

South Carolina Toolkit for Evidence-Based Prevention Programs and Strategies

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SECTION I

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Keys to Developing Performance-Based Prevention

Key Indicators of Performance-Based Prevention

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“Would you tell me please which way I ought to go from here?” “That depends a good deal on where you want to get to,” said the cat. “I don’t much care where,” said Alice. “Then it doesn’t matter which way you go,” said the cat.

– Lewis Carroll

Unlike Alice, providers of substance abuse prevention now have available a body of research and practice knowledge that can aid in determining where they want to go and the best approaches to use to get there. However, without an understanding of what works, providers of substance abuse prevention are frequently, like Alice, unsure of the direction they should take. The result is that prevention efforts frequently are not performance-based and do not result in a decrease in the problems caused by the use of alcohol, tobacco and other drugs. These problems are complex and, unfortunately, cannot be solved by simple solutions. Understanding key indicators of performance-based prevention gives prevention providers needed tools for identifying needs, selecting and planning programs and strategies, implementation and measurement of outcomes.

William Lofquist, one of the pioneers of modern prevention technology, is often quoted as saying that *“Those who promote positive change most effectively may not be those who provide the new set of answers, but those who allow a new set of questions.”* It is with this principle in mind that the following indicators are offered as keys to developing successful performance-based prevention efforts. A word of caution: Beware of those who claim to have the magic silver bullet of substance abuse prevention! The following makes no claim to being “the answer” and reflects only the author’s attempt to understand how substance abuse prevention can work.

“Why are some programs and strategies more successful than others in reducing the problems that result from the use of alcohol, tobacco and other drugs by youth and/or adults or in preventing or delaying the onset of use of these substances by children and youth?” Perhaps the most frequent answer given is a lack of funding to adequately implement the prevention program or strategy. While this is rightfully a major concern, because substance abuse prevention funding seemingly is not a priority at the community, state or federal levels of government or private organizations, it does not completely answer this question because there are numerous examples of well-funded programs that have not shown significant results. This paper will examine key indicators of performance-based prevention that the author believes critical to successful programs or strategies. Among these are the following:

- a commitment to use evidence-based prevention programs and strategies;
- a commitment to blend individual and environmental approaches;

- a commitment to collaboration;
- development of a framework based on the above;
- use a logic model of planning, implementation, outcome measurement and continuous quality improvement; and
- a commitment to nurture, sustain and improve efforts by supporting inclusive prevention resource systems at the community and state level.

A commitment to use evidence-based prevention

The first key to developing a performance-based prevention begins with commitment – first by the heart and second by the head.

The commitment from the heart is a passion to change the current level of problems caused by the use of alcohol, tobacco and other drugs. If you do not want to see things change, then chances are your commitment to prevention will not be lasting. Preventionists are change-agents, committed to working for changes that may not be seen for years.

However, a commitment to change is not enough. From the head, there must be a willingness to apply the lessons learned from theories and programs shown to be science-based or, as the process is sometimes referred to, research- or evidence-based. Why? Because the use of evidence-based theories, programs or strategies increases the likelihood that the interventions selected will have a greater probability of success. This is a critical step that many prevention providers find difficult to take because it can mean forsaking familiar programs for approaches that require learning a new set of decision-making skills and new or altered commitment of resources on the part of an agency.

“Evidence-based” refers to the process by which experts use commonly agreed upon criteria for assessing the outcomes of an intervention and have consensus that the findings are credible and can be substantiated. It begins with the question “*What is the level of evidence that this intervention will have results with this problem and target population?*” The federal Center for Substance Abuse Prevention recommends that substance abuse prevention providers determine the level of credibility that best meets their needs by applying five processes for scientific-review. Briefly, these are:

- Level 1. The program or principle has been identified or recognized publicly or received awards, honors or mentions. At this level, there is not sufficient evidence to ensure that the intervention is effective.
- Level 2. The program has appeared in a non-refereed professional publication or journal. At this level, there is suggestive value, but professional journals do not have the same standards for expert review by peers as do peer-reviewed journals.
- Level 3. The program’s documented outcomes have been subjected to thorough scrutiny by an expert/peer-consensus process for the quality of implementation and evaluation methods and/or appeared in a peer-

reviewed journal. Many substance abuse prevention providers believe this is the minimum acceptable level for selecting a program for implementation. At this level, the cautious substance abuse provider will still closely examine how well the program's activities are suited for the setting and target population before implementing the program.

