</tr>
<tr>
<td>SPF</td>
<td>Goal</td>
<td>Objective</td>
<td>Work/Action Plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Provide progress via narrative</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Track progress toward CHANGE</td>
</tr>
</tbody>
</table>

Check Point

What is the County doing to leverage CalOMS Pv?

Does the County’s approach to CalOMS Pv connect to the evaluation plan?
From the field

- Real world application of SPF: Approaches to evaluation and monitoring

Application Objective

- Complete the final section of worksheet section II, resulting in defined short-term outcomes associated with interventions (strategies/activities)
- Complete worksheet section IV, resulting in the identification of outcome indicators, measures, and logistics for implementation
### Session I: Developing Data-Driven Goals and Objectives

Use your Community Assessment, Logic Model and other documents to start the “thread” on one identified problem. *Please note if/where you are missing information.*

#### First:

- **a.** Select one problem you’ll use throughout the training to learn this process
  
  - Use your data to answer “how do you know?” about this problem. Cite specific & quantified data sources

- **b.** Identify “WHY” by identifying contributing factors to the problem.

- **c.** Identify “WHY HERE” as the more local and specific ways the general contributing factor displays itself at the community level.

#### Next:

- **a.** Invert or flip your statements into goals, objectives and short term objectives

  
  Format:  (Reduce / Increase) _______(problem)
  (Reduce / Increase) _______(contributing factor)
  (Reduce / Increase) _______(local condition)
Session II: Getting to Outcomes with Measurable Targets

Build on Session I to make goals and objectives concrete and measurable, and identify expected outcomes and indicators.

Think about these questions in developing concrete measurable statements, followed by an indicator of change, and how you can measure it. Use pages ______ as examples of indicators along with ways to gather/measure these indicator data.

- What drug use or consequence will be addressed?
- What specific population or community will be targeted?
- What amount (percentage) of change is expected?
- By when is the change expected to occur?
- How will you measure the change (instrument/tool)?
- At what level will you measure the change?

1) Assemble one **Goal (Long-Term) Outcome** statement:

Format:

- By what date will how much of what (indicator) type of change occur to whom as measured by what?

2) Assemble one **Objective (Intermediate-Term) Outcome** statement:

Format:

- By what date will how much of what type of change occur to whom as measured by what?

2.A.: *If you have time, complete statements for your other objectives*

3) Assemble information into one **Short Term Objective Outcome** statement:

Format:

- By what date will how much of what type of change occur to whom as measured by what?

3.A.: *If you have time, complete statements for your other short term objectives*
## Session III: Now Focus on Strategies

Use the worksheet boxes pull the thread further along and identify strategies that specifically address the short term and longer term objectives. What action or strategy will get you where you want to go?

Keep in mind that no single strategy is likely to make change at the County level. What is a set of actions that can help you achieve the objective? Name the strategies that add up to a comprehensive intervention on your contributing factors and problem.

### Questions to consider

1. Is there evidence this strategy is effective?
2. Does the strategy address the contributing factors and local conditions in your community?
3. What modifications might be needed to fit your local culture?
4. Are there sufficient resources and capacity to implement this strategy?
5. What are the expected outcomes, or immediate results, of using this strategy?

### Format: ______ strategy involving _______( provide info or support, modify barriers, change consequences, change physical design or policy) activities

### Expected Short Term Outcomes

- Identify what you can reasonably expect to happen as a result of implementing these activities. **Clue: these may look a lot like the process outcomes you report to Cal OMS Pv.**

Use the column for this on the next page. This should “add up” in both directions, from activities to goals and vice versa. *This /these strategies will achieve our short term objectives, which together add up to achieving our longer term objectives, which collectively contribute to achieving our goal.*

**Format: What happens in the short term by implementing this strategy?**

- Increase ______ operations by ___% in the first year as measured by____.
- Increase knowledge of ___ by __% as measured by ____.
- Reduce / increase police calls for service by ___% of ____ incidents as measured by police reports in ___ period.
**Session IV: Pulling All the Pieces Together**

First: Complete this chart based on Session I-III worksheets to put all your expected outcomes in one place.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objectives</th>
<th>Short Term Objectives</th>
<th>Strategies (What you’ll do to get there?)</th>
<th>Expected Outcomes (Or What Change Are You Looking For?)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Short Term &lt; 1 year</td>
</tr>
</tbody>
</table>
Next, answer these questions for every short, intermediate and long term outcome to form an outline of your evaluation plan.

1. Insert one expected outcome statement: ______________________________________________.
2. Complete evaluation plan questions.
3. If you have time, complete evaluation planning for your other expected outcomes.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Tools (Interviews, surveys, observations, record comparisons, etc.)</th>
<th>Who Collects Data (Name staff, peer leader, outside expert)</th>
<th>Timeline (e.g. before &amp; after program; every 3 months)</th>
<th>Application of Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>How will you know?</td>
<td>• How will you track change?</td>
<td>• Who is responsible for this task? or • Who is the access point? Who contacts the access point?</td>
<td>• When will it be gathered? • When will it be available for review?</td>
<td>• Who will see the findings? • How will the information be used?</td>
</tr>
<tr>
<td>What will indicate progress? Success?</td>
<td>1. For #1 a. b. c.</td>
<td>1. For #1 a. b. c.</td>
<td>1. For #1 a. b. c.</td>
<td>1. For #1 a. b. c.</td>
</tr>
<tr>
<td></td>
<td>2. For #2 a. b. c.</td>
<td>2. For #2 a. b. c.</td>
<td>2. For #2 a. b. c.</td>
<td>2. For #2 a. b. c.</td>
</tr>
<tr>
<td></td>
<td>3. For #3 a. b. c.</td>
<td>3. For #3 a. b. c.</td>
<td>3. For #3 a. b. c.</td>
<td>3. For #3 a. b. c.</td>
</tr>
</tbody>
</table>
REFERENCES & RESOURCES
Sample Outcome-Based Logic Model Format

<table>
<thead>
<tr>
<th>Identified Problem or Need (supported by data)</th>
<th>CONTRIBUTING FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. __________________</td>
</tr>
<tr>
<td></td>
<td>2. __________________</td>
</tr>
<tr>
<td></td>
<td>3. __________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GOAL (or Aim)</th>
<th>RESOURCES (What do we have to help meet our goal?)</th>
<th>STRATEGIES (What methods will we use?)</th>
<th>EXPECTED OUTCOMES/OBJECTIVES (What do we think will happen as a result of our efforts?)</th>
<th>MEASUREMENT INDICATORS (Specifically, how will we know what happened?)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>SHORT TERM</td>
<td>INTERMEDIATE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Community Logic Model for Preventing Alcohol-Involved Traffic Crashes (15- to 24-year-olds)

Community Logic Model for Preventing Illicit Drug Use Among Adolescents

The Logic Model for Program Planning and Evaluation

Paul F. McCawley
Associate Director
University of Idaho Extension

What is the Logic Model?
The Logic Model process is a tool that has been used for more than 20 years by program managers and evaluators to describe the effectiveness of their programs. The model describes logical linkages among program resources, activities, outputs, audiences, and short-, intermediate-, and long-term outcomes related to a specific problem or situation. Once a program has been described in terms of the logic model, critical measures of performance can be identified.1

Logic models are narrative or graphical depictions of processes in real life that communicate the underlying assumptions upon which an activity is expected to lead to a specific result. Logic models illustrate a sequence of cause-and-effect relationships—a systems approach to communicate the path toward a desired result.2

A common concern of impact measurement is that of limited control over complex outcomes. Establishing desired long-term outcomes, such as improved financial security or reduced teen-age violence, is tenuous because of the limited influence we may have over the target audience, and complex, uncontrolled environmental variables. Logic models address this issue because they describe the concepts that need to be considered when we seek such outcomes. Logic models link the problem (situation) to the intervention (our inputs and outputs), and the impact (outcome). Further, the model helps to identify partnerships critical to enhancing our performance.

Planning Process
The logic model was characterized initially by program evaluators as a tool for identifying performance measures. Since that time, the tool has been adapted to program planning, as well. The application of the logic model as a planning tool allows precise communication about the purposes of a project, the components of a project, and the sequence of activities and accomplishments. Further, a project originally designed with assessment in mind is much more likely to yield beneficial data, should evaluation be desired.

In the past, our strategy to justify a particular program often has been to explain what we are doing from the perspective of an insider, beginning with why we invest allocated resources. Our traditional justification includes the following sequence:

Figure 1. Elements of the Logic Model.3

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>INPUTS</th>
<th>OUTPUTS</th>
<th>OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>What we Invest!</td>
<td>What we Do!</td>
<td>Who we Reach!</td>
<td>Short-</td>
</tr>
<tr>
<td>• time</td>
<td>• workshops</td>
<td>• customers</td>
<td></td>
</tr>
<tr>
<td>• money</td>
<td>• publications</td>
<td>• behaviors</td>
<td></td>
</tr>
<tr>
<td>• partners</td>
<td>• field days</td>
<td>• practices</td>
<td></td>
</tr>
<tr>
<td>• equipment</td>
<td>• equipment demonstrations</td>
<td>• policies</td>
<td></td>
</tr>
<tr>
<td>• facilities</td>
<td></td>
<td>• procedures</td>
<td></td>
</tr>
</tbody>
</table>

Change in:
• knowledge
• skills
• attitude
• motivation
• awareness

Change in:
• behaviors
• practices
• policies
• procedures

Change in situation:
• environment
• social conditions
• economic conditions
• political conditions

External Influences, Environmental, Related Programs
1) We invest this time/money so that we can generate this activity/product.
2) The activity/product is needed so people will learn how to do this.
3) People need to learn that so they can apply their knowledge to this practice.
4) When that practice is applied, the effect will be to change this condition;
5) When that condition changes, we will no longer be in this situation.

The logic model process has been used successfully following the above sequence. However, according to Millar et al., logic models that begin with the inputs and work through to the desired outcomes may reflect a natural tendency to limit one’s thinking to existing activities, programs, and research questions. Starting with the inputs tends to foster a defense of the status quo rather than create a forum for new ideas or concepts. To help us think “outside the box,” Millar suggests that the planning sequence be inverted, thereby focusing on the outcomes to be achieved. In such a reversed process, we ask ourselves “what needs to be done?” rather than “what is being done?” Following the advice of the authors, we might begin building our logic model by asking questions in the following sequence.

1) What is the current situation that we intend to impact?
2) What will it look like when we achieve the desired situation or outcome?
3) What behaviors need to change for that outcome to be achieved?

4) What knowledge or skills do people need before the behavior will change?
5) What activities need to be performed to cause the necessary learning?
6) What resources will be required to achieve the desired outcome?

One more point before we begin planning a program using the logic model: It is recognized that we are using a linear model to simulate a multi-dimensional process. Often, learning is sequential and teaching must reflect that, but the model becomes too complicated if we try to communicate that reality (figure 2). Similarly, the output from one effort becomes the input for the next effort, as building a coalition may be required before the “group” can sponsor a needed workshop. Keep in mind that the logic model is a simple communication device. We should avoid complications by choosing to identify a single category to enter each item (i.e., inputs, outputs or outcomes). Details of order and timing then need to be addressed within the framework of the model, just as with other action planning processes.

**Planning Elements**

Using the logic model as a planning tool is most valuable when we focus on what it is that we want to communicate to others. Figure 3 illustrates the building blocks of accountability that we can incorporate into our program plans (adapted from Ladewig, 1998). According to Howard Ladewig, there are certain characteristics of programs that inspire others to value and support what we do. By describing the characteristics of our programs that communicate relevance, quality, and impact, we foster buy-in from our stakeholders and audience. By including these characteristics within the various elements of the logic model.
model, we communicate to others why our programs are important to them. The elements of accountability are further described in the context of the logic model, below.

**Situation**
The situation statement provides an opportunity to communicate the relevance of the project. Characteristics that illustrate the relevance to others include:

- A statement of the problem. (What are the causes? What are the social, economic, and/or environmental symptoms of the problem? What are the likely consequences if nothing is done to resolve the problem? What are the actual or projected costs?);
- A description of who is affected by the problem. (Where do they live, work, and shop? How are they important to the community? Who depends on them—families, employees, organizations?);
- Who else is interested in the problem? Who are the stakeholders? What other projects address this problem?

The situation statement establishes a baseline for comparison at the close of a program. A description of the problem and its symptoms provides a way to determine whether change has occurred. Describing who is affected by the problem allows assessment of who has benefited. Identifying other stakeholders and programs builds a platform to measure our overall contribution, including increased awareness and activity, or reduced concern and cost.

**Inputs**
Inputs include those things that we invest in a program or that we bring to bear on a program, such as knowledge, skills, or expertise. Describing the inputs needed for a program provides an opportunity to communicate the quality of the program. Inputs that communicate to others that the program is of high quality include:

- Human resources, such as time invested by faculty, staff, volunteers, partners, and local people;
- Fiscal resources, including appropriated funds, special grants, donations, and user fees;
- Other inputs required to support the program, such as facilities and equipment;
- Knowledge base for the program, including teaching materials, curriculum, research results, certification or learning standards etc.
- Involvement of collaborators—local, state, national agencies and organizations involved in planning, delivery, and evaluation.

Projects involving credible partners, built on knowledge gained from research and delivered via tested and proven curricula, are readily communicated as quality programs. Assessing the effectiveness of a program also is made easier when planned inputs are adequately described. By comparing actual investments with planned investments, evaluation can be used to improve future programs, justify budgets, and establish priorities.

**Outputs**
Outputs are those things that we do (providing products, goods, and services to program customers) and the people we reach (informed consumers, knowledgeable decision makers).
makers). Describing our outputs allows us to establish linkages between the problem (situation) and the impact of the program (intended outcomes). Outputs that help link what we do with program impact include:

- publications such as articles, bulletins, fact sheets, CISs, handbooks, web pages;
- decision aids such as software, worksheets, models;
- teaching events such as workshops, field days, tours, short courses;
- discovery and application activities, such as research plots, demonstration plots, and product trials.

The people we reach also are outputs of the program and need to be the center of our model. They constitute a bridge between the problem and the impact. Information about the people who participated and what they were taught can include:

- their characteristics or behaviors;
- the proportion or number of people in the target group that were reached;
- learner objectives for program participants;
- number of sessions or activities attended by participants;
- level of satisfaction participants express for the program.

Outcomes

Program outcomes can be short-term, intermediate-term, or long-term. Outcomes answer the question “What happened as a result of the program?” and are useful to communicate the impacts of our investment.

Short-term outcomes of educational programs may include changes in:

- awareness—customers recognize the problem or issue;
- knowledge—customers understand the causes and potential solutions;
- skills—customers possess the skills needed to resolve the situation;
- motivation—customers have the desire to effect change;
- attitude—customers believe their actions can make a difference.

Intermediate-term outcomes include changes that follow the short-term outcomes, such as changes in:

- practices used by participants;
- behaviors exhibited by people or organizations;
- policies adopted by businesses, governments, or organizations;
- technologies employed by end users;
- management strategies implemented by individuals or groups.

Long-term outcomes follow intermediate-term outcomes when changed behaviors result in changed conditions, such as:

- improved economic conditions—increased income or financial stability;
- improved social conditions—reduced violence or improved cooperation;
- improved environmental conditions—improved air quality or reduced runoff;
- improved political conditions—improved participation or opportunity.

External Influences

Institutional, community, and public policies may have either supporting or antagonistic effects on many of our programs. At the institutional level, schools may influence healthy eating habits in ways that are beyond our control but that may lead to social change. Classes in health education may introduce children to the food pyramid and to the concept of proportional intake, while the cafeteria may serve pizza on Wednesdays and steak fingers on Thursdays. The community also can influence eating habits through availability of fast-food restaurants or produce markets. Even public policies that provide support (food bank, food stamps) to acquire some items but not others might impact healthy eating habits.

Documenting the social, physical, political, and institutional environments that can influence outcomes helps to improve the program planning process by answering the following:

- Who are important partners/collaborators for the program?
- Which part(s) of the issue can this project realistically influence?
- What evaluation measures will accurately reflect project outcomes?
- What other needs must be met in order to address this issue?

Evaluation Planning

Development of an evaluation plan to assess the program can be superimposed, using the logic model format. The evaluation plan should include alternatives to assess the processes used in planning the program. Process indicators should be designed to provide a measurable response to questions such as:
• Were specific inputs made as planned, in terms of the amount of input, timing, and quality of input?
• Were specific activities conducted as planned, in terms of content, timing, location, format, quality?
• Was the desired level of participation achieved, in terms of numbers and characteristics of participants?
• Did customers express the degree of customer satisfaction expected?

The evaluation plan also should identify indicators appropriate to the desired outcomes, including short-, medium- and long-term outcomes. Outcome indicators also should be measurable, and should be designed to answer questions such as:

• Did participants demonstrate the desired level of knowledge increase, enhanced awareness, or motivation?
• Were improved management practices adopted, behaviors modified, or policies altered to the extent expected for the program?
• To what extent were social, economic, political, or environmental conditions affected by the program?

Conclusion
Developing appropriate and measurable indicators during the planning phase is the key to a sound evaluation. Early identification of indicators allows the program manager/team to learn what baseline data already may be available to help evaluate the project, or to design a process to collect baseline data before the program is initiated. The logic model is useful for identifying elements of the program that are most likely to yield useful evaluation data, and to identify an appropriate sequence for collecting data and measuring progress. In most cases, however, more work on a project will be required before indicators are finalized. Outcome indicators to measure learning should be based on specific learner objectives that are described as part of the curriculum. Indicators to measure behavioral change should specify which behaviors are targeted by the program. Conditional indicators may require a significant investment of time to link medium-term outcomes to expected long-term outcomes through the application of a targeted study or relevant research base.

Figure 4. Insertion of evaluation plan into the logic model.
Workbook for Evaluation Planning

Project to be Evaluated: ________________________________

Date: ________________________________________________
Evaluation Plan Template

This evaluation plan can help you organize information about your evaluation. Refer to the module for explanations of each column.

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Indicators</th>
<th>Data Sources/Methods</th>
<th>Person Responsible</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
Analyze the Information

Think about how you will analyze the findings and draw conclusions from the data you have collected. Consider the following questions.

What are your criteria for success in your program?

To what will you compare the information you collected?

What information might still be needed in order to justify your conclusions (for example, statistical information, financial information)?
Analyze the Information (continued)

This table may be useful for thinking about how to analyze different types of information you have collected.

<table>
<thead>
<tr>
<th>Type and Source of Information</th>
<th>Qualitative or quantitative data?</th>
<th>Resources available to help analyze the information</th>
<th>Standard of comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Plan to Share the Evaluation Results

Make a list of the audiences with whom you would share the results of the evaluation. Next to each audience, write how you might share the results (i.e., in what format).

<table>
<thead>
<tr>
<th>Audiences</th>
<th>How to share results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Write one or more steps you might take to follow up and ensure the findings are translated into decisions and actions.
Resources

Evaluation Frameworks

Measuring the Difference: Guide to Planning and Evaluating Health Information Outreach
http://nnlm.gov/evaluation/guide/
The National Network of Libraries of Medicine presents step-by-step guides to planning and evaluation methods.

The Pinkbook
http://www.cancer.gov/pinkbook/page1
This National Cancer Institute resource guides an individual through the steps of a health communication project. Aspects of evaluation may be found in a variety of sections of the manual, and especially in the “Assessing Effectiveness” section.

W.K. Kellogg Foundation Evaluation Handbook
This handbook may guide evaluation for any type of program and uses a nine-step approach to evaluating.

Agency for Toxic Substances and Disease Registry Evaluation Primer on Health Risk Communication Programs and Outcomes
http://www.atsdr.cdc.gov/HEC/evalprmr.html
This is by the Department of Health and Human Services Agency for Toxic Substances and Disease Registry. The principles and techniques provided in the evaluation primer are designed to improve the capacity of risk communication practitioners and decision makers to evaluate the efficiency and effectiveness of health risk communication messages, materials, and campaigns.

Introduction to Program Evaluation for Comprehensive Tobacco Control Programs
http://www.cdc.gov/tobacco/evaluation_manual/contents.htm
CDC's Tobacco Information and Prevention Sources has this evaluation guide for tobacco control programs based on the CDC framework.

Practical Guide to Monitoring and Evaluation of Rural Development Projects
This guide, developed by the International Fund for Agricultural Development (IFAD), was written to help project managers improve the quality of monitoring and evaluating in IFAD-supported projects.

UNDP Participatory Evaluation Framework
The United Nations Development Programme provides this handbook to its staff to help to introduce participatory evaluations into UNDP programming and to strengthen the learning and management culture of UNDP.

USDHHS Program Managers Guide to Evaluation
http://www.acf.hhs.gov/programs/opre/other_resrch/pm_guide_eval/reports/pmguide/pmguide_toc.html
The Department of Health and Human Services Administration on Children, Youth, and Families (ACYF) has developed this Guide to explain program evaluation - what it is, how to understand it, and how to do it. It answers questions about evaluation and explains how to use evaluation to improve programs and benefit staff and families.

Program Objectives
The Pink Book
http://www.cancer.gov/pinkbook/page5
This National Cancer Institute resource guides an individual through the steps of a health communication project. It includes information about how to craft program objectives.

Community Toolbox
http://ctb.ku.edu/tools/en/sub_section_main_1087.htm
The Tool Box provides over 6,000 pages of practical information to support your work in promoting community health and development. This link will take you to information about writing objectives. The website is created and maintained by the Work Group on Health Promotion and Community Development at the University of Kansas in Lawrence, Kansas.


Extension Service Tip-sheet for writing program objectives
Penn State Cooperative Extension created this brief tip-sheet with six steps to keep in mind when writing objectives.

March of Dimes instructions for SMART Objectives
This is the March Of Dimes three-page guide to writing program objectives. It is very understandable and gives examples.

