Session 4 Handouts

*Substance Abuse Prevention Skills* *Training*

Agenda

* **Strategic Prevention Framework**
	+ Step 4: Implementation
	+ Step 5: Evaluation
	+ Sustainability
* **Bringing It All Together**

Learning objectives

* By the end of this session, you will be able to:
	+ List different types of interventions and describe the criteria for selecting an intervention
	+ Recognize the keys to sustainability and how they are integrated into the SPF
	+ Describe high-quality implementation and why it’s important
	+ Explain the purpose of evaluation, and what to consider when reporting the results
	+ Identify ways to apply the training material to your work
	+ List the keys to sustainability and how they are integrated into the SPF

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**INFORMATION SHEET 4.1 – examples of different interventions**

Interventions that prevent substance abuse include programs, practices, and environmental strategies. Some interventions focus on changing individuals, while others focus on changing the environment in some way.1 For instance, certain education-based programs are designed to help individuals develop the intentions and skills to act in a healthy manner. Policies, on the other hand, focus on creating an environment that supports healthy behavior.2

The success of any intervention, or combination of interventions, depends on strong collaboration. By working together, partners can bring different perspectives to bear on a problem, thereby effecting change.

Following are descriptions of some of the different types of interventions.3

**Education-based programs** focus on helping people develop the knowledge, attitudes, and skills they need to change their behavior. Education is one of the most commonly used strategies for attempting to discourage young people from using alcohol and illegal substances. Other common education-based programs are for parents, merchants (who sell alcohol), and beverage servers (who work in restaurants and bars).

**School and community bonding** activities address the risk factor of low attachment to school and community. Specific interventions can include mentoring and alternative activities, such as opportunities for positive social interaction.4

**Communication and public education** involves the media because of the significant role it plays in shaping how people think and behave. Many of the messages on television, billboards, and the Internet, as well as in music and magazines, glamorize drug, alcohol, and tobacco use. Yet, the media can be used to encourage positive behaviors, as well. Communication strategies such as social marketing and media advocacy can be used to influence community norms, increase public awareness, and attract community support for prevention.

* **Social marketing** uses advertising principles to change social norms and promote healthy behaviors. Social marketing messages are designed to convince specific groups to adopt a new behavior by showing them the benefits they will receive in return.
* **Media advocacy** focuses on shaping the way social issues are discussed in the media in order to build support for changes in public policy. It involves working directly with local newspapers, television, and radio to influence both the amount of media coverage provided and the content of that coverage in order to affect the way people talk and think about an issue.

**Policies** are standards that are formalized. But for policies to be adopted, they must reflect the accepted norms and intentions of a particular community. Imagine, for example, trying to regulate smoking in public places 50 years ago, when smoking was not only acceptable but chic. It would have been impossible!

**Enforcement** is essential if policies are going to be effective in deterring people and businesses from illegal behaviors. Enforcement can include surveillance, community policing, and arrests. There must also be significant penalties—this makes a difference.

