Guidance for Substance Abuse Prevention Provider Work Plans

South Dakota Department of Human Services
Division of Alcohol and Drug Abuse

November 2009

Table of Contents

Introduction

The South Dakota Department of Human Services' (DHS) Division of Alcohol and Drug Abuse administers funding for substance abuse prevention from a variety of State and Federal partners, to support a diverse array of strategies and activities. These funding sources, partners and focus areas include:

- ***Substance Abuse Prevention and Treatment Block Grant*** (SAPT BG) funds from the Substance Abuse and Mental Health Services Administration (SAMHSA). These funds support the following six key strategies: information dissemination, education, problem identification and referral, alternatives, community-based process and environmental strategies;
- ***Safe and Drug Free Schools and Communities*** (SDFSC) funds from the U.S. Department of Education through the Governor's Office and the South Dakota Department of Education. These funds support information dissemination, training, community-based programming, coordination between State agencies, protection of students to and from school, before and afterschool programs that promote drug-free life styles, education on—and activities to prevent—intolerance and hatred,
- ***South Dakota Department of Health*** funds that support Community Tobacco Prevention Initiatives.
- ***South Dakota Office of Highway Safety*** funds that support school-based prevention efforts, diversion programming, and community-based efforts related to highway safety issues.
- ***South Dakota Department of Education*** funds for support, development and implementation of methamphetamine awareness training for parents, school staff, and community members.
- ***South Dakota Department of Health*** funds that support rape and sexual assault prevention.

Substance abuse prevention funding is distributed to a wide array of community-based organizations for six key program areas that primarily focus on preventing substance abuse among youth: Prevention Resource Centers, Community Mobilization Projects and Community Prevention Networkers, Primary and Intensive Diversion Programming, School-Based Prevention projects, Community Tobacco Coalitions, and collaborative projects between the Division and the Office of Highway Safety, Department of Health and the Department of Education.

The Division is committed to working in partnership with prevention providers and communities across the state to enhance prevention outcomes at every level. Research has shown that the most successful approaches to preventing substance abuse are those which are comprehensive and community-based, rather than single events. While the Division has funded both types of approaches in the past, it now intends to pursue a more comprehensive and outcome-oriented approach, as detailed in the Prevention Activities Position Paper that was developed and disseminated in April 2008.

In particular, the Division intends to focus prevention funding in support of the following outcomes:

- Reduce the percentage of youth who have used alcohol in the past 30 days
- Reduce the percentage of youth who have used tobacco in the past 30 days

- Reduce the percentage of youth who have used marijuana in the past 30 days
- Reduce the percentage of youth who have used inhalants in the past 30 days
- Reduce the percentage of youth who have used methamphetamines in the past 30 days
- Reduce the percentage of youth who have ridden in the past year in a vehicle driven by someone who had been drinking
- Reduce the percentage of youth who have been in a physical fight within the past year

These seven key indicators will be used to measure the State's success in preventing problems and consequences associated with substance abuse. In order to support these priority areas, providers are encouraged to target their efforts toward students in grades K through 12 as well as young persons who are of college age. In addition, parents and school staff are important target populations as well.

Toward this end, in SFY2009-2010 the Division instituted a new requirement that recipients of substance abuse prevention funding base their Work Plans on assessment of community data. In support of that requirement, the Division developed and disseminated a guidance document, "*Needs Assessment Information for Prevention Providers and Community Coalitions*" in March 2009.

For SFY2010-2011, the Division intends to increase the accountability and effectiveness of the use of substance abuse prevention funds by continuing its transition to outcome-based contracting. This guidance document is intended to support the development of comprehensive prevention Work Plans that are based on local data and designed to achieve measurable outcomes.

Because substance abuse prevention initiatives that take steps to enhance community readiness and capacity are much more likely to achieve their outcomes, the Division is also requiring that all applicants for prevention funding develop a component in their Work Plan for local capacity development.

Particularly important areas of development and readiness include whether or not the community:

- has representative and coordinated leadership working across sectors for the common good;
- has adequate capacity to carry out its work and achieve its common mission and vision;
- is engaged in the use of effective practices and processes; and
- is able to generate resources to sustain outcomes.

The Work Plans developed through this process are intended to serve as long-term, future-oriented documents that are updated and modified annually as needed.

Instructions, an example logic model, Work Plan templates, Work Plan examples and a glossary of terminology are provided in the remainder of this guidance document.

General Instructions

Assessment

This guidance document serves as a companion to "*Needs Assessment Information for Prevention Providers and Community Coalitions*" (March 2009). Applicants for substance abuse prevention funding must conduct local needs assessments, and submit prevention work plans based on local data using the templates contained in this document. Funding applicants are encouraged to refer to both documents when developing and conducting local planning efforts.


In Section A of the Substance Abuse Prevention Work Plan (Pg 16), summarize assessment findings related to the prevalence, incidence, burden and populations affected by priority substance abuse problems and/or consequences addressed by your plan. In Section A of the Capacity Development Work Plan (Pg 18), include data or information that sheds light on the capacity development issues that will be addressed in your plan.

✶ See sample Substance Abuse and Capacity Development Work Plans on pages 22-33 for examples.

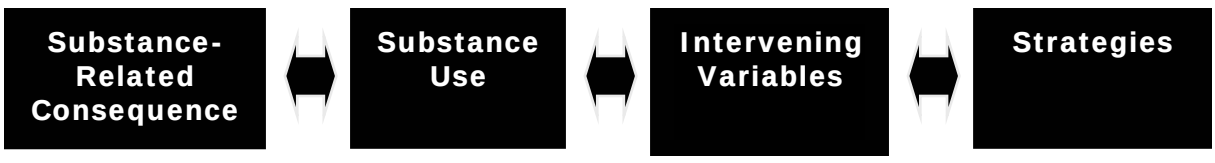
Logic Models

A **logic model** is a conceptual framework that broadly outlines a series of data-driven and logical steps that are used to identify and link problems, consequences, and underlying conditions or intervening variables; and broadly plan a course of action to prevent and reduce future occurrences of the problem. Logic models are useful tools for describing relationships among multiple factors and components in a community, and identifying strategies that can impact those relationships to achieve a desired outcome. You will use logic models to summarize your findings about your community substance abuse problems as you complete the required Substance Abuse Provider Work Plans.

The Substance Abuse and Mental Health Administration's (SAMHSA) Strategic Prevention Framework (SPF) uses outcome-based logic models and program-level logic models to support prevention planning. An **outcome-based logic model** describes relationships among multiple factors and components in a community and how they may be used to achieve change in a desired outcome. It maps the identified problem in terms of three components:

- A clear definition of problem(s) to be addressed (consequences and/or behaviors)
- Intervening variables which have scientific evidence of contributing to the problem, and
- Prevention strategies (programs, policies, practices) that have evidence of effectiveness in impacting the intervening variables and the targeted problem.

Outcome Based Logic Model Schematic



Prevention providers will be required to complete an outcome-based logic model for each substance abuse prevention problem statement they develop and submit for funding through the work plan development process. These logic models should be fleshed out as you develop your work plan, and will serve as a one-page summary of—the details contained in your work plans.

An example logic model for addressing underage drinking is provided on page 21. Note that many of the selected strategies impact multiple intervening variables. An example substance abuse prevention work plan using the logic model findings is provided on pages 22-30.

 As you develop your Substance Abuse Prevention Work Plan, complete a logic model for each problem statement and related intervening variables or underling conditions and proposed strategies. These will serve as a one-page overview of your plans to address each problem or consequence. A logic model template is provided on page 15. ✶ A sample logic model is provided on page 21.

Problem Statements

A **problem statement** is a brief description of the behaviors that currently ***exist*** and need to change that cause the substance abuse problems and consequences documented by your local data.

When you develop your problem statements, describe what ***exists*** that is a problem, not what ***doesn't exist***. A problem statement that defines a problem as a 'lack' of something assumes that addressing the 'lack' will solve the problem. In reality, there are usually many important factors that contribute to the problems and consequences associated with alcohol, tobacco and other drug (ATOD) use and abuse.