- Level 4. The program has undergone an expert/peer process of qualitative and/or quantitative meta-analysis. At this level, multiple studies show consistently positive conclusions.
- Level 5. Replication of the program has appeared in several refereed professional journals. The best level of evidence of a program's effectiveness is that it can be replicated across settings and populations.

The U.S. Department of Education has taken a similar approach in its guidelines for funds made available to states through the Safe and Drug-Free Schools and Communities Act (SDFSCA). Known as the "Principles of Effectiveness," these require recipients of funds to coordinate with other available prevention efforts within their communities to maximize the impact of all drug and violence prevention programs and resources. In addition, an applicant seeking these funds must address the following four principles:

1. Programs must be based on a thorough assessment of objective data about the drug and violence problems in the schools and communities.
2. With the assistance of a local or regional advisory council (when required by the SDFSCA), a set of measurable goals and objectives must be established and programs must be designed to meet those goals and objectives.
3. Programs for youth must be designed and implemented based on research or evaluation that provides evidence that the programs prevent or reduce drug use, violence or disruptive behavior among youth.
4. Programs must be evaluated periodically to assess their progress toward achieving their goals and objectives, and evaluation results must be used to refine, improve and strengthen the programs, and to refine their goals and objectives as appropriate.

Once a commitment to using an evidence-based approach has been made by prevention providers, the challenge becomes one of learning which programs and strategies meet the criteria given above for a Level 3 program. At Level 3, there is some degree of assurance that if implemented as described and evaluated, there is a good chance of having the same results. Unfortunately, many prevention providers stop at this point in the planning process and begin to focus solely on implementation. There are several other key indicators of success that should be considered before implementation. A commitment to use of evidence-based prevention provides the foundation for use of these additional indicators.

A commitment to blend individual (host) and environmental (policy) approaches

In *Alcohol and the Community: A Systems Approach to Prevention*, author Harold Holder presents a compelling argument that drinking alcohol is not only a personal choice frequently driven by biological factors, but also a matter of custom and social behavior within an individual's specific community that is influenced by access and economic factors, such as the level of disposable income and the cost of alcoholic beverages. Thus, the more promising prevention approaches will adapt an ecological perspective of the community and the role of substances within the community. Holder encourages prevention providers to incorporate the following propositions into a new paradigm for preventing alcohol problems or problems resulting from the use of nicotine and other drugs:

- Substance abuse problems are the natural result of dynamic, complex and adaptive systems called “communities.”
- Intervening only with high-risk individuals or small groups can produce short-term reductions in substance abuse, but the system will produce replacements for individuals who leave high-risk status and the system will adapt to changes in the compositions and behavior of its subgroups and populations.
- The most effective prevention programs will incorporate strategies to alter the system (community) that produces substance abuse.
- Prevention programs have historically been “single focused”; that is, attempting to accomplish a goal by one program or strategy rather than by concurrent, mutually reinforcing approaches.
- Without an understanding of the community as a dynamic system – that is, without a model that increases our ability to understand and effectively change the system – it is unlikely that effective long-term prevention will occur.

Individual approaches to substance abuse prevention define the problem as one of poor decision-making by individuals. Health is seen as a personal concern, and prevention approaches are directed at improving decision-making or resistance skills. Individual approaches are critical to successful prevention programs, especially those that target small groups of individuals or high-risk populations. However, focusing only on individual approaches causes prevention providers to be one-dimensional in their efforts.

Environmental approaches to substance abuse prevention define the problem at the policy level. Health is seen as a social issue, in addition to being an individual decision, and prevention approaches are directed at changing public laws, policies and practices to create environments that decrease the probability of substance abuse.

The challenge to prevention providers is to first become two-dimensional in conceptualizing approaches to prevention and then to blend these approaches to maximize outcomes.

A two-dimensional approach to prevention can be illustrated by the following:

Individual	Environmental
<ul style="list-style-type: none"> • Approach defines individual problems that place a person at risk. 	<ul style="list-style-type: none"> • Approach defines problems at the policy level.
<ul style="list-style-type: none"> • Substance use is seen as a personal choice. 	<ul style="list-style-type: none"> • Substance use is seen as both an individual and a systems issue.
<ul style="list-style-type: none"> • Approach consists of short-term programs. 	<ul style="list-style-type: none"> • Approach involves long-term policy changes.
<ul style="list-style-type: none"> • Programs are used to change individual behavior. 	<ul style="list-style-type: none"> • Strategies are used to influence changes in policies.

