

## CHAPTER 3

# Criteria for Determining a Prevention Program

### Chapter Overview

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- Summary

In this chapter we will focus on criteria for determining a prevention program. Criteria assist in knowing what prevention is and what it is not. These criteria, then, can help guide both program development and program evaluation. When I work with students or trainees in prevention, we spend a lot of time becoming familiar with criteria and then applying them against prevention programs that have been evaluated as “excellent.” I ask them: “What makes these programs excellent?” Students work in small groups to apply these criteria in seeking to answer the question. When we begin to consider developing and evaluating prevention programs, these criteria also serve to ground that effort.

The criteria that follow are informed by the meta-analyses cited in the previous chapter, as well as from other sources. The first eight intervention criteria presented are adapted from the “review of reviews” by Nation et al. (2003). This is a good place to begin.

## Broad Criteria for Determining Prevention Programs

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### Comprehensiveness

Effective prevention programs are comprehensive in scope. They tend to be longer term and sometimes longitudinal, address protective and risk factors, and include person-centered and system-centered components. Each of these areas is discussed below.

*Longer Term.* “Single-shot” prevention presentations—that is, those that are presented briefly and for one time, such as a 1-hour lecture on preventing stress or a 2-hour workshop on that topic—typically are unable to produce sustainable preventive effects. Longer-term programs are more likely to effect growth and change, but length alone is not sufficient. For instance, prevention programs conducted over a longer time period but that are limited to one domain, such as a knowledge or skill area, possess limited potency.

*Protective and Risk Factors.* By contrast, effective prevention programs tend to be both longer term and comprehensive, echoing the basic tenet of multiplicity discussed earlier. These programs typically include several planned interventions aimed to accomplish interlacing goals revolving around increasing protective factors (strengths) while decreasing risk factors (deficits). For example, in a substance abuse prevention program aimed at teenagers, protective factor interventions might include presentation of cognitive information to increase awareness and knowledge, psychoeducation skill development segments to develop resistance skills, and pairing participants with mentors to provide ongoing support. Risk reduction factors in the same program might target reduction of stressors in teens’ lives, advocating for increased resources to address teenage substance abuse, and educational campaigns aimed at parents to instruct them in how to eliminate home access by teenagers to unprescribed and over-the-counter medicines.

*Person Centered and System Centered.* In addition to a multimodal approach, successful prevention programs are focused broadly to include members of the targeted population (person centered) but also settings, situations, and environments that are relevant and influential (system centered). Person-centered aspects of a substance abuse prevention program might target parents, school personnel, and peers, while system-centered components might address aspects of environments, such as their physical properties, policies, and procedures. As has been pointed out (e.g., Conyne, 2004; Hawkins & Catalano, 1992), a range of factors needs to be addressed across domains or settings that have main impact on the program participants.

### Direct Experiencing Methods

Effective prevention interventions tend to be interactive, involving participants in direct, hands-on experience (Tobler et al., 2000; Tobler & Stratton, 1997). After

reviewing three meta-analyses for school-based adolescent drug prevention programs, Tobler (2000) found that noninteractive prevention programs produced a 4% reduction in prevalence rates while interactive programs yielded a 21% reduction. She concluded that small, interactive programs were the more successful. Such findings favoring direct experience have been found in a broad range of areas, cautioning against prevention programs that emphasize one-way transmission or group discussion of knowledge and information rather than highlighting skill development and other forms of direct participation and experience.

## Sufficient Dosage

Successful prevention programs provide enough potency to produce intended effects. Termed *sufficient dosage*, or the intensity of the intervention, this concept in prevention is not unlike what we might ordinarily think of when treating a cold, where the dosage size of cough syrup is measured. I think of sufficient dosage as applying the so-called “Goldilocks Rule,” adapted from the fairy tale *Goldilocks and the Three Bears*. Those of you with long memories may remember how Goldilocks entered a house in the forest, looking to find the porridge, chair, and bed that were “just right.” Not too hot or cold (porridge), not too big or too little (chair), and not too hard or soft (bed). In each case she sorted through options that were too this or too that, until finding the ones that were—again—“just right.”