A problem statement that reads: "there is a lack of enforcement of underage drinking laws" assumes that enforcement alone will solve the problem. In reality, there may be many factors—such as community norms and availability of alcohol—that also contribute to the problem. Defining the problem as a lack of enforcement alone will narrow your planning focus and direct energy and resources to strategies that aren't likely be effective or sufficient on their own, and cause other important factors to be missed. A better problem statement would be: "Sixty percent of youth have consumed alcohol on one or more occasions during their lifetime."

Keeping the focus on the priority behaviors, consequences, and/or underlying causal conditions at this stage in the planning process will help you select a comprehensive array of strategies later on that will be more effective in preventing the problems and consequences you have identified.

 In Section B of the Substance Abuse Prevention Work Plan (Pg 16), succinctly describe the priority ATOD problems that currently exist. If you have more than one problem statement, use a separate plan template for each. In Section B of the Capacity Development Work Plans (Pg 18), succinctly describe the priority capacity development issue.
✶ See sample Substance Abuse and Capacity Development Work Plans on pages 22-33 for examples.

Target Populations

After developing your problem statements, identify the populations upon which your initiative will need to focus. **Target populations** are those individuals and groups who either are directly affected by, involved in, or contributors to the key problems and/or consequences identified in your problem statement.

Target populations may be direct or indirect. **Direct target populations** are those who are directly affected by or involved in a problem or consequence (e.g., underage youth who drink alcohol). **Indirect target populations** are those who play an important role in the conditions that promote or prevent the problem (e.g., adults who condone or permit underage drinking).

In addition to direct and indirect target populations, the Institute of Medicine (IOM) has developed an important framework for classifying prevention strategies and activities into three primary categories: universal, selective, and indicated. Direct and indirect target populations may be targeted through any one of these three strategy categories. Within the universal category, however, CSAP requires that States and their subrecipients report number of persons served through direct and indirect activities. While strategy types are not the same as direct and indirect populations, the distinction can be confusing, and so definitions and examples of universal direct and indirect activities are provided below.

Universal prevention strategies and activities target entire groups (e.g., classroom, grade or grades of students, school, neighborhood, community) without regard to individual risk. on the premise that all share the same general risk for being affected by—or involved in—substance abuse problems and consequences.

- ***Universal direct strategies*** serve an identifiable group of participants who have not been identified on the basis of individual risk. Universal direct strategies support population-based prevention activities, and may involve interpersonal and ongoing/repeated contact. Examples include school curriculums, afterschool programs and coalition outreach efforts.
- ***Universal indirect strategies*** also serve persons who have not been targeted on the basis of individual risk, and support population-based programs and environmental strategies. Examples of strategies include establishing ATOD policies, modifying ATOD advertising practices and programs and policies implemented by coalitions. Collecting data on persons reached through universal indirect strategies frequently requires estimates based on demographic and market data. A policy change, for example, will likely impact everyone in the community, while data on persons served by a media campaign may need to be drawn from market demographics.

Selective populations are a subset of the total population that is considered to be at higher risk because of certain characteristics or inclusion in higher risk categories (e.g., children of alcoholics or adjudicated youth). Like universal populations, members of selective populations are not screened or assessed for individual risk but are selected based on shared risks (e.g., biological, psychological, social, or environmental) or other factors, such as age, gender, or place of residence. When selective populations are targeted, strategies will focus on all members of the group.

Indicated populations are groups of individuals who have been identified as exhibiting early warning signs of problems, such as experimentation with substance abuse or instances of intense use (e.g., binge drinking). Strategies for indicated populations address the specific risk factors and other underlying causal conditions experienced by the individuals in an attempt to delay the onset and reduce the severity of problems.

 In Section C of both Work Plans (Pgs 16 and 18), describe the populations your project will target. For the Substance Abuse Prevention Work Plan, note the IOM categories into which they fall.

✶ See sample Substance Abuse and Capacity Development Work Plans on pages 22-33 for examples.

Goals

Goals describe general desired changes in behavior. *Substance abuse prevention* goals describe the changes in *human* behaviors that are needed to prevent the problems and consequences identified in your problem statement (e.g., decrease alcohol use by youth). Substance abuse *prevention system* goals reflect desired changes in the "behavior" of your local *prevention system* that are needed to make it more effective in achieving and sustaining outcomes (e.g., all key sectors of the community will coordinate efforts to reduce underage drinking). In general, it's advisable to have no more than one to three goals. Any more than that is a sign you are probably trying to do too much.

 In Section D of the Substance Abuse Prevention Work Plan (Pg 16), state the change in the behaviors that promote the ATOD-related problems, consequences and/or consumption patterns that your initiative will seek to achieve. In Section D of the Capacity Development Work Plan (Pg 18), state the change in community or organizational capacity your initiative will seek.

✶ See sample Substance Abuse and Capacity Development Work Plans on pages 22-33 for examples.

Objectives

Objectives describe specific changes in the intervening variables and underlying conditions that must occur in order to achieve your goals. **Intervening variables** are factors that have been identified as being strongly related to—and influential in—the occurrence and magnitude of substance use problems and consequences. Examples of intervening variables and underlying conditions are availability of ATODs, social norms regarding use, enforcement of policies and laws, and perceptions of risk and harm of substance abuse.

 In Section G of both Work Plans (Pgs 17 and 19), state the change in the intervening variables and underlying conditions that your initiative will seek to achieve.

✶ See sample Substance Abuse and Capacity Development Work Plans on pages 22-33 for examples.

Outcomes

Outcomes state the degree of change you hope to achieve within a certain time frame. Outcomes should be specific, measurable, achievable, realistic, and time limited, and they may be long-term, intermediate or immediate.

- **Long-term Outcomes** are linked to goals and reflect a quantifiable degree of behavior change;
- **Intermediate Outcomes** are linked to objectives and reflect a quantifiable change in underlying conditions or perceptions and attitudes, and
- **Immediate Outcomes** are linked to strategies and activities and reflect a quantifiable change in knowledge, skills and abilities.

In Section E of both Work Plans (Pgs 16 and 18), state the degree of change in the priority problems (i.e., long-term outcomes related to ATOD problems, consequences, consumption and capacity development) that your prevention initiative will seek to achieve within an established time frame. This will link the long-term outcome to the goal in Section D.

In Section H (Pgs 17 and 19), state the degree of change in intervening variables and underlying conditions (i.e., intermediate outcomes) related to ATOD problems, consequences, conditions, and capacity development that your initiative will seek to achieve within an established time frame. This will link the intermediate outcome to the objective in Section G.

In Section P (Pgs 17 and 19), state the degree of change your initiative will seek in knowledge, skills and abilities (i.e., immediate outcomes) related to ATOD problems, consequences, consumption, and capacity development within an established time frame. This will link the immediate outcome to the activities in Section K.

✶ See sample Substance Abuse and Capacity Development Work Plans on pages 22-33 for examples.

Strategies and Activities

A **strategy** is a course of action that is based on a theory of change. A **theory of change** is a logical belief, based on assessment and evaluation, that a specific course of action will result in certain desired outcomes. Strategies may consist of programs, policies and/or practices. An **activity** is a specific action that is undertaken as part of an overall strategy. Most strategies will require the identification and completion of numerous activities.

The strategies you select should be documented to be effective in preventing the specific problems, consequences, and underlying conditions targeted by your goals and objectives. SAMHSA has defined **evidenced-based strategies** as interventions that are based on a strong theory or conceptual framework that comprise activities grounded in that theory or framework and that produce empirically verifiable positive outcomes when well implemented. The full SAMHSA definition for evidence-based strategies is provided in the Glossary on pages 34-35.

Evidence-based status alone does not ensure that a strategy will be appropriate or effective within your community. It's important to make sure that the strategies you select are culturally and situationally-appropriate, as well as good conceptual and practical fits to your community.