**Examples of interventions by levels of risk and by developmental stage**

|  | **Promotion** | **Universal Prevention** | **Selective Prevention** | **Indicated Prevention** |
| --- | --- | --- | --- | --- |
| Infancy and early childhood | Public education about the importance of the milestones ofdevelopment | Community policies that promote access to early childhood education | Prevention education for new immigrant families with young children who live in poverty | Parenting skills training for parents that are in substance abuse treatment |
| Middle childhood | Promoting positive school climate for youth-serving agencies in the community  | Social and decision-making skills training for 6th grade youth | Social/emotional skills training for youth in low-income housing developments | Mentoring for middle school youth in low-income homes with parental substance abuse or parental mental illness |
| Adolescence | Promoting emotional self-regulation and positive school and community engagement among adolescents | Implementation and enforcement of youth (tobacco and alcohol) access laws coupled with media campaign to increase awareness of enforcement activitiesEducation for physicians on prescription drug misuse and preventive prescribing practices | Alternative activities and opportunities for positive social interaction among LGBT and non-LGBT youthFacilitated skills group focusing on support, goal setting and monitoring, self-esteem, decision-making and better management of angerfor adolescents identified as high risk | Screening, brief intervention, and referral for court-referred youth arrested for non-violent offensesA school-based prevention program to teach skills on how to manage stress among youth age 14-19 who have been identified as experimenting with alcohol or other drugs |
| Young adulthood | Promoting emotional self-regulation and positive community engagement among young adults | Mandatory participation for freshmen college students in a prevention program that focuses on building problem solving skills, emotion-focused coping, and cognitive and behavioral skills. | Employee assistance programs for young adults at high risk of binge drinkingHigh school or dormitory-based programs for youth at risk for substance abuse that reinforce positive coping skills and help-seeking behaviors | Information and referral for young adults who violate campus/ community policies/ laws on alcohol and drugs |
| Adulthood | Community awareness campaigns on low-risk alcohol use during the holiday season | Alcohol-serving policies at sporting and community events that include the general publicWorkplace prevention interventions designed to teach employees 18 years and older how to deal with stressors at work and at home | Prevention programs for adults with a history of family substance abuse | Brief motivational interview for pregnant women experimenting with alcohol or other drugs |
| Older adulthood | Awareness education on healthy aging, coping, and alcohol and other drug use | Policies regulating the misuse of alcohol and other drugs in senior living facilitiesTraining for home health aides on older adult misuse of alcohol and prescription medication  | Positive social interaction and alternative activities for isolated older adults | Screening, consultation, and referral for families of older adults admitted to emergency rooms with potential alcohol-related injuries |

***Universal*** *preventive interventions focus on the general public or a population subgroup that has not been identified on the basis of risk.*

***Selective*** *preventive interventions focus on individuals or subgroups of the population whose risk of developing behavioral health disorders is significantly higher than average.*

***Indicated*** *preventive interventions focus on high-risk individuals who are identified as having minimal but detectable signs or symptoms that foreshadow behavioral health disorders, prior to the diagnosis of a disorder.*

**INFORMATION SHEET 4.2 – Criteria for Selecting Interventions**

Once a community has reached consensus on its priority risk/protective factor(s), it can begin to think systematically about which intervention(s) to select. There are three criteria to consider:4

* **Effectiveness:** Is the intervention effective?
* **Conceptual Fit:** Will the intervention(s) impact the selected risk or protective factor?
* **Practical Fit:** Is the intervention feasible for the community?

**Evidence of Effectiveness**

This refers to whether an intervention has previously demonstrated evidence of effectiveness, which means that it was evaluated and found to be effective under a particular set of circumstances. Experts agree that an intervention is evidence-based if it fulfills one of the following three conditions:

1. It is included in a federal registry of evidence-based interventions.
2. It is reported in peer-reviewed journals (with positive effects on the primary targeted outcome).
3. When no appropriate interventions are available through the first two primary resources on evidence-based interventions, then prevention planners may need to rely on other, weaker sources of information to identify an intervention that addresses the problem, the population served, and the cultural and community context in which it will be implemented. With this third option, documented effectiveness must be 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.
* 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 at multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects.
* Guideline 4: The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes well-qualified prevention researchers who are experienced in evaluating prevention 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).

When selecting an intervention, it is important to consider whether the evidence of effectiveness is weak or strong. Priority should be given to interventions with strong evidence of effectiveness.

For particular problems, there may be fewer programs that are evidence-based and listed in federal registries or peer reviewed journals. For example, there aren’t many evidenced-based programs that address prescription drug abuse than that address underage drinking. There are also fewer evidence-based programs that have been shown to be effective for certain population groups.

