# South Carolina Prevention Evaluation Handbook

## Sixth Edition
## 2019

# ■ Acknowledgement

This revised Prevention Evaluation Handbook is based on earlier editions that were developed by several people with a long history of championing prevention efforts in South Carolina, notably James A. Neal and Steven Burritt. We are very appreciative of their efforts and legacy. Thanks to Dave Currey at PIRE for contributing the section on community surveys.

Special thanks to Michelle Nienhius of the South Carolina Department of Alcohol and Other Drug Abuse Services for her guidance and support in developing this document and for her dedication to substance abuse prevention in South Carolina and beyond.

The PIRE South Carolina Team

Michael George, PhD (mgeorge@pire.org)

Al Stein-Seroussi, PhD (stein@pire.org)

Mikella Allen (mallen@pire.org)

# ■ Table of Contents

# Introduction

Welcome to the South Carolina Prevention Evaluation Handbook. This resource is a collaborative effort between the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) and Pacific Institute for Research and Evaluation (PIRE), which assists and consults with DAODAS on the evaluation of state and local prevention activities.

We hope this handbook will be helpful as you evaluate your prevention efforts. It is both a general resource on evaluation and a tool to guide you through the specific requirements and suggestions that DAODAS has in place. Our hope is that having this book at your fingertips will ease your mind as you try to recall the details of a proper evaluation framework, which can be overwhelming and intimidating to many in our field.

We intend to update this handbook (or relevant sections) as needed as guidelines are adjusted and updated. This will ensure that it is always a timely and useful resource for you. If you think this may not be the most recent version, you can download the most recent edition from the South Carolina Prevention Documents website (http://ncweb.pire.org/scdocuments/).

**Section 1** of this handbook provides a short overview of evaluation concepts and the partnership that DAODAS and PIRE have formed to advance prevention evaluation in our state.

**Section 2** contains an overview of prevention strategies and how they relate to the DAODAS reporting systems.

**Section 3** focuses on the DAODAS Standard Survey – what it is and how it should be used. This section also discusses how to best interpret your survey results.

**Section 4** discusses several other evaluation-related issues, including fidelity, follow-up designs, and comparison groups.

**Section 5** is a discussion of using community surveys to supplement existing survey data.

**Appendix A** includes descriptions of environmental strategies and data fields that are included in the Environmental Prevention Strategies Reporting System.

**Appendix B** includes tools a list of common terms used in prevention and evaluation.

# PIRE's Role in South Carolina's Prevention Evaluation

PIRE provides general evaluation guidance and expertise to DAODAS and substance abuse prevention professionals throughout South Carolina through a contract with DAODAS. PIRE's work in the state substance abuse prevention system began with the initiation of the Governor's Cooperative Agreement for Prevention (G-CAP) in 2000. Since then, based on the successful components of the G-CAP evaluation processes, PIRE has assisted DAODAS in enhancing the overall quality of prevention evaluation throughout the system of county alcohol and drug abuse authorities. PIRE's primary responsibilities include the following:

- Prepare outcome reports for local organizations using the DAODAS Standard Survey;
- Prepare an annual statewide outcomes report;
- Provide evaluation-related expertise, training, and technical assistance to local providers, as needed;
- Create and distribute a weekly e-mail digest of useful information for the prevention field (Prevention Highlights); and
- Host and maintain the South Carolina Prevention/Evaluation Resources website (also known as the SC Prevention Documents website) with documents that have been developed specifically for DAODAS. This website, which is open to the public, has documents on a range of topics and that span many years.

PIRE staff are available to provide evaluation-related assistance to the county prevention staff. The table below provides their contact information.

If you need further assistance or clarification on any of the information in this handbook, please feel free to contact the DAODAS prevention staff at 803-896-1184 or PIRE staff. We would also appreciate your feedback so that we can further develop the handbook in future editions.

| PIRE South Carolina Team | | |
|---|---|---|
| **Michael George, PhD** | mgeorge@pire.org | 803-479-3628 |
| **Al Stein-Seroussi, PhD** | stein@pire.org | 919-265-2616 |
| **Mikella Allen** | mallen@pire.org | 803-896-1167 |

# Section One: Overview of Evaluation

# ■ Evaluation

**Evaluation** is the systematic collection and assessment of information to determine the results, or worth, of an effort. We invest resources in evaluation to learn whether our efforts create the types of changes that we believe will increase individuals' likelihood of leading healthy, productive lives.