Situational appropriateness means the strategies are carefully aligned with—and responsive to—the target populations and the unique contextual and cultural conditions of your community. **Conceptual fit** means that prevention strategies are based on a theory of change that is carefully aligned with the intervening variables and underlying conditions that contribute to the priority problems and consequences you have identified and described in your objectives. A strategy that is not aligned to your community conditions is unlikely to be effective in changing substance abuse problems or consequences. **Practical fit** means that prevention strategies are carefully aligned to the capacity, resources, and readiness to act of the community itself as well as the organizations responsible for implementing the strategies.

Strategies may be environmental or individual, and may consist of policies, practices, and programs. **Environmental strategies** consist of long-term approaches that focus on changing conditions in the shared social environment that contribute to problems and consequences (e.g., social norms and availability of alcohol, tobacco, and other drugs). Because environmental prevention addresses ATOD problems by changing underlying social and cultural factors, it is able to achieve positive outcomes for people across the Institutes of Medicines (IOM) continuum of services.

Environmental strategies are nearly always universal in their reach, and frequently take the form of policies and practices. **Policies** may be written rules, regulations, standards, or laws that are designed to prevent problems (e.g., minimum-age purchase laws for alcohol and tobacco), or informal and unwritten standards and norms (e.g., decisions to prioritize prosecution of certain offenses, such as sales of age-restricted products to minors). **Practices** are activities that are based on implementing policies designed to prevent problems and consequences (e.g., Responsible Beverage Service Training, sobriety checkpoints).

Because environmental strategies require supportive activities from other strategy classifications such as education, information dissemination and community-based process, it can sometimes be difficult for prevention practitioners to accurately determine whether—and which of—their activities are truly environmental in nature. Environmental prevention has three key emphases:

1. changing community norms,
2. reducing availability of ATODs, and
3. passing and enforcing laws, policies and practices.

So, while media campaigns are an important support to environmental approaches, if they aren't part of an overarching attempt to target norms, access and policy development, they don't constitute environmental prevention on their own. Similarly, while community-based processes such as community mobilization, coalition development and planning are key to successful environmental prevention efforts, they also do not constitute environmental prevention when they aren't connected to an overarching effort to change norms, reduce availability or implement or enforce policies.

Individual strategies focus on changing individual behaviors and do not address conditions that exist in the environment. Individual strategies may target universal, selective, or indicated populations and frequently take the form of short-term or time-limited programs that are designed to enhance resiliency, decision-making, and risk-resistance skills.

Research documents that comprehensive approaches using both environmental and individual strategies are the most effective in changing behavior.

As you review potential strategies to determine which will be the most effective for your community, consider the following information:

- The characteristics of the target population for which the strategy has been documented to be effective, including age, gender, and ethnicity, as well as universal, selective, or indicated.
- The nature and intended reach and scope of the strategy (e.g., environmental policies and practices aimed at population-level behavior change or individual programs aimed at individual behavior change).
- The geographic setting for which the strategy has been documented to be effective (e.g., rural, suburban, or urban).
- The **domains**, or social environments in which the strategy has proved to be effective (e.g., individual/peer, family, school, or community).
- The specific intervening variables and underlying conditions the strategy has proved successful in addressing.
- The specific outcomes the strategy has proved successful in achieving.
- The implementation and evaluation requirements associated with the strategy (e.g., staffing patterns and qualifications, required training and technical assistance, strategy activities, required materials and supplies, adaptation or fidelity protocols, evaluation needs).
- The other costs associated with the strategy (e.g., personnel, operating expenses, supplies and materials, contractual services, facility expenses, media).

The term **fidelity** refers to the extent to which there is faithful adherence to the core components of a strategy (as identified by the developer of that strategy) when the strategy is implemented by others in new and varied settings. The term **adaptation** refers to adding or subtracting any of a strategy's components, altering those components, or changing the way a strategy is administered. To ensure a good outcome, it is important to implement prevention strategies with fidelity.

To limit the need to make adaptations, or to limit the number of adaptations you need to make to a strategy, there are steps you can take *before* choosing a specific prevention strategy to implement in your community. In addition to ensuring that all proposed strategies are situationally-appropriate and good conceptual and practical fits to your community, here are some additional points to consider:

- Identify and understand the strategy's core values, assumptions and components. (Core components are those elements that are essential to achieving positive outcomes.)
- Identify any truly unique characteristics of your target population, and determine whether adaptation is needed to address those characteristics.
- Determine that you have the capacity to gather the necessary data—including baseline data—to adequately evaluate the strategy.

It is possible you won't find a strategy that exactly matches your situation. You may find that a strategy that seems to be a good fit with your desired outcomes, intervening variables and underlying conditions, and target population may be a less than perfect fit due to requirements associated with implementation and evaluation and your community's capacity and/or readiness

to meet those requirements. When strategies are carefully selected but still present challenges to implement due to capacity limitations of the community or the provider organization, providers are strongly encouraged to build capacity before seeking adaptations to strategies.

You may also find that a strategy that 1) targets the key intervening variables and underlying conditions you want to address, 2) is directed at those outcomes your community has identified as highest priority, and 3) is developmentally appropriate for your target population, has not been validated or replicated within the cultural context of your target population (e.g., rural Native American girls). In a situation such as this, it's advisable to consult with the developer of the strategy for input and assistance in adapting the strategy to meet your community's specific needs. Even a strategy that has yet to be tested with your particular target population may still be able to meet your needs as it is currently designed.

Adaptations generally fit into the following categories:

- Structural changes (e.g., number of sessions, setting, target population)
- Changes to content (e.g., curriculum, activities)
- Changes to the method of delivery (e.g., peer-led, cultural adaptations)

Because the structure, content, and delivery of each strategy constitute core elements of the intervention, any adaptations must be carefully considered. Researchers and developers of science-based and promising strategies are legitimately concerned that significant changes to those strategies will weaken their effectiveness. It is always important to maintain consistency with those scientific prevention principles upon which the strategy is based.

Finally, when selecting strategies, be sure to consider the sustainability of the outcomes that will be produced. Strategies that seek to produce steady positive change over time, increasing the degree of change as community readiness for change increases, are likely to be the most effective. Early, small successes will create a track record that can attract new partners and resources.


In Section J of both Work Plans (Pgs 17 and 19), state the broad courses of action you plan to take. If you are implementing an evidence-based program or strategy, provide the name of it here.

In Section K of both Work Plans (Pgs 17 and 19), list the key activities that will need to occur in order to implement your strategies.

✶ See sample Substance Abuse and Capacity Development Work Plans on pages 22-33 for examples.

Implementation

The most carefully planned initiatives can—and sometimes do—fail to achieve their identified outcomes. A key reason for this often involves the absence of a detailed plan for how the initiative will be implemented.

An **implementation plan** contains detailed information on the activities, timelines, processes, roles and responsibilities and outputs that will be required for your prevention initiative to operate as planned. **Outputs** are the quantifiable and time-limited products of an activity that help to achieve outcomes and demonstrate that all processes are occurring as planned (e.g., the *number* of persons trained to implement a selected strategy by a certain date).

Keep in mind that some complex activities (e.g., creation of a special work group with multiple tasks) may require that their individual implementation plan components be nested within the overarching implementation plan. Finally, implementation plans should be flexible enough that evaluation data can be used to make needed adjustments in the implementation of the project.

In Section L of both Work Plans (Pgs 17 and 19), provide a time line (i.e., start and end dates) for all activities.

In Section M of both Work Plans (Pgs 17 and 19), identify who is responsible for the completion of each activity, including names and titles or affiliations.

In Section O of both Work Plans (Pgs 17 and 19), list the products (i.e., outputs) that will need to be produced as a result of—or in preparation for—each activity.

✶ See sample Substance Abuse and Capacity Development Work Plans on pages 22-33 for examples.

Evaluation

It's important to be prepared to measure your initiative's progress in achieving outcomes from the very beginning of your project. This will help to provide early detection and correction of problems, and significantly enhance your initiative's ability to achieve its identified outcomes.