Prevention providers should avoid “choosing sides” by becoming an advocate for an environmental approach over an individual approach or vice versa, but should rely upon the evidence to guide them in the selection of programs and strategies and always strive to blend individual and environmental approaches. For example, most high schools, colleges and communities are concerned about the use of alcoholic beverages by individuals under the age of 21. The Office of Juvenile Justice and Delinquency Prevention’s 1999 publication, *Strategies to Reduce Underage Alcohol Use: Typology and Brief Overview*, reviews 36 approaches to preventing underage drinking and ranks the research evidence on the outcomes of each approach. School-based curricula rank low in terms of measurable outcomes on changing underage drinking behavior. A one-dimensional prevention provider who advocates only approaches that are intended to provide the individual with healthy decision-making skills may erroneously choose a school-based curriculum as the approach to reduce underage drinking. A two-dimensional prevention provider will not only choose individual evidence-based approaches, but will also, at the same time, plan to implement environmental approaches that have been shown to be highly effective, such as compliance checks, zero-tolerance laws and increases in the cost of alcoholic beverages.

An article in the January/February 1999 *Prevention Pipeline* – “Integrating Environmental Change Theory Into Prevention Practice” by Michael Klitzner – gives preventionists practical strategies for implementing policy changes.

Since few prevention practitioners receive training in substance abuse prevention theory prior to coming to work, understanding the theories that support individual behavior changes and those supporting environmental system changes needs to be part of their in-service education.

However, a significant challenge to prevention providers is devoting the time and the resources to stay current with the research on what works and why. Thanks to the Internet, this information is becoming increasingly accessible to prevention practitioners. However, few Internet sites devote the time required for reviewing the research literature to produce up-to-date summaries of lessons learned. In addition, federal agencies such as the Center for Substance Abuse Prevention occasionally produce documents or conduct

videoconferences on lessons learned from science and practice. State clearinghouses on alcohol, tobacco and other drugs usually subscribe to the journals in which the research is published, but seldom do they have the resources to synthesize the information in a form that is useful to prevention providers.

A commitment to collaboration

Research, practice and common sense combine to tell us over and over again that interventions need to be mutually reinforcing and concurrent within the school, family, media, workplace and community to maximize effectiveness. For example, as in the previous illustration, if an assessment of needs indicates that underage drinking is a significant problem in Community X, and the community decides to set a goal of reducing underage drinking, all of the strategies and programs initiated should be designed to reach this goal. Some of the approaches may target the individual behavior of youth through school-based programs that focus on life-skills training or through peer initiatives (such as those developed in many states using the Teen Institute model or similar programs), while other approaches target reducing access to alcohol through compliance checks, merchant education or keg registration. However, accomplishing this level of comprehensive planning is perhaps the greatest challenge facing prevention practitioners at all levels, because it requires a commitment to collaborate on the part of individuals and organizations. Far too frequently, collaboration is given only lip service by prevention providers for a number of reasons. Among these are the following:

- *A lack of clarity and support on the part of community leaders of effective prevention strategies, hence unrealistic expectations from prevention consumers.* Informing key decision-makers of what works and why is an ongoing task of prevention providers.
- *The fragmentation of effort at the federal and state levels that impacts on commitments to systems collaboration at the community level.* Federal funding for substance abuse prevention comes to the states from several different agencies that in turn distribute funding through their systems. At the community level, the recipients of these funds are told of the need to collaborate; however, this recommendation is typically not modeled at the state and federal levels. In addition, collaboration requires the flexibility to blend funding to meet local needs. This level of flexibility is seldom granted to communities. Agencies and organizations at the state and community levels must place a value on developing prevention resource systems that are intentional in their linkages and funding.
- *A lack of knowledge of risk and protective factors that correlate with the needs identified through an assessment and that can be used to develop a community risk- and protective-factor profile, therefore guiding the selection of goals, objectives, strategies and activities that foster collaboration among community health and human service providers.* Thanks to David Hawkins and others, prevention providers now recognize the need to target risk and protective factors. However, as a field, we are still learning which risk factors pose a greater risk than others, such as

easy access to substances, family members with a history of substance abuse or poor academic achievement. *In other words, not all risk factors are equal. Nor are all protective factors equal.* Hence, whether the approach is to decrease risk or build upon protective assets, or preferably to blend approaches, the prevention planner must be able to apply the lessons learned from research and practice in selecting the risk and protective factors to be targeted and the most effective interventions. Not all interventions will equally impact identified risk and protective factors. Therefore, careful planning of the interventions identified is needed to maximize outcomes.