Evaluation Questions

W.K. Kellogg Foundation resources
The W.K. Kellogg Foundation website has information about writing evaluation questions. It is somewhat targeted at their own programs, but is still useful.

http://www.wkkf.org/Pubs/Tools/Evaluation/Pub770.pdf

The CDC Standards for assessing the quality of evaluation activities
http://www.cdc.gov/eval/standard.htm

Human Subjects Reviews and Institutional Review Board (IRB) Resources

Description of IRB
Wikipedia’s article describing the history and purpose of IRBs

The Community IRB Member
http://www.orau.gov/communityirb/sites.htm
This site has a list of Online IRB resources from various agencies.
Washington State Department of Health.
Health Data. Human Subjects and Public Health Practice: Guidelines for Ethical Data Collection

US Department of Health and Human Services (DHHS)
http://www.hhs.gov/ohrp/irb/irb_guidebook.htm
Office for Human Research Protections (OHRP). IRB Guidebook

Health Resources and Services Administration (HRSA)
http://www.hrsa.gov/humansubjects/
This site houses a training module called “Protecting Human Subjects Training”

Human Subjects Protection Resource Book
A joint project of the U.S. Department of Energy, Department of Defense, and
Department of Veterans Affairs. Provides current information on the protection
of human subjects in research. Target audience: investigators, Institutional
Review Boards (IRBs), research organizations, research subjects, and others.

Gathering and Analyzing Data

http://www.wkkf.org/Pubs/Tools/Evaluation/Pub770.pdf
“Determining Data Collecting Methods” pages, 70-86, and "Analyzing and Interpreting Data" pages 87-95.

Collecting and Analyzing Evaluation Data
This handbook by the National Network of Libraries of Medicine,
Outreach Evaluation Resource Center includes information about analyzing both qualitative and
quantitative data.

User-Friendly Handbook for Mixed Method Evaluations
The National Science Foundation (NSF) handbook is targeted towards researchers. It is designed to be a
user-friendly manual for project evaluation. It gives useful insight into mixed method evaluations, which
combine quantitative and qualitative techniques.

University of Wisconsin Cooperative Extension resources
http://www.uwex.edu/ces/pdande/evaluation/evaldocs.html
The Cooperative Extension of the University of Wisconsin-Extension issued this list of practical, easy-to-
use guides designed to help program managers better plan and implement credible and useful evaluations.
Included in the list are a number of documents about collecting and analyzing data.

NSF, An Overview of Quantitative and Qualitative Data Collection Methods
This PDF is separate from the preceding NSF handbook. It is also written for researchers. It examines the
relative virtues of qualitative approaches to data collection and discusses some of the advantages and
disadvantages of different types of data-gathering tools.

General Evaluation Resources
The following resources are helpful and informative. The Regional Academic Environmental Public Health Center does not promote or endorse any of the following organizations.

**CDC Framework for Program Evaluation**  
http://www.cdc.gov/eval/framework.htm  
This is the main site with resources for the CDC evaluation framework. It contains various PDF documents with both overviews and thorough descriptions of the framework.

**Community Toolbox**  
http://ctb.ku.edu/  
This Web site gives you access to a broad range of information related to community-oriented programs, including assessment and evaluation. “Evaluation” is under “Plan the Work” and “Solve a Problem.”

**Evaluation Guides from the Outreach Evaluation Resource Center**  
http://nnlm.gov/evaluation/guide/  
The series of publications gives step-by-step planning and evaluation methods.

**Kellogg Foundation Evaluation Handbook**  
http://www.wkkf.org/Pubs/Tools/Evaluation/Pub770.pdf  
The thorough PDF gives step-by-step planning and evaluation methods.

**Kellogg Foundation Logic Model Development Guide**  
http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf  
The thorough PDF gives step-by-step planning and evaluation methods.

GAO-02-923 Program Evaluation: Strategies for Assessing How Information Dissemination Contributes to Agency Goals
http://www.gao.gov/cgi-bin/getrpt?GAO-02-923#search=%22environmental%20health%20program%20evaluation%22
In addition to background information about conducting evaluations (including another example of a logic model template), this document gives “Case Descriptions” that are specific examples of programs and their evaluation approaches.

Northwest Center for Public Health Practice evaluation resources
http://www.nwcphp.org/resources/evaluation/
This site has a number of sources for information, some of them already listed here.

McNamara, Carter. Basic Guide to Program Evaluation
http://www.managementhelp.org/evaluatn/fnl_eval.htm

The Public Health Agency of Canada, Guide to Project Evaluation: A Participatory Approach
http://www.phac-aspc.gc.ca/ph-sp/phdd/resources/guide/

The Public Health Agency of Canada, Program Evaluation Toolkit
This site provides a different framework for evaluation than what the NWCPHP Environmental Program Evaluation module presents. It is a useful perspective on project evaluation, and is well explained. The toolkit has variety of templates (“worksheets”).

Horizon Research Incorporated manual, Taking Stock: A Practical Guide to Evaluating Your Own Programs
This guide was written by a private entity. It provides a framework for evaluation that is different from CDC’s.

Online Evaluation Resource Library
http://oerl.sri.com/

American Evaluation Association. Evaluation resources
http://www.eval.org/Resources/onlinehub-txt.htm
List of online evaluation handbooks and texts.

CDC Prevention Research Center’s Project DEFINE
http://www.cdc.gov/prc/program-evaluation/index.htm
This site has varied information about evaluation, including a “conceptual framework,” which is another type of logic model.

Assessment for Environmental Health

PACE EH
http://www.naccho.org/topics/environmental/CEHA.cfm
In order to use the PACE EH online module, you will need to register. Registration is free. Click the Online Module link in the right-hand column. The site has instructional material, resources, and examples of PACE EH programs in various settings.
Community Toolbox
http://ctb.ku.edu/
This Web site gives you access to a broad range of information related to conducting community-oriented programs, including assessment. “Community Assessment” is under “Learning a Skill.”

Mobilizing for Action through Planning and Partnerships (MAPP)
http://mapp.naccho.org/MappModel.asp
The MAPP resource also provides information about a broad range of assessment and project planning-related topics. On the linked Web site, view the lower part of the left-hand column to see the aspects of MAPP community assessments.

Washington State Department of Health. Fact sheet for Environmental Health Assessment
http://www.doh.wa.gov/ehp/oehas/fact%20sheets%20pdf/Public%20Health%20Assessment%20Fact%20Sheet.pdf#search=%22Community%20environmental%20health%20assessment%22
Appendix
Qualifications for Evaluation Consultants


• **Background and Experience.** “The individual or group should have specific background and experience in conducting evaluations of school- and community-based substance abuse prevention programs.

• **Knowledge of a Variety of Evaluation Techniques.** “The individual or group should be able to offer assistance with a variety of quantitative and qualitative evaluation techniques in order to allow flexibility in evaluation planning (unless, of course, the program seeks consultation in some specific area such as statistical analysis).

• **Sensitivity to Program Goals and Local Values.** “The individual or group should be sensitive to the program goals, and to values and attitudes of the school or community in which the evaluation will be conducted.”


• **Familiarity With Alternative Instrumentation.** “One obstacle often faced in outcome evaluations is the lack of adequate information about available and appropriate evaluation instruments…. Even after locating and ordering the chosen instruments, program staff and evaluators often know little about which ones are best for their population. Many measurement issues must be considered, such as language skills, age appropriateness, cultural relevance, length of the instrument, attention span, and validity and reliability of different tests and sources of information…. The validity of the evaluations results is only as good as the quality and fit of the evaluation measures.”

• **Awareness of Current Theories of Substance Abuse Etiology and Logic Models.** “…[P]rograms must have a theory of causation that guides their choice of intervention strategies….Having a clear concept of what a prevention program is all about is necessary for both effective program evaluation and appropriate, useful evaluation.”

Additional criteria:

• **Affordability.** Assume that the evaluator’s investment of time may be twice what is anticipated or contracted, because the unexpected must be considered. The evaluator’s fees and expenses should be at a level that this amount of time can be compensated by the program.

• **Adequate Availability and Accessibility.** Outside evaluators must be available to assist the program when crises develop, for example, when the proposed source of data relevant to an evaluation, such as a school or criminal justice program, withdraws permission for data collection, or when a new component is added to the prevention program.

• **Communication Skills.** Outside evaluators must be able to explain their work to program staff and volunteers, including how and why specific information must be collected. They must also be able to communicate their methodology and findings in credible, clear language to members of the academic community, to program funding sources, and to the interested members of the community.
Areas of Evaluator Expertise

From the US DHHS Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration. CSAP’S Prevention Pathways, Evaluation Technical Assistance http://preventionpathways.samhsa.gov/eval/

**Process Evaluation**: Expertise and experience in collecting information and evaluating the extent to which the process of the prevention activity exceeded, achieved, or fell short of expectations, and the implications for this process on outcomes.

**Psychometrics/Instrumentation**: Experience and expertise in the development and application of instruments that reliably collect valid information from individual sources.

**Statistical Analyses/Modeling**: Experience and expertise in the selection, use, and interpretation of appropriate statistical techniques to analyze quantitative data. This must be more than the ability to “plug in” standard formulas or techniques, and includes understanding of how unevaulated factors may influence results.

**Stochastic Modeling**: Experience and expertise in the selection, use, and interpretation of models that organize randomly-selected observations into a probability framework. This type of evaluation is useful when there are a large number of uncontrolled observations, such as nighttime single car crashes, a typical measure of the success of prevention of driving under the influence.

**Interview Facilitation**: Experience and expertise in eliciting and interpreting valid and reliable information from the interview process. This may include key informant interviews, individual participant interviews, telephone and community intercepts, group sessions such as focus groups, and iterative processes such as Delphi technique, etc.

**Impact Evaluation**: Experience and expertise in identifying and measuring the probable impact of a program on larger community processes. For example, assuming that only a portion of juvenile crime is committed by prospective participants in a prevention activity, impact evaluation must be able to assess the extent to which changes in the overall incidence of juvenile crime reflects the impact of the success of failure of the program. In addition, impact evaluation must incorporate unplanned impacts, such as declining participation in a competing youth development activity as a result of recruitment of youth into the prevention effort.

**Cost-Benefit/Cost-Effectiveness Evaluation**: Expertise and experience in determining the economic implications of the prevention effort.

**Policy Analysis**: Expertise and experience in examining the effects of authoritative decisions affecting outcomes, including worksite policies, community policies, and government laws, regulations, and ordinances. These include both intended and unintended consequences, and variation resulting from enforcement or lack of enforcement.
An Overview of the Five Most Common Data Collection Methods

Survey

Kinds of surveys: questionnaires, checklists

Purpose: To quickly and easily obtain information in a non-threatening way

Strengths
• Anonymity
• Inexpensive to administer
• Easy to analyze/compare
• Provides large amounts of data (breadth of info)
• Sample questionnaires already exist

Weaknesses
• Respondents may not provide careful feedback
• Wording can bias response
• Impersonal
• Not much depth of information
• May need sampling expert

Interview

Purpose: To fully understand individuals’ impressions and experience and to learn more about their answers

Strengths
• Depth and range of information
• Can develop relationship with participant
• Responsive

Weaknesses
• Time-consuming
• Difficult to analyze/compare
• Costly
• Interviewer bias may influence responses

Document Review

Purpose: To get an impression of how a program operates without interrupting the program; review of records, files, finances, memos, etc.

Strengths
• Comprehensive and historical information
• Does not interrupt staff or participant routine
• Data already exists
• Few information biases

Weaknesses
• Time-consuming
• Data may be incomplete
• Requires clear direction
• Inflexible and non-responsive
• Restrictive

Observation

Purpose: To gather accurate information about how a program actually
<table>
<thead>
<tr>
<th><strong>Focus Group</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose:</strong> To explore a topic in depth through group discussion</td>
</tr>
<tr>
<td><strong>Strengths</strong></td>
</tr>
<tr>
<td>• Depth and range of information</td>
</tr>
<tr>
<td>• Quick way to get impressions</td>
</tr>
<tr>
<td>• Conveys key information about program</td>
</tr>
<tr>
<td><strong>Weaknesses</strong></td>
</tr>
<tr>
<td>• Difficult to analyze results</td>
</tr>
<tr>
<td>• Need good facilitator</td>
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<tr>
<td>• Need to coordinate schedules of six to eight people</td>
</tr>
<tr>
<td>• Can be expensive</td>
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</tbody>
</table>

**Strengths**
- Clarifies program processes
- Can view events as they occur
- Responsive—can adapt as events occur
- Provides insight into topics that no one will discuss
- Identifies processes that are not obvious or conscious to staff/participants

**Weaknesses**
- Difficulty in interpreting observed behaviors
- Hard to categorize/code behaviors
- Observer may influence behavior of staff/participants
- Expensive
### Part 1: Problem Statements, Goals and Objectives

<table>
<thead>
<tr>
<th>Key Things to Look for...</th>
<th>Strengths</th>
<th>Opportunities to Improve</th>
<th>Changes to make or Next Steps</th>
</tr>
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<tbody>
<tr>
<td><strong>Score from 1 to 4</strong></td>
<td></td>
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<tr>
<td>4 (high): present-complete; feasible; logical</td>
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<tr>
<td>1 (low): absent/minimal completion; unviable; lacks logical connection/alignment to other components</td>
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</table>

1. **Problem statements**
   a. Logical links to collected data in Needs Assessment
   b. Logical links to capacity assessment & capacity building in (SPF Step 2)
   c. Clearly articulated statements resulting from the “process for determining priority issues”

2. **Contributing Factors** - Local risk and protective factors that underlie the identified problems
   a. If addressed will logically help reduce the problem(s)
   b. Link directly to problem statement(s)
   c. Substantiated by data

3. **Goals & Objectives**
   a. Goals - statements of broad intent
   b. Objectives – for each goal, clear measurable statements that articulate how much of a change is expected in which contributing factor by when

**Other**
# Part II: Getting To Outcomes

## County Summary/Key Points from:

### Outcomes, Indicators, and Measures

<table>
<thead>
<tr>
<th>Score from 1 to 4</th>
<th>Key Things to Look for...</th>
<th>Strengths</th>
<th>Opportunities to Improve</th>
<th>Changes to make or Next Steps</th>
</tr>
</thead>
</table>
| 4 (high): present/complete; feasible; logical | 1. Outcomes are direct extension of Goals/Objectives  
a. If outcome is achieved it will demonstrate progress toward or accomplishment of objective.  
b. Logically link strategies and objectives used to address contributing factors.  
c. Feasible to accomplish intended outcomes through identified strategies in period of time specified in plan | | | |
| 1 (low): absent/minimal completion; unviable; lacks logical connection/alignment to other components | 2. Proposed outcomes reflect incremental progress toward overall goal,  
a. Short, intermediate and long-term outcomes  
b. Quantifiable targets and thresholds | | | |
| | 3. Indicators are appropriate measures of progress toward outcomes  
a. Proximate to the problem  
b. Provide meaningful information and are relevant to the prevention problem  
Reflect appropriate county-level change. | | | |
| | Other | | | |

Strategic Plan Analysis
### Part III: Implementation

#### Strategies and Implementation

<table>
<thead>
<tr>
<th>Key Things to Look for...</th>
<th>Strengths</th>
<th>Opportunities to Improve</th>
<th>Changes to make or Next Steps</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
</tr>
<tr>
<td>1 (low): absent/minimal completion; unviable; lacks logical connection/alignment to other components</td>
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<tr>
<td>1. Strategies - selection of evidence-based “best practices” that will be used to make a change in contributing factors in order to achieve goals and objectives tied to problem statements</td>
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<tr>
<td>2. The Plan demonstrate how strategies are linked to problem statements, goals and objectives</td>
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<tr>
<td>a. Identifies population groups / geographic areas of focus / cultural relevance to communities of focus</td>
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<tr>
<td>b. Outlines how strategies will be implemented according to best practices</td>
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<tr>
<td>c. Identifies steps to be taken to implement strategies in order to achieve short, intermediate and long-term outcomes</td>
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<tr>
<td>3. The strategy selection portion of the Plan identifies:</td>
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<tr>
<td><strong>Who</strong></td>
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<td><strong>Will do what</strong></td>
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<td><strong>By when</strong>, and</td>
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<tr>
<td><strong>How</strong>, they will know (link to process and outcome measures)</td>
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<tr>
<td>Other</td>
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</table>

**County Summary/Key Points from:**

**Strategic Plan Analysis**
## Part IV: Pulling All the Pieces Together

### County Summary/Key Points from:

**Evaluation Plan, Data Collection, Analysis and Dissemination**

<table>
<thead>
<tr>
<th>Score from 1 to 4</th>
<th>Key Things to Look for...</th>
<th>Strengths</th>
<th>Opportunities to Improve</th>
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<tr>
<td></td>
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<tr>
<td></td>
<td><strong>1 (low):</strong> absent/minimal completion; unviable; lacks logical connection/alignment to other components</td>
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<tr>
<td>1. Evaluation Plan – identifies how process and outcome indicator will be measured and used to reflect progress toward prevention goals.</td>
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<tr>
<td>a. Evaluation incorporates data used to substantiate problem statements, contributing factors and objectives (which should be linked together)</td>
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<tr>
<td>b. Describes how short, intermediate and long-term outcomes will be measured.</td>
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<tr>
<td>2. Evaluation Plan is viable and realistic.</td>
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<tr>
<td>a. Roles, responsibilities and timelines are established; capacity and buy-in are established.</td>
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<tr>
<td>b. Evaluation resources align with the intensity of services or priority level of goal/objective; there are no gaps or pointless redundancies.</td>
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<tr>
<td>c. Appropriate measures are used (sound, accessible, and relevant to indicating success of the objective).</td>
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<tr>
<td>3. Methods for data collection and data analysis are established.</td>
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</tr>
<tr>
<td>a. Data collection, processing and analysis align with the resources and capacity of the County.</td>
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<tr>
<td>b. CalOMS Pv use is optimized for the evaluation plan.</td>
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<tr>
<td>4. Evaluation Plan is updated to reflect changes or revisions in:</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>a. Strategic Plan goals/objectives and outcomes Resources and capacity</td>
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### Strategic Plan Analysis
ADDITIONAL RESOURCES
Identifying and Selecting Evidence-Based Interventions

Revised Guidance Document for the Strategic Prevention Framework State Incentive Grant Program
Identifying and Selecting Evidence-Based Interventions

*Revised* Guidance Document for the Strategic Prevention Framework State Incentive Grant Program

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov
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ORIGINATING OFFICE

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VI Identifying and Selecting Evidence-Based Interventions
Executive Summary

The purpose of this guidance is to assist State and community planners in applying the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Strategic Prevention Framework (SPF) to identify and select evidence-based interventions that address local needs and reduce substance abuse problems.

Section I. Summarizes the five steps of SAMHSA’s SPF and sets the stage for selecting evidence-based interventions to include in a comprehensive strategic plan.

Section II. Focuses on two analytic tasks included under the SPF: assessing local needs, resources, and readiness to act; and developing a community logic model. Explains the importance of these tasks in community planning to identify the best evidence-based interventions for specific local needs.

Section III. Details how prevention planners can apply the community logic model to determine the conceptual fit or relevance of prevention strategies that hold the greatest potential for affecting a particular substance abuse problem. Also discusses how to examine candidate interventions from the perspective of practical fit or appropriateness for local circumstances, cultural contexts, and populations.

Section IV. Discusses the importance of strength of evidence to inform and guide intervention selection decisions. Presents the three definitions of “evidence-based” provided under the SPF SIG Program and the advantages and challenges of using each one to select prevention interventions. The three definitions of “evidence-based” are as follows:

- Inclusion in Federal registries of evidence-based interventions;
- Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; or
- Documented effectiveness supported by other sources of information and the consensus judgment of informed experts, as described in the following set of guidelines, all of which must be met:

  Guideline 1: The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and

  Guideline 2: The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and

  Guideline 3: The intervention is 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; and

**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 interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

**Section V.** Summarizes the process of working through three considerations that determine the best fit of interventions to include in comprehensive prevention plans:

- Conceptual fit to the logic model: Is the candidate intervention relevant to the targeted problem and outcomes?
- Practical fit to the community’s needs and resources: Is it appropriate to the community’s population, cultural context, and local circumstances, including community readiness?
- Strength of evidence: Is there sufficient documented effectiveness to support a decision to select the particular intervention and include it in a comprehensive community prevention plan?

**Section VI.** Discusses the respective roles and expectations for SAMHSA/CSAP and SPF SIG States and their sub-recipient communities, jurisdictions, and Federally recognized tribes and tribal organizations to ensure the identification and selection of best fit, evidence-based prevention interventions for each community.
I. Introduction

A. Background and Context

The Substance Abuse and Mental Health Services Administration (SAMHSA) envisions “a life in the community for everyone” and has as its mission “building resilience and facilitating recovery.” SAMHSA strives to achieve its mission through programs supported by three goals: accountability, capacity, and effectiveness. The Center for Substance Abuse Prevention (CSAP) helps to create healthy communities. SAMHSA/CSAP helps States to provide resources and assistance to communities so that communities, in turn, can prevent and reduce substance abuse and related problems. SAMHSA/CSAP also provides training, technical assistance, and funds to strengthen the State prevention systems that serve local communities. SAMHSA/CSAP works with States to identify programs, policies, and practices that are known to be effective in preventing and reducing substance abuse and related problems.

All of SAMHSA’s mission and goals are driven by strategic planning to align, manage, and account for priority programs and issues across the three Centers. Chief among SAMHSA’s priorities is the Strategic Prevention Framework (SPF)—a five-step planning process to guide the work of States and communities in their prevention activities.

Step 1. Assess population needs (nature of the substance abuse problem, where it occurs, whom it affects, how it is manifested), the resources required to address the problem, and the readiness to act;

Step 2. Build capacity at State and community levels to address needs and problems identified in Step 1;

Step 3. Develop a comprehensive strategic plan. At the community level, the comprehensive plan articulates a vision for organizing specific prevention programs, policies, and practices to address substance abuse problems locally;

Step 4. Implement the evidence-based programs, practices, and policies identified in Step 3;

Step 5. Monitor implementation, evaluate effectiveness, sustain effective activities, and improve or replace those that fail.

