

Preparing an Intervention for NREPP Submission and Potential Review

A Learning Course on Submitting Interventions for the NREPP Review

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Course Overview

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-based Programs and Practices (NREPP), formerly the National Registry of Effective Programs, is a searchable online rating system for mental health promotion, substance abuse prevention, and mental health and substance abuse treatment interventions. This decision support tool is designed to assist the public in identifying approaches that have been scientifically tested and that can be readily disseminated to the field.

Development of an evidence-based program or practice begins long before the intervention is ready for NREPP review; research studies are carefully designed and completed with target outcomes in mind, and implementation materials are drafted and fine-tuned to prepare for dissemination. However, if inclusion in NREPP is a future goal, program developers should consider the NREPP review system and submission requirements as they progress through the natural stages of program development.

Intended Audience

This course was created for developers of mental health or substance abuse programs, including principal investigators of relevant research studies, who are working toward submission to NREPP.

Learning Objectives

This course will help users do the following:

- Learn the purpose of NREPP and the benefits of inclusion in the Registry
- Understand NREPP's minimum review requirements and SAMHSA's areas of interest
- Identify the documentation required for the NREPP review
- Assess an intervention's readiness for submission
- Prepare and submit an intervention for NREPP review

Considerations for Submission to NREPP

Program developers voluntarily submit their interventions to NREPP for review during annual open submission periods. These submitted interventions are considered for inclusion in NREPP on the basis of clearly defined minimum review requirements. Programs meeting these requirements may be accepted for review, depending on current SAMHSA areas of interest and funding resources. Only accepted programs are reviewed by independent experts¹ and posted on the NREPP Web site. As such, NREPP is not a comprehensive registry of all mental health and substance abuse interventions, and not all interventions submitted to NREPP are accepted for review.

The About NREPP² section of the Web site provides more information on the history and purpose of NREPP.

Benefits of Inclusion in NREPP

Preparation for and participation in an NREPP review can be a resource-intensive process, requiring the support of key players in the development and evaluation of an intervention and the contribution of multiple sets of program materials. Yet, more than 300 developers have submitted interventions to be considered for review and inclusion in NREPP.

The benefits of investing the effort required to prepare a submission to NREPP are threefold:

1. **Potential for increased sustainability.** Evaluation studies for the interventions that are accepted for review by NREPP can help to substantiate the impact of these interventions, promoting their continued use beyond initial funding periods. Recognition by NREPP also validates claims that practices are evidence based, justifying continued and new implementation with funders and decisionmakers. In addition, some funding sources require that proposed interventions be listed in a national evidence-based registry.
2. **Opportunity for dissemination.** The NREPP Web site is a searchable resource that attracts a variety of users, who may choose to implement interventions reviewed by NREPP.
3. **Guidance for continued program development.** The rating criteria used in the NREPP review process are the result of extensive collaboration between SAMHSA and stakeholders in the field – as outlined in the changes to NREPP published in the March 2006 Federal Register notice³. The criteria represent the prevailing ideas for the assessment of evidence-based practice research quality and dissemination capability of mental health and substance abuse interventions. Ratings and comments provided by NREPP's expert reviewers can provide direction for future studies and the ongoing development of program materials. Program developers with interventions that are not yet ready for NREPP can also use the rating criteria to guide study design or the translation of a research protocol into a complete dissemination package.

¹ Selection and Training of Reviewers, <http://www.nrepp.samhsa.gov/ReviewSelection.aspx>

² About NREPP, <http://www.nrepp.samhsa.gov/AboutNREPP.aspx>

³ Federal Register, Vol. 71, No. 49 (March 14, 2006), 13132-13155, <http://www.nrepp.samhsa.gov/pdfs/March-2006-FRN.pdf>

Determination of Submission Readiness

With NREPP's open submission periods occurring annually, developers should not rush to submit an intervention. At a minimum, developers should not submit their program until they believe their program meets the minimum review requirements outlined in the September 2011 Federal Register notice⁴, as only programs meeting the requirements will be considered for review.

Further, interventions with an evidence base and dissemination system developed beyond the minimum review requirements will often receive higher ratings in the Quality of Research and Readiness for Dissemination portions of the NREPP review. As a result, developers should consider the timing of their submission relative to their program's development. Program developers can use the NREPP Submission Checklist to document progress toward submission.

⁴ Federal Register, Vol. 76, No. 180 (September 16, 2011), 57742-57744, http://www.nrepp.samhsa.gov/pdfs/FRN_Sept2011.pdf

The NREPP Submission Process

Program developers who prepare a complete submission packet can apply for review during the NREPP open submission period, which occurs annually. A typical NREPP submission cycle, illustrated in the figure below, begins in the summer and ends in the spring, with specific activities occurring in each season.

Summer. Information on the submission period and minimum review requirements is published in a Federal Register notice, prior to the open submission period. (The Federal Register notice for the current cycle was published in September 2011⁵.)