Prevention programs that are just right in dosage typically are measured by such considerations as the number, frequency, and length of each session, the overall brevity or length of the program, and the amount, kind, and expense of resources employed. Because some research has indicated that the durability of prevention effects may wither over time (e.g., Zigler, Taussig, & Black, 1992), “booster sessions” can be used in an attempt to sustain them. These follow-up sessions, analogous to vaccination boosters, renew attention to knowledge and skills that were conveyed initially in the program. The booster session concept in prevention programs is borrowed from medical practice, where a booster shot in the arm is readministered to continue the potency of an originally dispensed vaccine. Botvin’s work in substance abuse prevention makes excellent use of such booster sessions (e.g., Botvin, Baker, Dusenbury, Botvin, & Diaz, 1995).

## Theory Driven

Effective prevention programs typically arise from theoretical guidance rather than experience or common sense, although the latter two factors sometimes too strongly characterize prevention efforts. The “science of prevention” (Coie et al., 1993) is a logical and sequential framework that illustrates one form of a theory-driven approach. It is etiology (cause) based. Preventive interventions are inserted between the chain of events assessed as linking risk and prospective disorder. This causal-link model, however, works better with certain public health initiatives than with mental health. Smallpox eradication offers magnificent testimony to public health success. On the other hand, the prevention of malaria, for instance, remains a daunting and significant challenge in certain areas of the Americas, Asia, and Africa,

despite a causal link: Find and treat the source (e.g., swamps) that gives rise to agents (female mosquitoes) that transmit the protozoan parasite to the host (humans) who then contracts the disease. Theoretically, at least, swamps can be drained, mosquitoes can be controlled or eliminated, and people can take precautions such as using mosquito nets when living in or visiting settings for which malarial infection is an identified risk. The reality being confronted in underdeveloped environments where malaria (and tuberculosis and AIDS) run wildly amok is highly resistive to such efforts due to a foreboding set of reasons that lay outside this discussion.

Etiology and effect are often unclear when mental health prevention is concerned, as there usually are numerous pathways through which risk and disorder may be associated. Moreover, a set of certain circumstances (e.g., absent father, child abuse) can lead to a wide range of dysfunction (e.g., school failure, hostility, substance abuse) rather than one that might be anticipated, or to none at all (Conyne, 2004).

Another set of theories, termed *intervention theories* (Nation et al., 2003), address the most effective ways to change or reduce these causal links. Positive Youth Development, multicultural psychology, social learning, developmental psychology, positive psychology, and social justice represent some of the bodies of knowledge that are important in mental health prevention (Kenny & Romano, 2009). Theoretical models that address individual-level factors have found utility in guiding prevention programs, such as the health belief model, theory of reasoned action, and attribution theory. Recently, ecological and developmental contextual theory have assumed importance and relevance in conceptualizing and delivering prevention programs (Reese, Wingfield, & Blumenthal, 2009; Walsh, DePaul, & Park-Taylor, in press). These theories emphasize how multiple personal and contextual factors influence development across the life span.

Two theories addressing readiness for change that have been used largely in psychotherapy and addictions treatment but that hold potential for prevention are the transtheoretical stages of change approach (Prochaska & DiClemente, 2005), which I referred to earlier, and motivational interviewing (Rollnick & Miller, 1995). In the first approach, intervention is geared to mesh appropriately with the pertinent stage of client readiness for change. These stages include pre-contemplation (“never thought about it”), contemplation (“beginning to think about it”), preparation (“planning to act”), action (“taking steps”), maintenance (“continuing commitment”), and—too often—relapse (“backsliding”). Motivational interviewing also places high importance on a client’s readiness and ambivalence about change, using client-centered, relationship-oriented approaches in an effort to help clients choose if and how to move ahead with change.

## **Provide Opportunities for Positive Relationships**

Prevention programs that are successful, as has been pointed out, tend to be interactive and involve direct experience. Implied is that direct interaction will spawn new positive relationships and strengthen any existing ones. Impactful programs accentuate human capital, intensifying connections among people and empowering them to fuller functioning (Conyne, 2004). In the case of prevention programs for children, reviews also have pointed to the value of providing opportunities for kids to

develop improved relationships with parents and peers, and with significant others in relevant systems—such as teachers in school. Carefully selected mentors can provide this kind of connection (Grossman & Tierney, 1998).