- *A lack of commitment on the part of prevention providers to utilize strategic planning to improve prevention efforts.* Many states and communities have developed some type of strategy to prevent substance abuse. Some have utilized the risk- and protective-factor information to develop a profile that is used to determine priorities for prevention efforts and can be used to determine which risk or protective factors to target. In addition, many states and communities have developed goals and objectives that support the national ones set by the Secretary of Health and Human Services. However, the substance abuse prevention system as a whole has not adequately supported planning as a major function of prevention practitioners. State and community agencies must place a value on developing comprehensive prevention strategies and plans that are inclusive and not agency work plans.
- *A low level of commitment on the part of prevention providers to confront the norms or laws within their state or community that promote easy access to alcohol, tobacco or other drugs or that promote use of these substances.*

The above barriers to collaboration present significant challenges to prevention providers, and failure to place an organizational value on the process of collaboration frequently results in program planning and implementation not being as successful as hoped.

Development of a prevention framework

“A picture is worth a thousand words” is a saying that everyone understands and with which most people agree. Business and industry certainly have recognized the value of showing the steps needed to produce their product and use flow charts for planning and quality control. Not only do graphic depictions of processes allow for the identification of important factors, easily scanned visuals provide a tool for showing the customer how the process works. Anyone who has been asked to explain substance abuse prevention in a few words recognizes its complexity. By developing, adopting and disseminating a framework for prevention that incorporates the above indicators, prevention providers can facilitate planning and learning at several levels

A commitment to use a logic model

A logic model of planning means that a program or intervention follows a logical design. Most descriptions of logic models have the following components in common:

- Planning begins with an assessment of the needs and assets of a population or a community.
- Program strategies and practices are grounded in clearly stated goals and objectives.
- Program strategies and activities are based on evidence-based theories and models.
- Efforts are evaluated with a built-in feedback loop to further improve outcomes.

Every prevention program or strategy should originate from some form of needs assessment that provides guidance in answering the questions “What are the problems resulting from substance abuse in this target population and how do we know it is a problem?” For planners of substance abuse prevention programs, this means gathering information on prevalence rates (who uses what and how much) and problem indicators (arrest rates, crash data, morbidity and mortality reports, etc.). From the survey and archival data gathered, the prevention planner can begin the process of determining which risk and/or protective factors to target. The Western Regional Center for the Application of Prevention Technologies encourages use of several steps to prioritize which risk and/or protective factors should be addressed. These are:

- Carefully review the data from the needs assessment to determine if there are risk or protective factors for which you have no data. If so, identify those and determine if or where appropriate data can be collected. Add this information to the data analysis.
- Determine which risks are most prevalent and which protective factors are most lacking. Base this profile upon trends, comparisons with similar data, comparisons across factors and your own interpretation of the data and possible explanations.
- Based on the needs-assessment data, determine at what developmental periods or transitions children, youth and adults are most at risk.
- Determine if the analysis shows identifiable clusters of risk or protective factors that, addressed together, could provide a synergistic response.
- Identify two to five risk factors that are most prevalent in your community. Do the same for protective factors.
- Using input from invested community partners, determine the resources available.

- Using science-based approaches that target the risk and/or protective factors agreed upon, develop an action plan that includes a vision, skills, incentives and resources needed to assess changes resulting from the intervention.