Fall. The 3-month submission period begins in the fall; for the current cycle, the submission period begins on November 1, 2011. Throughout the submission period, program developers can use the NREPP Online Submission System to upload relevant electronic documents.

Winter. At the close of the submission period, NREPP staff carefully screen the submitted materials for evidence that the interventions meet the minimum review requirements; for the current cycle, the submission period ends on February 1, 2012. Only interventions that meet these requirements are considered for acceptance, and the final selections are determined by the availability of SAMHSA's funding resources. Special consideration may be given to submissions related to SAMHSA's current areas of interest.

Spring. Programs receive notification of SAMHSA's decision. Accepted programs are added to the list of other interventions awaiting review. Programs that are not accepted for review are given the reason for decline and are welcomed to resubmit during future open submission periods once the submission packet has been revised by the program developer to address deficiencies.

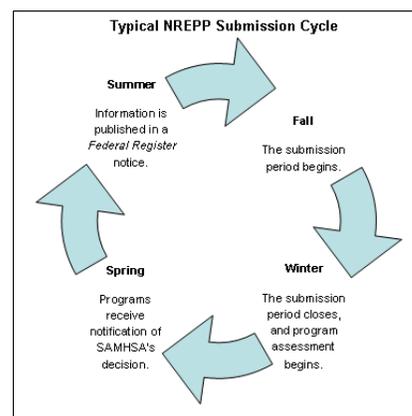


Figure: Typical NREPP Submission Cycle

Minimum Review Requirements

Each submitted program packet will be assessed for evidence of the four minimum requirements:

1. **Significant positive behavioral outcomes.** Submitters must identify one or more significant positive behavioral outcomes in mental health, mental disorders, substance abuse, or substance use disorders among individuals, communities, or populations. These outcomes must be attributable to the intervention and must be accompanied by statistics noting a significant difference of $p \leq .05$. Examples of reviewed outcomes for summaries listed in NREPP include the following:

- Substance use
- Depression symptoms

⁵ Federal Register, Vol. 76, No. 180 (September 16, 2011), 57742-57744, http://www.nrepp.samhsa.gov/pdfs/FRN_Sept2011.pdf

- Violence
 - Substance abuse treatment retention
 - Family functioning
 - Suicide attempts
 - HIV risk behavior (e.g., drug injection with a “dirty” needle)
2. **Experimental or quasi-experimental design.** The significant positive behavioral outcomes must have been identified in at least one evaluation study with an experimental or quasi-experimental design. In designs that include a control or comparison group, analysis must include assessment of differences between groups over time.
 3. **Results published in a peer-reviewed journal or comprehensive evaluation report.** The study identifying significant positive behavioral outcomes must have been published in a peer-reviewed journal or other professional publication or documented in a comprehensive evaluation report. A comprehensive evaluation report must include information describing a review of related literature, theoretical framework of the intervention, purpose of the study, methodology, findings/results with statistical analysis and p values for significant results, discussion, and conclusions. Common publications submitted for review include the following:
 - Peer-reviewed journal article
 - Technical publication article
 - Final grant report
 4. **Materials for dissemination.** All required implementation materials, training and support resources, and quality assurance procedures must be developed and ready for use by the public at the time of submission. The intervention being disseminated must match the intervention evaluated in the studies. Examples of materials satisfying this requirement include the following:
 - Intervention curriculum
 - Implementation handouts and videos
 - Training PowerPoint presentation
 - Trainers manual
 - Fidelity tools
 - Outcome measures

SAMHSA's Areas of Interest

Not all submissions that meet the minimum review requirements are accepted for review. In selecting interventions for NREPP review, SAMHSA may give special consideration to the following types of interventions:

- **Interventions with results that have been repeated with an identical or similar population and protocol.** SAMHSA may give special consideration to interventions that have repeated evaluation studies. In these additional evaluation studies, the original investigator or an independent party must have used the same protocol with an identical or similar population and/or have slightly modified the protocol for use with a slightly different population. These additional evaluation studies must, however, report results that are consistent with the positive findings from the original evaluation study.
- **Interventions with free implementation materials.** Cost of implementation is a key factor in the selection of new interventions by agencies and organizations. SAMHSA recognizes that some program developers have made great efforts to provide implementation, training, and/or quality assurance tools to the public at no cost, and these submissions may be given special consideration.
- **Interventions targeting underserved populations.** SAMHSA may give special consideration to interventions that address a clearly defined and documented underserved population, including minority populations, elderly individuals, young adults, and individuals who are incarcerated.
- **Interventions contributing to content areas with limited evidence-based interventions.** SAMHSA may give special consideration to interventions that address issues underrepresented by interventions in NREPP and in the mental health and substance abuse field.

SAMHSA's areas of interest may change with each submission period.