**Finding Evidence-Based Interventions**

* U.S. Department of Education

*Exemplary and Promising: Safe, Disciplined, and Drug-Free Schools Programs* <https://www2.ed.gov/admins/lead/safety/exemplary01/report_pg7.html>

* U.S. Department of Justice, Office of Justice Programs

*Model Programs Guide*

<http://www.ojjdp.gov/mpg/>

* National Institute of Drug Abuse

*Preventing Drug Use among Children and Adolescents: A Research-Based Guide*

<http://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents>

* Centers for Disease Control and Prevention

*Guide to Community Preventive Services*

<http://www.thecommunityguide.org>

**Peer Reviewed Journals**

* *American Journal of Public Health*
* *Journal of Addiction Studies*
* *Annual Review of Public Health*
* *Journal on Studies of Alcohol*
* *Preventive Medicine*
* *Journal of School Health*
* *Journal of Adolescent Health*
* *Journal of the American Medical Association*
* *Public Health and Research*

**Searchable Databases**

* Google Scholar

<http://scholar.google.com/>

* U.S. National Library of Medicine

<http://www.pubmed.gov>

**Conceptual Fit**

Conceptual fit considers how relevant a type of intervention is at doing the following:

* Addressing the priority risk/protective factor and problem
* Producing positive outcomes with the substance abuse problem or risk/protective factors
* Targeting multiple contexts (e.g., individual, family school/community). For example, some types of interventions, like media campaigns and merchant education, occur in the community, whereas parental education occurs within the family context.

To assess the conceptual fit of an intervention, consider whether it clearly fits with your logic model by asking the following questions:

* Does it address the problem (e.g., underage drinking)?
* Does it address the risk/protective factors and conditions associated with the problem (e.g., social norms that accept or encourage youth drinking, low perceived risk of alcohol among youth, easy access to alcohol among youth, low enforcement of alcohol laws)?
* Does it target a relevant population and/or context (e.g., youth, parents, retailers, law enforcement)?

**Practical Fit**

Practical fit refers to the appropriateness of a specific intervention for a specific community. 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. The following questions will help determine the practical fit of an intervention:

* ***Is it feasible?*** Does the community have the resources (e.g., human, organizational) needed for the intervention?
* ***Is there synergy?*** Does the intervention add to or reinforce other prevention interventions?
* ***Is the community ready?*** Will stakeholders and the community support the intervention?
* ***Is the intervention culturally relevant?*** Will the cultural group(s) that are the focus of the intervention be receptive to it? Are they involved in the planning and implementation?

**INFORMATION SHEET 4.3 – Conceptual Fit – Sample Risk and Protective Factors and Interventions for Underage Drinking**

| **Risk Factors** | **Possible Interventions** |
| --- | --- |
| Social Access |
| Party hosts and people furnishing alcohol believe that they will not be caught or punished. | * Increase enforcement of furnishing and hosting laws (e.g., party patrols, shoulder-tap checks)
* Media campaign and/or media advocacy describing penalties for furnishing and hosting, and campaign on social host liability
* Work with media to publicize incidents of furnishers/hosts being caught and prosecuted
 |
| Community norms support the practice of adults hosting drinking parties for teens as an inevitable “rite of passage.”  | * Social marketing campaign targeting community norms
 |
| Parents feel that their children will drink anyway, so they prefer that they are “safe” and drink at home. | * Social marketing campaign aimed at parents
 |
| Parents are not monitoring their home alcohol supply. | * Social marketing campaign aimed at parents
 |
| Retail Access |
| Low prices make alcohol accessible to youth.  | * Alcohol tax increase
 |
| Clerks don’t check IDs.Clerks do not know how to recognize fake IDs. | * Merchant education and clerk training
* Partner with retailers
* Compliance checks
 |
| Retail merchants’ laws are not enforced.  | * Compliance checks
 |
| Low Enforcement |
| Lack of enforcement by police of underage drinking laws. Lack of prosecution by judges of underage drinking laws. | * Enforcement of existing underage age drinking laws and prosecution of existing underage drinking laws
* Work with media to publicize incidents of underage drinking
* Partner with law enforcement and the District Attorney’s Office regarding prosecution
 |
| Promoting Alcohol Use  |
| Alcohol use is promoted through advertising, movies, music. | * Restrict alcohol advertising
* Restrict alcohol-related promotional events in community settings
 |
| Promoting Alcohol Use |
| Alcohol use is promoted through advertising, movies, music. | * Restrict alcohol advertising
* Restrict alcohol-related promotional events in community settings
 |
| Peer Norms |
| Peer norms favor alcohol use. | * Social marketing campaign targeting peer norms around substance use
* Educationcurriculum
 |
| Family Norms |
| Parent or sibling uses alcohol (or there is the perception that a parent or sibling uses alcohol).  | * Social marketing campaign targeting family norms around substance use
* Education curriculum
 |
| Parental monitoring of their children (or perception of monitoring) is limited. | * Social marketing campaign targeting parental monitoring
* Education curriculum
 |
| Parental care or involvement with their children is low. | * Educationcurriculum
 |
| Perception of Harm |
| Perception of harm from alcohol use is low. | * Social marketing campaign targeting perceptions of harm
* Education curriculum
 |