Throughout all five steps, implementers of the SPF must address issues of cultural competence and sustainability. Cultural competence is important for eliminating disparities in services and programs offered to people of diverse racial, ethnic, and linguistic backgrounds, gender and sexual orientations, and those with disabilities. Cultural competence will improve the effectiveness of programs, policies, and practices selected for targeted populations.
Sustainability of outcomes is a goal established at the outset and addressed throughout each step of the SPF. Prevention planners at both State and local levels need to build systems and institutionalize the practices that will sustain prevention outcomes over time, beyond the life of any specific program.

Under the SPF State Incentive Grant (SIG) Program, prevention planners are specifically required to select and implement evidence-based interventions. SAMHSA/CSAP recognized that this requirement necessitates the availability of a broad array of evidence-based interventions and further must allow prevention planners the flexibility to decide which options best fit their local circumstances. To assist the field in meeting this requirement, SAMHSA/CSAP convened an Expert Workgroup during 2005 to develop recommendations and guidelines for selecting evidence-based interventions under the SPF SIG Program.

The Expert Workgroup was composed of nationally recognized substance abuse prevention experts from a wide spectrum of academic backgrounds and theoretical research perspectives. The guidance presented in this revised document is grounded in the thinking and recommendations of the SAMHSA/CSAP Expert Workgroup and incorporates feedback from the field, including prevention scientists, to clarify guidelines for documented effectiveness and the process for applying them.

**B. Purpose of the Guidance**

This guidance is directed toward prevention planners working through SPF Steps 3 and 4 and to help them select and implement evidence-based interventions successfully. The guidance lays out an analytic process with a few key concepts to apply in selecting interventions that are conceptually and practically fitting and effective.
II. SPF Implications for Community Planning to Identify and Select Evidence-Based Interventions

A. Local Needs and Resource Assessment: Key Data Tool to Guide Community Planning

Prevention experts agree that substance abuse problems are usually best addressed locally—at the community level—because they are manifested locally. Yet some prevention approaches may be most effective when implemented on a larger scale, perhaps through a statewide change in laws (e.g., change in the alcohol index for driving under the influence). Experts also agree that substance abuse problems are among the most difficult social problems to prevent or reduce. Substance abuse problems require comprehensive solutions—a variety of intervention approaches directed to multiple opportunities.

The challenge of selecting the optimal mix of strategies is complicated by the limited availability of public resources on evidence-based interventions. In practice, practitioners seeking to reduce substance abuse problems will need to put together their own mix of interventions. An optimal mix of interventions will fit the particular needs of the community—its population, cultural context, and unique local circumstances, including community readiness. Some interventions in the comprehensive plan may be deemed “evidence-based” through inclusion in Federal registries or reported findings in the peer-reviewed literature, while others may document effectiveness based on other sources of information and empirical data. An optimal mix of strategies will combine complementary and synergistic interventions.

The needs and resource assessments in Step 1 will guide development of the comprehensive prevention plan, from profiling the problem/population and the underlying factors/conditions that contribute to the problem, to checking the appropriateness of prevention strategies to include in the plan. It is crucial to use local data and information to identify effective strategies that fit local capacity, resources, and readiness. However, finding local data is often difficult. Creative approaches to data sources, including the use of proxy measures and information gleaned through focus groups, may be necessary.

B. The Community Logic Model: Key Conceptual Tool for Community Planning

The community logic model reflects the planning that needs to take place to generate community level change. Building the logic model begins with careful identification or mapping of the local substance abuse problem (and associated patterns of substance use and consequences among the population affected) to the factors that contribute to them. Developing the logic model starts with defining the substance abuse problem, not choosing the solutions—that is, the programs, practices, or policies already decided upon by States or communities.
Given that comprehensive plans combine a variety of strategies, it is important to understand the relationships between these problems and the factors or conditions that contribute to them. Few substance abuse problems are amenable to change through direct influence or attack. Rather, they are influenced indirectly through underlying factors that contribute to the problem and its initiation, escalation, and adverse consequences.

These underlying factors include the following:

- *Risk and protective factors* that present themselves across the course of human development and make individuals and groups either more or less prone to substance abuse in certain social contexts.

- *Contributing conditions* and environmental factors implicated in the development of the problems and consequences associated with substance abuse. Examples may include specific local policies and practices, community realities, or population shifts.

Identifying the underlying factors that drive changes in the targeted substance abuse problem and outcomes is essential to determining which programs, practices, and policies will best address that problem and its initiation, progression, and pattern and consequences of use.

Linking the substance abuse problem to the underlying factors, and ultimately to potentially effective prevention strategies, requires analysis and a conceptual tool. The logic model in Figure 1 serves as the conceptual tool to map the substance abuse phenomenon and the factors that drive it.

**Figure 1. Community Logic Model, Outcomes-Based Prevention**

6 Identifying and Selecting Evidence-Based Interventions
Logic models lay out the community substance abuse problem and the key markers leading to that problem. They represent systematic plans for attacking local problems within a specific context. The community logic model makes explicit the rationale for selecting programs, policies, and practices to address the community’s substance abuse problem. Used in this way, the logic model becomes an important conceptual tool for planning a comprehensive and potentially effective prevention effort.

Examples of Community Logic Models

The sample community-level logic models in Figures 1A and 1B illustrate the relationships between an identified substance abuse problem or consequence in an identified population and the salient risk and protective factors/conditions that contribute to the problem. Each risk and protective factor/condition, in turn, highlights an opportunity—or potential point of entry—for interventions that can lead to positive outcomes in the targeted problem.

While different communities may show similar substance abuse problems, the underlying factors that contribute most to them will likely vary from community to community. Communities will tailor the logic model to fit their particular needs, capacities, and readiness to act.

**Figure 1A. Community Logic Model for Preventing Alcohol-Involved Traffic Crashes (15- to 24-year-olds)**
Figure 1B. Community Logic Model for Preventing Illicit Drug Use Among Adolescents

<table>
<thead>
<tr>
<th>Substance abuse problem (Example)</th>
<th>Risk and protective factors/conditions (Examples)</th>
<th>Strategies (Examples)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illicit drug use</td>
<td>Disrupted parent/child relations</td>
<td>Family/Parenting skills training</td>
</tr>
<tr>
<td></td>
<td>Alienation from pro-social peers</td>
<td>Social skills training</td>
</tr>
<tr>
<td></td>
<td>Academic failure</td>
<td>Tutoring</td>
</tr>
<tr>
<td></td>
<td>Positive school environment</td>
<td>Changing school climate</td>
</tr>
<tr>
<td></td>
<td>Social competence</td>
<td>Communication, decision-making and problem solving skills training</td>
</tr>
<tr>
<td></td>
<td>Other factors from the research literature</td>
<td>Other evidence-based interventions</td>
</tr>
</tbody>
</table>
III. Using the Community Logic Model and Assessment Information to Identify Best Fit Interventions

A. Establishing Conceptual Fit: Is It Relevant?

Relevance: If the prevention intervention does not address the underlying risk and protective factors and conditions that drive or contribute to the targeted substance abuse problem, then it is unlikely to produce positive outcomes or changes in that problem.

The community logic model can be used to guide the identification and selection of types of programs, practices, and policies for substance abuse prevention that are relevant for a particular community. Community logic models are tailored to reflect and meet the unique circumstances of a particular community. SAMHSA/CSAP expects SPF SIG States to develop an epidemiological profile and create an initial generic logic model. In turn, each community participating in the program will tailor the generic logic model to its needs.

Because substance abuse problems are complex, multiple factors and conditions will be implicated—some more strongly than others. Communities are encouraged to identify a comprehensive set of interventions directed to their most significant risk and protective factors and conditions and targeted to multiple points of entry. Figure 2 illustrates the Human Environmental Framework, one tool available to guide thinking about multiple points of entry for interventions directed to risk and protective factors across the life span and across social environments as well as to defining points of entry for interventions in different life sectors.

The community logic model can be used to check the conceptual fit of interventions considered for the comprehensive community plan. The logic model screens for the types of interventions most likely to affect positive changes in the targeted substance abuse problem in a particular community, population, and cultural context.
This figure depicts social environments or spheres of influence in concentric circles that flare outward, moving progressively away from direct influence on the individual toward increasingly indirect influence and advancing over time. A comprehensive intervention plan should identify a mix or layering of interventions that target salient risk and protective factors in multiple contexts across the life span.

B. Establishing Practical Fit: Is It Appropriate?

Appropriateness: If the prevention program, policy, or practice does not fit the community’s capacity, resources, or readiness to act, then the community is unlikely to implement the intervention effectively.

A second important concept in selecting prevention interventions is practical fit with the capacity, resources, and readiness of the community itself and the organizations responsible for implementing interventions. Practical fit is assessed through a series of utility and feasibility checks that grow out of the needs and resource assessment and capacity-building activities conducted in SPF Steps 1 and 2.

SAMHSA/CSAP encourages practitioners to use their community assessment findings to judge the appropriateness of specific programs, policies, and practices deemed relevant to
the factors and conditions specified in the community logic model. Below is a list of utility and feasibility checks to consider in selecting prevention strategies.

**Utility and Feasibility Checks**

*Utility Checks*

- Is the intervention appropriate for the population identified in the community needs assessment and community logic model? Has the intervention been implemented successfully with the same or a similar population? Are the population differences likely to compromise the results?

- Is the intervention delivered in a setting similar to the one planned by the community? In what ways is the context different? Are the differences likely to compromise the intervention's effectiveness?

- Is the intervention culturally appropriate? Did members of the culturally identified group participate in developing it? Were intervention materials adapted to the culturally identified group?

- Are implementation materials (e.g., manuals, procedures) available to guide intervention implementation? Are training and technical assistance available to support implementation? Are monitoring or evaluation tools available to help track implementation quality?

*Feasibility Checks*

- Is the intervention culturally feasible, given the values of the community?

- Is the intervention politically feasible, given the local power structure and priorities of the implementing organization? Does the intervention match the mission, vision, and culture of the implementing organization?

- Is the intervention administratively feasible, given the policies and procedures of the implementing organization?

- Is the intervention technically feasible, given staff capabilities, time commitments, and program resources?

- Is the intervention financially feasible, given the estimated costs of implementation (including costs for purchase of implementation materials and specialized training or technical assistance)?

Each of the points in the checklist warrants thoughtful consideration among those involved in planning, implementing, and evaluating the prevention strategies in the comprehensive community plan.
IV. Using Public Resources and Review Processes to Identify Evidence-Based Interventions and Determine Their Evidence Status

Evidence-Based Interventions and Evidence Status

The preceding sections defined logic models and detailed their usefulness in the prevention planning process. This section addresses how those logic models can be translated into action once a problem or set of problems has been identified through the needs-assessment process. Our expectation is that intervention selection is grounded in a well-defined conceptual model (e.g., the community logic model) that includes malleable behaviors, environments, or other factors (referred to as underlying factors in Section II) that can be targeted over the course of development in a variety of contexts. This section presents guidance for selecting interventions from: A. Registries of evidence-based programs; B. The peer-reviewed research literature; and C. Other documentation supporting effectiveness (used in the absence of a registry listing or direct support from the peer-reviewed literature).

The strength of evidence for tested interventions falls along a continuum from strong to weak. Strength of evidence is assessed using established scientific standards and criteria for applying those standards and comprises four major elements:

1. Rigor of the evaluation design (e.g., use of appropriate intervention and control or other comparison groups, group assignment strategy, control of dosage and contextual factors that can provide an alternative explanation of the results or findings).

2. Rigor and appropriateness of the methods used to collect and analyze the data (e.g., use of appropriate data collection designs, use of measures that match outcomes targeted by the intervention, data collection without bias, and use of appropriate statistical tests).

These two elements directly affect the inferences that can be drawn about cause and effect—the degree to which the results obtained from an evaluation can be attributed to the intervention exclusively rather than to other factors.

3. The magnitude and consistency of the effects of the intervention on targeted outcomes. Magnitude refers to the amount of change or impact that an intervention produces for a given outcome—that is, its “effect size.” Equally important is consistency in the pattern of positive effects reported on the targeted outcomes.
4. The extent to which findings can be generalized to similar populations and settings. This element refers to the likelihood that the same pattern of positive findings will hold for similar populations under similar conditions.

Taking into account these four methodological elements, strong evidence means that the evaluation of an intervention generates consistently positive results for the outcomes targeted under conditions that rule out competing explanations for effects achieved (e.g., population and contextual differences). Experts agree that evidence for the effectiveness of an intervention becomes “stronger” with replication and field testing under a variety of circumstances. However, there is less agreement about the threshold of evidence or cut-off point below which evidence should be considered insufficient. Ultimately, prevention planners and practitioners must judge the merits of the evidence supporting the selection of one intervention relative to another.

In some cases, planners may not be able to find an intervention that meets their needs in the Federal registries or the peer-reviewed research literature. In these instances, other sources of information such as articles in non-peer-reviewed journals, book chapters, or unpublished program evaluation reports may be available. These sources may provide weaker support for effectiveness; thus, they should be reviewed as specified in the guidelines.

In general, we recommend using the following decision rules when considering these other sources of supporting information:

1. Out of two similar interventions that address the targeted needs equally well, choose the one for which there is stronger evidence of effectiveness, both in terms of the consistency and strength of effects on the desired outcomes and quality or rigor of the evaluation methodology utilized.

2. Reserve the option to select an intervention with little or weak evidence of effectiveness for circumstances in which there are no interventions with stronger evidence that appropriately address the needs identified for a particular population, culture, or local context.

**SPF Definitions of Evidence-Based**

The SPF SIG Program specifically requires implementation of evidence-based interventions. Evidence-based interventions are defined in the SPF SIG Program by inclusion in one or more of the three categories below:

A. Included in Federal registries of evidence-based interventions;

B. Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; or
C. Documented effectiveness supported by other sources of information and the consensus judgment of informed experts (as specified in the Guidelines that follow).

Each of the three definitions helps identify interventions appropriate to targeted needs and each has its own advantages and challenges. Prevention planners and practitioners must be prepared to consider the relative adequacy of evidence when deciding to select a particular prevention intervention to include in their comprehensive community plan.

A. Using Federal Registries

Federal registries are readily accessible and easy-to-use public resources for identifying interventions that reduce substance use risk factors and consequences or increase protective factors thought to be associated with reduced potential for substance abuse. Many registries use predetermined criteria and a formalized rating process to assess the effectiveness of interventions reviewed. Some registries apply quality scores to the intervention. These quality scores are indications of the strength of evidence according to the ratings applied. Thus, inclusion of an intervention in a registry can be viewed as providing some evidence of effectiveness. However, the level of evidence required by registries varies considerably. When choosing among interventions that have been reviewed by registries, we generally recommend selecting the one with the highest average score, provided that it demonstrates positive effects on the outcomes targeted for the population identified. Ultimately, while selecting interventions from registries may seem easier in some respects, it still requires planners and practitioners to think critically and make reasoned judgments about intervention selection, taking into account the degree of congruence with the particular cultural context and local circumstances.

Advantages

*Federal Registries*—

- Provide concise descriptions of the interventions.
- Provide documented ratings of the strength of evidence measured against defined and accepted standards for scientific research.
- Present a variety of practical information, formatted and categorized for easy access and potentially useful to implementers.
- Offer “one-stop” convenience for those seeking quick information on the interventions included.
Challenges

_Federal Registries—_

- Include a limited number of interventions depending on how they are selected.
- Include interventions most easily evaluated using traditional scientific methods. Consequently, registries include predominantly school- and family-based interventions and relatively few community, environmental, or policy interventions.
- Are based on evidence that may be out of date if the registry does not provide a process for incorporating new evidence.
- May be confusing to consumers seeking to compare the relative strength of evidence for similar programs included on different registries since the criteria and rating procedures may vary from one registry to another.

Federal registries include:

- SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP)
  http://www.nrepp.samhsa.gov
  Provides descriptions of and rates evidence for various interventions related to substance use and abuse and mental health problems.
- OJJDP Model Programs Guide
  http://www.dsgonline.com/mpg2.5/mpg_index.htm
  Provides descriptions of and rates evidence for youth-oriented interventions, many of which are relevant to the prevention of substance use and abuse.
- Exemplary and Promising Safe, Disciplined and Drug-Free Schools Programs Sponsored by the U.S. Department of Education
  http://www.ed.gov/admins/lead/safety/exemplary01/exemplary01.pdf
  Provides descriptions of and rates evidence for educational programs related to substance use.
- **Guide to Clinical Preventive Services**
  
  Sponsored by the Agency for Healthcare Research and Quality [AHRQ]
  
  [http://www.ahrq.gov/clinic/cps3dix.htm](http://www.ahrq.gov/clinic/cps3dix.htm)
  
  Provides recommendations regarding screening and counseling in clinical settings to prevent the use of tobacco, alcohol, and other substances.

- **Guide to Community Preventive Services**
  
  Sponsored by the Centers for Disease Control and Prevention [CDC]
  
  [http://www.thecommunityguide.org](http://www.thecommunityguide.org)
  
  Provides recommendations regarding generic programs and policies to prevent and reduce tobacco use and alcohol-impaired driving.

- A list of other registries may be found at SAMHSA’S website:
  

**B. Using Peer-Reviewed Journals**

The research literature constitutes another primary resource for identifying evidence-based prevention interventions, including those not listed in Federal registries. When the literature is used to determine strength of evidence, all articles relevant to the specific intervention should be considered. In other words, it is not sufficient to garner support for an intervention from a single document selected from a larger body of work. We recommend careful review of all documents that have been published on a particular intervention to ensure that the outcomes reported comprise a consistent pattern of positive effects on the target outcomes.

Unfortunately, using the primary literature is not easy and can be very time consuming and resource intensive, particularly for practitioners without ready access to university libraries or electronic copies of journal articles. Additionally, a healthy degree of skepticism and considerable technical expertise is required to review articles and interpret results, as the quality of the study reported depends on many factors such as the conceptual model or theory on which the intervention is based, the measurement and design strategies used to evaluate it, and the findings that are presented.

**Assessing Elements of Evidence Reported in Peer-Reviewed Journals**

Listed below are key elements addressed in most peer-reviewed journal articles, along with some questions to consider.
A defined conceptual model that includes definitions and measures of intermediate and long-term outcomes. Does the article describe the theory or provide a conceptual model of the intervention and link the theory or model to expectations about the way the program should work? Does the article describe the connection of the theory or the conceptual model to the intervention approach, activities, and expected outcomes in sufficient detail to guide your decision?

Background on the intervention evaluated. How closely does the problem targeted by the intervention match the identified needs of your community? Does the article adequately describe the proposed mechanism of change of the intervention? Are the structure and content of the intervention described in enough detail? Is the context or setting of the intervention described to an extent that allows you to make an informed decision concerning how well it might work in the communities targeted?

A well-described study population that includes baseline or “pre–intervention” measurement of the study population and comparison or control groups included in the study. Does the article describe in detail the characteristics of the study population and the comparison or control groups used? How well does the study population match your local target group?

Overall quality of study design and data collection methods. Does the article describe how the study design rules out competing explanations for the findings? Are issues related to missing data and attrition addressed and satisfactorily resolved? Did the study methodology use a combination of strategies to measure the same outcome using different sources (e.g., child, parent, teacher, archival)?

Analytical plan and presentation of the findings. Does the article specify how the analytical plan addresses the main questions posed in the study? Do the analyses take into account the key characteristics of the study’s methodology? Does the article report and clearly describe findings and outcomes? Are the findings consistent with the theory or conceptual model and the study’s hypotheses? Are findings reported for all outcomes specified?

A summary and discussion of the findings. Does the discussion draw inferences and conclusions that are clearly related to the data and findings reported?

Advantages

Peer-Reviewed Journals—

- Typically present detailed findings and analyses that document whether or not the program, practice, or policy has an adequate level of evidence that the intervention works.
• Provide authors' contact information that facilitates further discussion about the appropriateness of the intervention to the target need.

• In some cases, report and summarize meta-analyses and other types of complex analyses (e.g., core components) that examine effectiveness across interventions or intervention components. These types of analyses are potentially very useful to prevention planners.

Challenges

Peer-Reviewed Journals—

• Leave it to the reader to interpret results and assess the strength of the evidence presented and its relevance and applicability to a particular population, culture, or community context.

• Describe in limited detail the activities and practical implementation issues pertinent to the use of the intervention.

C. Using Other Sources for Documenting Effectiveness

When no existing evidence-based interventions are available in registries or the research literature to address the problem, then empirical support for other interventions may be found in unpublished reports (e.g., doctoral theses) or published, non-peer-reviewed sources (e.g., book chapters, evaluation reports, and Federal reviews). We recommend caution when relying on these other sources of support because they usually have not been subjected to the methodological scrutiny provided by registries and peer-reviewed journals. Ultimately, the “burden of proof” for documented effectiveness lies with the program planners and practitioners making the selection decision. Under what conditions is it appropriate to select an intervention that is not included in an established Federal list of evidence-based programs or reported with positive effects in the peer-reviewed journal literature? When no appropriate interventions are available through these primary resources on evidence-based interventions, then prevention planners may need to rely on other, weaker sources of information to identify an intervention that is appropriate for the assessed community need, the population served, and the cultural and community context in which it will be implemented.

When selecting interventions based on other sources of supporting information, all four of the following guidelines should be met:

• Guideline 1: The intervention is based on a theory of change that is documented in a clear logic or conceptual model;

• Guideline 2: The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature;
Guideline 3: The intervention is 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; and

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 interventions similar to those under review, local prevention practitioners, and key community leaders as appropriate (e.g., officials from law enforcement and education sectors or elders within indigenous cultures).