There are two key types of evaluation for which you need to plan. **Process evaluation** monitors the process indicators and outputs identified in your implementation plan to help you ensure that all activities are being successfully implemented. Process evaluation information should identify—in real time—those processes that are working well and those that are not so that adjustments can be made. **Process indicators** are specific, measurable, and time-limited measures that reflect whether project activities are taking place as planned (e.g., that a required set of trainings were held within the established time frames). Process indicators are an important component of process evaluation, and it's a good idea to also include financial process indicators in your implementation plan to monitor whether the overall cost of the project is staying within the established budget.

Outcome evaluation measures progress toward desired outcomes by monitoring **outcome indicators** that are logically linked to outcomes and can serve as valid interim benchmarks—or indicators—of interim success. Like outcomes, outcome indicators should be specific, measurable, achievable, realistic, and time-limited measures.

Outcome evaluation measures progress toward long-term, intermediate and immediate outcomes. Long-term outcomes reflect the quantifiable degree and date of accomplishment of your goals.

Intermediate outcomes reflect the quantifiable degree and date of accomplishment of your objectives, and immediate outcomes reflect a change in knowledge, skills, abilities or attitudes due to implementation of an activity or intervention.

Process and outcome evaluation measures can be qualitative or quantitative. Optimally, your evaluation will collect information on both. **Quantitative measures** focus on quantity (e.g., "how many people were reached?" and "what degree of change was achieved?" **Qualitative measures** look at performance and the quality of the outcome (e.g., "how well was it done?" and "what benefits to health and well-being were achieved?"

<table>
<tr><th colspan="2">Considerations</th></tr>
<tr><th>Process Evaluation Considerations</th><th>Evaluation Methodologies</th></tr>
<tr><td>
• Are activities being implemented as planned and on schedule? If not, why not?
• Have modifications in processes, outputs, timelines, or persons responsible taken place?
◦ If so, what modifications and why?
◦ What impacts could the modifications have on future implementation steps?
• What challenges, if any, exist, and what steps are being taken to address them?
• What learnings have occurred?
• What modifications, if any, need to be made to the implementation of the project?
</td><td rowspan="3">
• What data will be collected, from what sources, and in what manner?
• How will information be presented, to whom, and by what timelines?
• How will outcome evaluation be firmly linked to–and inform–process evaluation?; and
• Conversely, how will process evaluation be firmly linked to–and inform– outcome evaluation?
</td></tr>
<tr><th>Outcome Evaluation Considerations</th></tr>
<tr><td>
• What differences, if any, exist between the baseline, planned, and actual outcomes are occurring?
• Are there patterns in the data that need additional analysis (e.g., variations in knowledge, skills, abilities, attitudes, or behaviors related to the desired outcomes)?
• What other explanations for change, or lack of change, other than the strategies and activities exist?
• What are the considerations for current and future implementation?
</td></tr>
</table>

In Section F of both Work Plans (Pgs 16 and 18), list long-term outcome indicators of the change in behavior related to ATOD problems, consequences, consumption and capacity development that your project will seek to achieve, including degree of change and timeline. NOTE: Because capacity development goals tend to be achievable in shorter periods of time than ATOD-related goals, you may or may not identify long-term outcome indicators for Capacity Development Work Plans.

In Section I of both Work Plans (Pgs 17 and 19), list intermediate outcome indicators of the changes in key intervening variables and other underlying conditions that your project will seek to achieve, including degree of change and timelines. For reasons noted above, you may or may not identify intermediate-term outcome indicators for Capacity Development Work Plans.

In Section N of both Work Plans (Pgs 17 and 19), list the process indicators that will be used to monitor the extent to which each activity is occurring as planned.

✶ See sample Substance Abuse and Capacity Development Work Plans on pages 22-33 for examples.

South Dakota Department of Human Services
Division of Alcohol and Drug Abuse

Logic Model for Substance Abuse Prevention Planning – [Cite Problem or Consequence]

As you develop your Substance Abuse Prevention Work Plan (see pages 16-17), complete a logic model for each problem statement and its related intervening variables or underling conditions and proposed strategies. These will serve as a one-page overview of your plans to address each problem or consequence.

Substance-Related Consequences	Substance Use	Intervening Variables and Underlying conditions	Strategies
		In these boxes, list the key intervening variables and underlying conditions that...	In theses boxes, list the strategies you intend to use to address the intervening variables and underlying conditions your project will address.
List in this box the substance abuse-related consequences that your work plan will impact	List in this box the substance use behavior your initiative will target, based on assessment data	...your project will address, based on assessment data.	Use arrow or lines to link the strategies to the intervening variables and underlying conditions that they are intended to address.
		Add or delete text boxes as needed	Add or delete text boxes as needed.

South Dakota Department of Human Services
Division of Alcohol and Drug Abuse

Complete a work plan for each problem statement and related goal your initiative proposes to address.
Complete an objective work sheet for each objective in your prevention project.

Substance Abuse Prevention Work Plan
A. Assessment Summary:
B. Problem Statement:
C. Target Population:
D. Goal:
E. Long-Term Outcome: **F. Long-Term Outcome Indicator(s):** • • •

G. Objective:						
H. Intermediate Outcome: .						
I. Intermediate Outcome Indicator(s): . • •						
J. Strategy:						
K. Activities	L. Timeline		M. Who Is Responsible.	N. Process Indicators	O. Outputs.	P. Short-Term Outcome(s) .
	Start Date	End Date				
.						
J. Strategy:						
K. Activities	L. Timeline		M. Who Is Responsible	N. Process Indicators	O. Outputs	P. Short-Term Outcome(s)
	Start Date	End Date				
Strategy:						
K. Activities	L. Timeline		M. Who Is Responsible	N. Process Indicators	O. Outputs	P. Short-Term Outcome(s)
	Start Date	End Date				

South Dakota Department of Human Services
Division of Alcohol and Drug Abuse

Complete a work plan for each problem statement and related goal your initiative proposes to address. Complete an objective work sheet for each objective in your prevention project.

Capacity Development Work Plan
A. Assessment Summary:
B. Problem Statement:
C. Target Population:
D. Goal:
E. Long-Term Outcome: **F. Long-Term Outcome Indicator(s):** • • •

G. Objective:						
H. Intermediate Outcome: I. Intermediate Outcome Indicator(s):. • •						
J. Strategy:						
K. Activities	L. Timeline		M. Who Is Responsible	N. Process Indicators	O. Outputs	P. Short-Term Outcome(s)
	Start Date	End Date				
.						
J. Strategy:						
K. Activities	L. Timeline		M. Who Is Responsible	N. Process Indicators	O. Outputs	P. Short-Term Outcome(s)
	Start Date	End Date				
Strategy:						
K. Activities	L. Timeline		M. Who Is Responsible	N. Process Indicators	O. Outputs	P. Short-Term Outcome(s)
	Start Date	End Date				