## Appropriately Timed

Teachers-in-training all learn about the concept of the “teachable moment.” Students are more open to learning and change at certain developmental points in their lives or when certain conditions occur than at other times. For instance, two middle school students become embroiled in a yelling match on the school playground. Observing the event, the supervising teacher intervenes, seeking to convert the yelling match into a teachable moment by stopping the action and introducing the two students to a helpful coping skills strategy developed by Horne (2005), whose suggested steps form the acronym SCIDDLE (Stop, Calm down, Identify the issue, Decide what to do, Do it, Look around to see what happens, and Evaluate how it works). At this point of real-world conflict, learning and applying the model has the advantage of being timed appropriately. Conversely, teaching the coping skills strategy abstractly in class or in a training session, while still of benefit, cannot take advantage of the naturally occurring event.

Another popular phrase, “It’s all in the timing,” applies to many situations. It can refer to profitable stock trading, the syncopation of jazz, the stroke of a successful hitter in baseball, and to the immediacy of effective feedback—as well as to prevention programs. Such programs need to be developmentally timed and appropriate in order to work. Kids and adults are developmentally ready for qualitatively different kinds of knowledge and skills. Expecting 5-year-old children to function in open-ended group sessions is unrealistic developmentally, but this may be appropriate for adults.

Because a preventive program is intended to be delivered “before the fact” (or as early as possible in problem development), it is advisable to time its delivery prior to disorder or problem onset. In an obvious case, but to make the point, a program to prevent students from dropping out of school needs to be made available to students who are still in school but may be at risk for this eventuality.

## Culturally Relevant

Prevention programs also need to be tailored appropriately to participants’ developmental and cultural characteristics. Tailoring programs to fit levels of intellectual, cognitive, and social functioning and to the cultural values of participants helps to assure program acceptance and involvement, if not success. You might consider how a prevention program based on social support could be designed to fit participants who are older rather than younger, that comprises Hispanics versus whites, or that is located in an impoverished rural setting versus a wealthy suburban one.

Ethnicity, race, and culture combine to powerfully shape contexts. How psychological problems and strengths are expressed in these different contexts should be understood and included within prevention program design and execution. Doing

so requires applying a culture-centered perspective giving credence to group and individual characteristics such as age, gender, race, ethnicity, abilities, religion, sexual orientation, language, immigration status, socioeconomic status, and others (Gottfredson, Fink, Skroban, & Gottfredson, 1997). Moreover, the participation of representatively diverse stakeholders needs to be included genuinely and collaboratively throughout program design, implementation, and evaluation (Kenny et al., 2009; Kenny & Romano, 2009).

## Competent Staff

Prevention programs that are researched and designed effectively, of course, are dependent on equally effective implementation. Without well-trained staff to implement the program, the probability for success is reduced. These staff need not be professionally trained or licensed, however. In fact, staff who represent the program participants along at least some obvious dimensions (e.g., ethnicity, race, age, gender, cultural ties) bring with them a kind of local expertise that can make an especially powerful contribution. A program I was involved with at the Illinois State University Student Counseling Service used college student paraprofessional peer students as helpers, psychoeducation workshop presenters, and campus environmental assessors. Closely trained and supervised, this student-to-student delivery format was experienced as authentic and was well received by other students.

As mentioned, competent staff must be trained but, also, they need to be supported and supervised (Lewis, Battistich, & Schaps, 1990, cited in Nation et al., 2003). Support is often particularly important. I have supervised numerous projects in schools, universities, and neighborhoods where most necessary conditions for effective application were in place except for maintaining staff continuity. A lack of resources sometimes accounts for turnover, but often, failure to sustain an accessible and meaningful system of support seemed more potent.

## Readiness of the Setting

This concept applies timing to the setting in which the program will be delivered. Because prevention programs are usually delivered in situ, it is necessary to consider setting readiness. Referred to usually as “community readiness,” use of the term *setting* allows for a broader understanding, inclusive of communities, schools, work places, and other host environments. The essential concept, however, is that any setting must be ready in order for a setting-based prevention program to work.

*Terroir* is a French term containing many shades of meaning that vintners (winemakers) apply to grape-growing conditions. I learned about this term during a tour of some California wineries. It seems that producing quality wines requires a positive terroir, where environmental conditions such as soil composition, moisture, sun, time, and temperature (and, no doubt, more) all interact harmoniously to nurture grape health and growth. Particular terroirs give rise to certain wine types and to overall wine quality. Environmental threats to terroir (e.g., harsh temperatures or short rainfall amounts) result in conditions that are unready to stimulate and support wine yield, resulting in lower productivity and an inferior wine.