Automatic Exclusions

Some interventions will not be considered for review, even if they meet the minimum review requirements. The following exceptions should be noted prior to submission:

- Stand-alone pharmacologic treatments, unless combined with one or more behavioral or psychosocial treatments
- Interventions developed or funded, even partially, by organizations with goals or activities that are inconsistent with SAMHSA's mission

The automatic exclusions may change with each submission period, and additional information on the current submission exceptions can be found in the 2011 Federal Register notice⁶.

⁶ Federal Register, Vol. 76, No. 180 (September 16, 2011), 57742-57744, http://www.nrepp.samhsa.gov/pdfs/FRN_Sept2011.pdf

Preparation of a Submission Packet

When program developers are ready to have their intervention considered by NREPP, they should use the most recent Federal Register notice as a guideline for preparing a submission packet. The items needed for the 2011-12 submission packet are described below. These requirements may change with each submission period.

- **Cover letter.** This brief document should include the complete name of the program, the names of the program developers, and a list of associated organizations. The key point of contact for the submission should be clear, and an email address and telephone number must be provided for this person. The cover letter should clearly state the submitter's intent for the program to be considered for NREPP and provide a brief description of the intervention. If the program falls within one of SAMHSA's current areas of interest, the cover letter should provide or reference information supporting this claim.
- **Outcomes.** A list of significant behavioral outcomes documented by evaluation studies of the intervention must be provided. This list should be accompanied by citations, with page numbers, clearly directing NREPP staff to the articles or reports that document these outcomes.
- **Documentation.** A full-text copy of every peer-reviewed journal article or comprehensive evaluation report supporting the minimum review requirements must be provided. Articles or reports that provide background information or theoretical foundations for the intervention should not be submitted at this time; every submitted article or report should satisfy the minimum review requirements.
- **Dissemination.** A brief narrative description or list of materials, resources, and systems that are available to support implementation must be provided. Actual copies of these items should not be provided at the time of submission.

Submission of an Intervention

By the first day of the open submission period, a submission form will be posted on the Submissions page of the NREPP Web site. To receive a username and password for the NREPP Online Submission System, interested program developers will need to provide key information to NREPP staff. Using the Online Submission System, program developers can upload their electronic materials throughout the submission period, submitting materials only when their packet is complete.

Although electronic submission is strongly suggested, program developers also may submit materials by mail or fax. For information about submitting in these formats, program developers should contact NREPP staff.

While screening submitted interventions, NREPP staff may contact program developers to ask questions or request additional materials. During this time, program developers can continue to add new material to the submission until February 1.

Notification of SAMHSA's Decision

After reviewing the submissions that meet minimum requirements, SAMHSA will identify programs to be accepted or declined for NREPP review. Program developers will be notified of SAMHSA's decision via email.

Accepted programs. Programs that have been accepted for review will be added to the list of interventions awaiting review and included in the Accepted for Review⁷ listing on the NREPP Web site.

When NREPP staff members are ready to begin the review process, they will contact the developer of the accepted program, who should be prepared to complete and submit an NREPP Principal Form. This form will identify the individual who will serve as the key point of contact throughout the NREPP review process. Upon receipt of this completed form and any relevant supporting documentation, NREPP staff will initiate a kick-off call. All relevant program and NREPP staff will participate in this call to discuss the NREPP review process and the materials needed for each component of the review.

Anyone that consents to a review is expected to authorize publication of the intervention summary on the NREPP Web site. If a summary is completed and consent is not given to publish the summary, a statement to that effect will be posted on the NREPP Web site.

Declined programs. Programs that do not meet all four minimum review requirements or are within an automatic exclusion area will not be considered by SAMHSA and will be declined for NREPP review. In addition, some programs that meet the minimum requirements and are considered by SAMHSA may be declined for review, depending on SAMHSA's areas of interest and funding resources.

Program developers with interventions that are not accepted for review will receive a notification from NREPP staff that explains the reason for the decision. NREPP staff members also are available, upon request, to answer any questions after the submission period ends so that program developers have the feedback they need to improve their packet for possible resubmission at a later date. However, NREPP staff cannot provide detailed technical assistance for improving individual submission packet components, and program developers interested in resubmission must prepare and submit a new packet during a future submission period.

⁷ Accepted For Review Listing, <http://www.nrepp.samhsa.gov/ReviewPending.aspx>

Documentation Needed for the NREPP Review

Upon acceptance of their intervention, program developers should be prepared to provide additional documentation, if needed, to support the review. This section describes the components of the review process and the additional information, beyond the initial submission packet, required for each component. This information is provided here for planning purposes only; the additional documentation is not needed for submission, and developers of an accepted intervention will receive further guidance from the NREPP review coordinators before the start of the review.

Quality of Research Review

For each accepted intervention, the quality of the research supporting its evidence base is evaluated by two external reviewers⁸ with specific expertise in the area of the intervention. The identity of these reviewers is not known to SAMHSA or program developers. The reviewers independently rate each significant behavioral outcome using six Quality of Research (QOR) criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

Further description and value labels for these six criteria can be found on the Quality of Research⁹ Web page.