Abe Wandersman, Ph.D., and his colleagues advocate a broader accountability model designed to promote organizational capacity to measure outcomes. They have identified basic accountability questions that they believe have been shown by experience to be keys to successful prevention programs. These are examined in some detail in *The Journal of Primary Prevention* (Volume 19, Number 1, Fall 1998) and further expanded in *Getting To Outcomes (GTO): Methods and Tools for Planning, Evaluation and Accountability*, a guidebook to help practitioners plan, implement and evaluate their science-based programs and strategies to achieve results. In addition, GTO training is becoming more widely available. GTO is based on answering 10 accountability questions about needs and resources, goals, science and best practices, fit, capacity, plan, implementation, process evaluation, outcome evaluation, continuous quality improvement, and sustainability (Wandersman, Imm, Chinman & Kaftarian, 2000). An overview of the accountability steps in the GTO model is presented below:

1. What are the underlying needs and conditions that must be addressed?
2. What are the goals, target populations and objectives (i.e., desired outcomes)?
3. Which science (evidence)-based models and best-practice programs can be useful in reaching the goals?
4. What actions need to be taken so the selected program “fits” the community context?
5. What organizational capacities are needed to implement the program?
6. What is the plan for this program?
7. How will the quality of program/initiative implementation be assessed?
8. How well did the program work?
9. How will continuous quality improvement strategies be incorporated?
10. If the program is successful, how will it be sustained?

Application of a logic model of program or strategy development, as outlined above, frequently requires a shift in thinking on the part of the individual prevention provider and his or her organization, primarily because the emphasis shifts from “doing programs” to learning how to improve the performance of programs. Continuous improvement is not a new concept to providers of substance abuse services as organizations strive to improve their operations in an environment that is increasingly competitive. Unfortunately, many organizations and individuals fail to grasp a basic truth – that continuous improvement requires a commitment to learning (Garvin, 1993). Without an ongoing process of improving actions through better knowledge and understanding, changes in policies and programs frequently are cosmetic and short-lived. Organizations

that are moving toward a new way of learning have been described as “learning organizations” or “knowledge-creating companies” (Kofman and Senge, 1993). A simple definition of a learning organization is “an organization skilled at creating, acquiring and transferring knowledge and at modifying its behavior to reflect new knowledge and insights” (Garvin, 1993). Organizations moving in this direction have incorporated three attributes within their processes for doing business. These are:

1. *Aspiration* – Individuals, teams and eventually the larger organization become increasingly able to focus on the things they truly care about and to make changes that promote those priorities;
2. *Dialogue* – Members of the organization, both individually and collectively, are increasingly able to reflect on and talk about long-held assumptions and behaviors. They develop the art of dialogue, not the “talking at you” form of communication that often passes for conversation in workplaces and in society at large.
3. *Conceptualization* – The organization recognizes that ideas, issues and problems look very different when viewed from different perspectives.

Learning organizations place a value on creating, acquiring and transferring knowledge and at modifying programs to reflect new knowledge and insights. In other words, if prevention-program providers continue to do things the same way, then the organization can expect to get the same performance. Using a logic model of program development, implementation and measurement of performance assists in reducing the likelihood that efforts are based on faulty theories and programs and that the organization will value learning ways to improve.

Developing prevention resource systems

Every state and territory, and hopefully individual community, benefits from federal funding intended to create or sustain programs to reduce the demand for alcohol, tobacco and other drugs. In addition, many states have created, through legislation or special appropriation, funds to develop substance abuse prevention programs.

Federal funds coming to the states for substance abuse prevention go to a number of different agencies, depending on the structure of a particular state’s government. Frequently referred to as “stovepipe” funding, traditionally these funds have gone to the state equivalent of the federal agency administering the funds. For example, Substance Abuse Prevention and Treatment Block Grant funds go to the governor’s designated single state authority; Safe and Drug-Free Schools and Communities funds, for the most part, go to state departments of education; Byrne Formula Grant Program funds go to public safety; and Centers for Disease Control and Prevention funds for tobacco prevention go to public health agencies. While these federal funds carry the encouragement to coordinate with other agencies invested in substance abuse prevention, this does not always occur.

Perhaps the most negative outcome of the “stovepipe” approach has been the tendency of the administering organizations at the state level to become so caught up in the mission dictated by their funding source that they operate as if they are unaware of the interrelationships among major health and social problems resulting from substance abuse. Organizations that focus on a single problem and operate in such a manner frequently fail to value communication, coordination and collaboration as a way of doing business. In addition, when the value of collaboration is not modeled at the state level, it is not seen at the community level as the way to plan and implement programs.

In recent years, there has been a trend toward substance abuse prevention funding going to a state’s governor in an effort to increase system effectiveness. In addition, some states have created coordinating organizations in an effort to minimize the negative aspects of “stovepipe” funding and to maximize collaboration.