In some respects, good prevention programs are like a good, complex wine. (You may never have thought of them that way!) Wine depends on grapes to take root, prosper, and be processed. The conditions need to be supportive and ready. So, too, with prevention programs. Several factors help to determine setting readiness for prevention: (a) Sufficient setting capacity is available; (b) setting members recognize that a problem or need exists; (c) members realize that any current programs or efforts are not enough; (d) an appropriate climate for implementation exists; and (e) a key champion for program installation is identified (Stith et al., 2006). With regard to problem and need recognition (point b, above), for instance, one set of researchers (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000; Oetting et al., 1995) identified nine stages, ranging from no awareness at all of a problem or need for prevention (Stage 1); through preparation (Stage 5), where planning and operational details have been accomplished and a trial prevention program has begun; to professionalization (Stage 9), where prevention efforts are fully defined and supported, staff training is in place, and setting members participate actively.

The Agency for Healthcare Research and Quality (AHRQ, 2008a) of the U.S. Department of Health and Human Services maintains a program, *Put Prevention Into Practice* (PPIP). A key PPIP component is concerned with staff and organizational readiness for prevention. A number of assessment products available through PPIP are useful, but the two most germane for this discussion of readiness are: (a) *Readiness Survey*, to ascertain staff attitudes, and (b) *Worksheet for Assessing Organizational Climate*, to describe the setting's suitability for prevention.

To give you a sense of how readiness is assessed in each instrument, excerpts are presented next. Staff respond to each of the 16 Readiness Survey statements by using a 7-point scale (1 = Very much; 7 = Not at all). The first 3 Readiness Survey statements are:

1. Prevention is an important aspect of the care we provide in this practice.
2. We think prevention should be more strongly emphasized in our practice.
3. Someone in our practice has the vision, leadership, and authority to make prevention happen here.

The Worksheet for Assessing Organizational Climate asks setting members to describe their values, attitudes, and beliefs about prevention, as well as those of their patients, and whether staff perceive a need for change and are ready to institute change. Resulting qualitative information is summarized and used to determine if prevention programming may be indicated.

## **Build Effective Collaborative Community Partnerships**

Prevention programs, as you have read, are typically conducted within external settings, not in a clinic office. By definition, community-based programs demand a community-based approach. Another way to state this is that it takes a team to do prevention. Therefore, effective collaborative community partnerships need to be established, which can then serve as guiding forces for prevention program development, implementation, and evaluation.

Steps have been identified for creating such team-based partnerships (e.g., Stith et al., 2006). These steps include attending to developing, leading, maintaining, and evaluating the partnership. For instance, if communication among partnership members is characterized by “turf wars” and disrespect, then the strength of the partnership is jeopardized, with the capacity to guide the prevention program compromised.

Participation of prevention specialists in this entire process requires careful consideration. A collaborative and co-expert model fits well with community partnerships (Elden & Levin, 1991; Jacobson & Rugeley, 2007), as I discussed in the preceding chapter. In such an approach community and professional partners cooperate laterally, with each contributing unique and complementary expertise. Dumka, Mauricio, and Gonzales (2007) illustrate this approach well in describing how a school advisory board was used in their *Puentes* prevention program with Mexican-origin families.

## Deliver With Fidelity and With Fit

Fidelity in relationships is a prized virtue. One who demonstrates it is thought to be loyal, devoted, faithful, and capable of allegiance. These qualities attend to delivering a prevention program with fidelity, too. In addition, the qualities of exactness and integrity apply. A program is delivered with fidelity when it is presented in accord with how it was intended. It can be trusted. Evidence-based programs (those that are buttressed by effectiveness and clinical support) that are delivered with fidelity tend to produce more positive outcomes than do programs lacking evidence and fidelity (Dusenbury & Hansen, 2004; D. Elliott & Mihalic, 2004; Zaza, Briss, & Harris, 2005).

Yet you might wonder, what about adaptation and flexibility during program delivery, where changing conditions might be met with changing program components or styles? How about adapting a proven program to fit local cultural differences or to mesh more closely with particular participant needs or setting characteristics? For example, given the stricture of fidelity, is it legitimate to shape a proven program to anticipate ethnic features of a unique population?