These guidelines are intended to assist prevention planners by expanding the array of interventions available to them. In a comprehensive prevention plan, these interventions should be considered supplements, not replacements, for traditional scientific standards used in Federal registry systems or peer-reviewed journals.

Advantages

Other Sources for Documenting Effectiveness —

- Enable State and community planners to consider interventions that do not currently appear on a Federal list or in the peer-reviewed literature but which have the potential to address the problem targeted.

- Provide opportunities for State and community planners to use locally developed or adapted interventions, provided they are supported by adequate documentation of effectiveness.

Challenges

Other Sources for Documenting Effectiveness —

- Place substantial responsibility on prevention planners and practitioners for intervention selection decisions.

- Require prevention planners and practitioners to develop and implement decision-making and documentation processes.

- Require prevention planners and practitioners to assemble additional documentation and assess its adequacy to support using a particular intervention as part of the larger comprehensive community prevention plan.
V. Summary Process Description: Selecting Best Fit Prevention Interventions

The process described here is rooted in the work conducted by local communities during SPF steps 1 and 2. It begins with creating a community logic model to map the local substance abuse picture and draws from the findings of local needs and resource assessment. Prevention planners apply the logic model and assessment findings in a process of thinking critically and systematically about three considerations that determine best fit interventions to include in a comprehensive community prevention plan:

- Conceptual fit with the community’s logic model: Does the candidate intervention target the identified problem and the underlying factors that drive or contribute to changes in the problem or outcomes?
- Practical fit with the community’s needs, resources, and readiness to act: Is the candidate intervention appropriate for the particular population, cultural context, and set of local circumstances?
- Evidence of effectiveness: Is there sufficient evidence or support for documented effectiveness to select the intervention and include it in the comprehensive community prevention plan?

Figure 3 depicts the process for thinking through these key considerations.

Identify types of programs, practices, and strategies that: target the identified problem, address the relevant underlying factors, target opportunities in multiple life domains.

Select specific programs, practices, and strategies that are: appropriate for the community’s population, cultural context, and feasible, given local circumstances, including resources, organizational resources, and readiness to act, and that demonstrate sufficient evidence or support for documented effectiveness.
Figure 3. Process Description: Selecting Best Fit Prevention Interventions

Identify types of interventions that
• address a community’s salient risk and protective factors and contributing conditions
• target opportunities for intervention in multiple life domains
• drive positive outcomes in one or more substance abuse problems, consumption patterns, or consequences

Select specific programs, practices, and strategies that
• are feasible given a community’s resources, capacities, and readiness to act
• add to/reinforce other strategies in the community–synergistic vs. duplicative or stand-alone efforts

AND
• are adequately supported by theory, empirical data, and the consensus judgment of informed experts and community prevention leaders

Demonstrate “Conceptual Fit”
Relevant?

Demonstrate “Practical Fit”
Appropriate?

Demonstrate “Evidence of Effectiveness”
Effective?

Best fit prevention interventions to include in comprehensive community plan
VI. SPF SIG Program Guidance: Roles and Expectations

Collaboration and partnership across all levels—Federal, State, and community or local grantee—are essential for successful and flexible implementation of the guidance provided in this document. The guidance details an analytical process and a few key concepts—what needs to be done to think through the selection of best fit, evidence-based prevention interventions. How this is accomplished will be determined by States and jurisdictions, and will vary from one to another. SAMHSA/CSAP’s technical assistance providers are available to work with States and jurisdictions to apply the process and concepts detailed in the guidance.

A. Federal Role

SAMHSA/CSAP will provide leadership and technical assistance to States and jurisdictions and will work with them to strengthen prevention systems in order to improve substance use outcomes and achieve targeted community change.

**Expectations**

- SAMHSA/CSAP will partner with States to develop and implement a plan that facilitates application of the guidance.
- SAMHSA/CSAP has directed its Center for the Application of Prevention Technologies (CAPT) with its five Regional Expert Teams, to allocate substantial technical assistance resources for States to apply the concepts in this guidance. At the request of States, the CAPT will conduct workshops and activities to help States work with communities to identify and select suitable and effective evidence-based interventions.

B. State/Jurisdiction Role

The role of the States and jurisdictions is to provide capacity-building activities, tools, and resources to communities to foster the development of sound community prevention systems and prevention strategies.

**Expectations**

- SAMHSA/CSAP expects States funded under the SPF SIG Program to strengthen their infrastructure and capacity to assist communities in identifying and selecting appropriate evidence-based interventions for their comprehensive plans. To assure accountability for this role, SAMHSA/CSAP expects States to establish a technical panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review, local prevention practitioners, and key community leaders as appropriate (e.g., officials from law enforcement and education sectors and elders within indigenous cultures). The responsibilities of this technical panel are to: 1) review comprehensive
community plans and the justification for interventions included in each community plan, 2) identify issues and problematic intervention selections to be addressed prior to plan approval, and 3) target technical assistance to work with communities to improve and strengthen their community plans.

- As part of their work, we expect the State-level technical expert panels to assess whether chosen interventions included in the sub-recipient, comprehensive community plans meet one or more of the definitions of “evidence-based” for the SPF SIG Program: included in Federal registries of evidence-based interventions; reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; or documented effectiveness supported by other sources of information and the consensus judgment of informed experts.

In thinking about the implications of this guidance, States should consider the questions below:

- How might the State engage informed experts, including community leaders, in applying the concepts in the guidance for funding comprehensive community plans (programs, practices, and policies) selected by communities?
- How might the State communicate its policies regarding funding and implementation of evidence-based programs, practices, and policies to community coalitions and organizations and other key stakeholders?

- SAMHSA/CSAP expects States, with their technical assistance providers, to work closely with communities in identifying and selecting evidence-based interventions. SAMHSA/CSAP and its technical assistance providers will work directly with States on this task.
- SAMHSA/CSAP expects States to develop capacities to assist communities on all key SPF topics, including: assessing needs and resources, using data to detail the substance abuse problem and underlying factors and conditions, building a community logic model, and examining intervention options for relevance and appropriateness.

C. Community Role

The role of SPF SIG sub recipient communities is to develop a comprehensive and strategic community prevention plan based on local needs and resource assessment. Following the steps of the SPF, communities use the findings from these activities to develop a logic model specific to the community and its substance abuse problem. Each community logic model reflects and maps the local substance abuse phenomenon. An effective logic model may serve as the primary tool to guide the selection of evidence-based programs, practices, and policies to include in a comprehensive plan.
Expectations

- SAMHSA/CSAP expects communities to partner with the State and its technical assistance providers, who in turn will partner with SAMHSA/CSAP and CSAP’s technical assistance providers.

Concluding Comments

As in all steps of SAMHSA’s Strategic Prevention Framework, the application of critical thinking skills is vital to selecting programs, practices, and policies to include in a comprehensive strategic plan. Those selected must be relevant, appropriate, and effective to meet community needs and address the community substance abuse problem. SAMHSA/CSAP and its technical assistance providers welcome the opportunity to partner with SPF SIG States, jurisdictions, and Federally recognized tribes and tribal organizations through technical assistance workshops and “science-to-service” learning communities to think through the selection of best fit, evidence-based prevention interventions.
## GLOSSARY

**Best fit interventions**
Interventions that are relevant to the community logic model (i.e., directed to the risk and protective factors most at play in a community) and appropriate to the community’s needs, resources, and readiness to act.

**Community logic model**
A graphic depiction or map of the relationships between the local substance abuse problem, the risk/protective factors and conditions that contribute to it, and the interventions known to be effective in altering those underlying factors and conditions.

**Conceptual fit**
The degree to which an intervention targets the community’s identified substance abuse problem and the underlying factors that contribute to the problem.

**Documented effectiveness**
Defined under the SPF SIG Program by guidelines for using other sources of information and support to document intervention effectiveness.

**Epidemiological profile**
A summary and characterization of the consumption (use) patterns and consequences of the abuse of alcohol, tobacco, marijuana, heroin, cocaine, methamphetamines, inhalants, prescription drugs, or other substances. The epidemiological profile identifies the sources of data on consumption patterns as well as the indicators used to identify consequences (e.g., morbidity and mortality). It should provide a concise, clear picture of the burden of substance abuse in the State using tables, graphs, and words as appropriate to communicate this burden to a wide range of stakeholders.

**Evidence-based interventions**
Evidence-based interventions are defined in the SPF SIG Program by inclusion in one or more of the three categories below:

A. Included in Federal registries of evidence-based interventions;

B. Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; or
C. Documented effectiveness supported by other sources of information and the consensus judgment of informed experts (as specified below).

**Evidence status or strength**

Refers to the continuum of evidence quality, which ranges from weak to strong. Strong evidence means that the positive outcomes assessed are attributable to the intervention rather than to extraneous events, and that the intervention reliably produces the same pattern of positive outcomes in similar populations and contexts.

**External validity**

The extent to which evaluation outcomes will be achieved in populations, settings, and timeframes beyond those involved in the study; the likelihood that the same pattern of outcomes will be obtained when the intervention is implemented with similar populations and in similar contexts.

**Guidelines for Documented Effectiveness SPF SIG Program**

- **Guideline 1:** The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and

- **Guideline 2:** The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and

- **Guideline 3:** The intervention is 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; and

- **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 interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.
**Internal validity**  
The extent to which the reported outcomes can be unambiguously attributed to the intervention rather than to other competing events or extraneous factors.

**Interventions**  
Interventions encompass programs, practices, policies, and strategies that affect individuals, groups of individuals, or entire communities.

**Outcomes-based prevention**  
An approach to prevention planning that begins with a solid understanding of a substance abuse problem, progresses to identify and analyze factors and conditions that contribute to the problem, and finally matches intervention approaches to these factors and conditions that ultimately lead to changes in the identified problem (i.e., behavioral outcomes).

**Practical fit**  
The degree to which an intervention is appropriate for the community’s population, cultural context, and local circumstances including its resources, capacities, and readiness to take action.

**Protective factors**  
Conditions for an individual, group, or community that decrease the likelihood of substance abuse problems and buffer the risks of substance abuse.

**Risk factors**  
Conditions for an individual, group, or community that increase the likelihood of a substance abuse problem.
The Community Builder’s Approach to Theory of Change

A PRACTICAL GUIDE TO THEORY DEVELOPMENT

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Section One: Theory Development
1. Introduction

A theory of change can be a helpful tool for developing solutions to complex social problems. At its most basic, a theory of change explains how a group of early and intermediate accomplishments sets the stage for producing long-range results. A more complete theory of change articulates the assumptions about the process through which change will occur, and specifies the ways in which all of the required early and intermediate outcomes related to achieving the desired long-term change will be brought about and documented as they occur.

To best realize the value of creating a theory of change as part of planning and evaluating social interventions, the Aspen Institute Roundtable on Community Change (Roundtable) developed an approach to help community builders create the most robust theories of change possible.1

The Community Builder’s Approach to Theory of Change: A Practical Guide to Theory Development is for planners and evaluators who are going to facilitate a process for creating a theory of change with community-based programs and community change initiatives. It was designed as a “refresher course” for planners, evaluators, and others who have attended one of the Roundtable’s Theory of Change Workshops,2 but we fully expect experienced facilitators will be able to quickly learn and apply the method as described in this guide. Please visit our web site, www.theoryofchange.org, for updated information and additional examples.

OVERVIEW OF THIS GUIDE

We’ve organized this guide into two sections. Section One answers the question “What is a theory of change?” It provides all the information needed to facilitate a theory of change process with a community group. This section

• reviews the major concepts that define theories of change;
• provides important background information for facilitators before they enter a planning session; and
• offers practical guidance for facilitating planning sessions.

Section Two is a resource toolbox for the theory of change facilitator. It includes

• a case study to show a portion of a finished theory of change;
• a list of materials to bring to a planning session;
• a participants list that suggests the ideal composition of a theory of change building team for a community-based program or initiative;
• a glossary that could be distributed at the training sessions; and
• a description of PowerPoint presentations that you can download from our web site, www.theoryofchange.org.

1. This work greatly benefited from the ongoing collaboration with Helène Clark and her colleagues at ActKnowledge. For more information about ActKnowledge, visit www.actknowledge.org.
2. For information on scheduling a workshop, please contact Andrea Anderson at andreaa@aspenroundtable.org or Helène Clark at hclark@actknowledge.org.
What Is the Community Builder’s Approach to Theory of Change?

The Community Builder’s Approach to Theory of Change is a method that a community group can use to think critically about what is required to bring about a desired social change. It is a process designed to depict how a complex change initiative will unfold over time. It creates an illustration of all the various moving parts that must operate in concert to bring about a desired outcome.

Our approach to theory of change requires stakeholders to be precise about the type of changes they want to achieve. This often requires participants to adhere to a level of conceptual clarity that they are not accustomed to, which is why we think it is necessary to have a skilled facilitator at the helm, managing the process.

We ask theory of change participants to predict exactly who or what is going to change, over what period of time, and by how much, at every single step in an often complex process. We ask them to specify how and why they expect change to happen in a particular way. We also ask how they are going to bring their resources to bear on creating early and intermediate changes that add up to their ultimate goal. Simple questions, in theory (pardon the pun!), but difficult to answer in practice.

A theory of change is essentially an explanation of how a group of stakeholders expects to reach a commonly understood long-term goal. In creating a process for doing this work, we have coined a few terms that may be unfamiliar, and we use familiar terms in new ways. Terms like pathway of change, precondition, indicator, outcome, intervention, and assumptions are commonly used in our field, but to us they have specific meanings:

**PATHWAY OF CHANGE**

For us, a pathway of change is a map that illustrates the relationship between actions and outcomes and also shows how outcomes are related to each other over the lifespan of the initiative. (See Figure 1.) It is the most easily recognized component in a theory of change because there are many planning approaches that employ boxes and arrows to depict program elements. Throughout this guide, we use the terms pathway of change and map interchangeably.

**WHAT ABOUT PROJECTS WITH MULTIPLE GOALS?**

Throughout this guide, we refer to the long-term goal or outcome, but in reality most community initiatives are working toward an interrelated set of long-term goals, each of which would need to be mapped in the way we describe.
We draw a pathway of change in a way that may seem peculiar at first because it looks like an organizational chart. (Believe it or not, this is an artifact of our early attempts to draw these in Microsoft Word.) The long-term goal of the initiative appears at the top of the map, and the outcomes that must be produced in order to get there are arranged in order on the subsequent layers of the map. We then read this map from the bottom to the top, suggesting that the earliest outcomes (at the bottom) are needed to get to the next level, and outcomes at the middle

**FINAL PRODUCT OF PATHWAY MAPPING**

![Diagram of pathway mapping](image)

- **Intermediate Outcomes or Preconditions**
- **Preconditions**
- **Preconditions**

Hopefully the map doesn’t get much more complex than this!

*Figure 1*
level are needed to get to the top. (It might help to think of it in terms of an organizational chart: it’s like starting off in a company mailroom, moving up to sales, then management, and then to the CEO’s office.)

**OUTCOME AND PRECONDITION**

We use specific language to describe the outcomes on the map. For us, everything in the pathway of change is a precondition to the long-term goal. That is, the outcomes on the path are all required to reach the goal—without each of them in place, we assume the goal cannot be attained. This logic helps us weed out extra outcomes that may be nice but unnecessary to achieve the goal we have in mind. An effective pathway of change reflects only the outcomes, or preconditions, that are at once necessary and, when taken together as a set, sufficient to reach the long-term goal.

Arranging outcomes on the map as the first step in the theory building process has a few advantages over other brainstorming or planning approaches, which often focus on “actions” or programs at the outset. First, we see the big picture quickly. Without having to read through a thick description of a complex plan, we can see how a group expects their early achievements to start a process that eventually leads to the desired long-term results. Second, it allows the group to think about what must change or be produced before thinking about how to actually do it. This is a new way of thinking for most people. When we facilitate theory of change groups, we like to tell people to imagine that they have unlimited power and resources when they draw the pathway of change so that they focus on getting all of the necessary and sufficient preconditions on the map before turning to the task of figuring out exactly how to make these preconditions a reality.

**INDICATOR**

Indicators tell the story of how success will be recognized at each step in the pathway of change. While this term is so often used in planning and evaluation efforts that most people assume that we’re all talking about the same thing, we use the term in a very specific manner when we talk about indicators as part of a theory of change. First, we define an indicator for each outcome (or precondition) on the pathway of change (see Figure 1), not just for the long-term goal. Second, the indicator must be defined in a way that includes a lot of detail. We call this operationalizing the indicator because we take an abstract concept and make it “operational” so that a research plan for gathering useful data can be designed around it. For us, the best way to operationalize each indicator is to ask a few questions:

- **Who or what is the target population of change?**
- **How much change has to occur on this indicator for us to claim to have successfully reached the outcome?**
- **How long will it take to bring about the necessary change in this indicator in the target population?**

Answering each of these questions for each of the indicators that will track progress on outcomes is quite a task, but one that is absolutely essential for making sure that the theory of change truly makes sense in the end.

**INTERVENTION**

While the pathway of change is the centerpiece of a theory of change, and often the most
recognized component, a complete theory of change must also describe the types of interventions that would be required to bring about each of the preconditions on the pathway of change. An intervention might be as simple as a single activity or as complex as an entire program. Instead of planning an omnibus strategy, participants in the theory of change process must match each outcome in the pathway of change to a specific intervention, revealing the often complex web of activity that is required to bring about the desired long-term community change. (See Figure 2.)
ASSUMPTIONS

Finally, a theory of change would not be complete without an articulation of the assumptions that stakeholders use to explain the change process they have envisioned. Assumptions explain both the connections between the preconditions for long-term change that occur in the early and intermediate stages of the change process, and the expectations about how and why proposed interventions will bring them about.

While assumptions are often the set of beliefs that guide a group (and often remain unstated until the theory of change process comes to town!), they may also be supported by research, or “best practices,” which can strengthen the case to be made about the plausibility of theory and the likelihood that stated goals will be accomplished.

Assumptions answer some of the probing questions that come up when a theory of change is being critiqued. For example, one group we worked with developed a theory largely based on the principles of resident control and empowerment. As they reviewed their theory, we pushed them to answer two simple—yet extremely important—questions they hadn’t thought about clearly. We asked, “Why is it important to build resident control of the housing investment decisions made by the local community development corporation?” and “How are we going to build resident control of the housing decisions that are made by the local community development corporation?”

Probing these questions in a group setting revealed that members held a variety of different assumptions about these important how and why issues. It was an important turning point for their work when they began to develop a consensus on the assumptions that they agreed reflected the “group think” about resident control and empowerment.

A REVIEW: THE CORE ELEMENTS OF A THEORY OF CHANGE

1. A pathway of change that illustrates the relationship between a variety of outcomes that are each thought of as preconditions of the long-term goal.

2. Indicators that are defined to be specific enough to measure success.

3. Interventions that are used to bring about each of the preconditions on the pathway, and at each step of the pathway.

4. Assumptions that explain why the whole theory makes sense!
The Bottom Line: Why Should I Care About Creating a Theory of Change?

People often ask how having a theory of change will help them plan a new initiative, or how they can use it as a part of their ongoing strategic planning processes. We have many answers to this question.

A THEORY OF CHANGE HELPS AVOID IMPLEMENTING A MISTAKE

How long will it take to reach my long-term goal?
Do we have the resources we need to implement this intervention?
Is the planned intervention enough to achieve the goal?
Can we get real community-level change toward this outcome?
Are these really the only required outcomes to reach the long-term goal?
Are there conditions outside our control that will impact our ability to produce these preconditions?

Figure 3
First, creating a theory of change raises new questions for stakeholders to consider while developing a strategic plan or evaluation. Figure 3 offers some examples of the type of questions that may be raised as the group works through the process. Creating a theory of change allows stakeholders to challenge the underlying logic of the connections between preconditions and planned interventions while everything is still on the drawing board.

Second, the process of creating and critiquing a theory of change forces stakeholders to be explicit about how resources will be used to bring about the preconditions of the long-term goal they are after. It also helps a group develop a realistic picture of the complexity of the change process required to produce their desired long-term results. In this respect, a theory of change can be thought of as an “expectation management tool” because it will clearly illustrate how much work must be done to reach a goal versus how much can realistically be done given the resources and time available.

Theories of change also help a group build consensus on how success will be documented. A great deal of hard thinking is required to clearly define a long-term goal and every precondition on the pathway of change. This work provides natural opportunities for reflection on important questions like “What do we really mean?” Such reflection can help to rid the plan of any fuzzy or vague language that might have otherwise slipped under the radar without this level of scrutiny.

Finally, creating a theory of change helps program stakeholders develop a shared understanding of what they are trying to accomplish, by making everything clear to everyone involved. In other words, after participating in the theory building process, all of the stakeholders should be on the same page about what they are trying to accomplish, the early and intermediate outcomes that must be reached to be successful, how all of the outcomes will be measured, and what actions they are going to have to take to bring all of this change about. They should also be clear about their assumptions—honestly acknowledging where there are gaps in their knowledge and where they are taking leaps of faith in their planning. In an era when organizations are being held accountable for results by funders and constituents, it is critical that the plans for an initiative are sound and that the results to be achieved are defined clearly beforehand so that everyone will know success when they see it.
Before the Meeting: A Step-by-Step Guide for Facilitators

Facilitating a theory of change process is difficult, but immensely rewarding work. This section will give you our “insider’s view” of what you will need to do to prepare for planning sessions. It is designed to help you become comfortable with the five main tasks involved in creating and refining a theory of change:

**Task 1: Identify the Long-Term Outcome**

The very first task of the process is often the easiest to take for granted. It may seem obvious that everyone in the planning group understands that they are working toward the same long-term outcome but you (and the participants!) will soon see that this is not always the case.

Even within an established program or initiative, folks often hold different ideas about the ultimate purposes of their work. Therefore, it is important to make sure that all participants are on the same page by starting with a session devoted to crafting a clear definition of the long-term outcome they hope to achieve through their program activities.