| **Protective Factors** | **Possible Interventions** |
| --- | --- |
| Individual Behaviors and Expectations |
| Low sensation seeking  | * Promotion of arts and science-related school activities
 |
| Fewer positive expectations of alcohol | * Media messages on the negative consequences of alcohol use
* Education curriculum
 |
| Attachment to Family and Community |
| Positive opportunities to belong | * Increased variety of social, enrichment, and physical activity opportunities for you
* Youth engagement in local prevention activities
 |
| Family connectedness | * Increased family-oriented community and school activities
 |
| Fewer friends who use substances | * Peer education opportunities
* Cross-age prevention curriculum
 |
| Parents’ disapproval of substance misuse and other deviant behavior | * Parent education curriculum
* Parent pledges supporting non-use
 |
| Prosocial community and school activities  | * Promotion of volunteer opportunities
 |
| Personal importance of religion | * Youth oriented/planned church activities
* Family-focused church activities
* Church-sponsored community service
 |

**workSHEET 4.4 – case study activity – Determining Fit**

**Purpose of Activity** – To consider practical fit when selecting evidence-based interventions.

**Instructions** –

1. Your case study group will use the risk factor it was previously assigned for **Worksheet 3.10: Case Study Activity – Prioritizing Risk/Protective Factors.**
2. Select one of the following evidence-based interventions for your risk factor. Refer to **Information Sheet 4.1: Examples of Different Interventions** for descriptions of the interventions.
* Parental monitoring
	+ Evidence-based curriculum targeting parents
* Social access
	+ Increase enforcement of underage drinking laws
* Perception of harm
	+ Social marketing campaign targeting youth perceptions of harm
* Positive opportunities to belong
	+ Youth advisory board with the local prevention coalition
1. In the table below, write the risk/protective factor and intervention you selected, and answer the questions to determine the practical fit for that intervention. You may want to use information about the case from **Worksheet 3.9: Case Study – Assessment Information.**

| **RISK/PROTECTIVE FACTOR:**  |
| --- |
| **SELECTED INTERVENTION:**  |
| Practical Fit Considerations | **Circle Your Answer** |
| Resources: Do we have the resources NOW to implement the intervention?  | **Yes No Need more info** |
| Contacts: Do we have the people involved that we need in order to be successful in implementing the intervention?  | **Yes No Need more info** |
| Support: Will the community support an intervention? Do we have the organizational support we need to implement the intervention?  | **Yes No Need more info** |
| Reflect culture: Will the cultural groups that are the focus of our intervention be receptive to what we plan to do? Are members of the focus population involved in the planning and implementation process?  | **Yes No Need more info** |
| Sustainable: Do we have a plan that includes considerations about how positive outcomes would be maintained over time?  | **Yes No Need more info** |
| Can be evaluated: Is there baseline data? Do we have a workable plan to collect and analyze our data before and after the intervention?  | **Yes No Need more info** |

information sheet 4.5 – key tasks of implementation

NIKE might encourage people to “Just do it!”, but implementing an intervention takes planning and preparation. Under the SPF, implementation includes three broad tasks:

* Enhance support and building capacity related to implementation
* Implementing evidence-based programs, policies and practices, paying specific attention to issues of adaptation and fidelity
* Monitoring implementation by collecting evaluation data and making mid-course corrections based on what the data reveal