Quality of Research Review Documentation Guidelines

To address the QOR criteria, program developers should consider the information in the following table and ensure that the appropriate documentation is available for review by NREPP. This documentation is not requested at the time of submission.

QOR Criterion	Factors Contributing to Reviewer Ratings	Examples of Documentation
<i>Reliability of measures</i>	Whether or not the measures used to evaluate the outcomes were developed and tested for use with the targeted population or setting Instrument test-retest, internal item consistency, and/or interrater reliability	The psychometric properties of each measure used, as noted in study articles and/or additional supporting documentation For measures that were adapted in any way, additional

⁸ Selection and Training of Reviewers, <http://www.nrepp.samhsa.gov/ReviewSelection.aspx>

⁹ Quality of Research, <http://www.nrepp.samhsa.gov/ReviewQOR.aspx>

	<p>of acceptable level</p> <p>Note: Reliability that has been documented by independent investigators will rate higher on this criterion.</p>	<p>information showing the reliability and validity of acceptable levels for those adaptations</p>
Validity of measures	<p>Whether or not the measures used to evaluate the outcome have been developed and tested for use with the targeted population or setting</p> <p>Instrument face, construct, content, convergent, discriminant, criterion, concurrent, and predictive validity of acceptable level</p>	
Intervention fidelity	<p>Level of documentation on efforts to maintain intervention fidelity at acceptable levels</p>	<p>Study articles and/or supporting documentation that explains the following:</p> <ul style="list-style-type: none"> • Implementer training for the target intervention group • Ongoing supervision with corrective action during the study to prevent drift (e.g., audiotaping sessions for supervisor review) • Any fidelity tools or quality assurance checklists used to measure adherence to the intervention manual and to measure intervention exposure and dosage, with data from use of tools reported • Reliability and validity information for any fidelity tools used
Missing data and attrition	<p>Level of sophistication in the explanation and management of missing data and/or</p>	<p>Study articles and/or supporting documentation that explains the</p>

	attrition	<p>following:</p> <ul style="list-style-type: none"> • Extent of missing data • Statistical management of missing data • Extent of attrition • Comparison of study dropouts with those completing the study in demographics and other variables related to outcomes • Statistical management of attrition
Potential confounding variables	<p>Depth of exploration of potential confounding variables</p> <p>Level of impact of confounding variables on outcome data</p>	<p>Study articles and/or supporting documentation that explains potential confounding variables and their potential impact on outcome data (e.g., statistical modeling of variables mediating or moderating outcomes, study design limitations that impact outcome interpretation)</p>
Appropriateness of analysis	<p>Sample size and statistical power to detect group difference</p> <p>Appropriate correction of the alpha level for a Type I error</p> <p>Appropriate statistical modeling of the generated dataset to allow a clear interpretation of a relationship between the intervention and outcome</p> <p>Note: Overly simple analyses may translate to lower scores on this criterion, as may lack of control for demographic- and/or outcome-related differences measured at pretest.</p>	<p>Documentation of statistical tests and sample size in study articles</p> <p>Supporting documentation accounting for the analysis selection</p>

For the purposes of NREPP, a study is defined as any evaluation completed on the same dataset or its subset. Program developers can submit up to three studies described in up to seven documents. This document limit includes all articles, reports, and supporting materials to be viewed by QOR reviewers.

Supplemental materials are documents that typically contain psychometric support for the measures used to evaluate outcomes, information on intervention fidelity associated with submitted studies, or any additional information contributing to the QOR rating of the submitted outcomes. Documents containing only background information, theoretical foundations of the intervention, or history on the development of intervention materials are rarely relevant for the QOR review.

Readiness for Dissemination Review

For each intervention, two independent reviewers¹⁰, whose identity is unknown to both SAMHSA and program developers, evaluate the availability and general quality of materials and dissemination support systems using three Readiness for Dissemination (RFD) criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

Further description and value labels for these three criteria can be found on the Readiness for Dissemination Web page¹¹.

Readiness for Dissemination Review Documentation Guidelines

To address the RFD criteria, program developers should consider the information in the following table and ensure that the materials are available for review by NREPP. This documentation is not requested at the time of submission.