A systems approach to substance abuse prevention is supported by research that recognizes the interrelationships that exist among high risk and/or addictive behaviors and by the experience of prevention planners who have created outstanding programs but have seen these “chimneys of excellence” wither over time as funding or priorities changed. The defining characteristic of a system is that it cannot be understood as a function of its isolated components. The behavior of the system does not depend on what each part is doing, but on how each part is interacting with the rest. For example, a car’s engine may be working just fine, but if the transmission is missing the car will not move. Collaboration has become a standard mandate in funding guidelines from federal and state agencies. However, the active practice of collaboration appears far too frequently to be one of those things funders impose on communities and fail to adequately practice at the state and federal levels for a myriad of excuses, ranging from “legislative mandates” to “not enough time.” If communities are to be successful in reducing the problems caused by alcohol, tobacco and other drugs, it is time to move away from a “stovepipe” mentality and begin to actively develop national, state and community prevention resource systems.

What is a prevention resource system? A prevention resource system is a conscious, intentional linkage among all agencies and organizations that have a mandate to deliver substance abuse prevention to collaboratively promote science-based prevention through planning, funding, training and evaluation of outcomes.

What are the functions of a prevention resource system? Mike Lowther, the director of the Southwest Center for the Application of Prevention Technologies and its predecessor, the Southwest Center for Drug-Free Schools and Communities, has been a pioneer in facilitating the development of the functions of prevention resource systems. Once functions are identified, they provide a useful tool for prevention planners to use in assessing the level of system development or, as it is frequently referred to, “community readiness.” Among the functions identified by Lowther and others who have been interested in systems development are the following:

1. **Intentional Networking** – There exists a network of agencies and organizations with a mandate to deliver substance abuse prevention. The

members of this network meet on a frequent basis. In addition, there exists a channel of communication among state and community prevention resource systems that provides input on policies and programs.

2. **Collaboration** – The agencies and organizations value and model learning together on how to improve substance abuse prevention. Leadership is shared among all members of the system. Approaches, plans, policies, programs and evaluations are an outcome of this process.
3. **Conceptual Clarity** – The agencies and organizations have reached consensus on a definition of “substance abuse prevention” and have developed a statement of “best practices” based on lessons learned from research. Plans, policies, programs and outcomes reflect the consensus definition and best practices.
4. **Strategic Planning** – The agencies and organizations have developed an approach based on principles of strategic planning (input from customers, needs assessment based on data indicating substance abuse, approaches based on science-based prevention, etc.) and disseminated the strategic plan. The plan is followed by all state or community agencies and organizations with a mandate to do substance abuse prevention and is routinely updated to reflect lessons learned.
5. **Policy Development** – Policies are consistent with the strategic plan and support science-based prevention approaches.
6. **Evaluation** – A consistent approach to measuring the outcome of policies and programs based on the strategic plan and lessons learned from research is used by all the state agencies and organizations. Lessons learned are used to improve performance.
7. **Funding Commitment** – There exists a commitment on the part of the agencies and organizations to provide funding and to leverage funding to fill gaps based on needs assessments as part of the strategic planning and lessons learned from research.
8. **Program Models** – The agencies and organizations agree on criteria for science-based program models and disseminate these criteria and program models.
9. **Technical Assistance** – The agencies and organizations have a process for the acquisition or delivery of technical assistance to communities that models the collaborative nature of the prevention resource system.
10. **Education and Training** – The agencies and organizations collaborate on multiple approaches to disseminating information on prevention technology and in providing training at the community level. Mechanisms exist to update information dissemination and training as needed.
11. **Cultural Competency and Inclusion** – The prevention resource system models cultural competency and inclusion at all levels of activity and programming.

12. **Marketing and Recognition** – There exists a process for informing the general public, customers and key decision-makers of the existence of the state prevention resource system and of the successful outcomes of prevention policies and programs.

Each of the above can be taken a step further by identifying the questions that need to be asked to determine the key indicators of the level of functioning of this aspect of a prevention resource system.