**1. Mobilizing support and building capacity related to implementation**

*Is the community aware of the problems and intervention(s) selected, and is there adequate support for the intervention? Have key leaders been brought to the table? Does the population that the intervention(s) serve believe that the problem(s) need to be addressed? Has the intervention been introduced to the stakeholders? What training is needed to support implementation?*

Mobilizing and building capacity to support implementation involves the following:

* **Increasing community awareness** of the problem and of the intervention(s) selected to address it. This will help improve the readiness of the community to adopt the intervention and carry it out successfully. It is like fertilizing the soil so that a plant— in this case, an intervention—will take root and flourish. So before implementing anything, do your homework and figure out how to best increase awareness of the problem among stakeholders, community leaders, and the population the intervention serves.
* **Introducing the intervention to stakeholders** to obtain their buy-in and expand partnerships. Getting stakeholders, partners and community members onboard and ready to implement an intervention can take time, particularly when there is turnover among key partners or if there is resistance. Partnerships may also need to be expanded to include new partners—to individuals or organizations you didn’t initially think needed to be involved or to individuals with specific skill sets.
* **Training** may be necessaryfor the people implementing the intervention if they do not have the necessary skills. Training can also help overcome hesitation or resistance by alleviating misperceptions and clarifying expectations. Some evidence suggests that training may also be correlated with the completeness and fidelity of implementation efforts: trained staff members are more likely to implement more of the key components of an intervention and do so according to the guidelines provided by the developer than untrained staff.

**2. Implementing evidence-based programs, policies, and practices, paying specific attention to adaptation and fidelity**

*In what ways can and should the intervention(s) be tailored to fit local circumstances? Will the adaptations compromise fidelity? Has an action plan been developed that outlines who is responsible for doing what and when? Have potential challenges to implementation been considered?*

SPF Step 3—planning—focuses on finding evidence-based interventions that are a good conceptual and practical fit for a community. Now it’s time to implement these interventions. When doing so, consider the following:

* **Balance fidelity with adaptation.** Fidelity refers to the degree to which a program is implemented as its developer intended. For example, when baking a cake, you have to be faithful to the recipe or it won’t work; changing the flavor of the icing might be okay, but changing the amounts of flour or salt could be disastrous! The same applies to interventions. It is possible that some elements of the intervention could be adapted without influencing the outcome, but most elements must be kept the same. Having said that, it is sometimes necessary to adapt an intervention to fit certain population groups or local circumstances, such as budget constraints, staff availability, and time issues.In these situations, it is important to think carefully about balancing the need for maintaining fidelity of the intervention with the need to adapt it.

*It is helpful to work with an evaluator, as well as the intervention developer, to determine how to best adapt it (i.e., to identify those elements that should be maintained.) Remember, interventions that are implemented with complete fidelity are more likely to be effective.*

* **Develop and carry out an action plan** that details what is to occur, who is responsible, and a timeline for doing so. Similar to an itinerary for a trip, this action plan will help ensure that everyone involved is on the same page, and that the intervention is carried out successfully.

**3. Monitoring implementation by collecting evaluation data, and making mid-course corrections based on what the data reveal**

*How will you know the intervention has been implemented successfully? What will you do if the results are not what you projected?*

This task includes these activities:

* **Monitoring implementation** to determine if the intervention was delivered the way it was designed. For example, was the same material presented, in the same number of sessions, over the same time frame, using the same methods? To find out, you will need to collect data on the details of implementation. Any adaptations—even those that are seemingly minor—could impact the evaluation results.
* **Making mid-course corrections** to the intervention or its implementation, if the monitoring data are not what you anticipated. Perhaps the intervention calls for six parent education classes, but the implementation schedule only includes four. This difference between intended and actual implementation may occur for many different reasons, including scheduling conflicts or discomfort with the content among either participants or trainer(s). Once you determine the reason(s) for the gap, take strides to close it. For example, if it turns out that the trainer feels ill-prepared to handle the content, you could provide additional coaching to increase trainer comfort and skills and add the two remaining classes back to the schedule.