RFD Criterion	Factors Contributing to Reviewer Ratings	Examples of Documentation
<i>Availability of implementation materials</i>	<p>Availability and accessibility of all information and materials required for successful implementation by potential implementers</p> <p>Note: Materials that are of high general quality will receive higher ratings on this criterion.</p>	<ul style="list-style-type: none"> • Manuals, guidebooks, workbooks, curricula, and videos • Outline of core components required to implement the program • Description of target participants • Qualifications required for

¹⁰ Selection and Training of Reviewers, <http://www.nrepp.samhsa.gov/ReviewSelection.aspx>

¹¹ Readiness for Dissemination, <http://www.nrepp.samhsa.gov/ReviewRFD.aspx>

		<p>implementers</p> <ul style="list-style-type: none"> • Description of the organizational structures that must be in place to implement the program effectively, with guidance for ensuring organizational readiness for implementation
<p>Availability of training and support resources</p>	<p>Availability and accessibility of the training necessary to support implementation by potential implementers</p> <p>The level of technical assistance, consultation, and/or other developer support available to ensure implementation success at new sites</p> <p>Note: Training and support that are of high general quality will receive higher ratings on this criterion.</p>	<ul style="list-style-type: none"> • Description of training available to implementers, including locations (e.g., on-site, off-site, online), frequency, and type (e.g., initial, booster, clinician, supervisor) • Explanation, if not evident from materials, of how new implementers learn about training and support opportunities • Materials used in training (e.g., training agenda, PowerPoint presentation, trainers manual, participant materials, videos, handouts, recommended readings, activity outlines) • Description of technical assistance, consultation, and/or coaching available to new implementers, including format (e.g., phone, email, off-site, on-site), source (e.g., program developer, developer proxy, source unregulated by developer), and level of support (e.g., brief

		<p>questions answered, comprehensive coaching system, content of support varying on the basis of the site’s needs)</p> <ul style="list-style-type: none"> • Outside resources for implementation development (e.g., related trainings, Web forum for communication for implementers across sites)
<p>Availability of quality assurance procedures</p>	<p>Provision of tools to support outcome measurement and to ensure fidelity at new implementation sites, along with clear guidance for use of the tools</p> <p>Note: Tools and quality assurance systems that are of high general quality will receive higher ratings on this criterion.</p>	<ul style="list-style-type: none"> • Full outcome and fidelity measures created for use by implementers • Protocol for using measures (e.g., who administers the measures, when they are administered, how they are administered, to whom they are administered) • Guidance for using data to improve program delivery • Description of any other program component that contributes to quality assurance (e.g., required training, required evaluation support, site certification by developer, computerized program delivery, highly scripted manual)

Program developers are expected to submit dissemination materials in the format in which they are disseminated to the public. For example, if materials are sent to interested implementers by email, these materials should be sent to NREPP via email when requested; if materials are disseminated in hard-copy format, program developers should be prepared to submit three copies of these materials to support the RFD

review (one copy for each reviewer and one copy for NREPP staff). Two copies will be returned after the review, with one remaining in the NREPP internal review library.

Developers of programs with voluminous materials may choose to submit a representative sample of materials for review. NREPP staff will provide further guidance to program developers who choose to submit in this fashion.

The RFD review assesses the ability of the developer to disseminate the intervention to the public to support implementation success. RFD reviewers do not assess the appropriateness and content of each individual dissemination component, but rather they assess the ability of each component to contribute to a successful overall dissemination package. For this reason, research articles documenting the development of materials, information on the theoretical background of the intervention, or assessments of the reliability and validity of quality assurance tools are not relevant for this portion of the review.

Descriptive Information

In addition to QOR and RFD review results, the NREPP intervention summaries include descriptive information for each intervention; this information is not assessed by reviewers. The descriptive information helps to paint a complete picture of the intervention for NREPP users and aid in the selection of the intervention best fitting an organization’s needs. For examples of what type of information is collected and how it is displayed, see NREPP intervention summaries¹².

Descriptive Information Guidelines

Some of the descriptive information in the summary is readily available in the materials requested for QOR and RFD review. For the descriptive information components described in the table below, however, program developers should be prepared to provide the additional information needed if the submitted intervention is accepted for review.

Descriptive Information Component	Information Needed
<i>Program Summary</i>	<p>A summary (200 words or less) of the intervention, including the following information:</p> <ul style="list-style-type: none"> • Full name of the intervention and acronym, if applicable • Definition of the target population (e.g., symptomatology, risks, age) • Effects the intervention is intended to produce on the population • Theoretical or conceptual origins of the intervention • Core components and any booster sessions or major variants

¹² NREPP Intervention Listing, <http://www.nrepp.samhsa.gov/ViewAll.aspx>

	<ul style="list-style-type: none"> • Basic implementation requirements (e.g., credentials of staff needed to deliver it, timing and length of sessions, program duration) <p>Note: The use of promotional language or jargon should be avoided.</p>
Implementation History	<ul style="list-style-type: none"> • Year of first implementation • Approximate number of sites (e.g., schools, clinics, practices, organizations, agencies) that have implemented the intervention • Approximate number of clients (e.g., individuals, families, couples, communities) who have received or participated in the intervention, as well as the unit used to define the client • List of States and/or U.S. territories where the intervention has been implemented • List of all countries outside of the United States where the intervention has been implemented • Approximate number of implementations that have been evaluated (1) in the United States and (2) internationally <p>Note: Descriptions are required for international studies, along with citations for any published articles or reports.</p>
National Institutes of Health (NIH) funding	Yes or no: Has the intervention been funded in part by NIH?
Comparative effectiveness research (CER) studies	Yes or no: Has the intervention been evaluated in studies meeting the definition of CER?
Adaptations	List of any population- or culture-specific adaptations, including translations
Costs	<p>Itemized costs for all materials and services provided to support implementation</p> <p>Yes or no: Is each item required for implementation?</p>
Contact Information	Full contact information for no more than two individuals to serve as contacts for more information on research and/or implementation