South Dakota Department of Human Services
Division of Alcohol and Drug Abuse

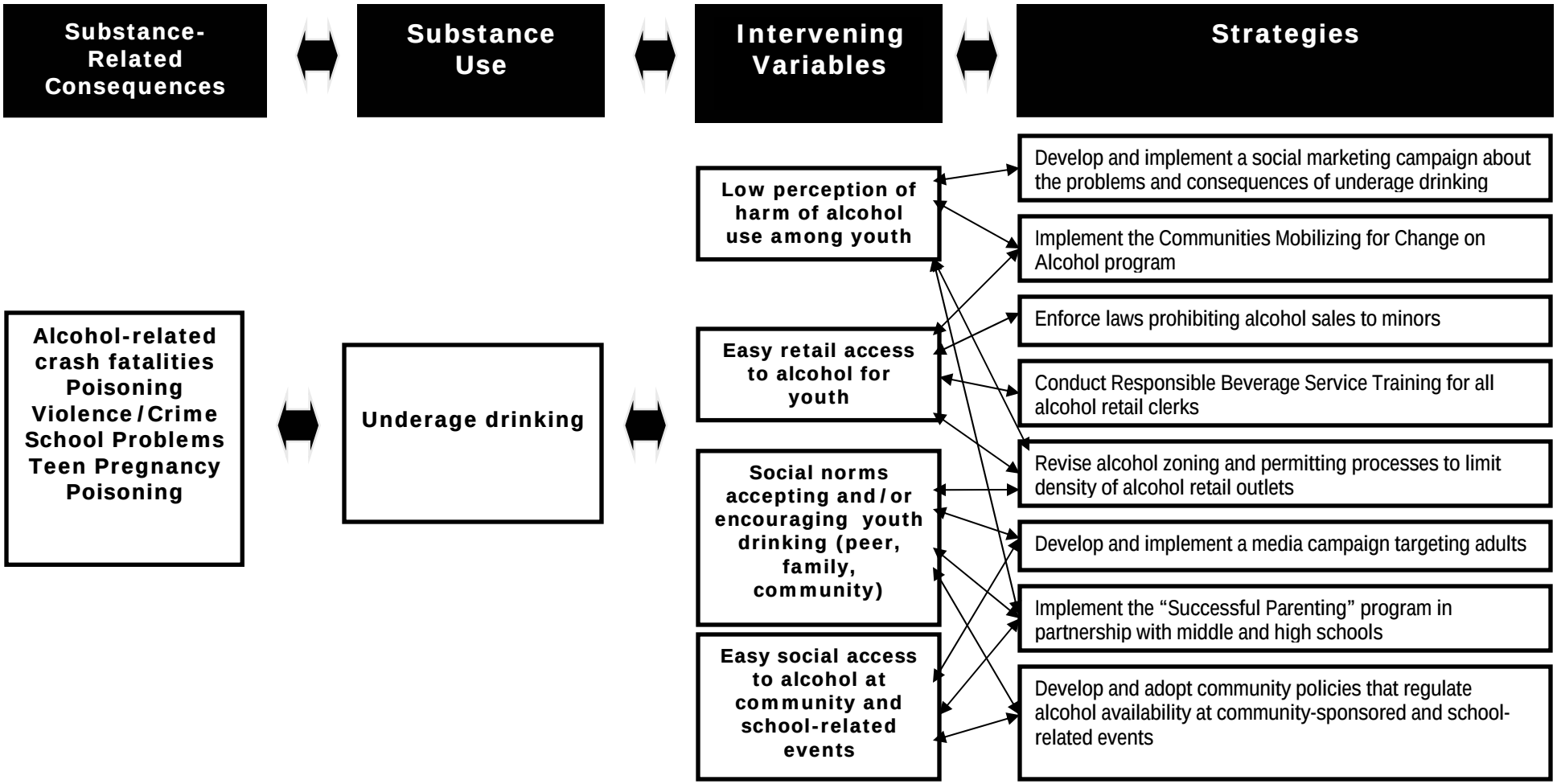
Requested Funds

Personnel Costs

Costs in this category include staff and fringe benefits (e.g. FICA, insurance, retirement). Include position title and salary for each staff person to be paid for through the project. In Column 1, list all positions for which salaries will be paid from this contract. In Column 2, enter the annual (12-month) salary rate for each position that will be filled for all or any part of the year. In Column 3, enter the number of months each position will be filled. In Column 4, enter the percent of time the staff will devote to the project during the number of months shown in Column 3. In column 5, enter the total salary cost. In Columns 6 and 7, enter the expected source of funding.

1. Personnel Positions	2. Annual Salary Rate	3. Number of Months	4. % of Time	5. Total Cost	Source of Funds	
					5. Funds from Applicant and Other Sources (Identify)	6. Requested from the Division of Alcohol and Drug Abuse
% of Fringe						
Category Subtotal			__ FTE	$	$	$

Example Logic Model for Substance Abuse Prevention Planning – Underage Drinking



Example Substance Abuse Prevention Provider Work Plan

*(**Note**: this is for demonstration purposes only, and is not meant to portray or prescribe all the activities of an actual work plan)*

Assessment Summary:

Data collection and analyses reveal that alcohol use is the priority substance abuse issue for youth ages 12-20. According to community archival, survey and social indicator data:

- 60% of youth between the ages of 12 and 20 reported drinking alcohol within the past 30 days
- Only 25% of youth ages 12 to 20 report perceiving underage drinking to be harmful
- Law enforcement data showed that during recent compliance checks, only 65% of local alcohol retail outlets refused to sell alcohol to underage youth
- A recent community survey found that 45% of parents surveyed agreed with the statement that "drinking is a rite of passage for kids, so it's better for them to drink at home"
- Alcohol is available for sale at all community events, including those oriented to families with children

Problem Statement: 60% of SD youth ages 12 to 20 report drinking alcohol in the past 30 days.

Target Population:

- Direct Target: Youth, ages 12-20
- Indirect Targets: Alcohol retail employees, parents, community members

NOTE: these are all "Universal" target populations)

Goal: Decrease 30-day alcohol use by youth aged 12 to 20.

Long-Term Outcome: By June 30, 2015, 30-day alcohol use among youth ages 12 to 20 will decrease by 20% to an overall rate of 48%.

Long-Term Outcome Indicator(s):

- By June 30, 2012, 30-day alcohol use among youth ages 12 to 20 will decrease by 5% to an overall rate of 57%.
- By June 30, 2013, 30-day alcohol use among youth ages 12 to 20 will decrease by 10% to an overall rate of 54%.
- By June 30, 2014, 30-day alcohol use among youth ages 12 to 20 will decrease by 15% to an overall rate of 51%.

Objective 1: Increase the perception of harm of underage alcohol use among youth ages 12 to 20

Intermediate Outcome: By June 30, 2013, 80% of youth ages 12 to 20 will report perceiving underage alcohol use to be harmful.

Intermediate Outcome Indicator(s):

- By June 30, 2011, 40% of youth ages 12 to 20 will report perceiving underage alcohol use to be harmful.
- By June 30, 2012, 60% of youth ages 12 to 20 will report perceiving underage alcohol use to be harmful.

Strategy: Develop and implement a social marketing campaign to educate youth about the problems and consequences of underage drinking

Activities	Timeline		Who Is Responsible	Process Indicators	Outputs	Short-Term Outcomes
	Start Date	End Date				
Conduct research to identify evidence-based practices and principles for developing and conducting social marketing campaigns.				Progress in completion of research per established timelines	Research findings	By [month/date/year], [%] of youth ages 12 to 20 will have increased knowledge about the problems and consequences associated with underage drinking
Identify key communication venues for youth target populations, including web-based social networking sites as well as print and broadcast media.				Progress in compilation of list per established timelines	List of communication venues	
Convene a youth work group to design social marketing campaign.				Progress of completion of campaign per established timelines	Campaign messages	
Schedule and recruit youth to participate in focus groups to review and provide feedback for any needed campaign modifications.				Percent of persons recruited and focus groups scheduled per numbers needed and established timelines	Focus group schedule and feedback; number of participants	
Place social marketing campaign elements in selected venues.				Percent of campaign material placed in selected venues per established timelines	Number of: paid media spots; public service announcements (PSAs); persons reached via media campaign, Twitter or other venues; website “hits.”	

Strategy: Implement the Communities Mobilizing for Change on Alcohol program						
Activities	Timeline		Who Is Responsible	Process Indicators	Outputs	Short-Term Outcomes
	Start Date	End Date				
Obtain curriculum and materials				Curriculum and materials are purchased and received per established timelines.	Curriculum and materials	Short-Term Outcome: By [month/date/year], [%] of community members will have increased knowledge about the problems and consequences associated with underage drinking
Recruit additional coalition members, including youth				Percent of: 1) recruitment materials completed, 2) meetings with potential members held, and 3) coalition members recruited per established time lines.	List of key sectors and potential members and supporters to be recruited, informational materials on the coalition effort, talking points, notes from meetings with potential new members, number of members recruited	
Train community coalition members				Percent of coalition members trained per established timelines	Number of trainings held; number of members trained	
Conduct face-to-face mobilizing				Percent of meetings with community stakeholders conducted per established timelines	Number of meetings conducted with community stakeholders	
Conduct environmental assessment of existing community laws and policies impacting accessibility of alcohol				Percent of persons recruited to conduct assessment per total numbers needed; percent of analysis completed per established timelines	Number persons recruited; completed environmental assessment	

Objective 2: Increase the number of retail alcohol outlets that refuse to sell alcohol to minor youth aged 12 to 20.