**Information sheet 4.6 – guidelines for adaptation5, 6**

Adaptation refers to how much, and in what ways, a program, policy, or practice is changed to meet local needs and circumstances. It is important to balance adaptation with fidelity. Fidelity refers to the degree to which a prevention program is implemented as its developer intended. Be aware that any change or adaption to a program can compromise its results.

Here are some general guidelines to follow when adapting a program:

* **Select programs with the best practical fit to local needs and conditions.**

This will reduce the likelihood that you will need to make any significant adaptations.

* **Change capacity before changing the program.**

It may be easier to change the program but changing local capacity to deliver it as it was designed (e.g. through training, mentoring) is a safer choice.

* **Consult with the program developer.**

Consult with the program developer to determine what experience and/or advice he or she has about adapting the program to a particular setting or circumstance.

* **Retain core components.**

There is a greater likelihood of effectiveness when a program retains the core component(s) of the original intervention. The program developer or your evaluator can identify these core components.

* **Add, rather than subtract.**

It is safer to add to a program (e.g. more activities, increased length of time an intervention is offered) than to modify or subtract from it.

**information sheet 4.7 – case study activity – implementation, part 1 & 2**

**Part 1**

**Purpose of Activity** – To begin to consider the tasks involved in implementing an intervention

**Instructions –**

1. Get in your case study groups.
2. Write the risk/protective factor and intervention you selected in Session 3, **Worksheet 4.4: Case Study – Determining Fit** in the space below.
3. Brainstorm and list the action steps you might take in the first 3-6 months of implementing this intervention. You can refer to **Information Sheet 4.5: Key Tasks of Implementation.**

**RISK/PROTECTIVE FACTOR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INTERVENTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

| Action Steps  |
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**Part 2**

**Purpose** – To consider some of the potential challenges that may arise with implementing an intervention and possible solutions

**Instructions –**

1. Write down your risk/protective factor and intervention in the space below.
2. In your groups, brainstorm potential challenges to implementing the intervention you selected and write them in the table below.
3. Exchange your list of challenges with another group.
4. Brainstorm potential solutions to the challenges identified by the other group for their risk/protective factor and intervention.

|  |
| --- |
| **RISK/PROTECTIVE FACTOR:** |
| **INTERVENTION:** |
| **Potential Challenges** | **Possible Solutions** |
|  |  |
|  |  |
|  |  |

**Worksheet 4.8 – overview of evaluation**

Evaluation is the systematic collection and analysis of information about an intervention to improve its effectiveness and make decisions.7 It is an intrinsic part of all the steps of the SPF.

Evaluation is useful for the following reasons:

* Helps to assess the progress of an intervention
* Identifies what does and does not work in a particular setting
* Can be used to build community capacity and influence decision-makers
* Strengthens accountability
* Supports sustainability

**Types of Evaluation**

An evaluation can be used to collect both process and outcome evaluation data. *Process* evaluation occurs during the implementation of an intervention; *outcome* evaluation occurs after the intervention has been implemented. Collecting these types of data will help you do the following:

* Monitor implementation
* Improve implementation and performance
* Determine which interventions and outcomes should be sustained

**Process evaluation** documents all aspects of the implementation of an intervention. It describes how the intervention was implemented—that is, if the same material was presented in the same number of sessions over the same timeframe using the same methods. Process evaluation answers the question: “Did we do what we said we would do?”

Process evaluation data can help you determine the following:

* + Were interventions implemented as planned?
	+ Who participated and for how long?
	+ What adaptations were made?
	+ Were the resources sufficient?
	+ What obstacles were encountered?

**Outcome evaluation** documents whether the intervention made a difference, and if so, what changed. It documents effects achieved *after* the intervention is implemented, such as short- and long-term changes in a population group’s knowledge, attitudes, skills, or behavior as a result of the intervention. Outcome evaluation answers the question: “Did our intervention make a difference—did it impact the risk factors and problem we wanted to address?”