Contact Information

NREPP staff can answer questions about preparing a submission and can be contacted through any of the following ways:

- By toll-free phone number at 1-866-43NREPP (1-866-436-7377)
- By email via nrepp@samhsa.hhs.gov
- Contact form

In addition, developers can sign up for open submission notifications to receive emails announcing the start and end dates for open submission periods and future Federal Register notice releases.

Feedback

NREPP appreciates feedback from users of this course, particularly if the course was found to be especially helpful or if suggestions can be made to help improve it. To provide feedback, please use NREPP's contact form at www.nrepp.samhsa.gov/ContactUs.aspx.

Appendix I: Resources

The following resources to accompany this course are available for download from the NREPP Web site.

- NREPP Principal Form
- NREPP Submission Checklist
- Quality of Research Review Documentation Guidelines
- Readiness for Dissemination Review Documentation Guidelines
- Descriptive Information Guidelines

Appendix II: Glossary

These definitions have been drawn from numerous sources and are tailored specifically for content on the NREPP Web site. The terms defined here may have slightly different meanings in other settings.

Adaptation	A modest to significant modification of an intervention to meet the needs of different people, situations, or settings.
Adverse effect	Any harmful or unwanted change in a study group resulting from the use of an intervention.
Attrition	The loss of study participants during the course of the study due to voluntary dropout or other reasons. Higher rates of attrition can potentially threaten the validity of studies. Attrition is one of the six NREPP criteria used to rate Quality of Research.
Baseline	The initial time point in a study just before the intervention or treatment begins. The information gathered at baseline is used to measure change in targeted outcomes over the course of the study.
Co-occurring disorders	In the context of NREPP, substance abuse and mental disorders that often occur in the same individual at the same time (e.g., alcohol dependence and depression); also known as comorbid disorders.
Comparative effectiveness research	<p>The Federal Coordinating Council on Comparative Effectiveness Research defines comparative effectiveness research, in part, as the conduct and synthesis of research comparing the benefits and harms of different interventions and strategies (e.g., medications, procedures, medical and assistive devices and technologies, diagnostic testing, behavioral change, and delivery system strategies) to prevent, diagnose, treat, and monitor health conditions in "real world" settings.</p> <p>(For the full definition, see the Federal Coordinating Council's June 30, 2009, Report to the President and the Congress on Comparative Effectiveness Research¹³).</p>

¹³ Download full report at <http://www.hhs.gov/recovery/programs/cer/cerannualrpt.pdf>.

Comparison group

A group of individuals that serves as the basis for comparison when assessing the effects of an intervention on a treatment group. A comparison group typically receives some treatment other than they would normally receive and is therefore distinguished from a control group, which often receives no treatment or "usual" treatment. To make the comparison valid, the composition and characteristics of the comparison group should resemble that of the treatment group as closely as possible. Some studies use a control group in addition to a comparison group.

Confounding variables

In an experiment, any characteristic that differs between the experimental group and the comparison group and is not the independent variable under study. These characteristics or variables "confound" the ability to explain the experimental results because they provide an alternative explanation for any observed differences in outcome. In assessing a classroom curriculum, for example, a confounding variable would exist if some students were taught by a highly experienced instructor while other students were taught by a less experienced instructor. The difference in the instructors' experience level makes it harder to determine if the differences in student outcomes (e.g., grades) were caused by the effects of the curriculum or by the variation in instructors. The likelihood that confounding variables might have affected the outcomes of a study is one of the six NREPP criteria used to rate Quality of Research.

Control group

A group of individuals that serves as the basis of comparison when assessing the effects of an intervention on a treatment group. Depending upon the study design, a control group may receive no treatment, a "usual" or "standard" treatment, or a placebo. The composition and characteristics of the control group should resemble that of the treatment group as closely as possible to make the comparison valid.

Core components

The most essential and indispensable components of an intervention (core intervention components) or the most essential and indispensable components of an implementation program (core *implementation* components).

Cultural appropriateness

In the context of public health, sensitivity to the differences among ethnic, racial, and/or linguistic groups and awareness of how people's cultural background, beliefs, traditions, socioeconomic status, history, and other factors affect their needs and how they respond to services. Generally used to describe interventions or practices.