It is very important for a group to be as specific as possible in the definition of their long-term outcome. Often, participants offer what we call “mega-outcomes,” which are big, complex long-term goals, such as “improved family functioning” or “integrated services for youth.” Outcomes like these sound good in conversation, and they may work in strategic plans or proposals, but they are too vague to serve as a foundation for a theory of change. Here are several reasons why such outcomes need to be “unpacked” into specifically defined components before starting to create a theory of change:

- **Vague outcome statements lead to fuzzy thinking about what needs to be done to reach them.**
- **Vague outcome statements sabotage the ability to build a consensus about what is important in terms of programming and allocating funds.**
- **Vague outcome statements make it difficult to figure out how to develop a measurement strategy to tell when and if they have been achieved.**

The fact that outcomes are often worded with fuzzy or vague language is more than just a semantic problem. Most social change agents actually work to bring about a complex set of changes that are easier to discuss with terms that are multidimensional, but the lack of clarity that arises when multidimensional concepts remain unpacked makes it harder to build a
case for getting the job done and for proving that it was done well. The Community Builder’s Approach to Theory of Change requires a level of specificity that most social planners are unaccustomed to, but eager to embrace because it will help them document their success.

It’s important for facilitators to enter the first step of the theory of change process with the understanding that most social interventions have goals with many components. So they should be ready to show participants how their thinking about how to reach goals will be greatly improved by unpacking large goals into smaller components.

**Task 2: Develop a Pathway of Change**

This is the most time-intensive step of the Community Builder’s Approach to Theory of Change, and the centerpiece of the theory development work. The goal of this task is to identify and sort all of the preconditions related to the ultimate outcome of interest into a pathway of change that moves linearly and chronologically toward the long-term goal.

Several things are important to stress to participants during this step.

First, the pathway of change map depicts the relationship among **nouns**—only outcomes (results, accomplishments, states, changes, etc.) are shown in the boxes at this point. All of the “stuff” that must exist in order for the long-term outcome to exist is linked together on this map. This is often terribly confusing to participants, and it will be important to refer to examples to get them to understand that the goal here is to depict the complete set of necessary and sufficient preconditions (requirements, ingredients, building blocks, etc.) that must exist **prior** to the existence of the long-term goal. Often, participants are inclined to focus on what they must **do** or what must be **done** to others in the process of creating the change. We can avoid this trap by reminding participants that **verbs** are not allowed on the pathway of change just yet!

Another thing to keep in mind (and to communicate to participants) is that the pathway of change is an important feature of the theory of change, but it is not the whole thing. The pathway map alone cannot tell the whole story of a program theory, but we use it as a skeleton on which successive waves of detail can be added to create a compelling theory of change. It will be important to stress this so that they do not think—even for a minute—that the map is all there is. There is much, much more detail to add in order to tell the full story, and without being reminded of that (a few times), participants may find it difficult to focus on outcomes at this stage of the process.

The final point to drive home is that the process used to create the map is “backwards mapping.” This means that the group should imagine that they are starting at the end of the initiative and walking backwards in their minds to the beginning by asking themselves over and over “What are the preconditions for the outcomes at this step?” This may be a hard concept to fully grasp at first, so the facilitator should tell the group to be open-minded about the process and willing to critique their early product until they get it right.
Task 3: Operationalize Outcomes

Once the pathway of change has been drafted, the group will turn to the task of operationalizing each of the outcomes in the pathway. (We use the term drafted deliberately because stakeholders may find that they need to improve, modify, or edit it as they move through the theory of change process.) Participants need to tackle this sometimes daunting task now so that they know exactly what targets they are shooting for as they plan interventions in the next step. Operationalizing outcomes at every step of the pathway of change will also help bring some important assumptions about the change process to the surface. (Assumptions will be more directly dealt with in Task 5.)

So what do we mean by operationalizing outcomes? By operationalize, we mean that for each precondition in the pathway of change, participants will need to answer the basic question “What evidence will we use to show that this has been achieved?” The answer to this question becomes the indicator that will be used to track progress and document success.

Remember, the indicator is the concept or idea that will be used to determine success—how it is actually measured is another thing entirely. It is very important for folks to clearly think about the best indicator first (assuming whatever information they want to use as an indicator can be gathered) and then turn to the task of figuring out how to measure it (or work with an evaluator to help think this through).

Often at this stage, folks will limit their thinking by bringing up only ideas related to the data they have access to, and consequently limit the power of this step in the theory building process by mismatching outcomes to indicators. For example, we have seen folks claim that test scores are a good indicator of youth advancement in a program, not because the program was designed to improve test scores but because these were the only data they had access to. The facilitator should be strict here and not allow the team to force-fit indicators by limiting their imagination here to the data they know they already have. Instead, encourage creative thinking about the best way to document success on each precondition, whether or not the group thinks the best indicator can actually be measured. Let the researchers worry about that!

This process is also iterative: the operationalization of outcomes (which are all preconditions, too) happens one at a time until each has been considered. For each precondition, the group will need to answer a number of questions:

• **What indicator will we use to measure success on this precondition?**

• **Who or what do we expect to change? (Parents? Children in the community? Teachers? Schools?) This group is the target population to be tracked with this indicator.**

• **What is the current status of our target population on this indicator? This is the baseline that will be used to measure successful change.**

• **How much does our target population have to change in order for us to feel that we have successfully reached this indicator? (Will a small change on the indicator be good enough?) This is the threshold that we need to cross in order to proclaim success on this outcome.**
• How long will it take the target population to reach our threshold of change on the indicator? This is the TIMELINE that will determine when to look for success by collecting data on the indicator. This is a very important task because long timelines on early or intermediate outcomes will have implications for how soon the long-term outcome can be reached.

Identifying indicators and making them fully operational is often the most difficult task in the theory of change process. Often, the difference between an indicator and a measure of that indicator confuses participants. For example, participants may suggest that a particular survey instrument is the indicator and may not understand that indicators are concepts and surveys are just one way to measure a given concept. Be prepared to tackle this issue.

Another common challenge is finding a way to operationally define a precondition with concepts that reflect the right point in time in the chain of events reflected by the pathway of change. The purpose of finding an indicator is to answer the question “How will we know we have created precondition X?” or “How will we document successfully reaching precondition X?” What often happens is that participants will blend their ideas of what a particular precondition looks like with concepts that are actually precursors or requirements of achieving the precondition. Here, an example will help explain the distinction you will have to coach the group to make.

Let’s assume that the group working on school readiness has identified “All children are healthy at age five” as a precondition to school readiness in their pathway of change. We have seen folks mistakenly point to concepts like “Children have adequate nutrition” or “Children get all immunizations” as indicators of the child health precondition. In situations like this, it is important to remind the group that a plausible chain of events leading up to “Children are healthy” would include immunizations and good nutrition as precursors, meaning that these two achievements would have to occur before children can be healthy. Since this is true, these two concepts would not make good indicators of the “All children are healthy at age five” concept. A better indicator of child health might be the percentage of kids who have a healthy height/weight ratio; the average number of days out of school due to illness; or the prevalence of asthma or other preventable childhood illnesses in the group.

Making sure that participants understand the need to choose indicators that match the point in time that the precondition will occur can be confusing, and will require a very hands-on approach by the facilitator to avoid making mistakes when defining appropriate indicators for the preconditions in the pathway of change.

Task 4: Define Interventions

Once the pathway of change has been created and each of the preconditions in the pathway has been operationalized, participants are ready to think about the program activities, policies, and/or other actions that would be required to bring about the outcomes on the map. This is not the time to get into a detailed discussion about the nitty-gritty of
As a group plots out their understanding of a particular change process, it will be based on the group’s shared assumptions—in other words, what group members take for granted. Two main types of assumptions underlie a theory of change:

- **Assumptions about why each precondition is necessary to achieve the result in the pathway of change and why the set of preconditions are sufficient to bring about the long-term outcome.**

- **Assumptions that come from social science theory that connects program activities to specific outcomes for specific populations or communities. This may include findings from “best practice” research as well as evidence from academic (or basic) research.**

Both types of assumptions have been silent partners in the theory development process up to this point: they haven’t been voiced, but have been present in the minds of participants as they created the pathway of change, operationalized outcomes, and thought about interventions. It’s important now to encourage participants to articulate these assumptions to their peers and to put them on the table to be examined, critiqued, and agreed on by the group as “givens” they can live with.

In addition, a third type of assumptions about the context/environment in which the theory of change is situated is important to consider at this point. For example, folks developing a theory of change to explain how a job-training program will produce full employment in the neighborhood may hold a number of assumptions about the local economy, race relations between potential employers and potential employees, and transportation access. Any one of these assumptions could prove inaccurate when compared to reality. When a theory of change is built around the wrong assumptions about the local context or environment, even the most elaborate pathway of change can fall apart once they are brought to light (not to mention that an implementation plan based on faulty assumptions is not likely to work).
to bring about the desired goal). Therefore, it is important to get a group to think critically about what they are holding to be true about their operating environment as well as the other links in the theory of change before they can sign off on their theory.

Even though we think of articulating assumptions as a discreet step in the theory development process, assumptions may surface throughout this process as participants think out loud. It may be important to discuss with the group the need to keep critical assumptions in mind (or to write them down as they come up in conversation), since this step is about checking the assumptions embedded in the theory that has been developed thus far. It may make sense to keep a running list of assumptions on a sheet of poster paper so that when the group gets to this step in the process it can be used as a jumping-off point.
Now that you have a solid understanding of the concepts that underlie the theory of change process, we’d like to share some practical information and advice about how you may guide theory builders through the process in group planning sessions. You may wish to bring this section with you to refer to during meetings.

Session 1: Identify the Long-Term Outcomes

The goal of this session is to clearly define the long-term goal of the theory of change. The session will feel like brainstorming to the participants and should be conducted with a democratic and inclusive tone so that everyone participates.

Schedule this first session for at least an hour. Attendees should include key stakeholders in the initiative, with the ideal group being no larger than ten. The meeting room should be equipped for a brainstorming session—for instance, a table that people sit around works better than a lecture format. Plaster the room with white poster paper and make sure you have an ample supply of post-it notes and markers for everyone in attendance.

Many groups find the following process helpful for this session:

- Brainstorming
- Sharing
- Refining
- Voting on the long-term goal (or goals)
- Operationalizing

BRAINSTORMING

We have found that the easiest way to reach a consensus on the various dimensions captured by a long-term goal is to allow the group to brainstorm about it for twenty minutes and then begin the process of constructing the definition of the long-term goal from the results of the brainstorming.

Here are some questions you can pose to get folks thinking about long-term outcomes:

- What are the ultimate goals of this program or initiative?
- How will you define success in this program?
- What are your funders or program participants expecting to get from their investment in the program?
- Given what you know today, what will be different in your community in the long term as a result of successfully reaching your goal?

Note: It will be helpful to define long term as a group. The time frame covered by the theory of change can be as long or as short as you wish; what’s important is that everyone is on the same page about whether long term means five, ten, twenty, or more years.
Instruct each member of the planning team to write out their ideas about the long-term goals that will be the focus of the theory of change, using post-it notes and sheets of white poster paper. Participants should write one definition per post-it note, so they can be sorted at the end. When everyone has finished, have folks stick their notes on the poster paper at the front of the room.

**SHARING**
The facilitator may choose to invite participants to come to the front of the room to read each of the notes for a few minutes or, alternately, read each note to the group. Often, the major ideas come up over and over again, with slightly different wording, and a few outliers emerge. Now is the time to sort these ideas into general categories. The major ideas that come up over and over should be discussed, and the group should be allowed to vote on the wording that best sums up the concept.

**REFINING**
During the brainstorming process, a number of way-out ideas will emerge, and it is the facilitator’s job to figure out what to do with them. The ideas can fall into a number of categories, and you will have to work with the group to figure out where to assign them.

Sometimes a new idea comes up that can be thought of as an additional dimension of the long-term outcome. In this case, most in the group will agree that this is a different twist on the long-term goal that hadn’t been officially incorporated into their thinking before, and that this is a valuable new insight that should be incorporated into the work that is being done.

Sometimes one of the new ideas is actually something that would have to occur in order to reach the long-term goal. Often a policy change, programmatic offering, or some other precondition of the long-term goal will be brought up during this type of brainstorming session. When this happens, ask the group whether they agree that the new idea reflects something that would have to occur before the long-term goal could be brought about, and move these items on to a “parking lot” that you can return to when you start the backward mapping in Session 2.

Finally, some way-out ideas are simply not related to the group’s work and reflect one member’s thoughts (or misunderstandings). Move these types of things to the parking lot as well. This requires diplomacy and tact. The theory of change process should not give all ideas equal value; some things that folks come up with will not belong in the theory and should not be forced in to make everyone feel good. One way to remove things from the parking lot—and out of the discussion altogether—is to review the parking lot after a task has been completed, discarding ideas that the group agrees do not belong in the theory.

**VOTING**
This step is to democratically decide which idea(s) reflects the group’s long-term goal. This process may proceed by voting if there are a few topics, or the facilitator may ask each person in turn to articulate what he or she sees as the “group think” on the long-term goal. This process should continue until the group has landed on a set of ideas that reflects a consensus on the ultimate goal of the initiative.

**OPERATIONALIZING**
The final step in this process is to make the long-term goal operational. This requires answering the following questions:
• What indicator(s) will we use to measure success on this outcome?
• In what population will we look for change in these indicators?
• What is the current status of our target population on the indicator(s)?
• How much does our target population have to change on these indicators in order for us to feel that we have successfully achieved the outcome?
• How long will it take the target population to reach our threshold of change on the indicator(s)?

(You may want to skip ahead to Session 3: Operationalize Outcomes for specific advice on how to move the group through this step.)

Session 2: Create a Pathway of Change

For most community improvement initiatives, creating a pathway of change will take several hours; we usually schedule this step for a half-day session. It will involve some back-and-forth discussion with the group and a great deal of good-natured debate about the extent to which all preconditions are necessary and the group of them are sufficient to bring about the outcome above it on the map.

There really is not much of a script for this task because the key here is getting folks to answer one question, “What are the necessary and sufficient preconditions for (insert outcome here)?” over and over again as they move backwards through the change pathway. Here are the steps we use to do this work:

• Brainstorming the first row of the pathway map
• Sorting and narrowing down the brainstormed list into the four to six most important preconditions
• Backwards mapping to surface the preconditions for each of the elements in the first row (and repeating the process iteratively until all of the preconditions are filled in the map)

BRAINSTORMING

We start off the brainstorming by asking people to define the four to six most important preconditions for reaching the long-term goal. It is important for participants to keep the details about the long-term goal in mind (Who/what will change? Over what time period? By how much? etc.). One way to jump-start brainstorming is to give each person some post-it notes, ask them to write a precondition on each one, and post their work on poster paper at the front of the room.

In this step it is important to get people to focus on preconditions that represent the most immediate outcomes related to the ultimate goal. What often happens is that people come up with preconditions that don’t belong in that first row because they would need to occur very early in the change process. It may be important to get the group thinking about how they are taking “backwards steps.” In other words, the group is moving from the last change that needs to happen before reaching their goal to the penultimate (next-to-last), to the early outcomes, and finally to the first outcome on the pathway of change.
SORTING AND NARROWING DOWN THE LIST
The facilitator should help the group sort its ideas about preconditions, grouping similar ideas together and trying to narrow the pool down to four to six ideas that reflect the group’s best thinking about the necessary and sufficient “last outcomes” to be reached before the long-term outcome can be realized.

Once these four to six ideas have been selected as the most important preconditions for the long-term outcome, the facilitator may choose to draw this first level of the pathway of change on a clean sheet of poster paper.

BACKWARDS MAPPING
Now the fun begins! For each of the preconditions, the group has to take more backwards steps, asking themselves: “What are the necessary and sufficient preconditions for bringing these outcomes into being?” Again, try to get the group to focus on the most important four to six preconditions, or the process will quickly get out of hand.

For backwards mapping, the group should move down one pathway at a time until they have filled in enough outcomes to reach the first row of the map.

The facilitator should ask participants to brainstorm about the necessary and sufficient preconditions, and then, using post-it notes, put them up on the board one at a time, creating a map of the outcomes and how they are related to each other. We find that it is helpful to use masking tape to draw “arrows” between the notes to show how each statement is related to the others. (Remember: preconditions at one stage should be related to outcomes at the stage above them on the map). Using tape at this stage is better than markers, because often the arrows need to be moved around a bit before the group settles on a final representation of how outcomes in the pathway are related to each other.

This backwards mapping process should continue for at least three steps, but not more than five. At each step, the group should stop, process its thinking, narrow down the pool of ideas, and note their choices in the appropriate place on the map.

The group should move backwards, answering the preconditions question, until the participants feel that they have crafted a storyline that makes sense as a way to depict how the change process will unfold.

Creating a pathway of change is more of an art than a science. There is no iron-clad rule about when to stop the backward mapping. The group’s sense of where there is an entry point into the problem they are trying to resolve will
come into play in determining how far back to go. Remind them that the final step on the map (the bottom row, or first outcome) is going to reflect the earliest outcomes of whatever action strategy they plan, so they need to be realistic in thinking about how deeply to draw this pathway map. As a rule of thumb, going three or four steps back usually depicts a reasonable and plausible storyline for a community’s change process.

Once the group has settled on the set of preconditions, take a break and draw the map (with the appropriate arrows required to illustrate the relationship that preconditions have to each other) on a large piece of poster paper (you may need to tape two or three pieces together). This will be the basis of the work you do for the rest of the theory building process, so make it neat and write in large letters with a marker so everyone can see it around the room.

REALITY CHECK

In an ideal world, social problems could be solved with neat, simple solutions. Reality, however, is often quite a different story. We recommend that groups build pathways of change with four to six preconditions tied to each long-term outcome, recognizing that this rule of thumb may not always work. Our early theory of change experiences taught us that without discipline, this task can generate an enormous number of preconditions and, ultimately, an overly complex theory of change. So we began encouraging groups to narrow their list of preconditions to a manageable set, as long as they did not make edits that sacrificed the explanatory power of the pathway in order to meet this standard. In some cases, particularly in complex community change initiatives, it will simply not be possible to keep the number of preconditions this low. Even in these cases, the facilitator can work with his or her team to keep them focused on the shortest possible list of preconditions sufficient to bring about the outcome in question.
Session 3: Operationalize Preconditions

Operationalizing preconditions is a time-consuming part of the process. If there are a lot of outcomes on the pathway of change map, it may make sense to choose a few to focus on during the group session to get the process started, explaining to the group that this type of work may need to be done during a series of meetings or as homework for a subcommittee of the larger planning group to take on.

We usually use the following process to operationalize preconditions. First, we make sure that a clean, uncluttered version of the pathway of change is posted at the front of the room. In addition, we often copy it on smaller paper as a handout for participants.

During this stage of the work, it may be helpful to post the definitions of the key terms (i.e., indicator, target population, threshold, and timeline) at the front of the room. Once the room is set up, we explain the definitions of each element to participants.

With everyone on the same page, we then assign each of the preconditions to a member of the group. (Often, each person has more than one. The facilitator asks participants to answer the following questions on one of their post-it notes. (How would we do theory of change work without post-its?)

- What indicator(s) will we use to measure success on this outcome?
- Who or what do we expect to change?
- What is the current status of our target population on the indicator(s)?
- How much does our target population have to change in order for us to feel that we have successfully reached the indicator(s)?
- How long will it take the target population to reach our threshold of change on the indicator(s)?

Notice that we did not ask participants to deal with the baseline question. That is a research question that will need to be accurately documented once the actual measurement instruments have been decided on. The participants’ task is not to think at this level of detail. Instead, the group is laying out the blueprint for the researcher/evaluator to use as a starting point for planning the strategy for documenting progress on each precondition in the theory.

We allow participants about fifteen minutes to finish the assignment and then one by one ask each person to share the indicators and all of the details about population, threshold, and so on with the group. Finally, we post them on the appropriate precondition box on the pathway of change.

The facilitator should expect that some folks will not come up with good indicators, or that some will get some other aspect of this a little wrong. Be prepared to put some of the not-so-good ideas aside for the group to work out together. Often the group will catch the mistakes as they happen, and the process will open up a discussion about what a better indicator might look like. This should be encouraged so that the final product reflects the group’s best thinking about how to document success at each step of the pathway of change.
Session 4: Devise Program Interventions

With a foundation of good work behind us, we are now ready to turn our focus to program planning. We use the following process to move a group through this phase:

- **Decide which subset of outcomes the group can and will attempt to produce.**

- **Map an action, strategy, program, or policy for as many of the outcomes as possible.**

**DECIDING ON OUTCOMES**

Deciding which subset of outcomes the group can and/or will attempt to do something about requires a group discussion and, sometimes, a bit of a reality check. We usually ask participants to study the pathway of change map for a few minutes before voting on which elements of the map fall within the control of their initiative by placing round stickers on the boxes that correspond to outcomes on which they think the group should be prepared to act.

This part of the process is one that we call “expectation management” because it is usually when the group has to come to grips with the fact that it may not have the capacity to act on each of the preconditions in the map. If the group is planning a community-wide initiative, it may be helpful for them to consider which of the outcomes may already be taken care of by other groups in the community and ask them to mark them as such on the pathway map.

By the end of this process, the group should have a subset of outcomes to use as the basis for planning actions/programs/policy changes.

**MAPPING ACTION FOR THE OUTCOMES IN PATHWAY OF CHANGE**

Most participants are eager to get to this stage so that they can begin to think about action after so much focus on outcomes. Since most participants are comfortable planning interventions, this part of the process will encourage their creative thinking.