Outcome evaluation data can help you determine the following:

* + What changes actually occurred
	+ How these changes compare to what the intervention was expected to achieve
	+ How these changes compare with those not exposed to the intervention

**Outcomes**

A community will need to identify the short-term and long-term outcomes it hopes to achieve with its overall comprehensive prevention plan, as well as for each intervention it implements. Remember that if the intervention does not address the underlying risk and protective factors that influence the targeted problem, then it is unlikely to produce positive outcomes or changes in that problem.

**Short-term Outcomes:**

* Short-term outcomes are the immediate effects that the intervention is expected to achieve. These outcomes are expressed as changes in knowledge, attitudes, and skills of the focus population at the end of the intervention.
* Short-term outcomes tend to be connected to changes that occur in the risk or protective factor.
* Be aware that how well the intervention is implemented can have an impact on short-term outcomes.

**Long-term Outcomes:**

* Long-term outcomes are the ultimate effects of the intervention at some point after the intervention is completed, maybe six months to a year later.
* Long-term outcomes depend on the short-term outcomes because short-term changes in knowledge, attitudes, or skills can lead to long-term behavior change.
* Long-term outcomes tend to be connected to the ultimate behaviors and related problems that you are trying to change.

worksheet 4.9 – activity – EVALUATION QUESTIONS

**Instructions –** Review each of the evaluation questions on this worksheet and select whether it is a process or outcome evaluation question.Check the appropriate box.

| Evaluation questions | Process | Outcome |
| --- | --- | --- |
| 1. How many individuals/groups did the intervention serve?  |  |  |
| 2. To what extent did the intervention lead to improved coping skills among participants? |  |  |
| 3. To what extent was the intervention implemented completely, as intended? |  |  |
| 4. How many youth participants used alcohol one year after the end of the intervention? |  |  |
| 5. To what extent did the intervention lead to a change in participants’ attitudes toward the harmful effects of using tobacco? |  |  |
| 6. How many students who were referred to the intervention actually participated? |  |  |
| 7. What cultural adaptations were made to the intervention? |  |  |
| 8. Were the people exposed to the intervention representative of the population the intervention was intended for? |  |  |
| 9. How are preliminary evaluation findings being used to improve the intervention? |  |  |
| 10. After the intervention, did people exposed to it have more positive normative beliefs compared to those not exposed? |  |  |

Information Sheet 4.10 – REPORTING evaluation results

Evaluation results are used to improve programs, sustain positive outcomes, and improve a community’s overall plan for addressing substance abuse and promoting wellness. But they can be used for other reasons as well, such as to help obtain funding or to build community awareness and support for prevention.

To make a difference, evaluation results need to get into the hands of the people who can use them. Keep in mind that *organizations* don’t use evaluation results—*people* do. The Department of Health, for example, isn’t going to use the results of an evaluation, but Cathy Smith in the Department of Health may. So, unless you get the results of the program evaluation into her hands and explain how she can use the results, they will sit on a shelf somewhere in the Department of Health.

When reporting your evaluation results, consider these tips:

* **Brief stakeholders regularly**,throughout the process, rather than waiting until the end of the project. No one likes surprises—positive or negative. If possible, present stakeholders with a draft of your report before it goes public.
* **Create a dissemination plan.** Identify the various audiences that need to see the results—including the focus population—the information that would be most useful to them, and how this information will be delivered.
* **Select appropriate reporting formats.**Not all formats are appropriate for all audiences. Think carefully about the best venue or vehicle for delivering results. Should it be a public presentation? A new section of your website? Or a more formalized report?
* **Help stakeholders understand the data.** Take time to review the findings with your stakeholders, discussing the ramifications of what you found. Don’t shy away from negative or unexpected results. Instead, use these as an opportunity to inform future prevention efforts.