Intermediate Outcome: By June 30, 2013 the compliance rate of retail alcohol outlets that refuse to sell alcohol to minors will increase to 95%.

Intermediate Outcome Indicator(s):

- By June 30, 2011 the compliance rate of retail alcohol outlets that refuse to sell alcohol to minors will increase to 75%.
- By June 30, 2012 the compliance rate of retail alcohol outlets that refuse to sell alcohol to minors will increase to 85%.

Strategy #1: Enforce laws prohibiting alcohol sales to minors

Activities	Timeline		Who Is Responsible	Process Indicators	Outputs	Short-Term Outcomes
	Start Date	End Date				
Recruit youth inspectors				Percent of needed youth recruited per the established timeline	Number of youth recruited	By [month/year] there will be an [%] increase in the knowledge and abilities of retail alcohol employees to refuse to sell alcohol to underage youth.
Train youth inspectors in compliance check protocols				Percent of youth trained per the established timeline	Number of youth trained	
Develop a schedule of alcohol outlets to be checked by law enforcement officers and youth inspectors				Percent of schedule completed per the established timeline	Schedule and list of outlets; inspection assignments	
Conduct compliance checks of alcohol retailers to identify sales to minors				Percent of compliance checks completed per the established timeline	Compliance check records and data	

Strategy #2: Conduct Responsible Beverage Service Training (RBST) for all alcohol retail clerks

Activities	Timeline		Who Is Responsible	Process Indicators	Outputs	Short-Term Outcomes
	Start Date	End Date				
Develop training materials				Material development progress per established timelines	Written training materials	By [month/year] there will be an [%] increase in the knowledge and abilities of alcohol servers to refuse to serve alcohol to underage youth.
Train individuals to serve as RBST trainers				Percent of trainers trained	Number of trainers trained	

Schedule alcohol clerk, bartender and server trainings				Percent of training sites and dates scheduled per established timelines	Schedule of training	
Recruit training participants				Percent of persons recruited per established timelines and schedules	Number of persons recruited	
Hold clerk, bartender and server trainings				Percent of trainings completed per established timelines	Number of trainings held; numbers trained	
Strategy #3: Revise alcohol zoning and permitting processes to limit density of alcohol retail outlets						
Activities	Timeline		Who Is Responsible	Process Indicators	Outputs	Short-Term Outcomes
	Start Date	End Date				
Conduct a literature search to identify model policies				Progress in completion of literature search per established timelines	Literature search findings/ model policies	By [month/year] local policy makers will have [%] increased knowledge of: 1) the impact of alcohol outlet density on underage drinking, and 2) models policies that have proven successful in reducing alcohol outlet density.
Identify key policy makers who have power over the decision-making process				Progress in identifying policy makers per established timelines	List of policy makers and contact information	
Schedule and hold meetings with policy makers to determine and engage support				Progress in scheduling and holding meetings per established timelines	Meeting schedule and notes	

Objective 3: Decrease access to alcohol in the home by youth aged 12 to 20.

Intermediate Outcome: By June 30, 2013, parents who report attitudes favorable to allowing youth access to alcohol in their homes will decrease by 66% to an overall rate of 15%.

Intermediate Outcome Indicator(s):

- By June 30, 2011, parents who report attitudes favorable to allowing youth access to alcohol in their homes will decrease by 33% to an overall rate of 30%.
- By June 30, 2012, parents who report attitudes favorable to allowing youth access to alcohol in their homes will decrease by 50% to an overall rate of 23.5%.

Strategy #1: Develop and implement a media campaign targeting adults

Activities	Timeline		Who Is Responsible	Process Indicators	Outputs	Short-Term Outcomes
	Start Date	End Date				
Conduct research to identify evidence-based practices and principles for developing and conducting media campaigns.				Progress in completion of research per established timelines	Research findings/ practices and principles	[%] of parents of youth ages 12 to 20 will have increased knowledge about the problems and consequences associated with underage drinking
Develop public service announcements (PSAs).				Progress of completion of PSA scripts per established timelines	PSA scripts	
Schedule and recruit people to participate in focus groups to review and provide feedback for PSAs.				Percent of persons recruited and focus groups scheduled per established timelines	Focus group schedule and feedback; number of participants	
Recruit local broadcasters to air PSAs.				Percent of local broadcasters recruited per established timelines	Number of PSAs aired	

Strategy #2: Implement the "Successful Parenting" program in partnership with middle and high schools						
Activities	Timeline		Who Is Responsible	Process Indicators	Outputs	Short-Term Outcomes
	Start Date	End Date				
Purchase curriculum and program materials				Curriculum and materials are purchased and received per established timelines.	Curriculum and materials	[%] of parents of youth ages 12 to 20 will be knowledgeable about the problems and consequences associated with underage drinking
Train program coordinators and school staff				Percent of staff trained per established timelines	Number of trainings held; number of staff trained	
Recruit program participants				Percent of program participants recruited per established timelines	Number of participants recruited	
Conduct pre-tests and hold sessions				Percent of sessions held per established timelines; degree to which sessions are implemented on time and with fidelity	Number of sessions held; number of participants; implementation records; pre-test data and findings	
Conduct evaluations and post-tests				Percent of evaluations and post-tests completed; evaluation and post-test scores	Post-test data and findings	

Objective 4: Decrease the availability of alcohol at community and school-related events.

Intermediate Outcomes:

- By June 30, 2014, the number of community and school-related events at which alcohol is unavailable or significantly restricted will increase by 33%.

Intermediate Outcome Indicator(s):

- By June 30, 2011, serving sizes of beer sold at the county fair will be reduced from 24 to 12 ounces.
- By June 30, 2012, alcohol sales at the county fair will be consolidated into one location.
- By June 30, 2012, alcohol sales at the annual school fundraiser will be discontinued, or the event will moved to an off-campus location with attendance restricted to adults ages 21 and older.
- By June 30, 2013, alcohol sales at the county fair will be restricted to a single, enclosed area located away from family-oriented events, with access restricted to adults able to provide verification of age.
- By June 30, 2013, alcohol sales at all venues where youth athletic events are taking place will be suspended until the events are concluded (e.g., golf course lounges; stadium, arena and athletic facilities concessions)

Strategy: Develop and adopt community policies that regulate alcohol availability at community-sponsored events

Activities	Timeline		Who Is Responsible	Process Indicators	Outputs	Short-Term Outcomes
	Start Date	End Date				
Identify key community and school-related events and the key event organizers and their affiliations and contact information.				Percent of information compiled per timeline	List of key community and school-related events and the key event organizers and their affiliations and contact information.	By [month/date/year], coalition members will be knowledgeable about: • alcohol availability and sales practices at community and school-related events, • State and local special use liquor license requirements and permitting processes • effective policies and practices to reduce availability.
Analyze the alcohol policies that are currently in effect at those events, and identify any key alcohol sponsorships.				Percent of research completed per timeline	List of the alcohol policies that are currently in effect at events, and key alcohol sponsorships	
Review State and municipal liquor license regulations for special use permits and identify any needed or proposed changes.						
Research and identify model and/or best practice alcohol policies that can address existing problematic practices related to alcohol availability at				Percent of information compiled per timeline	Model and/or best practices	

community and school-related events.						By [month/date/year], the number of event organizers and policy makers and opinion leaders who are knowledgeable about the benefits of—and approaches to—decreased alcohol availability at community and school-related events will increase by [%].
Develop talking points and informational materials about proposed policy changes.				Percent of material developed per timeline	Written talking points, flyers, etc	
Identify school and community policy makers and opinion leaders whose support will help, or be instrumental to, change alcohol availability at community and school-related events (including law enforcement).				Percent of information compiled per timeline	List of school and community policy makers and opinion leaders	
Conduct targeted outreach to event organizers and identified school and community policy makers and opinion leaders to increase their awareness of the need for alcohol availability change at events and enlist their support.				Percent of meetings completed per timeline	Notes from meetings with event organizers and school and community policy makers and opinion leaders	
Identify alternative sources of revenue other than alcohol sponsorships to support events.				Percent of research on alternative sources completed per timeline	List of potential alternative sources of revenue other than alcohol sponsorships	
Work with event organizers to adopt and implement the policy changes.				Meetings are being held with organizers and policies are being implemented per timelines.	Meeting notes, implementation schedule and checklist	
Evaluate changes in: 1) attendance at the events, 2) attendee satisfaction with the event experience, and 3) law enforcement practices and outcomes.				Completion rates of surveys and other data points (e.g., law enforcement records)	Evaluation plan, data collection tools and protocols	