Cultural competence	In the context of public health, the knowledge and sensitivity necessary to tailor interventions and services to reflect the norms and culture of the target population and avoid styles of behavior and communication that are inappropriate, marginalizing, or offensive to that population. Generally used to describe people or institutions. Because of the changing nature of people and cultures, cultural competence is seen as a continual and evolving process of adaptation and refinement.
Dissemination	The targeted distribution of program information and materials to a specific audience. The intent is to spread knowledge about the program and encourage its use.
DSM (Diagnostic and Statistical Manual of Mental Disorders)	The Diagnostic and Statistical Manual of Mental Disorders, or DSM, is the standard reference handbook used by mental health professionals in the United States to classify mental disorders. There have been five revisions of the DSM since it was first published by the American Psychiatric Association in 1952. The most recent version is the DSM-IV or Fourth Edition, published in 1994; a text revision (DSM-IV-TR) was published in 2000. Earlier editions that may be referenced in NREPP include the DSM-III (1980) and DSM-III-R (1987).
Effective Program	A few Effective Programs were re-reviewed for NREPP using updated criteria in 2006-2007 and can now be found by searching for the program on the Find an Intervention page.
Evidence-based	Approaches to prevention or treatment that are based in theory and have undergone scientific evaluation. "Evidence-based" stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.
Experimental	A study design in which (1) the intervention is compared with one or more control or comparison conditions, (2) subjects are randomly assigned to study conditions, and (3) data are collected at both pretest and posttest or at posttest only. The experimental study design is considered the most rigorous of the three types of designs (experimental, quasi-experimental, and preexperimental).
Externalizing behaviors	Social behaviors and other external cues that reflect an individual's internal emotional or psychological conflicts. Examples include spontaneous weeping, "acting out," and uncharacteristic aggression. Reduction of externalizing behaviors is a frequently used measure of the success of treatment or intervention for mental or emotional disorders.

Fidelity	Fidelity of implementation occurs when implementers of a research-based program or intervention (e.g., teachers, clinicians, counselors) closely follow or adhere to the protocols and techniques that are defined as part of the intervention. For example, for a school-based prevention curriculum, fidelity could involve using the program for the proper grade levels and age groups, following the developer's recommendations for the number of sessions per week, sequencing multiple program components correctly, and conducting assessments and evaluations using the recommended or provided tools.
Generalizability	The extent to which a study's results can be expected to occur with other people, settings, or conditions beyond those represented in the study. Threats to generalizability include lack of randomization, effects of testing, multiple-treatment interference, selection-treatment interference, effects of experimental arrangements, experimenter effects, and specificity of variables.
Implementation	The use of a prevention or treatment intervention in a specific community-based or clinical practice setting with a particular target audience.
Implementation team	A core set of individuals charged with providing guidance through full implementation of the intervention. This team helps ensure engagement of the stakeholders, increases readiness for implementation, ensures fidelity to the intervention, monitors outcomes, and addresses barriers to implementation.
Indicated	One of the three categories (Universal, Selective, Indicated) developed by the Institute of Medicine to classify preventive interventions. Indicated prevention strategies focus on preventing the onset or development of problems in individuals who may be showing early signs but are not yet meeting diagnostic levels of a particular disorder.
Internal validity	The degree to which the intervention or experimental manipulation was the cause of any observed differences or changes in behavior.
Internalizing behaviors	Behaviors that reflect an individual's transfer of external social or situational stresses to emotional, psychological, or physical symptoms. One well-known internalizing behavior is a child's development of stomach cramps when the parents argue; another is insomnia during a high-stress situation at work. Reduction of internalizing behaviors is a frequently used measure of the success of treatment or intervention for mental or emotional disorders.

Intervention	A strategy or approach intended to prevent an undesirable outcome (preventive intervention), promote a desirable outcome (promotion intervention) or alter the course of an existing condition (treatment intervention).
Legacy Programs	<p>The label used by SAMHSA for all former Effective and Promising Programs, which were reviewed between 1997 and 2004 as part of the Center for Substance Abuse Prevention's Model Programs Initiative.</p> <p>Summaries for these Legacy Programs are listed in the Legacy Programs section at www.nrepp.samhsa.gov/ViewAllLegacy.aspx.</p>
Logic model	A tool that allows key stakeholders to develop a strategic plan to address an identified community problem.
Mental health promotion	Attempts to (a) encourage and increase protective factors and healthy behaviors that can help prevent the onset of a diagnosable mental disorder and (b) reduce risk factors that can lead to the development of a mental disorder.
Mental health treatment	Assistance to individuals for existing mental health conditions or disorders.
Missing data	Data or information that researchers intended to collect during a study that was not actually collected or was collected incompletely. Missing data may occur, for example, when survey respondents do not answer all questions in a survey, or when the researchers "throw out" or exclude survey questions because the responses do not meet validation checks. Missing data can threaten the validity and reliability of a study if steps are not taken to compensate for or "impute" (replace with calculated data) the missing information. Missing data are one of the six NREPP criteria used to rate Quality of Research.
Model Program	Most of the Model Programs were re-reviewed for NREPP using updated criteria in 2006-2007 and can now be found by searching for the program on the Find an Intervention page at www.nrepp.samhsa.gov/Search.aspx .
Outcome	A change in behavior, physiology, attitudes, or knowledge that can be quantified using standardized scales or assessment tools. In the context of NREPP, outcomes refer to measurable changes in the health of an individual or group of people that are attributable to the intervention.