We find that breaking this task into small group or individual assignments works well, so you may want to assign small groups one or two outcomes on the map, and then ask them to take fifteen minutes to think of the interventions that would be required to bring that outcome about. At the end of this time, each group would report back to the group as a whole by posting their intervention on the board (on top of the outcome it corresponds to). When all of the interventions have been mapped, each group would then take turns explaining its rationale for expecting the intervention to bring about the targeted outcome at the levels identified by the indicators that were chosen earlier. The process continues until each outcome on the map has been (a) ruled to be outside of the influence of the initiative; (b) ruled to be the result of a domino effect that starts earlier in the change process; or (c) matched to an intervention that can plausibly be expected to produce the desired results.

Here are some questions to help guide the process:

- **For each of the outcomes on our map that we think we may have some influence over, what type of intervention would we need to implement in order to bring it about?** The group should be encouraged to avoid very tactical thinking here. Instead, a general description of the type of strategy or type of program (i.e., parent education classes, home ownership workshops, micro-loans to local
entrepreneurs) should be described in just enough detail to allow the group to determine if it is plausible that the intervention would bring about the outcome being considered. Planning the details of the implementation strategy is a task that they will take up once they have completed the theory of change and know exactly what types of programs they have to implement.

- **Will any specific programs/interventions that we currently offer bring about an outcome on this map?** In existing programs, this step is often helpful in identifying gaps in the current menu of program offerings.

- **Mapping each element of an existing program to the range of outcomes in the pathway allows folks to see where they need to create or implement new activities.**

- **Will policy changes or institutional practices be required to bring about this outcome?** If so, **what type of change is required?** Often when folks are interested in systems change we use this step to get them to be specific about exactly the type of public policy or institutional practice they think must change in order to bring about the required outcome in the pathway of change.

### THREE CORE CONCEPTS TO REMEMBER

1. **Outcomes are made operational by defining indicators that suggest how much, for whom, and when the outcome is to be realized.** It is important to keep this standard of success in mind when the interventions are being planned so that they have a high enough intensity to bring about the desired effect. It may make sense to make a list of the indicators that correspond to each outcome, making it available to people as they sit down to think about interventions.

2. **Some outcomes may come about as part of a domino effect, meaning that achieving an outcome at one stage may lead to the outcome above it on the map without any additional action on the part of the program.** Therefore, the group may be able to complete this task without having mapped an intervention to every outcome on the map, as long as the domino effect is a logical explanation in a particular case.

3. **This is a brainstorming session that should set the stage for more intense work after the meeting.** All planners know that they cannot come up with an actual plan of attack in a single session, so they should not be given the impression that this is all of the action planning they have to do. This step in the process is designed to draw the general outlines around plausible strategies that a work group is going to have to flesh out in subsequent sessions.
Session 5: Articulate Assumptions

This step in the process should be conducted like a review session. Perhaps the best way to start is to walk the group through the work they’ve done so far. The facilitator’s aim is to get everyone on the same page about the storyline that is being told by the pathway of change, the indicators that will be used to track success, and the intervention strategies that will be put in place to produce targeting outcomes.

After reviewing the theory of change elements with the group, the facilitator will open up a structured discussion so that the group can move through the theory in a systematic way.

As the facilitator, you may want to pose some questions to the group in a memo before they reconvene to discuss their underlying assumptions. Having thought about these questions before the meeting should improve the quality of the responses tremendously.

Here are some of the questions we frequently use:

- **When you look at the total picture, do you believe that the theory makes sense?**
- **Do the preconditions make sense as the logical steps toward the long-term outcome?**
- **How will we be able to bring about the outcomes at the levels we have predicted?**
- **Is there anything going on in the real world that may make it difficult to get this theory off the ground the way we’ve planned it?**

Expect that this session will raise a lot of questions that the group will have to answer before they can give the theory the final stamp of approval. Even if it seems frustrating, or a bit after the fact, this step in the process is crucial for checking the underlying logic of theory against the standards of quality:

- **Is this theory of change **PLAUSIBLE**?**
  Have we created a compelling story about the pathway of change that would lead to the long-term goal in this community?

- **Is this theory of change **FEASIBLE**?**
  Do we have the capacities and resources to implement the strategies that would be required to produce the outcomes in the pathway of change?

- **Is this theory **TESTABLE**?**
  Have we specified how success will be measured clearly enough that we can recognize progress toward our goal when we see it? Have we defined indicators for each outcome in clear terms that a researcher or evaluator can use to produce a research plan?

Critiquing assumptions from many angles, even if it feels tedious, is a skill that participants should sharpen so that they can take the lessons from participating in the theory of change process and apply them to other planning tasks they may face.
THE IMPORTANCE OF QUESTIONING ASSUMPTIONS

The following example, drawn from a comprehensive community revitalization plan, illustrates the importance of probing assumptions. Here is just one outcome from the group’s theory of change with its related precondition and interventions:

**OUTCOME**

The visual appeal of neighborhoods will improve.

**PRECONDITION**

All properties in identified neighborhoods will be brought up to standard in accordance with city/state rules and regulations.

**INTERVENTIONS**

1. Conduct research and disseminate rules and regulations to landlords, tenants, and property owners.
2. Plan and conduct mandatory educational workshops for property owners and renters based on violations of city and state regulations.
3. Recruit technical assistance from agencies, city, state, and other sources to develop and implement a beautification program for identified neighborhoods.

One assumption implied by the set of action strategies is that owners are simply unaware of the regulations, and that by sharing the regulations with them they will change their behavior. But is this reasonable? It’s probable that landlords in particular may need to be forced by the threat of a fine to cooperate. Another assumption in question is that the homeowners can afford to fix the violations, and that once they’re made aware of them, they’ll act accordingly. If this assumption proves false, then the project is unlikely to reach its long-term outcome. These are just a few of the questions that could be posed to this group, illustrating the importance of testing assumptions before programs are implemented. In both of these cases, the planned intervention may make sense at first blush, but with a little probing, we see that it’s quite possible that neither assumption will hold up under scrutiny.
5. Conclusion

When you’ve probably agree that creating a theory of change is a lot of work. We hope you’ll also agree that the process is well worth the effort. Even if groups don’t get all of it right, the rigorous thinking required can’t help but improve program planning, implementation, and evaluation.

While we have discussed the theory of change process in this guide as taking place in the course of a few meetings, it’s probably realistic to use the time frame that most community groups invest in strategic planning as a guide for how long it will take to do this work. We have found that spending six months in this process is usually what it takes to give everyone the time to first learn and then apply the theory of change approach (as opposed to dumping all of the work on a few worker bees).

We also highly recommend that groups invest in a bit of research about the problem they are planning to resolve before and during the theory of change process. This approach is heavily dependent on the quality of information available. In other words, “garbage in, garbage out.” Using the available literature on the topic as well as conducting local research to test key assumptions can be very useful in developing a plausible theory of change.

We also encourage folks to think of their theory as a living document instead of something that they produce and then file on a shelf. The best way to use a theory is to periodically update it by convening a group to review the pathway of change and assumptions in the theory and compare it to the real-world initiative they have implemented. Using a theory in this way can help an organization structure its learning process, drawing out lessons that can improve its work, and it can also provide useful insights for the field.

We encourage you in your theory of change endeavor and hope that you’ll let us know how the approach works (or doesn’t) for your group. We also welcome examples from your work that we can share with others. Folks are always interested in real examples of how the theory of change has been applied. Please visit www.theoryofchange.org if you would like to submit your theory of change as an example and for other theory of change resource materials.

Good luck!
Section Two: Resource Toolbox
Case Study: Project Superwoman

Project Superwoman is a community-based program to assist women who have survived domestic violence and who are unable to find stable employment at livable wages. This case study is based on a real program, but modified to use as an example to show a theory of change in action.

PROJECT BACKGROUND

Project Superwoman was founded as a collaboration of a social service provider, a nonprofit employment training center, and a nonprofit shelter for women experiencing domestic violence. Their goal was to help women obtain the kind of employment that can keep them out of poverty and off public assistance while providing stability and upward mobility. With these criteria in mind, the collaborative identified jobs in electrical, plumbing, carpentry, and building maintenance as viable options providing entry-level positions, possible union membership, and opportunities for advancement at higher than minimum wage scales.

Like any program, Project Superwoman is based on a number of assumptions. One is that women can learn nontraditional skills and that employers can be identified who will hire them. Based on this premise, the project’s strategy was to provide both training and support needed by this population to enter and remain in the workforce. The founders believed that most of the women they could train would be single mothers and that having been in an abusive situation, these women would have low self-esteem and impaired coping skills. They also recognized that even women whose lives were fairly stable may face crises from time to time and need practical help to resolve problems and/or psychological support.

The founders had learned from previous experience that women who had not been in the workforce before—and those who had experiences with the courts, foster care, and the welfare system—had learned adaptive behaviors to dealing with these systems that were counterproductive in the workplace. Therefore, they devised a program that provides training in nontraditional skills, training in expectations in the workplace, and intensive psychological support. Based on their resources, they decided to provide assistance with some crises, such as housing evictions or court appearances, but not take on the larger issue of helping women get their lives in order. To make this feasible, they identified screening criteria to ensure that the women entering the program had already addressed major issues such as dealing with substance abuse or foster care problems.

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3. This case was created by Heléne Clark, Director of ActKnowledge. She can be reached at hclark@actknowledge.org.
PROJECT SUPERWOMAN: A THEORY OF CHANGE

Long-Term Employment at a Livable Wage for Domestic Violence Survivors

Survivors Attain Coping Skills

Survivors Know How to Get Help and Deal with Their Issues

Survivors Have Marketable Skills in Nontraditional Areas

Women Serve Internships

Women Attend Training in Nontraditional Skills

Women Attend Training about Expectations in the Workplace

Women Are Educated as to How to Use Interns

Women Enroll in Program

Women Have New Support System

Women Attend Regular Child Care

Women Hear about the Program

Employers Are Ready to Commit and Attend Program

Social service agency, training program, and nonprofit shelter provider for survivors of domestic violence collaborate to develop an employment program geared to the particular issues for survivors of domestic abuse.

Intervention
Domino Effect (no intervention needed)
Assumptions (see facing page)
Related Interventions (see facing page)
### Assumptions

- **A** There are jobs available in nontraditional fields for women.

- **B** Jobs in nontraditional areas of work for women, such as electrical, plumbing, carpentry, and building management, are more likely to pay livable wages and are more likely to be unionized and provide job security. Some for these jobs also provide a ladder for upward mobility, from apprenticeship to master, giving entry-level employees a career future.

- **C** Women who have been in abusive relationships need more than just skills; they need to be emotionally ready for work as well.

- **D** Women can learn nontraditional skills and compete in the marketplace.

- **E** The program cannot help all women, and so entry into the program must include screening so that women who have sufficient literacy and math skills to take the training and have lives stable enough to attend classes are admitted. The program does not have the resources to handle providing basic skills or major social services.

- **F** Women who have left abusive situations are often single mothers and therefore cannot work unless they have child care.

- **G** Women must be out of the abusive situation. The program assumes that women still in abusive situations will not be able to attend regularly, may pose a danger to others, and will not be emotionally ready to commit.

### Interventions

1. Implement outreach campaign
2. Screen participants
3. Set up counseling sessions
4. Lead group sessions
5. Provide help for short-term crises, such as housing evictions or court appearances
6. Provide one-on-one counseling
7. Develop curricula in electrical, plumbing, carpentry, and building maintenance
8. Conduct classes
9. Develop curricula and experiential learning situations
10. Conduct classes
11. Identify potential employers
12. Create employer database
13. Match women to internships
14. Help women secure permanent jobs

### Sample Indicator

**OUTCOME:**
Long-term employment at a livable wage for domestic violence survivors

**INDICATOR:**
Employment rate

**TARGET POPULATION:**
Program graduates

**BASELINE:**
47% of program attendees are unemployed
53% are earning minimum wage

**THRESHOLD:**
90% of the graduates remain in job at least six months and earn at least $12 per hour
2. Suggested Materials

- Two or three poster-size pads of post-it notes (to post around the room)
- Markers (enough for participants to each have one in blue, green, or black, as well as a red marker for the facilitator to use as a highlighter)
- Pads and pens for participants
- Post-it notes for each participant (allow at least two packets of 5x7 notes per person)
- Multicolored stickers for voting
- PowerPoint theory of change introduction
- Materials for exercises and examples
- LCD projector and screen
- Masking tape

3. Suggested Participants List*

In order to create a theory of change that will truly be useful, the folks most responsible for implementing and evaluating programs should be invited to the sessions. Even if the executive director is not going to actively take part in planning the details of the program, he/she should attend the theory of change sessions to gain a clear understanding of how much work is involved in creating a good theory (and become aware of current gaps in clear thinking!).

WHO SHOULD BE INVITED:

- Program staff directly responsible for delivering service
- Executive director
- Researchers familiar with the program/subject matter
- Evaluator for program
- Program clients
- Funders

*Limit to eight to ten people
**4. Glossary**

**ASSUMPTIONS:** Statements about how and why we expect a set of outcomes to come about as depicted in the pathway of change. These statements can reflect understandings of the change process taken from research, or they can be taken from practical experience. They should also reflect an understanding of the context within which a program operates. Often assumptions raise questions about the extent to which we can bring about the change we expect, given what we have to work with.

**BACKWARDS MAPPING:** The process of working from the long-term goals backwards toward the early stages of the change process. In many ways, this is the opposite of how most people think about planning. Backwards mapping focuses on the question “What must occur before our outcome can be achieved?” instead of asking “What can we do to bring the outcome about?” It brings to the surface necessary and sufficient preconditions for reaching the outcome of interest.

**INDICATORS:** Concepts that will be used to assess the extent to which outcomes are achieved. Often, indicators are simple ideas that can be counted, but sometimes they reflect more complex ideas that must be observed qualitatively.

**INTERVENTIONS:** The verbs or activities that will be put in place to bring about a particular precondition (or a group of them). Interventions can be programs or community-wide change initiatives that implement several programs. We also use the term to describe changes to public policy or institutional practice that need to be in place for an outcome to occur.

**OUTCOMES:** The building blocks of the change process. These are the conditions, or states of being, that must be in place in the early and intermediate stages of the change process in order for long-term goals to be reached. We use the terms *outcome* and *precondition* interchangeably, but find that it is easiest to think about early and intermediate states of being as early and intermediate outcomes.

**PATHWAY OF CHANGE:** The map that explains how long-term outcomes are brought about by depicting the preconditions of change at each task. Long-term changes are brought about by reaching intermediate preconditions; intermediate changes are brought about by reaching early preconditions. The pathway of change is the skeleton on which all of the other details are added. It summarizes the theory but does not (and cannot) tell the whole story.

**PRECONDITIONS:** Everything on a pathway of change can be understood as a precondition (precursor or requirement) for the next outcome above it on the map. Preconditions must be achieved in order for the next logical task in the sequence to be achieved. We identify preconditions by asking “What are the conditions that must exist in order for our outcome to be achieved?” This question is posed for long-term and intermediate outcomes on the map during the process of backwards mapping.
5. PowerPoint Presentations and Training Materials

It is a good idea to start the day with a review of the Community Builder’s Approach to Theory of Change. We have made two PowerPoint presentations available online at www.theoryofchange.org. These presentations offer two levels of introduction to the concepts for you to choose from:

*The Working Group’s Introduction to Theories of Change for Planning and Evaluation* (Version I) is an appropriate starting point if you are going to be working with a group that identifies itself as the planning team or task force responsible for creating the theory of change and a subsequent strategic plan or evaluation plan. This version includes in-depth review of the concepts, and examples and exercises that you can use as teaching tools. **Allow a whole day to review the slide show and lead a group through the exercises.**

*The Community’s Introduction to Theories of Change as a Participatory Planning Tool* (Version II) introduces the fundamental concepts in plain language that anyone can understand. It does not assume any familiarity with planning or evaluation, and can be used in a community setting to introduce the concepts to a working group. This presentation can be given in a forty-five-minute session.
COUNTY STRATEGIC PREVENTION PLAN RESOURCE DOCUMENT

Prepared By:
The Community Prevention Initiative (CPI)

The Community Prevention Initiative (CPI) is a project managed by the Center for Applied Research Solutions (CARS) and funded by the California Department of Alcohol and Drug Programs (ADP)
The purpose of this document is to provide a sample outline for developing a county-wide AOD Strategic Prevention Plan. While the California Department of Alcohol and Drug Programs (ADP) does not have a required format, a number of counties have expressed interest in having a generic template or sample document as a resource when working on their plans.

The document is organized into three major sections:

- **Part I: Sample Strategic Prevention Plan Outline (pages 3-9)**
- **Part II: Considerations and Text Examples (pages 10-21)**
- **Part III: Relevant Data Indicators and Sample Tables (pages 22-31)**

Part I provides a general outline by which counties can approach the development of a Strategic Prevention Plan document. The outline is organized into 6 sections, an introduction and five sections corresponding with each step of the Strategic Prevention Framework (SPF) process. Within each of the sections an overview is provided which provides a broad description of the information covered as well as a specific list of relevant questions for consideration when developing your plan.

It should be noted, that while the document is organized by the 5 SPF steps, the process is meant to be on-going and at times concurrent. For example, while evaluation is listed as the last step, ideally the evaluation design is conceptualized on the front-end and provides feedback to both the planning and implementation phases.

Part II of the document provides more detailed considerations for approaching each of the SPF stages as well as text examples. The examples are not comprehensive and are only meant to provide a framework from which to approach the development of your county prevention plan.

In Part III of the document, a listing of relevant data indicators and their corresponding sources is provided. This neither represents a comprehensive list nor a required list. It is only meant to provide examples of relevant data to be included in the needs assessment process. Additionally, a number of sample tables are included which counties may find helpful when identifying ways to illustrate their information.

It is recognized that counties are progressing at different rates towards completing their plans. While some counties are beginning to compile their information into a document other counties have already completed their plans. It is hoped this document will be a valuable resource for either your current or future prevention planning efforts.
Part I: Sample Outline
I. INTRODUCTION AND COUNTY OVERVIEW

Overview: In this section a brief overview of the process by which the Strategic Prevention Plan was developed and the integration of the Strategic Prevention Framework (SPF) steps can be provided. It may also be helpful to identify the individuals and/or agencies that were involved in the planning process as well as the steps taken in developing the plan.

Some counties also incorporate an overview of their county profile (e.g. demographic and geographic characteristics) as well as identifying the guiding prevention principles for the county in the introductory portion of the document. The vision and mission statements for the county AOD prevention efforts can also be highlighted in a few sentences.

Questions for Consideration

- What was the approach taken by the county to integrate the SPF process and to develop the Strategic Prevention Plan?
- What general steps were taken in developing the plan and who was involved?
- What are the unique demographic and geographic characteristics of the county relative to AOD prevention services?
  - Extent of ethnic and cultural diversity
  - Degree of rural, urban, and suburban communities
  - Extent of population density or geographic isolation
- What external factors may affect prevention (e.g. social, economic, political, population growth/change, etc.)
- What are the county’s AOD prevention vision and mission?
- Are there prevention principles that guide overall county prevention planning and implementation?

(Note: It is also appropriate to provide the county overview including the demographic and geographic characteristics within the Needs Assessment section).
II. SPF STEP 1- NEEDS AND RESOURCE ASSESSMENT

Overview: According to the Center for Substance Abuse Prevention (CSAP), “A community assessment is a systematic process for examining the current conditions of a situation (such as substance abuse) and to identify the level of risk and protection in your community”. Conducting a thorough and systematic needs and resource assessment will allow you to objectively identify:

- The nature, extent, and specific types of existing AOD problems in your county—with a particular focus on consequences and consumption.
- The underlying risk and protective factors associated with these problems.
- The current services and prevention strategies currently available to address these corresponding risk areas and the extent of unmet needs or underutilized resources to address the identified AOD problems—“the gap” in resources and services for the targeted community.

Ideally, this should be the first step in prevention planning and findings should ultimately guide the clear definition of the problem to be addressed, the specific community (and/or sub-populations) to be targeted, and prevention strategies that will be the most appropriate for creating positive change.

LINKS: The Needs Assessment phase:
- Runs parallel with the SPF Capacity Building process (i.e. community member representation and engagement in the Needs Assessment process contributes to building coalitions and partnerships relevant to the SPF process)
- Connects to the Evaluation module (i.e. needs data may overlap with evaluation data.)
- The data presented within this section should clearly link to the Problem Statements, Goals, and Objectives in the Strategic Planning module.

Questions for Consideration
- What was the methodology used to conduct the needs assessment for your county?
- What were the core questions investigated and addressed by the needs and resource assessment?
- What are the core datasets/indicators collected and analyzed? Note any local data sets.
- Were there any limitations to accessing and analyzing the data? For example, difficulty accessing population and/or community specific data. If so, describe any efforts or attempts to overcome these obstacles (e.g. developed and conducted local community assessments).
- What are the key findings (with a focus on consequences and consumption relative to specific populations and communities)?
- What are the current prevention services available in your county that address these specific issues for these population and/or community groups? What are the gaps in service?
- Based on the key data findings and current prevention approaches available/not available, what prevention priorities have been identified for the county?
- How do these priority areas translate into specific problem statements?

(Note: It may be appropriate to articulate specific priorities and problem statements in this section or in the planning sections—CalOMS Prevention includes Problem Statements within the Assessment module. Assessments of community readiness could also be addressed in this section or within Capacity Building).
III. SPF STEP 2 - CAPACITY BUILDING

Overview: Engagement of key stakeholders at the community level is critical to plan and implement successful prevention activities that will be sustained over time. Key tasks may include, but are not limited to, convening leaders and stakeholders; building coalitions; training community stakeholders, coalitions, and service providers; organizing agency networks; leveraging resources; and engaging stakeholders to help sustain the activities.

The purpose of this section is to describe the current level of capacity to address the prevention issues, the extent to which capacity was built during the initial planning process, and the degree to which capacity will be built overtime and the strategies to be taken in order to accomplish this. In this section describe your plan for using existing resources and for establishing new partnerships that will assist your county with addressing the key assessment findings and problem statements that support your prevention plans.