Certainly, arguments exist for intentionally modifying program regimens to sensitively address local conditions, including such considerations as differential developmental risk, age level, setting resources, and multicultural dimensions (Castro, Barrera, & Martinez, 2004; Collins, Murphy, & Bierman, 2004; Stith et al., 2006). This perspective prioritizes the fit of a program over its fidelity. Culturally relevant approaches, for example, have generally been found to yield higher participant acceptance, involvement, and satisfaction than those that are generic (Reese et al., 2009), produce programs that are more relevant to participants (Nation et al., 2003), and can improve recruitment, retention, and outcome effectiveness (Kumpfer, Alvarado, Smith, & Bellamy, 2002; Reese, Vera, Simon, & Ikeda, 2000). Opposing arguments (e.g., D. Elliott & Mihalic, 2004; Pentz, 2004) suggest that program implementation deviating from proven design and implementation steps, either purposefully or spontaneously, diminishes program effectiveness and complicates the interpretation of results. Kelly (2004) considers how inadequate program replication can usurp the effect of an evidence-based intervention. Stith et al. (2006) summarize a number of strategies to increase



fidelity even when engaging in adaptations of efficacious prevention programs, and Byrd and Reininger (2009) helpfully describe one approach in detail.

Drawn from several sources, strategies to increase both fidelity and fit include: (a) Identify and include the core components of the program that cannot be altered or adapted, (b) build in adaptations to fit local conditions without threatening the core components of the program, (c) seek to reach maximum adherence and dosage, (d) integrate ongoing feedback and supervision related to program implementation, (e) supply adequate staff training and supervision, (f) assess and address roadblocks that threaten implementation fidelity, and (g) design the program for feasibility so that it can be conducted and maintained in the real world, which is replete with constraints.

## Groups

Prevention programs that are effective often incorporate group-based components in some way (Conyne & Horne, 2001). The group mode is highly suited for prevention because of its economic advantage over individual approaches, and its capacities for transmitting knowledge, developing competencies, and stimulating direct interaction among participants. These elements are all essential ingredients in successful prevention programs.

Early and focused group interventions have shown success (e.g., Brand, Lakey, & Berman, 1995) in limiting both chronic and severe mental health symptoms, in enhancing the functioning and strengths of participants, and in preventing certain educational and mental health problems. Groups for prevention afford a major step in equalizing and enhancing mental health care (Conyne & Hage, in press).

Prevention groups typically involve small numbers of members who are healthy and/or at risk, and who meet face to face with a trained group leader (or leaders). Members interact with each other. Leaders facilitate an appropriate blend of content (e.g., substance abuse information) with group process (e.g., interpersonal feedback) in order to help members acquire or broaden strengths they can apply to avoid future harmful events and situations and to live their lives more fully (Conyne & Horne, 2001; Conyne & Wilson, 2000). Small psychoeducation groups (Brown, 2008) structured around human relations and skill development hold much promise for reaching prevention goals (DeLucia-Waack, 2006; Ettin, Heiman, & Kopel, 1988; Shechtman, 2001).

## Research and Evaluation: “The Proof Is in the Prevention”

“The proof is in the pudding” is another old maxim that Mom (or Dad) might have taught us. It suggests that ingredients, recipes, preparation, equipment, and the cook’s skill all affect the pudding but the test of its goodness—the proof—is determined by the pudding itself. Does it work? Will anyone come back for seconds? If you really like it, can you somehow replicate it yourself?

Likewise, “the proof is in the prevention” for prevention programs. Assessment, design, and delivery are all important and each influences a prevention program, but the test of its effectiveness—the proof—is determined by the prevention effect.

Does the prevention program work? Is it effective in promoting well-being and forestalling dysfunction and problems? Can it be replicated, or authentically modified, with other populations and in other settings?

A number of meta-analyses of prevention have been conducted. These studies have identified evidence-based best practices in delivering prevention interventions, which we will turn to in just a moment.

First, though, let me unpack the preceding sentence because it is loaded with complicated terminology. The term *meta-analyses* refers to sets of different statistical techniques that are used to retrieve, select, analyze, and combine research results from related independent studies that have been conducted and reported previously. Thus, an overarching, integrative perspective is yielded that can aid understanding and future progress. *Evidence-based practices* integrate the best research available with acceptable clinical proficiency while factoring in patient characteristics, preferences, and culture (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006). And *best practices* (which were discussed in Chapter 2) are those that a body of respected colleagues and professional associations have identified as genuinely representing effective and ethical delivery and that can be generalized to comparable situations.