Function	Key Indicators
1. Intentional Networking	<p>Are meetings scheduled on a routine basis?</p> <p>Are records of the outcome of meetings maintained and disseminated to all invested groups?</p> <p>Are all the agencies and organizations that have a mandate to deliver substance abuse prevention active participants?</p> <p>Do open channels of communication exist with the customers of agencies and organizations delivering prevention services?</p>
2. Collaboration	<p>Is leadership among participants a shared responsibility?</p> <p>Is planning a collaborative process?</p> <p>Is there a process for conflict resolution?</p>
3. Conceptual Clarity	<p>Is there consensus on a definition of “substance abuse prevention” that guides all the participating agencies and organizations?</p> <p>Is there a statement on “best practices” that is used to guide decisions of policy, funding, technical support and training by all the participants?</p>

<p>4. Strategic Planning</p>	<p>Have the agencies and organizations collaboratively developed an approach to substance abuse prevention?</p> <p>Were community deliverers of prevention services and customers of prevention services allowed input in the approach?</p> <p>Does the approach/plan reflect “best practices”?</p> <p>Are there specific outcome measures that will be used to improve performance?</p> <p>Has the approach/plan been disseminated to decision-makers?</p>
<p>5. Policy Development</p>	<p>Are the policies of the agencies and organizations consistent with the prevention definition, “best practices” and approach/plan?</p> <p>Do the agencies and organizations actively support policies that reinforce substance abuse prevention within the environment (zero tolerance, regulations that restrict access by underage youth to alcohol and tobacco, smoke-free workplaces, etc.)?</p>
<p>6. Evaluation</p>	<p>Have the agencies and organizations agreed on a database for assessing needs and determining outcomes?</p> <p>Are outcome measures based on the approach/plan, and do they reflect lessons learned from research?</p> <p>Is there a process for providing technical assistance to community prevention providers in planning and implementing outcome measures?</p> <p>Are the lessons learned from evaluation used to improve the performance of substance abuse prevention?</p>

<p>7. Funding Commitment</p>	<p>Is prevention funding a priority within the budgets of participating agencies and organizations?</p> <p>Is funding used to fill gaps in substance abuse prevention services based on the approach/plan?</p> <p>Are there examples of efforts to leverage funding from multiple sources to meet needs identified in the approach/plan?</p> <p>Are guidelines for funding reviewed by the agencies and organizations prior to release?</p> <p>Is a collective review of proposals for funding a routine function of the participants in the prevention resource system?</p>
<p>8. Program Models</p>	<p>Have criteria been established and disseminated for programs that meet the test for science-based prevention?</p> <p>Have community and/or school-based consumers of prevention funding been provided access to information or training on successful program models?</p> <p>Do recipients of funding of program models have to demonstrate the validity of modifications prior to program implementation?</p>
<p>9. Technical Assistance</p>	<p>Is there a process for community or school prevention deliverers to make technical assistance needs known to the state-level providers?</p> <p>Is there a collaborative process among the agencies and organizations to plan, deliver and report on technical assistance?</p> <p>Is there support of training for persons who deliver technical assistance?</p> <p>Is technical assistance delivered as part of a team?</p>

10. Education/Training	<p>Are there channels of communication from the agencies and organizations that routinely provide new prevention technology information?</p> <p>Is training on substance abuse prevention routinely made available to community- and school-based providers?</p> <p>Is participation in training reflected in the policies and funding of prevention providers?</p> <p>Do colleges and universities offer courses on substance abuse prevention?</p>
11. Cultural Competency	<p>Do the agencies and organizations delivering substance abuse prevention model cultural diversity and inclusion?</p> <p>Do requirements exist for program models to be culturally appropriate?</p>
12. Marketing/Recognition	<p>Is there a consistent process to inform customers at all levels of prevention successes?</p> <p>Is there a consistent process to inform key decision-makers of the existence of the prevention resource system?</p>

Development of prevention resource systems is a work in progress. The above functions are not intended to be inclusive, and planners developing state or community prevention resource systems (and someday, hopefully, a federal prevention resource system) are invited to add to this list as needed. In addition, prevention planners using a systems approach are encouraged to share “lessons learned” to assist our field in constantly improving promising approaches to preventing problems caused by alcohol, tobacco and other drugs.

Summary

In summary, keys indicators of performance-based prevention are:

- a commitment to use evidence-based prevention programs and strategies;
- a commitment to blend individual and environmental approaches;
- a commitment to collaboration;
- development of a framework based on the above;

- use of a logic model of planning, implementation, outcome measurement and continuous quality improvement; and
- a commitment to nurture, sustain and improve efforts by supporting inclusive prevention resource systems at the community and state level.

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