It would also be appropriate to address the current prevention services that are available and the extent to which there is a specific gap in services. (Note: this could also be addressed in the Needs Assessment section). A summary of any programs and policies that are in place to address the specific prevention goals is beneficial to include and helps to further justify the need for services. A sample table is provided in the Appendix for your reference.

LINKS: The Capacity Building phase:
- Contributes to the Needs Assessment activities
- Plays a role in the Planning component
- Supports or facilitates SPF Implementation.

Questions for Consideration

- What is the current level of capacity to address the identified prevention priorities (problem statements)?
- To what extent was capacity built during the initial assessment and planning phase?
- What efforts will the county engage in to continue to build prevention capacity to address these prevention priorities (problem statements)?
- What is the current and future role of any prevention advisory groups that were already established or will be established to guide county prevention efforts.
- What are the plans or efforts to establish county-wide prevention systems and infrastructures to foster sustainability?
- Address the degree to which the county has established agreements and responsibilities with partner agencies and stakeholders. It may also be appropriate to discuss how integration of the SPF process and newly adopted Strategic Prevention Plan will impact future competitive bidding or RFA procedures within the county if applicable.
- What types of training and technical assistance would be needed to further build capacity?
IV. SPF STEP 3 - PLANNING PROCESS

Overview: This section provides an overview of the steps and procedures taken to identify the prevention priorities and to develop the Strategic Prevention Plan. Additionally, counties may address the manner in which the SPF process is being integrated into on-going prevention planning efforts. Considerations for determining prevention priorities can be discussed. A major focus of this section is clearly articulating the specific prevention goals and objectives. A visual representation of the goals and objectives as they relate to specific prevention strategies and measures is helpful. Please refer to Part III of the document for sample tables.

The goals and objectives should clearly address the problem statements and needs assessment findings. It is critical for counties to adopt a reasonable number of goals and objectives for which they will be able to successfully report and measure changes overtime. The goals and objectives that are entered into the CalOMS Prevention Planning module are automatically linked to the Evaluation module for reporting progress overtime. It is more important to identify a few key outcomes and objectives relative to the specific problems identified in the needs assessment, than to adopt a large number of broad goals and objectives which will be difficult to measure and report changes overtime.

### LINKS: The Planning phase:
- Is driven by the Needs Assessment findings and Problem Statements
- Engages community members and organizations identified through the Capacity Building phase;
- Establishes the most appropriate prevention approaches for Implementation;
- Outlines the link between planned objectives and methods for measuring progress in the Evaluation phase.

Questions For Consideration

- How were community members engaged in the planning process?
  - How were members/agencies/organizations engaged in the assessment and interpretation of needs data and identification of prevention priorities?

- What criteria were used to establish prevention priorities? Describe the process for selecting priority issues, populations and/or communities?
  - What are the populations and/or community sectors that are being served

- What are the specific problem statements, corresponding goals and objectives, and prevention strategies that the county has identified? This can be illustrated by using a logic model and/or other tabular format--please refer to Part III of the document for examples.

- How was the long-term sustainability of these prevention efforts taken into account during the planning phase? Has the county adopted specific goals, objectives, and approaches that foster or are directly related to sustainability?

- How was cultural relevance of services taken into account during the planning phase?
V. SPF STEP 4 - IMPLEMENTATION

Overview: This section provides an overview of the manner in which the county is implementing the selected prevention services. This is the SPF phase in which counties reflect on considerations relative to selecting and implementing prevention services that are directly in response to their problem statements, goals, and objectives previously identified. The extent to which the approaches are directly relevant, culturally appropriate, and feasible given the resources should be addressed. While ADP is not requiring the adoption of evidence-based services, an underlying assumption of the SPF process is that the extent to which there is evidence to support the effectiveness of certain prevention strategies should be taken into consideration during the selection process.

Examples of work plans which relate specific tasks and activities to the corresponding goals, objectives, and measures are provided in Part III of the document.

LINKS: The Implementation phase:
- Is a direct culmination of the Planning Goals, Objectives, and Strategies
- Leverages the coalitions and partnerships engaged during Capacity Building to facilitate and sustain successful prevention services.
- Coincides with the onset of Evaluation of progress towards achieving the Goals and Objectives

Questions for Consideration
- Describe the specific prevention services that have been selected. How were these approaches selected?
- How do the prevention services being proposed relate to the Institute of Medicine’s (IOM) population categories? Are the interventions chosen considered to be serving/engaging Universal, Selective, or Indicated population groups? Or a combination?
- Please address how the chosen prevention strategies are culturally relevant to the intended participants and/or communities being served.
- Why do you expect that the chosen prevention strategies will meet the identified needs and have the intended impact?
- Given the current resources, describe the feasibility of accomplishing the objectives and describe the extent to which services are expected to be sustained.
- What are the specific tasks and activities to be accomplished in order to achieve the goals and objectives? The time frame for completing specific activities should be identified as well as the person or organization responsible. Please see Part III of the document for sample work plans.
- What measurements will be taken and how during implementation?
VI. SPF STEP 5 - EVALUATION

Overview: This section provides an overview of the methodology for planning and conducting the evaluation of prevention services throughout the county. The evaluation should address how the county is going to measure and report on the progress towards achieving their goals and objectives. The goals and objectives that are entered into the CalOMS Prevention Planning module are automatically linked to the Evaluation module for reporting progress overtime. These objectives may translate into short-term, intermediate, and long-term outcomes when developing a logic model or evaluation plan for your county. Data collection, analysis, and reporting methods are also appropriate to address in this section. If applicable, describe the role of the evaluator and any collaboration between the evaluator and project stakeholders. Include a copy of the preliminary evaluation plan (please refer to Part III of the document for a sample plan).

LINKS: The Evaluation phase:
- Potentially utilizes data from the Needs Assessment as baseline data.
- Measures the progress towards achieving the goals and objectives defined during the Assessment and Planning phases and entered into CalOMS Prevention
- Is implemented concurrently with the prevention service Implementation
- Provides information for on-going Planning and Implementation

Questions for Consideration
- **What is the overall evaluation design and methodology?**
- **What measurable change in the proposed problem/need will result by using the proposed program(s) or strategies? What are the short-term, intermediate, and long-term objectives, measures, and indicators?**
- **Describe how the chosen objectives are measurable and realistic within the proposed time frame given the project resources.**
- **What are the data collection procedures and timeline?**
- **What types of data analysis and reporting will be undertaken? And the timeframe for conducting.**
- **Who will be responsible and/or involved with the evaluation process? Will the county be working with an evaluator?**
- **How will the evaluation data and findings feedback into the planning, resource application, continuous improvement and implementation processes?**
- **How will the evaluation information be disseminated to key stakeholders?**
- **Include an evaluation plan—see Part III of the document for a sample plan.**
Part II: Considerations and Text Examples
Considerations for Developing Vision and Mission Statements

Visions Statements: A vision statement briefly articulates the ideal conditions for your county. It represents the hope for how things should be and helps envision the success of the prevention initiative in your county. A vision statement should be succinctly stated, easily communicated and understood, and broad enough to represent diverse perspectives within a common goal or framework.

Mission Statements: A mission statement more specifically expresses the reason for the initiative, in other words, why are you proposing these efforts? It justifies the existence of the proposed efforts and states the ultimate purpose. It says what, in the end, you want to accomplish in a more specific way than the vision statement. Mission statements are clear and concise statements that are typically outcome oriented and inclusive of different perspectives. It provides the touchstone to unify disparate interests in a shared prevention purpose.

Data Collection Considerations: As you are embarking on your data collection efforts, all of the potential data sources may be a bit overwhelming. It is strongly recommended that you narrow your efforts to those factors specifically related to issues for specific communities or sub-populations as much as possible to make the task more manageable.

County demographics, population, ethnic data, geographic size, resources and community assets are important for the county to note. Collection and analysis of data indicators related to consumption and consequences at the county, community, and sub-population levels is ideal. Include National Outcome Measures (NOMs), as appropriate. (Please refer to Part III of the document for a list of relevant data indicators and sources).

1. An emphasis should be placed on the collection of objective consequence (e.g., harm, cost, setting) and consumption (e.g., demographics, substances, quantities) data.
   a. Examination of objective data includes incidence and prevalence data that describe the extent of substance abuse in the community.
2. Subjective data can be utilized to supplement and complement your objective data.
   a. For example, community members’ perceptions of alcohol use or availability in their community (as compared to actual use and/or availability rates).
3. The use of existing or archival data is encouraged whenever possible. Counties are encouraged to utilize data collected by other agencies and to collaborate.
4. Key community stakeholder and partner agency collaboration is strongly encouraged during the community assessment process and more importantly as you transition into program planning efforts.

Data Analysis Considerations: Data in itself does not necessarily improve decision making. In order to maximize the potential impact of the prevention services and approach, it is beneficial to have data that disclosed demographic sub-groups and/or community sectors that are experiencing the greatest substance-related harm. For example, average values or percentages for the entire County are of limited value. Unfortunately, needs data is often available most readily at the County level which does not answer many of the questions necessary to setting priorities at a more defined community level. Data-based decisions should be supported by appropriate analyses.
A few basic techniques and comparisons are important for guiding a data-based planning process. There are several analysis procedures which relate data to empirical criteria useful for informing decisions:

1. **Prevalence Rates.** What portion of the population is involved in a problem or behavior—what is the prevalence rate?
2. **Trends Over Time.** What are the trends in the problem or behavior—are they getting worse over time and by how much?
3. **Comparisons.** How do rates or trends compare with other communities, counties, or state levels? Is there an indication that problems are relatively more or less serious based on these comparisons?
4. **Data Disaggregation.** Does breaking down the data by various sub-population demographics or sub-communities indicate potential ‘hot spots’ or “target populations” masked within the overall data? For example, are disaggregated rates or trend lines different across demographic sub-groups or communities? In other words, are we experiencing a greater problem in one or more of our sub-populations or communities within the county?

### Data Interpretation Considerations

1. **Population-Based Rates.** In order to make meaningful comparisons between geographic areas that differ in population size (or schools with different enrollment sizes), population-based rates should be used (e.g. the number of occurrences for every 1,000 people as compared to using the number of occurrences).
2. **Rare Occurrences.** Rates measuring rare events (e.g. deaths due to alcohol or drug use) or rates for counties with very small population sizes should be interpreted with caution. These rates are easily affected by small changes in occurrences.
3. **Meaningful Comparisons.** Indicator rates should be interpreted and reported comparatively. For example reporting the rate of violent behavioral incidents for a school is not meaningful unless the rates are compared to other school rates.
4. **Longitudinal Data.** Trends overtime (e.g. a three year period) are a stronger risk indicator than reporting rates for a single year.
5. **Multiple Sources.** Utilizing multiple indicators within a given domain is stronger evidence than utilizing a single indicator.
6. **Specificity.** Provide specific data and data sources whenever possible
   a. For example, “According to the California Department of Justice, there were a total of 733 deaths due to alcohol and drug use, which ranks the county 57th statewide.”
   b. As compared to “there was a high incidence of alcohol and drug related deaths”
7. **Critical Need.** A critical need for services should be established for each target community and/or sub-population identified. It would be ideal to serve the highest risk communities/sub-populations; however, it may not be feasible. If it is not feasible, the reasons should be documented.
**Planning Considerations:** To foster successful planning and implementation phases of the SPF, it is important to clearly articulate the limits of the planning process and prevention efforts at the onset. The identification of realistic parameters for determining objectives, activities, and participation may be required or proscribed from the planning process. These parameters could include:

- **Service Groups.** Priorities or limitations concerning problems or populations. For example, the funding for the recent State Incentive Grants (SIG) was focused specifically on community-based approaches to reduce binge drinking for 12 to 25 year olds. A needs assessment for this project would need to center around these goals.

- **Participation.** Priorities or limitations concerning participants in planning and interventions. For example, the conditions of a grant may set expectations concerning who will sit at the planning table as part of the community coalition.

- **Resources.** Resource availability and requirements directly related to the planning process, such as grant amounts or committed resources if applicable, and potential needs for resource acquisition.

- **Data-Driven.** Expectations concerning the planning process. For example, the SPF planning process is expected to be data-driven. It is important to set clear expectations about what this means. For example, it may be expected that problem priorities be clearly justified by empirical information and clearly stated criteria rather than agency perspective, personal commitments to particular outcomes or populations, or other individual preferences.

Clearly setting the parameters of the needs assessment and planning process provides a context for identifying and applying criteria, and avoids frustration and inertia as planning proceeds.

**Determining Prevention Priorities:** In order to make effective data-driven decisions, those involved in the county-wide prevention planning process need to interpret the information and determine criteria for determining prevention priorities. The following is a list of questions for consideration when determining how to identify priorities for the county:

1. **How important are indications of harmful consequences as distinct from indications of substance use itself?** This is a fundamental decision that has important implications for the kinds of prevention strategies that will be emphasized, (e.g., will the emphasis be on reducing use itself, or on abuse and specific consequences such as alcohol-related automobile crashes?)

2. **How important is the prevalence of the problem or the use of substances – what is the portion of sub-populations or community groups that are involved or impacted by the substance**

3. **How important is the trend in the behavior or harmful outcome?** Does the fact that a problem is getting worse or better influence whether it should be a priority?

4. **How important is the relative rate or trend as compared between communities or population groups?** To what extent does the group want to focus on problems that are greater in their community as compared to others? To what extent does the group want to focus on problems
that are worse in specific demographic sub-populations than others (e.g., age groups, genders, racial/ethnic/cultural groups)?

5. How does the community view the problem? Do community members see it as a priority? Is the issue so deeply and widely felt that there is a groundswell of support for addressing this problem? How do you know?

6. Will you be able to actually measure change(s) in this particular problem area that will be meaningful to communities in your county?

7. How do you weigh problems with great current public interest, but low impact, versus issues that can create greater public health and safety harm, but are so common they are unseen, such as underage alcohol and tobacco use?

The county planning group members may adopt additional criteria that are important, and it is likely members will want to balance several, or all, of the above criteria in making their ultimate decisions about prevention priorities. Most important, an outcome of the establishing criteria for priority-setting is for members to develop an understanding of the advantages and disadvantages of datasets and to identify their own criteria for interpreting the data. The data discussion provides a foundation for building group consensus on the methods for prioritizing those problems, communities, and populations that will be the primary focus of prevention efforts over the next few years.

The following considerations may be useful in gaining further consensus on adopting specific prevention strategies and objectives:

- **Evidence-based Practices.** Are there effective prevention services, strategies or policies that specifically address the problem area, or would it necessitate the development of new, unproven approaches?

- **Availability of Resources.** Does the community have access to sufficient resources to address this problem? Do the proposed efforts require additional funding and support or require partnerships with other organizations and agencies?

- **Ability to Impact the Problem.** Is the problem so pervasive that any community-based effort is unlikely to affect the outcomes? Can you build a dike in the river to stop the flow of water or will it be the equivalent of simply throwing stones in the water, of having no substantial impact on the flow?

- **Anticipated Barriers and Resistance.** Are there substantial interests that will resist necessary change in a specific area, or other challenges that must be considered in setting realistic priorities for action?

**Considerations for Developing Problem Statements:** In addition, the following criteria are useful in determining which problems or issues are the most significant and feasible to pursue. The problem / issue should be:

- **Immediate.** “Immediacy” about the concern means people want to act on it. If something is immediate, it “hits” people in their “gut,” not their head. Immediate concerns hit many people because lots of people are affected by them.

- **Specific and Measurable.** It can be specified because it is concrete, not abstract. Concerns must be explicitly identified to be acted on. Where is the problem located? Who is affected by it? How are they affected? Can you measure the problem now? Will you be able to measure that you have made a change?
• **Solvable in a reasonable amount of time.** The scope of the activity has to be of a scale that allows you to be effective. If you take on the problem of “alcohol abuse”, it is too big to address. If you take on the issue of specific problematic environments where alcohol is provided to minors and/or high-risk drinking leads to alcohol-related crime & violence, you can achieve goals on this issue. This also means having the resources necessary to work on the specific identified problems. How long will it take to solve this issue? If the time is too long you may lose the community members’ interest in the process. The time line needs to be reasonable and geared to the immediacy of the issue.

• **Able to result in real improvement in people’s lives.** Will the issue that you have chosen to address improve people’s lives? If yes, how? How do you know that it will help? Have the residents of the community told you? It is important that the results of the work meet the expectations of the community.

• **Widely and Deeply felt.** How many people have expressed concern about the issue? Solving problems related to high-risk alcohol environments often requires a strong community coalition. Do residents feel passionate about this issue? The level of depth of feeling can frequently be measured by the willingness to work on the issue.

• **Non-divisive and consistent with the group’s values.** The work should not split the community or coalition into factions. Rather, the issue should unify the base of people with whom you are working. Values serve as a base to assess if the issue is consistent with what is important to the community. If the solution to a problem makes members of the community uncomfortable or if the means do not justify the ends, a new solution must be found.

• **Resonate Strongly.** Does the statement resonate strongly enough with the public and authorities needed to enact, operate and sustain the actions such that they can counter any interests benefiting from the current norms?

*Adapted from the Community Anti-Drug Coalitions of America (CADCA) website http://cadca.org/*
Considerations for Defining Measurable Goals and Objectives

The goals and objectives should address the problem statements and be in alignment with the needs assessment findings. **It is critical for counties to adopt a reasonable number of goals and objectives for which they will be able to successfully report and measure changes overtime.** It is more important to identify a few key outcomes and objectives relative to the specific problems identified in the needs assessment, than to adopt a large number of broad goals and objectives. **Additionally, the goals and objectives should be time sensitive.** For example, it may be more appropriate to focus on building community capacity and increasing community awareness regarding an AOD issue in year one, anticipating intermediate types of outcomes in year two such as changes in attitudes regarding substances, and reserving longer-term changes such as actual reductions in substance use for years 3 through 5.

**Goals:** A goal is a measurable statement of desired longer-term, global impact of the prevention program. They reflect the longer-term outcomes the services are intended to have. AOD prevention goals typically address changes in use or incidence of harmful consequences.

**Objectives:** An objective is a more specific measurable statement which reflects more immediate or direct outcomes of the services/program—which directly support the goal. Objectives typically reflect changes in participant behaviors or attitudes that occur as a result of the prevention services/strategies. They may also focus on altering consequences experienced by the user or the behavior of users that affect others.

**Objectives should be specific, measurable, appropriate, realistic, and time-bound.**
- Designed to cover a single end result.
- Written in quantifiable terms that are easily measurable and specifically stated to articulate measurable progress in terms of expected increases or decreases
- Conditions to be achieved rather than activities to be performed.

**A sample formula for developing objectives:**
- How much of what change will occur to whom by when as measured by what?

Of the __________________________ (state the addressed population), ______ participants in prevention services will __________________________ (show decreases or increases), in the (insert specific indicator) as measured by _______________ (state the evaluation tool) over the next (identify timeframe in years or months).

**Examples of indicators include:** 30 Day Use and Age of Onset

**Examples of measurement tools include:** surveys, local or state data sources, service program data, community input (e.g. focus groups) and direct observational methods (e.g. merchant compliance checks).
Considerations for Selecting Prevention Approaches

According to the California Department of Alcohol and Drug Programs, prevention is defined as, “Strategies, programs and initiatives which reduce both direct and indirect adverse personal, social, health, and economic consequences resulting from problematic ATOD availability, manufacture, distribution, promotion, sales, and use. The desired result is to promote safe and healthy behaviors and environments for individuals, families, and communities.”

Approaches for selecting services include defining the population involved and the strategies, programs, and/or initiatives to be used.

- The population may be categorized using the Institute of Medicine’s universal, selective and indicated categories.
- Strategies used over the past 15 years may still be defined using CSAP’s six prevention strategies as used in the CalOMS Prevention data reporting, which have associated services.
- CSAP is also introducing prevention policies and practices in addition to the term “program” to more fully address the range of prevention actions.

Utility Checks

- Is the intervention appropriate for the population identified in the community needs assessment and community logic model? Has the intervention been implemented successfully with the same or a similar population? Are the population differences likely to compromise the results?
- Is the intervention delivered in a setting similar to the one planned by the community? In what ways is the context different? Are the differences likely to compromise the intervention’s effectiveness?
- Is the intervention culturally appropriate? Did members of the culturally identified group participate in developing it? Were intervention materials adapted to the group?
- Are implementation materials (e.g., manuals, procedures) available to guide intervention implementation? Are training and technical assistance available to support implementation? Are monitoring or evaluation tools available to help track implementation quality?

Feasibility Checks

- Is the intervention culturally feasible, given the values of the community?
- Is the intervention politically feasible, given the local power structure and priorities of the implementing organization? Does the intervention match the mission, vision, and culture of the implementing organization?
- Is the intervention administratively feasible, given the policies and procedures of the implementing organization?
- Is the intervention technically feasible, given staff capabilities and time commitments and program resources?
- Is the intervention financially feasible, given the estimated costs of implementation (including costs for purchase of implementation materials and specialized training or technical assistance)?

### Examples of Vision Statements

- Create safe and healthy communities free of alcohol and other drugs
- Healthy individuals, families and communities free of alcohol and other drug problems

### Examples of Mission Statements

- To reduce alcohol and other drug use by youth through collaboration, education and policy change.
- To promote child health and development through a comprehensive family and community initiative.
- To reduce binge drinking among youth and young adults by increasing awareness regarding the harmful consequences and promoting healthy decision making.
- To reduce methamphetamine use among adults and related issues by creating a comprehensive community-based prevention approach.
- AOD Prevention seeks to empower communities, individuals and families to adopt healthy behaviors that prevent substance abuse and its related consequences.
- Individuals, organizations and coalitions providing leadership and coordination to develop and maintain a comprehensive alcohol and other drug prevention system in the County.
- The mission of the County Alcohol and Other Drug Office is to reduce community and individual problems related to alcohol and drug abuse countywide.
Example: Needs Assessment Introduction

A county-wide needs assessment was conducted to determine the AOD prevention priorities regarding alcohol use. For the purposes of the current assessment, data were collected to answer the following questions:

- What is the nature and extent of drug use in the county? What specific age groups and communities are impacted the most? What drugs are we seeing increased use rates for?
- What are the harmful consequences of drug use in our county? What specific age groups and communities are impacted the most? Which drugs are having the greatest impact?
- What are the community risk and protective factors associated with these issues?
- What are the existing prevention efforts? What is the most critical gap in prevention services? What evidence-based prevention approaches are needed to address this gap?