Outcome evaluation	An evaluation to determine the extent to which an intervention affects its participants and the surrounding environments. Several important design issues must be considered, including how to best determine the results and how to best contrast what happens as a result of the intervention with what happens without the program.
Preexperimental	A study design in which (1) there are no control or comparison conditions and (2) data are collected at pretest or posttest only; includes simple observational or case studies. The preexperimental study design provides the most limited scientific rigor of the three types of designs (experimental, quasi-experimental, and preexperimental).
Process evaluation	An evaluation to determine whether an intervention has been implemented as intended.
Program drift	A threat to fidelity due to compromises made during implementation.
Program fit	The degree to which a program matches a community's needs, resources, and implementation capacity.
Promising Program	A few Promising Programs were re-reviewed for NREPP using updated criteria in 2006-2007 and can now be found by searching for the program on the Find an Intervention page at www.nrepp.samhsa.gov/Search.aspx .
Psychometrics	The construction of instruments and procedures for measurement.
Quality assurance	Activities and processes used to check fidelity and the quality of implementation.
Quality of Research	One of the two main categories of NREPP ratings. Quality of Research (QOR) is how NREPP quantifies the strength of evidence supporting the results or outcomes of the intervention. Each outcome is rated separately. This is because interventions may target multiple outcomes, and the evidence supporting the different outcomes may vary. These QOR ratings are followed by brief "Strengths and Weaknesses" statements where reviewers comment on the studies and materials they reviewed and explain what factors may have contributed to high or low ratings. For more information on the scientific reviewers who rate QOR and how ratings are derived, see the NREPP page on Review Process Quality of Research (www.nrepp.samhsa.gov/ReviewQOR.aspx).

Quasi-experimental	A study design in which (1) the intervention is compared with one or more control or comparison conditions, (2) subjects are not randomly assigned to study conditions, and (3) data are collected at pretest and posttest or at posttest only; includes time series studies, which have three pretest and three posttest data collection points. The quasi-experimental study design provides strong but more limited scientific rigor relative to an experimental design.
Ratings	NREPP provides two types of ratings for each intervention reviewed: Quality of Research and Readiness for Dissemination. Each intervention has multiple Quality of Research ratings (one per outcome) and one overall Readiness for Dissemination rating. QOR and RFD ratings are followed by brief "Strengths and Weaknesses" statements where reviewers comment on the studies and materials they reviewed and explain what factors may have contributed to high or low ratings.
Readiness for Dissemination	One of the two main categories of NREPP ratings. Readiness for Dissemination (RFD) is how NREPP quantifies and describes the quality and availability of an intervention's training and implementation materials. More generally, it describes how easily the intervention can be implemented with fidelity in a real-world application using the materials and services that are currently available to the public. For more information on the reviewers who rate RFD and how ratings are derived, see the NREPP page on Review Process Readiness for Dissemination.
Reliability of measure	The degree of variation attributable to inconsistencies and errors involved in measures or measurements. Key types include test-retest, interrater, and interitem. Reliability of measures is one of the six NREPP criteria used to rate Quality of Research.
Replication	The original investigator(s) or an independent party has used the same protocol with an identical or similar target population, and/or has used a slightly modified protocol with a slightly different population, where results are consistent with positive findings from the original evaluation.
Selective	One of the three categories (Universal, Selective, Indicated) developed by the Institute of Medicine to classify preventive interventions. Selective prevention strategies focus on specific groups viewed as being at higher risk for mental health disorders or substance abuse because of highly correlated factors (e.g., children of parents with substance abuse problems).
Substance abuse prevention	Attempts to stop substance abuse before it starts, either by increasing protective factors or by minimizing risk factors.

Substance abuse treatment	Assistance to individuals for existing substance abuse disorders.
Sustainability	The long-term survival and continued effectiveness of an intervention.
Symptomatology	The combined symptoms or signs of a disorder or disease.
Universal	One of the three categories (Universal, Selective, Indicated) developed by the Institute of Medicine to classify preventive interventions. Universal prevention strategies address the entire population (national, local community, school, neighborhood), with messages and programs to prevent or delay the use/abuse of alcohol, tobacco, and other drugs.
Validity of measure	The degree to which a measure accurately captures the meaning of a concept or construct. Key types include pragmatic/predictive, face, concurrent/criterion, and construct. Validity of measures is one of the six NREPP criteria used to rate Quality of Research.

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)
www.nrepp.samhsa.gov