Example Substance Abuse Prevention Provider Work Plan - Capacity Development

Assessment Summary: Analysis of coalition membership and meeting records—compared to community demographic data—indicates that not all sectors of the community are currently engaged in, or represented by, coalition activities. In addition to an absence of Hispanic/Latino community representatives, the coalition also has few members representing parents, clergy, media representatives, business people and prevention service recipients. Focus groups and face-to-face interviews with members of these groups indicate that the work of the coalition is not well known, and people are unaware of the opportunities for—and the benefits of—participation in the coalition. In addition, members of the Hispanic/Latino community have expressed perceptions that some of the approaches used by the coalition are not culturally relevant, appropriate or accessible.

Problem Statement: The membership of the Community Coalition is not representative of all sectors and demographic groups within the community. In particular, members of the Hispanic/Latino community are not represented on the coalition.

Target Population:

Direct Targets: Parents, clergy, media representatives, business people, prevention service recipients, and representatives from the Hispanic/Latino community

Indirect Targets: Hispanic/Latino and other community opinion leaders, Chamber of Commerce, Interfaith association, school administrators

Goal: Membership of the Community Coalition will reflect the demographics of the community.

Long-Term Outcomes:

- By June 30, 2011, at least two new youth and parent representatives, two youth or adult service recipients, and at least one new representative from the clergy, media, Hispanic/Latino community and business sectors will be actively involved in the Coalition.
- By March 31, 2011, the Community Coalition will meet all National Standards for Culturally and Linguistically Appropriate Services in Health Care.

Objective 1: Increase the number of youth, parents, clergy, media representatives, business people, prevention service recipients, and representatives from the Hispanic/Latino community that are aware of: the work of the coalition, the benefits the coalition brings to the community, and opportunities to become involved in coalition work.

Intermediate Outcome: By December 30, 2010, at least 60% of community members will perceive participation in the coalition to be beneficial to themselves and to the community at large.

Strategy: *Recruit new coalition members representative of the community through face-to-face contacts*.

Activities	Timeline		Who Is Responsible	Process Indicators	Outputs	Short-Term Outcome(s)
	Start Date	End Date				
Assemble a Recruitment Task Force from the Coalition to head up recruitment efforts for each sector.	7/1/10	9/30/10	Project Director, Coalition Chair	Percent of Task Force recruited per time line	Recruitment Task Force Appointed by Chair and recorded in minutes	By June 30, 2010, all community members will be aware of the existence, vision, mission and activities of the Community Coalition.
Complete a list of at least ten potential candidates for each sector targeted for growth.	10/1/10	12/31/10	Recruitment Task Force	Percent of list completed per time line	Number of names generated by the Recruitment Task Force	
Identify coalition members who might have a tie to each person on the list and determine who will contact them.	10/1/10	12/31/10	Recruitment Task Force, Project Director	Percent of coalition members identified per time line	Completed Recruitment Plan developed and written by the Task Force	
Develop talking points for explaining the work of the coalition and opportunities and benefits of coalition membership.	10/1/10	12/31/10	Recruitment Task Force	Percent of talking points completed per timeline	Talking Points	
Determine responsible person and timeline for each contact on the list.	10/1/010	12/31/10	Recruitment Task Force, Project Director	Percent of responsible persons and time lines identified for each contact per time line	Timelines & responsibility centers appear on the Recruitment Plan	
Complete contacts and report back results.	1/1/11	3/31/11	Recruitment Task Force, Project Director	Percent of contacts and reports completed per timeline	Minutes record number of contacts completed and number of members from each sector recruited	
Hold youth leadership event specifically designed to gain youth involvement in the Coalition.	7/1/10	6/30/11	Youth Education Committee	Youth leadership event held as scheduled	Number of youth in attendance at event. Number of youth recruited for coalition.	
Revise plan and make additional contacts	4/1/10	6/30/11	Recruitment Task	Percent completion of	Revised written plan	

until objectives are met.			Force, Project Director	plan and contacts made per time line	completed	

Objective 2: Increase the cultural competence of the coalition, particularly with regard to Hispanic/Latino populations.						
Intermediate Outcome: By December 30, 2010, the Community Coalition will have a written plan developed and being implemented for addressing the unique substance abuse prevention needs, concerns and cultural considerations of Hispanic/Latino and other ethnic minority members of the community.						
Strategy: *Complete assessment of current cultural competency, then complete and implement a plan for improving cultural competency.*						
Activities	Timeline		Who Is Responsible	Process Indicators	Outputs	Short-Term Outcome(s)
	Start Date	End Date				
Develop or acquire assessment tools and survey	1/1/10	2/28/10	Cultural Diversity Committee	Percent completion of development or acquisition of assessment tools and survey per timeline	Tools and survey	By June 30, 2010, the Community Coalition will have increased knowledge of the unique needs, concerns and cultural considerations of Hispanic/Latino and other ethnic minority members of the community with regard to substance abuse prevention.
Translate materials as needed	3/1/10	3/31/10		Percent of needed translations completed	Translated materials	
Recruit persons to conduct face-to-face interviews and implement assessments	4/1/10	6/30/10		Percent of persons needed completed per established timelines	List of interviewers and assessment administrators	
Identify venues for survey administration	4/1/10	6/30/10		Percent of number of venues needed identified	List of venues	
Complete community survey and assessment of cultural competence	7/1/10	8/31/10		Percent of survey completed per established timelines	Completed assessment of cultural competence	
Evaluate survey and assessment results	9/1/10	9/30/10		Percent of data returned and analyzed per timelines	Assessment data and report	
Develop plan for improving cultural competence based on assessment	10/1/10	12/31/10		Percent and/or sections of plan completed per established timelines	Written plan for increasing cultural competence	
Present Cultural Competency Plan to Coalition for approval & implementation	1/1/10	3/31/11		Plan is being implemented according to established timelines	Plan is formally approved by the Coalition	

Glossary of Key Terms

30-day use: A measure of the number of individuals who report using alcohol, tobacco, or other drugs at least once in the prior 30 days.

Activity:

Assessment: The formal and objective process of collecting and analyzing valid data to identify patterns that yield meaningful and actionable information. Areas of assessment include *contextual conditions*, needs (i.e., problems), resources, readiness to identify behaviors and conditions as problems and take action, organizational infrastructure and capacity, and gaps in services.

Collaborators: A subset of stakeholders who will actively work to help develop and implement system initiatives.

Conceptual fit: The degree to which an intervention targets the risk and protective factors that contribute to or influence the identified community substance abuse problem.

Contextual conditions: Perceptions or realities in the overall environment that have existed, or currently exist, and help explain why things are the way they are. Types of conditions are history, norms, *culture*, traditions and beliefs, socioeconomics, geography, boundaries, demographics, politics, policies, prevention infrastructure, relationships, and workforce.

Cultural competence: The ability to work effectively across cultures by transcending personal *paradigms* (e.g., values and attitudes) and adopting and implementing behaviors and practices that honor and respect the beliefs, language, interpersonal styles, and behaviors of others.

Direct target population: A group of individuals who are the focus of an *intervention* because they are directly affected by or involved in a problem or consequence (e.g., underage youth who drink alcohol).

Domains: The social environments in which *risk* and *protective factors* are found, in which a course of action has proved to be effective (e.g., individual/peer, family, school, or community).

Environmental strategies: Long-term approaches that focus on changing conditions in the shared social environment that contribute to, or protect against, problems and consequences (e.g., social norms and availability of alcohol, tobacco, and other drugs). Environmental strategies seek population-level change, are nearly always universal in their *reach*, and frequently take the form of ongoing policies and *practices*.