Back to examples of meta-analyses that have been reported in prevention. Dryfoos (2000) reviewed over 100 prevention programs in the areas of school dropout, teen pregnancy, juvenile delinquency, and substance abuse. School-based curricula have been examined (Elias, Gager, & Leon, 1997), as have prevention programs that address children and adolescents (Durlak & Wells, 1997; Weissberg & Greenberg, 1998). Tobler et al. (2000) reported a meta-analysis of 207 universally school-based programs in the area of drug prevention, following such previous analyses by Tobler. Bruvold (1993) presented results of a meta-analysis of adolescent smoking prevention programs. Nation et al. (2003) reported a “review of reviews” that focused on universal and selective prevention programs meeting acceptance criteria in the areas of substance abuse, risky sexual behavior, school failure, and juvenile delinquency and violence. These meta-analyses have contributed to a deeper understanding of the basic tenets of prevention.

Determining prevention effect, though, is much easier said than done. The taste and relative cost of pudding determines its judged value. While arriving at this judgment is subjective, it is pretty straightforward. Taste it—how do you like it? With prevention (or any other mental health or education approach), there is no such simple and direct judgment available, as we somewhat painfully realize. Rather, a set of research and evaluation criteria exist to help arrive at proof.

Those interested in developing and conducting prevention programs will be pleased to discover that an impressive number of programs have been evaluated as being effective, using stringent evaluation criteria to arrive at that judgment. Moreover, resources have been compiled for identifying many of these evidence-based prevention practices, including easily accessible online resources. These resources provide a gateway to effective programs, although the programs contained are not funded well and are not yet being converted to broader application (Dodge, 2008)—but that is another, albeit very important, issue. Nonetheless, guidance is available through these references to assist in program

development, implementation, and evaluation. Let's take a look at some of the online resources (Note: See Appendix H for more listings).

## Online Resources

An existing, tested program may generally mesh well with local needs or, more likely, might provide the scaffolding for careful adaptation. Another way of saying this is that it may not be necessary to “reinvent the wheel” in many cases (although in some situations creative innovation is necessary or desirable). Regardless, though, when planning a prevention effort, it is advisable to carefully review resources containing evidence-based programs for input (see Byrd & Reininger, 2009, and Conyne, 2004, for two helpful compilations).

For instance, Byrd and Reininger (2009) summarize 36 online resources that list and describe evidence-based prevention programs, and I encourage you to access this source. As an introduction to online resources, 5 of them are extracted here:

1. Agency for Healthcare Research and Quality (AHRQ; <http://www.ahrq.gov>): Clicking on “Evidence-Based Practice” ushers you into an identification of effective prevention programs based on rigorous scientific analyses. Although many of the examples are more clinically focused, public health prevention programs also are included.
2. Center for Study and Prevention of Violence (CSPV, 1996; <http://www.colorado.edu/cspv>): Its “Blueprints” and “CSPV Databases” sections provide interactive, searchable databases of effective prevention interventions in violence and other related subjects. Model programs (n = 11) meeting strict criteria for scientific evidence are listed, and another 18 promising programs are identified.
3. The Collaborative for Academic, Social, and Emotional Learning (<http://www.casel.org>): This registry lists effective prevention programs that promote social and emotional learning in schools, as well as others that have not yet met the “select” criteria used in the evaluation process.
4. The Guide to Community Services (<http://www.thecommunityguide.org>): This Web site of the Centers for Disease Control and Prevention provides review results on the effectiveness and cost effectiveness of fundamental community preventive health services.
5. National Registry of Evidence-Based Programs and Practices (<http://www.nrepp.samhsa.gov>): This Web site of the Substance Abuse and Mental Health Services Administration features model programs that have evidenced solid proof of preventing or reducing substance abuse and other high-risk behaviors in schools, communities, and work settings.

## Evidence-Based Criteria

What means were used to judge programs deemed to be effective? In the Colorado Blueprints project, for example, the criteria used are that the program showed evidence

of (a) a deterrent effect within a strong research design; (b) sustained effects that endure for at least 1 year beyond the prevention program's completion; (c) multiple-site replication, demonstrating that the principles and processes of the program are not limited to one setting alone; and (d) important mediating effects being addressed (e.g., risk and protective factors), as well as the program being cost effective.

Criteria used in other evidence-based examinations, such as by the National Registry of Evidence-Based Programs and Practices, are similarly strict. Notable minimum requirements are that the preventive intervention is able to demonstrate one or more positive outcomes, results have been published in a peer-review publication or have been specified in an evaluation report, and the public can access intervention documentation. Extra points are earned when a quasi-experimental or experimental research design was employed.