**Tailoring Dissemination**

Remember that each stakeholder has his or her own interests, and will be most interested in the findings that relate to or impact these interests. One size will not fit all. To ensure that your presentation is most relevant to the various stakeholders and community members, consider these questions (in order):

* WHAT data have you collected?
* WHY do you want to share the data?
* WITH WHOM will you share the data?
* HOW MUCH data do they want to know?
* HOW are you going to present the data?
* WHO will present the data?
* WHERE will the data be presented?
* WHEN will the data be presented?

**Sample table for reporting results7**

|  |
| --- |
| **METHODS** |
| **AUDIENCE**  | Abstracts & Briefings | Annual/ Evaluation Reports | Fact Sheets | Brochures and Posters | Exhibits | Press Conferences | Press Releases | Town Meetings |
| Current/ Potential Funder | X |  |  |  |  |  |  |  |
| New Potential Funder | X |  | X |  |  |  |  |  |
| Administrator | X | X |  |  |  |  |  | X |
| Board Members | X | X | X |  |  |  |  | X |
| Community Groups |  |  | X | X |  |  |  | X |
| General Public |  |  | X | X | X |  | X | X |
| Organizations |  |  | X |  | X |  |  |  |
| Media |  |  | X |  |  | X | X | X |

**Factors that Influence Whether Results Will be Used**

Whether, and how, your evaluation results get used depends largely on the following:

* + **How findings are reported**, including layout, readability, and user-friendliness; these all make a difference. Timing is also critical. If a report is needed for a legislative session, but isn’t ready in time, then the chances of the data being used drop dramatically.
	+ **The qualityof the evaluation and relevance of the findings**. For example, if the evaluation design is logically linked to the purpose and outcomes of the project, the findings are far more likely to be used.
	+ **Political context or climate.** Some evaluation results will get used because of political support, and others will get squashed because of political pressure.
	+ Other **factors, such as** **the size of your organization or program**. For example, sometimes larger programs or targeted programs get more press.
	+ **Competing information.** For example, are there results from similar programs that confirm or deny your results? Are there other topics competing for attention?

**iNFORMATION SHEET 4.11 – KEYS TO SUSTAINABILITY**

**Keys to Sustainability**

Sustaining effective behavioral health promotion and prevention efforts requires ongoing attention to a number of key elements which are integrated into the steps of the SPF:7

* Build community support
* Enhance organizational capacity
* Ensure effectiveness

**Build Community Support**

Cultivating community support for prevention and behavioral health promotion and the positive outcomes they achieve is built on the success of organizational efforts to collaborate. Community support can be built by:

* Encouraging community ownership through positive relationship building and collaboration
* Celebrating promotion/prevention successes and accomplishments in public and through social media
* Developing community promotion/prevention leaders and champions, and connecting to other prevention efforts locally, regionally, and statewide

 **Enhance Organizational Capacity**

Assuring that community agencies, organizations, and institutions have adequate internal organizational capacity to achieve positive outcomes involves exploring the answers to a number of questions:

* Do organizations have strong administrative structures that will allow them to be competitive for grants and other opportunities?
* Are there formal linkages, such as memoranda of understanding (MOUs), with key partners? Do partners share equal responsibility for addressing community issues?
* Do partnering organizations have resources and expertise they are willing to share?

**Ensure Effectiveness**

Effectiveness is more than just using evidence-based interventions. Effectiveness depends on making sure the logic model lines up in the following ways:

* Interventions are aligned with the problem and risk factor and have sufficient reach.
* Evidence-based practices that are a good fit conceptually and practically are used.
* The implementation is high quality, and includes buy-in from the community, administrative support, and adequate training for staff to do the intervention.
* The evaluation plan provides ongoing process and outcome data, so improvements can be made as needed.

**INFORMATION SHEET 4.12 – SAMHSA’S STRATEGIC PREVENTION FRAMEWORK AT A GLANCE**

**INFORMATION SHEET 4.13 – ACTIVITY – ASSESS YOUR LEARNING EXPERIENCE**

On your own, complete the following statements:

1. **Something new I learned this week is…**

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1. **Something I already know but gained a better understanding of this week is…**

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1. **Something I’m still wondering about is…**

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1. **Something from this training that I will use in the next month is…**

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