The primary goal of the needs assessment was to determine the county prevention priorities in order to identify specific populations and communities to focus our efforts on over the next five years. A three-tiered approach was employed. Data was collected at the county, community, and school level. The needs assessment was based on a combination of objective and subjective data including both archival and locally developed measures. Despite considerable attempts, some data was not available at the community level—which limited the sub-group analyses. The ultimate goal of the needs assessment was to determine prevention priorities to guide development problem statements, goals, and objectives for the county-wide Strategic Prevention Plan.

A highly recognized classification system is a framework developed by Hawkins and Catalano based on extensive prevention research. This provided a logical and theoretical framework from which to approach the data collection and needs analysis process. The framework identifies four major domains of risk for substance abuse and related problems, including:

- **Community Factors:** Such as the availability of substances, community laws and norms favorable to use, extreme economic deprivation, high rates of transition and mobility.
- **Family Factors:** Such as family history of substance abuse, poor family management practices, parental drug use and favorable attitudes toward drug use, and family conflict.
- **School Factors:** such as academic failure, low commitment to school, school-related problem behaviors
- **Individual and Peer Factors:** Such as peer rejection, early and persistent problem behavior, alienation and rebelliousness, friends who use drugs, favorable attitudes toward drug use, and early initiation of drug use.
Example 1: Key Findings

- According to a California household survey of health-related behaviors conducted in 2001 and 2003, nearly two-thirds of County residents over the age of 18 use alcohol at least once in a thirty day period. An estimated twenty-percent of respondents in 2003 engaged in binge drinking behaviors each month, measured as drinking more than five drinks on one occasion, up from seventeen percent in 2001.

- Both alcohol use and binge drinking were found to be more prevalent among County residents than within the California populations statewide, with reported rates of binge drinking within the county increasing from 2001 to 2003.

- Most recent survey data shows rates of alcohol use and binge drinking to be considerably higher among males than females, with males reporting binging rates of more than twice the prevalence reported among females in 2003.

- Across age groups, reported alcohol use in 2003 was comparable for most adults, with the exception of 18 to 24 year olds, whose use was slightly lower than use among their older counterparts. However, a comparison of binge drinking rates showed that bingeing was most prevalent within this same age group, as compared to rates within older age groups. This pattern suggests that while older adults were somewhat more likely to use alcohol in their daily life, problem drinking behaviors were much more concentrated among younger adult drinkers. A high occurrence of problem drinking was also found among adolescents under the age of 18 who reported the highest rates of binge drinking overall.

Example 2: Key Findings

- **Police reports** – 37% of the alcohol-related infractions are committed by youth aged 13 to 20, and this demographic comprises 18% of the county’s residents; on average, police respond to 9 parties with underage drinking per 1,000 residents each weekend; the zip codes with the highest percentage of both underage alcohol-related infractions and parties are 95826, 95870, and 95888.

- **CHP** – Adolescents who are English Language Learners are disproportionately represented in the DUI arrests. DUI arrests are 3.7 times higher on days when there is a game at the local stadium and 2.6 times higher when there is a concert. DUI arrests are 3.9 times higher during Spring Break and 1.4 times higher during other school breaks, 1.9 times higher during Prom Season and 1.7 times higher during Graduation Season.

- **Alcohol sales** – These zip codes, plus 95871, account for 71% of all of the alcohol sold in our county, but only 46% of our residents. Only 53% of the merchants in these zip codes are in full compliance; however, 92% have responded positively to suggestions that they receive extensive RBS training.

- **Hospital discharge** – The data available suggests that patients under 21 years old are more likely to combine alcohol with other substances than their legal-age counterparts. Additionally, they are more likely to be admitted during breaks from school and other major events, including graduation (Spring Break has an average of 13.7 admits/day and Prom Season has an average of 12.4 admits/event versus 8.8 admits per 1,000 residents). Non English speaking youth are generally overrepresented in alcohol-related intakes.

- **CHKS** – 7th graders are binge drinking at significantly greater rates (5.7% during the past 30 days for 04-05, compared with 4.0% in 02-03 and 3.7% in 00-01), while the binge drinking data on 9th and 11th graders remains fairly constant (approximately 13 % for 9th graders and 24% for 11th graders). Additionally, for the first time since we began collecting CHKS data, girls are binge drinking more frequently than their male counterparts – at 9th and 11th grade.
Examples of Problem Statements

- The growing number of large teen drinking parties and associated problems to youth and neighborhoods
- Youth are obtaining alcohol from and consuming alcohol in social settings, which results in threats to individual health and safety, as well as community impacts such as vandalism, property damage, violence and other injuries
- Level of violence and other alcohol-related problems occurring downtown in and near Outlets
- Alcohol is an age restricted product and yet it is readily available to local youth, either through youth purchasing it illegally, or youth acquiring it from others, including family.
- A significant number of local adolescents are polydrug users and participating in binge drinking.

Examples of Goals:

- Reduce alcohol use amongst youth
- Reduce methamphetamine use within the target community
- Reduce binge drinking rates amongst youth and young adults

Examples of Objectives:

- By July 1st, 2008, decrease the percentage of retailers within the targeted community willing to sell to minors from 30% to 15%
- By July 1st, 2008 decrease the number of teen drinking parties within the specified community through enforcement of social host ordinances from 50 parties per month to 25 per month.
- By July 1st, 2008, increase awareness of young adults, ages 18 to 25 living within the targeted zip code areas, regarding the harmful consequences of binge drinking from 30% to 75%.
- By July 1st 2009, decrease the percentage of 11th graders at the targeted high schools reporting 30 day binge drinking from 35% to 20%.
Part III: List of Relevant Data Indicators and Sample Tables
### Examples of Relevant Data Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevalence of Alcohol and Drug Use</strong></td>
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<tr>
<td>Lifetime Prevalence ATOD Use</td>
<td>California Healthy Kids Survey (CHKS), California Department of Education</td>
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<tr>
<td>Any Alcohol Use</td>
<td>California Health Interview Survey (CHIS), UCLA Center for Health Policy Research, California Department of Health Services, Public Health Institute</td>
</tr>
<tr>
<td>Any Binging</td>
<td>California Health Interview Survey (CHIS), UCLA Center for Health Policy Research, California Department of Health Services, Public Health Institute</td>
</tr>
<tr>
<td>30 Day ATOD Use</td>
<td>California Healthy Kids Survey (CHKS), California Department of Education</td>
</tr>
<tr>
<td>30 Day ATOD Use (On School Property)</td>
<td>California Healthy Kids Survey (CHKS), California Department of Education</td>
</tr>
<tr>
<td>30 Day Alcohol Use</td>
<td>California Health Interview Survey (CHIS), UCLA Center for Health Policy Research, California Department of Health Services, Public Health Institute</td>
</tr>
<tr>
<td>30 Day Binge Drinking</td>
<td>California Health Interview Survey (CHIS), UCLA Center for Health Policy Research, California Department of Health Services, Public Health Institute</td>
</tr>
<tr>
<td>Age of First ATOD Use</td>
<td>California Healthy Kids Survey (CHKS), California Department of Education</td>
</tr>
<tr>
<td>ATOD Peer Use</td>
<td>California Healthy Kids Survey (CHKS), California Department of Education</td>
</tr>
<tr>
<td><strong>Admissions to Alcohol and Drug Treatment</strong></td>
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<tr>
<td>Treatment Admissions Rate per 100,000</td>
<td>California Alcohol and Drug Data System (CADDs) Admission Data, CA Department of Alcohol and Drug Programs; <a href="http://www.cahwnet.gov">http://www.cahwnet.gov</a></td>
</tr>
<tr>
<td>Treatment Admissions Under 18, rate per 100,000</td>
<td>California Alcohol and Drug Data System (CADDs) Admission Data, CA Department of Alcohol and Drug Programs; <a href="http://www.cahwnet.gov">http://www.cahwnet.gov</a></td>
</tr>
<tr>
<td>Treatment Admissions and Rates, by Primary Drug Type</td>
<td>California Alcohol and Drug Data System (CADDs) Admission Data, CA Department of Alcohol and Drug Programs; <a href="http://www.cahwnet.gov">http://www.cahwnet.gov</a></td>
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<tr>
<td>Treatment Admissions and Rates by Age</td>
<td>California Alcohol and Drug Data System (CADDs) Admission Data, CA Department of Alcohol and Drug Programs; <a href="http://www.cahwnet.gov">http://www.cahwnet.gov</a></td>
</tr>
<tr>
<td>Treatment Admissions and Rates by race/ethnicity</td>
<td>California Alcohol and Drug Data System (CADDs) Admission Data, CA Department of Alcohol and Drug Programs; <a href="http://www.cahwnet.gov">http://www.cahwnet.gov</a></td>
</tr>
<tr>
<td><strong>Alcohol and Drug Related Crime and Offenses</strong></td>
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<tr>
<td>Felony and Misdemeanor Arrests for Alcohol Offenses, rate per 100,000 (Can be broken down by type of offense, age, and ethnicity)</td>
<td>California Arrest Data, California Department of Justice, Office of the Attorney General, Criminal Justice Statistics Center <a href="http://caag.state.ca.us/cjsc">http://caag.state.ca.us/cjsc</a></td>
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<tr>
<td>County Alcohol Arrest Rate per 100,000 (Can be broken down by type of offense, age, and ethnicity)</td>
<td>California Arrest Data, California Department of Justice, Office of the Attorney General, Criminal Justice Statistics Center <a href="http://caag.state.ca.us/cjsc">http://caag.state.ca.us/cjsc</a></td>
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<td>County Drug Arrest Rate per 100,000 (Can be broken down by type of offense, age, and ethnicity)</td>
<td>California Arrest Data, California Department of Justice, Office of the Attorney General, Criminal Justice Statistics Center <a href="http://caag.state.ca.us/cjsc">http://caag.state.ca.us/cjsc</a></td>
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<tr>
<td>Drug and Alcohol Related School Offenses</td>
<td>CA Department of Education, <a href="http://www.cde.ca.gov">http://www.cde.ca.gov</a></td>
</tr>
<tr>
<td>Local Police Calls for Service by specific zipcodes or areas</td>
<td>Local Law Enforcement Data Sets</td>
</tr>
<tr>
<td>Blood Alcohol Levels at time of Arrest for various offenses</td>
<td>Local Law Enforcement Data Sets</td>
</tr>
<tr>
<td><strong>Drinking and Driving</strong></td>
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<tr>
<td>Fatalities in Alcohol-Involved Accidents, Rate per 100,000</td>
<td>Statewide Integrated Traffic Records System (SWITRS), California Highway Patrol (CHP)</td>
</tr>
<tr>
<td>Parties In Alcohol-Involved Accidents (by age, gender, and race)</td>
<td>Statewide Integrated Traffic Records System (SWITRS), California Highway Patrol (CHP)</td>
</tr>
<tr>
<td><strong>“Had Been Drinking” Drivers, rate per 100,000</strong></td>
<td>Statewide Integrated Traffic Records System (SWITRS), California Highway Patrol (CHP)</td>
</tr>
<tr>
<td><strong>Youth who have Ridden in a Car with Someone who has been Drinking</strong></td>
<td>Statewide Integrated Traffic Records System (SWITRS), California Highway Patrol (CHP)</td>
</tr>
</tbody>
</table>

### Alcohol and Drug-Related Morbidity

| Hospital Admissions due to Alcohol and Drug Related Causes | California Hospital Discharge Data Set, Office of Statewide Health Planning and Development (OSHPD) |
| Hospital Admissions due to Alcohol Related Causes | California Hospital Discharge Data Set, Office of Statewide Health Planning and Development (OSHPD) |
| Hospital Admissions due to Drug Related Causes | California Hospital Discharge Data Set, Office of Statewide Health Planning and Development (OSHPD) |
| Place of last drink before admission by type of drug used | Place of Last Drink Data |

### Alcohol and Drug Related Mortality

| Deaths due to Alcohol and Drug Related Causes, rate per 100,000 (by age, gender, and ethnicity) | Death Statistic Masterfile and California Health Status Profiles, California Department of Health Services, Vital Statistics Section |
| Deaths Due to Cirrhosis of the Liver, rate per 100,000 | Death Statistic Masterfile and California Health Status Profiles, California Department of Health Services, Vital Statistics Section |
| Drug Induced Deaths, rate per 100,000 | Death Statistic Masterfile and California Health Status Profiles, California Department of Health Services, Vital Statistics Section |
| Alcohol Related Deaths, rate per 100,000 | Death Statistic Masterfile and California Health Status Profiles, California Department of Health Services, Vital Statistics Section |

### Availability and Access of Alcohol and Other Drugs

| Retail Liquor Licenses | CA Alcohol Beverage Control; [http://www.abc.ca.gov](http://www.abc.ca.gov) |
| Disciplinary Actions | CA Alcohol Beverage Control; [http://www.abc.ca.gov](http://www.abc.ca.gov) |
| Sales to Minors | CA Alcohol Beverage Control; [http://www.abc.ca.gov](http://www.abc.ca.gov) |
| Shoulder Tap Operations | CA Alcohol Beverage Control; [http://www.abc.ca.gov](http://www.abc.ca.gov) |
| License Suspensions | CA Alcohol Beverage Control; [http://www.abc.ca.gov](http://www.abc.ca.gov) |
| Local areas deemed overconcentrated by ABC | CA Alcohol Beverage Control; [http://www.abc.ca.gov](http://www.abc.ca.gov) |
| Sources of Alcohol and Other Drugs for Youth | Youth Tobacco Coalition Alcohol Survey |
| Places Youth Most Likely Drink | Tobacco Youth Survey (TYS) |
| Parents/Adults Who Provide Youth Alcohol | Tobacco Youth Survey (TYS) |
| Youth Perceptions of ease of access | Tobacco Youth Survey (TYS) |
| ATOD Availability | Healthy Kids Survey (Self Report Data). Data is housed at the district level. |

### Risk and Harm Perception

| ATOD Use Perception of Harm | Healthy Kids Survey (Self Report Data). Data is housed at the district level. |

### Other Risk Factors

<p>| Child Abuse and Neglect Reported Incidents | Child Protective Services (CPS) |
| Children in Foster Care | CA Health and Welfare Agency, Department of Social Services, Statistical |</p>
<table>
<thead>
<tr>
<th>Topic</th>
<th>Source</th>
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</thead>
<tbody>
<tr>
<td>Reported Runaways</td>
<td>CA Department of Justice, Law Enforcement Information Center: <a href="http://caag.state.ca.us/cjsc">http://caag.state.ca.us/cjsc</a></td>
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<tr>
<td>Teen Births</td>
<td>CA Health and Human Services Agency, CA Department of Alcohol and Drug Programs; <a href="http://www.cahwnet.gov">http://www.cahwnet.gov</a></td>
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<tr>
<td>Juvenile Law Enforcement Dispositions</td>
<td>CA Department of Justice, Law Enforcement Information Center: <a href="http://caag.state.ca.us/cjsc">http://caag.state.ca.us/cjsc</a></td>
</tr>
<tr>
<td>Adolescent Suicide</td>
<td>CA Health and Human Services Agency, CA Department of Alcohol and Drug Programs; <a href="http://www.cahwnet.gov">http://www.cahwnet.gov</a></td>
</tr>
<tr>
<td>AFDC</td>
<td>CA Health and Welfare Agency, Department of Social Services, Statistical Services Bureau; http:www.cahwnet.gov</td>
</tr>
<tr>
<td>Domestic Violence Calls for Assistance</td>
<td>CA Department of Justice, Criminal Justice Statistics Center; <a href="http://caag.state.ca.us/cjsc">http://caag.state.ca.us/cjsc</a></td>
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<tr>
<td>Academic Performance Index</td>
<td>CA Department of Education, California Basic Education Demographics (CBEDS); <a href="http://www.cde.ca.gov">http://www.cde.ca.gov</a></td>
</tr>
<tr>
<td>Dropout/Graduation Rates</td>
<td>CA Department of Education, California Basic Education Demographics (CBEDS); <a href="http://www.cde.ca.gov">http://www.cde.ca.gov</a></td>
</tr>
<tr>
<td>Free/Reduced Lunch Rates</td>
<td>CA Department of Education, California Basic Education Demographics (CBEDS); <a href="http://www.cde.ca.gov">http://www.cde.ca.gov</a></td>
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<tr>
<td>Calworks/AFDC Enrollment</td>
<td>CA Department of Education, California Basic Education Demographics (CBEDS); <a href="http://www.cde.ca.gov">http://www.cde.ca.gov</a></td>
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<tr>
<td>Absences</td>
<td>Collected and housed at the district and/or school level</td>
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<td>Suspensions</td>
<td>Collected and housed at the district and/or school level</td>
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<tr>
<td>Expulsions</td>
<td>Collected and housed at the district and/or school level</td>
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<tr>
<td>School Violence Incidents</td>
<td>California Healthy Kids Survey (CHKS), California Department of Education</td>
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<tr>
<td>Perception of School Safety</td>
<td>California Healthy Kids Survey (CHKS), California Department of Education</td>
</tr>
<tr>
<td>Gang Involvement</td>
<td>California Healthy Kids Survey (CHKS), California Department of Education</td>
</tr>
</tbody>
</table>

**Examples of Local Data Sources**

- Locally developed surveys
- Key informant interviews
- Focus groups
- One-On-One interviews
- Local police calls for service data
- Place of last drink data
- Local areas deemed overconcentrated by ABC
- Shoulder taps
- Decoy operations
**COMMUNITY RESOURCES TO PREVENT AND/OR ADDRESS AOD USE AND CONSEQUENCES**

<table>
<thead>
<tr>
<th>Program/Strategy</th>
<th>Agency/Organization</th>
<th>Target Population &amp; # served</th>
<th>Funding Period</th>
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<tbody>
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</table>
Sample Logic Model Format

<table>
<thead>
<tr>
<th>Identified Problem or Need (supported by data)</th>
<th>CONTRIBUTING FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>GOAL (or Aim)</th>
<th>RESOURCES (What do we have to help meet our goal?)</th>
<th>STRATEGIES (What methods will we use?)</th>
<th>EXPECTED OUTCOMES/OBJECTIVES (What do we think will happen as a result of our efforts?)</th>
<th>MEASUREMENT INDICATORS (Specifically, how will we know what happened?)</th>
</tr>
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<tbody>
<tr>
<td></td>
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<td></td>
<td>SHORT TERM</td>
<td>INTER-MEDIATE</td>
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<tr>
<td>Identified Problem</td>
<td>Objectives</td>
<td>Examples of Strategies</td>
<td>Short-Term Outcomes</td>
<td>Intermediate Outcomes</td>
</tr>
<tr>
<td>-------------------</td>
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<tr>
<td>Youth are obtaining alcohol from and drinking alcohol in social settings, which results in threats to individual and community health and safety, as well as community impacts such as vandalism, property damage, and other injuries</td>
<td>Reduce adult provision of alcohol to youth in homes</td>
<td>Establish social host liability ordinances in cities and county</td>
<td>Increased community awareness of laws pertaining to adult provision of alcohol</td>
<td>Decreased rates of underage alcohol use (CHKS)</td>
</tr>
<tr>
<td>Some parents are unaware of new and existing research on the impacts on youth who drink alcohol</td>
<td>Increase adult awareness of the nature and extent of youth alcohol use and associated risks</td>
<td>Establish social host liability ordinances in cities and county</td>
<td>Increased community awareness of laws pertaining to adult provision of alcohol</td>
<td>Decreased rates of underage alcohol use (CHKS)</td>
</tr>
<tr>
<td>Youth have easy access to alcohol at some events</td>
<td>Reduce access to alcohol at events sponsored by public and nonprofit organizations</td>
<td>Develop and implement “Parent Pledges” in local communities</td>
<td>Increased community dialogue on issue of teen drinking</td>
<td>Decreased rates of underage alcohol use (CHKS)</td>
</tr>
</tbody>
</table>

*Goal: Reduce alcohol-related problems associated with social access to alcohol

Youth binge-drinking in past 30 days (CHKS)
Youth drinking and driving (CHKS)
Youth drinking and driving (CDOJ)
Liquor law violations (CDOJ)
### Implementation Plan: Sample 1

<table>
<thead>
<tr>
<th>Problem Statement:</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Corresponding Goal:</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Corresponding Objectives:</th>
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</table>

<table>
<thead>
<tr>
<th>Strategy(ies)</th>
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<table>
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<tr>
<th>Action Steps:</th>
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<table>
<thead>
<tr>
<th>Indicator and Target Levels</th>
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<table>
<thead>
<tr>
<th>Measure</th>
</tr>
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</table>
### Sample 2: Implementation Plan

<table>
<thead>
<tr>
<th>Problem Statement: Corresponding Goal:</th>
<th>Objectives</th>
<th>Specific Tasks</th>
<th>Person/Agency Responsible</th>
<th>Timeframe for Accomplishing</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>Outcomes (Degree of Change—Short-Term, Intermediate, and Long-Term)</td>
<td>Indicators (Performance Measures) How will you track change?</td>
<td>Method of Data Collection (Interviews, surveys, observations, record comparisons)</td>
<td>Tools (CHKS, etc.)</td>
<td>Who Collects Data (Staff name, peer leader, outside expert)</td>
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