## Common Denominators of Successful Programs

In addition to evidence-based criteria, which tend to address outcomes and how they were achieved, other important criteria focus more directly on the programs themselves. The following material is adapted from Conyne (2004):

*14 Ounces of Prevention.* Price, Cowen, Lorion, and Ramos-McKay (1988) identified five “common denominators of success” that applied to the primary prevention programs that were identified as “excellent” in the 14 Ounces of Prevention study. These programs

- (a) were targeted and well planned, containing multiple components that were sensitive to the population and setting as well as to the conditions to be prevented;
- (b) were designed to positively alter the life trajectories of participants, that is, to change future patterns of behavior, life conditions, and social settings;
- (c) provided new skills and social support so that program participants gain resources and repertoires in such areas as communication and problem solving that can make a positive difference in their lives;
- (d) strengthened natural support systems, parsimoniously accentuating positive processes that already exist rather than importing more costly external resources; and
- (e) were able to demonstrate evidence of success in terms of reduced occurrence of problems and in strengthened functioning.

*Criteria to Assess Programming.* Durlak (2003) suggests eight generalizations that characterize effective prevention and health promotion programming. It is reassuring that these points are highly consistent with those presented by Price et al., above, and with some of the evidence-based criteria, suggesting that general agreement about evaluative criteria exists. You will recognize some of these criteria from earlier in this chapter.

According to Durlak, successful prevention and health promotion programming interventions (a) are data based and theory driven, (b) recognize that adjustment is affected by multiple factors at multiple levels, (c) emphasize behavior change and skill development, (d) are well timed, (e) use developmentally appropriate techniques and

materials, (f) monitor to assure good program implementation, (g) are tailored and adapted for the particular population and setting, and (h) are evaluated carefully.

When I teach students in my graduate level Preventive Counseling course how to analyze preventive interventions, I provide them with criteria to use in describing and evaluating the programs. These criteria were constructed to subsume those presented by Price et al. and Durlak, and to be consistent with evidence-based approaches. The resulting 47 criteria, arranged into eight categories (purpose; population; methods and settings; timing and appropriateness; personal competencies; system-centered changes; role; and planning, research, and evaluation) are presented next (expanded from Conyne, 2004).

## A Checklist of Criteria for Evaluating Prevention Programs

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### Purposes

- What is being prevented or promoted?
- What is the program's purposive strategy (system change, person change, everyday prevention)?
- What are the program goals and objectives?
- How do they relate to methods?

### Population

- What is the target population?
- How are the program participants functioning (well functioning, at risk, early stage of problem)?

### Methods and Settings

- How is assessment involved?
- How have evidence-based methods been considered and/or used?
- What methods of intervention are used (education, organization, media, consultation, advocacy, intended prevention within remedial methods, etc.)?
- Is multiplicity addressed through components, levels, methods?
- How are setting members involved in the program phases?
- What settings are involved (family, work, school, neighborhood, other)?
- How are person-centered and system-centered variables included?
- How do methods and settings interact?
- How do they relate to program purposes?
- How is the program adapted culturally?
- How are social justice values incorporated?

### Timing and Appropriateness

- How is the program timed (before the fact, early stage)?
- How is developmental and contextual appropriateness addressed?

## Gradients

- How is the gradient of Stressors + Organic Factors + Exploitation/Self-Esteem + Coping Skills + Support involved?
- How is the gradient of Risk Factors/Protective Factors involved?

## Personal Competencies

- How is knowledge developed?
- How are skills developed?
- How are values and attitudes addressed?

## System-Centered Changes

- How is social support incorporated?
- How are environmental factors addressed?
- How are stressors reduced?
- How are oppression and exploitation addressed (if a factor)?

## Role

- What is the program deliverer's role or roles (e.g., direct service counselor, researcher, director, group facilitator, consultant, evaluator)?
- To what degree is collaboration manifested?

## Planning, Research, and Evaluation

- To what degree are program development and evaluation steps represented in the program?
- Does evaluation address both process and outcome?
- Can core components of the program be identified?
- How has the program been adapted?
- Is the program culturally relevant or potentially culturally relevant?
- To what degree is collaboration with participants evidenced?
- Does the program include direct, interactive experience?
- How sophisticated is the research design?
- How contextually sensitive is the research design?
- Are results evidence based?
- Are results documented?
- Are results sustainable?
- Have results been published?
- Have results been otherwise disseminated?
- Have results been replicated?
- Has the program been tested across settings?
- Is the program cost effective?