Evidence-based strategies: Interventions based on a strong theory or conceptual framework that comprise activities grounded in that theory or framework and that produce empirically verifiable positive outcomes when well implemented. SAMHSA's SPF and SAPT Block Grant guidance for documenting strategies as evidence based is that they must meet at least one of the three following criteria:

- Inclusion in a Federal list or registry of evidenced based interventions; or
- Being reported (with positive effects on the primary targeted outcome) in a peer–reviewed journal; or
- Documented effectiveness supported by other sources of information and the consensus judgment of informed experts based on the following guidelines:
  - The intervention is based on a theory of change that is documented in a clear logic or conceptual model;
  - The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature;

- 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
- 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).

Goals: General statements of the major accomplishments that need to be achieved to realize an expressed vision. Substance abuse prevention goals generally describe changes in behaviors that will prevent problems and related consequences. Prevention system goals reflect desired changes in the behavior of the system that are needed to make the system more effective in achieving and sustaining outcomes.

Immediate outcomes: Immediate outcomes reflect a change in knowledge, skills, abilities or attitudes due to implementation of an activity.

Implementation plan: A plan that lays out exactly how a prevention initiative or capacity development plan will unfold. The implementation plan should contain specific information on all timelines, processes, activities, roles and responsibilities, needed *outputs*, and *process indicators* to provide guidance to staff and partners and inform stakeholders of activities.

Indicated populations: Groups of individuals who have been identified as exhibiting early warning signs of problems, such as experimentation with substance abuse or instances of intense use (e.g., binge drinking). SAMHSA's SAPT Block Grant defines indicated populations as "individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels." Strategies for indicated populations address the specific *risk factors* and other underlying causal conditions experienced by the individuals in an attempt to delay the onset and reduce the severity of problems.

Indicator: A formal measure of a behavior or condition for which a baseline has been established and which is regularly monitored and reassessed to determine progress toward desired goals, objectives, and outcomes.

Indirect target population: A group of individuals who are the focus of an intervention because they play an important role in the conditions that promote or prevent the problem.

Individual strategy: A course of action that focuses on changing the attributes of individuals to change individual behaviors, and does not address conditions that exist in the environment. Individual strategies may target *universal*, *selective*, or *indicated populations*. While they frequently take the form of short-term or time-limited programs that are designed to enhance resiliency, decision making, and risk-resistance skills, the strategies may also consist of long-term efforts.

Intermediate outcomes: Intermediate outcomes reflect the quantifiable degree and date of accomplishment of your objectives.

Intervening variables: Factors that have been identified as being strongly related to—and influential in—the occurrence and magnitude of substance use problems and consequences.

Interventions: Courses of action that include programs, practices, policies, and other strategies that affect individuals, groups of individuals, or entire communities.

Lifetime use: A measure of experimentation (i.e., use on at least one occasion) with alcohol, tobacco, or other drugs.

Logic model: A conceptual framework that broadly outlines a series of data-driven and logical steps that are used to identify and link problems, consequences, and underlying conditions or intervening variables; and broadly plan a course of action to prevent and reduce future occurrences of the problem. The Substance

Abuse and Mental Health Administration's (SAMHSA) Strategic Prevention Framework State Incentive Grant (SPF SIG) grant program uses **outcome-based logic models** and **program-level logic models** to support prevention planning.

Long-term outcomes: Long-term outcomes reflect the quantifiable degree and date of accomplishment of your goals.

Needs assessment: Identification of the patterns of alcohol, tobacco, and other drug consumption; the social, economic, and public health consequences of consumption; and the underlying conditions that give rise to problems and consequences in order to guide the identification of prevention priorities and the development of an effective response.

Objectives: Specific statements that are logically linked to desired goals and describe changes in the underlying conditions that have to occur to achieve these goals.

Outcome evaluation: Monitoring and producing actionable information on progress toward accomplishing desired achievements.

Outcome indicator: An interim measure that is logically linked to a desired outcome and can provide information on incremental stages of progress toward achieving the outcome.

Outcome-based logic model: This type of logic model describes relationships among multiple factors and components in a community and how they may be used to achieve change in a desired outcome. An outcome-based logic model maps the identified problem in terms of three components:

- A clear definition of problem(s) to be addressed (consequences and behaviors)
- Intervening variables which have scientific evidence of contributing to the problem, and
- Prevention strategies (programs, policies, practices) with evidence of effectiveness to impact one or more intervening variables and/or the targeted problem.

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

Outcomes: Statements of intended accomplishment that demonstrate that quantifiable progress is being made. Outcomes may be immediate (e.g., a change in knowledge, skills, abilities, perceptions, or attitudes—typically measured by a pre- and posttest after an intervention); intermediate (e.g., a change in underlying causal conditions); or long term (e.g., a change in behavior). In any case, outcome statements should be specific, measurable, achievable, realistic, and time limited.

Outputs: Time-limited and quantifiable products of an activity that contribute to the achievement of outcomes, such as number of persons trained to implement a selected strategy.

Policies: Formally codified rules, regulations, standards, or laws that are designed to prevent problems (e.g., minimum-age purchase laws for alcohol and tobacco); or informal and unwritten standards and norms (e.g., decisions to prioritize prosecution of certain offenses, such as sales of age-restricted products to minors).

Practical fit: The degree to which an intervention meets the resources and capacities of the community and coincides with or matches the community's readiness to take action.

Practices: Activities that are based on implementing policies designed to prevent problems and consequences (e.g., Responsible Beverage Server Training and sobriety checkpoints).

Problem statement: A concise description of the priority problems and consequences that were identified during the assessment process and which the planning process will address.

Process evaluation: Monitoring and producing actionable information on the effectiveness of the implementation of an initiative to derive information to help the initiative more effectively and efficiently achieve desired outcomes.

Process indicators: Specific, measurable, and time-limited measures that demonstrate the degree to which activities are carried out as planned.

Program-level logic model: This type of logic model outlines the theory behind and contribution of specific intervention components and activities to change individuals or a population.

Programs: Structured interventions that are designed to change attributes or conditions within a defined area or population. Programs are usually individual in focus but may also address environmental issues.

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

Qualitative measures: Measures that seek to appraise performance and the quality of the outcome: how well an action was done and what benefit it produced.

Quantitative measures: Measures that are able to frame action in terms of quantity: how much action was implemented and what amount of change was achieved.

Risk factors: Conditions for an individual, group, or community that increase the likelihood of a substance abuse problem.

Selective population: A subset of the total population that is considered to be at higher-than-average risk because of certain characteristics or inclusion in higher risk categories, such as children of alcoholics or adjudicated youth. SAMHSA's SAPT Block Grant defines selective populations as "individuals or a subgroup of the population whose risk of developing a disorder is significantly higher that average." Like universal populations, members of selective populations are not screened or assessed for individual risk, but are selected based on shared risks (e.g., biological, psychological, social, or environmental) or other factors, such as age, gender, or place of residence. When selective populations are targeted, strategies will focus on all members of the group.

Situational appropriateness: A course of action that is carefully aligned with, and responsive to, the *target populations* and contextual and cultural conditions, resources, readiness, and capacities of the systems implementing and receiving the course of action.

Stakeholders: Those individuals or organizations that will be involved in, affected by, interested in, or have power over an initiative in one way or another.

Strategy: A course of action based on a *theory of change* that is undertaken to achieve a vision.

Target population: Those individuals and groups who are affected by the problems and consequences—or who are involved in the occurrence of the problems and consequences—upon whom interventions must be focused to be effective.

Theory of change: A reasoned belief, based on assessment and evaluation, that a specific course of action will produce a desired degree of positive change.

Universal populations: Entire groups (e.g., a classroom, grade or grades of students, school, neighborhood, or community) that are targeted by interventions without regard to individual risk, on the premise that all share the same general risk for being affected by or involved in the problems and consequences. SAMHSA's SAPT Block Grant defines universal populations as "the general public or a whole population group that has not been identified on the basis of individual risk."