In addition to using these criteria to analyze existing prevention programs, they can serve as a checklist to assist program development.

**LEARNING EXERCISE 3.1****Applying Prevention  
Criteria to a Model Program**

Let's try to summarize your learning at this point. You've been reading about several criteria that are useful for assessing prevention programs and that also are helpful to keep in mind when designing such programs. Choose ONE of these criteria and apply it to the following description of the Life Skills Training (LST) program of Botvin and colleagues (from the Blueprints project):

*Program Targets:* LST targets all middle/junior high school students, with booster sessions occurring in the 2 years following program completion.

*Program Content:* LST is intended to prevent or reduce gateway drug use (i.e., tobacco, alcohol, and marijuana). The 3-year program is primarily implemented in school classrooms by school teachers. LST is delivered in 15 sessions in year 1, 10 sessions in year 2, and 5 sessions in year 3. Sessions last an average of 45 minutes and can be delivered once a week or as an intensive mini-course. The program consists of three major elements: (a) general self-management skills, (b) social skills, and (c) information and skills specifically related to drug use. Skills are learned through the use of training techniques such as instruction, demonstration, feedback, reinforcement, and practice.

What did you discover when doing this exercise?

## Hey! We Can't Do Everything: The Ethic and Importance of Collaboration

Indeed, there is no way that any one professional or professional organization (such as a counseling center) can be expected to deliver in all these areas. Each of us possesses our own areas of expertise, and for most of us, these are limited and focused. That's only the way it should be. Being ethical practitioners, our job is to identify and function within our areas of expertise and to know when, where, and how to refer to or to collaborate with others whose expertise is found in other needed areas.

There really is no predicament here but, rather, an opportunity. What is it? The opportunity is the gift of collaboration. After all, prevention is a team-based, interdependent activity where professionals function together and with members of an identified population to produce a workable prevention plan that can be effectively delivered and evaluated.

Diverse competencies, experience levels, and perspectives are melded into a team as prevention is undertaken. Embracing and enacting such a collaborative spirit is a prevention ethic to be cultivated.

Collaboration to pool expertise and experience can occur in two ways. First, a team can be formed to produce or to adapt a new prevention program. This is the strategy that is focused on in this book. In the second case, two or more partner organizations, each owning a successful track record in their own area, can combine their respective resources to yield an adapted prevention effort. An example

includes grafting a mental health component to the root of an already successful community sports or arts program so that intentional attention is given to psychological or educational goals.

See what you can do with the following learning exercise that considers collaboration.

### LEARNING EXERCISE 3.2

#### Forming a Collaboration

- A. Write your thoughts to the following three questions:
  1. What skills does it take to work well collaboratively?
  2. How can a staff member of a counseling agency function in this way?
  3. Indeed, how can a counseling agency itself do so?
- B. Imagine that your counseling agency is interested in preventing high school dropouts in your community. Thinking collaboratively, what general strategies might be possible to pursue?

Developing an understanding of prevention criteria can aid in both the evaluation of preventive programs and their creation. So, spending time learning and applying them will enhance your effectiveness in prevention program development and evaluation.

## Summary

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Just what constitutes prevention and how to determine whether a program is credible can be difficult tasks. How to create prevention programs can also be an uncertain proposition: Where do you begin? This chapter sought to address these issues by focusing on prevention criteria—those elements that can help define what prevention is, whether a program might be successful, and how to develop programming.

The main criteria for judging and creating prevention programs that were discussed in this chapter include: (a) comprehensiveness, (b) direct experiencing, (c) sufficient dosage, (d) theory driven, (e) provide opportunities for positive relationships, (f) appropriately timed, (g) sociocultural relevance, (h) competent staff, (i) readiness of setting, (j) involvement of effective collaborative community partnerships, (k) delivered with fidelity and with fit, and (l) use of groups.

Research and evaluation also was considered as it relates to criteria. Results of meta-analyses were summarized, several online resources were identified that point to evidence-based programs, common denominators of program success were enumerated, and an extensive checklist for assessing prevention programs was presented.

Finally, the ethic of collaboration in prevention programming was highlighted as essential to good practice. There is no realistic way that any one professional or professional organization can do everything. We all need to work together in sharing resources, experience, and perspectives in planning and delivering prevention programs. Creative and resource-rich programs can result.