We are all constant evaluators, as we are always trying to determine if what we and others do works or doesn't work. The type of evaluation we bring to prevention, however, should be well-defined and systematic to demonstrate accountability. Our personal impressions about whether something is effective rarely meet the evaluation expectations of our funders anymore.  We hope that you will find the process personally fulfilling as well. With a good evaluation plan, you will not have to wonder if the positive responses you get from people you reach are an actual reflection of an important change in their beliefs, attitudes, values, skills or behaviors.  You will have the data that affirm your hard work.

Considerable expertise is required to conduct certain aspects of a high-quality evaluation, but the skills and practices to implement a basic prevention evaluation are mostly common sense and learnable. Something about evaluation, however, seems to make even very bright people anxious.  If you can overcome the anxiety, you will find that evaluation practices typically make sense, require only basic math skills, and can be explained in terms that almost everyone can understand.  Once you set up and implement one evaluation plan correctly, the next one will be even easy.

Time is also a common barrier to doing evaluation well, but we must all recognize that, in most cases, our funders are now requiring us to demonstrate what we have done with their money and with what effect. Failing to make time to document those quality results will likely come back to haunt us. Recognizing that evaluation is an integral part of all that we do, and not an "added duty," will ensure that we do not overlook our responsibility.

# Evaluation Goals and Objectives

Writing actionable and measurable goals and objectives is outlined in *From Planning to Evaluation – Your Guide to Evaluating Your Efforts in* IMPACT which can be found at the SC Prevention/Evaluation Resources website, also known as the SC Prevention Documents website. For that reason, we will not provide a lot of detail here about writing your goals and objectives. But a short primer may be helpful.

**Goals** are statements of the ultimate outcomes of a program. They are a declaration of your intended destination. **Objectives** are measures of the progress towards reaching the goals. Thus, objectives are typically sub-categories of your goals. Although it is often challenging to decide at what "level" your goals and objectives are, goals are often broad statements of the destination (e.g., To reduce substance use among middle and high school students), whereas objectives are measures that reflect progress towards the goal (e.g., To reduce current alcohol use among middle and high school students; To reduce marijuana use among middle and high school students; To reduce nonmedical use of opioids among middle and high school students).

Objectives can be divided into process and outcome objectives. **Process objectives** are specific statements describing ways that you intend the intervention to be implemented. **Outcome objectives** are specific statements describing the measurable change you hope to accomplish. An example of goals, process objectives, and outcome objectives is below.

| Goal 1. Reduce substance use among middle and high school students | |
|---|---|
| **Objective 1 (Process)** | Execute MOUs with three middle schools in our county to deliver Life Skills Training to all 7th grade students. |
| **Objective 2 (Process)** | Deliver all eight sessions of Life Skills Training to all 7th grade students in our county, reaching approximately 200 students. |
| **Objective 3 (Outcome)** | Reduce alcohol use alcohol use among program participants, as measured by the DAODAS Survey. |
| **Objective 4 (Outcome)** | Reduce marijuana use among program participants, as measured by the DAODAS Survey. |

The important thing to remember about goals and objectives related to evaluation is that your objectives provide the basis for your evaluation. There should be a logical link between the process objectives and your process evaluation plan, and between the outcome objectives and your outcome evaluation plan. **Process evaluation** focuses on how a program is implemented and operates. Common items to track include number of participants (per event or session), length of delivery session, names of participants, demographics of participants, and amount of staff time devoted to delivery and preparation. Process evaluation also includes **fidelity assessment**—that is, assessing the extent to which a program is being implemented the way it was designed to be implemented, or whether the implementer adhered to the implementation guidelines. **Outcome evaluation** is the systematic assessment of the results or effectiveness of a program or activity. Depending on what you are assessing and what data are available, different evaluation designs (e.g., pre- and post-testing, post-testing only, and reviewing archival data) are required. The bottom line is that your evaluation plan should explain how you will assess each objective that you specify.
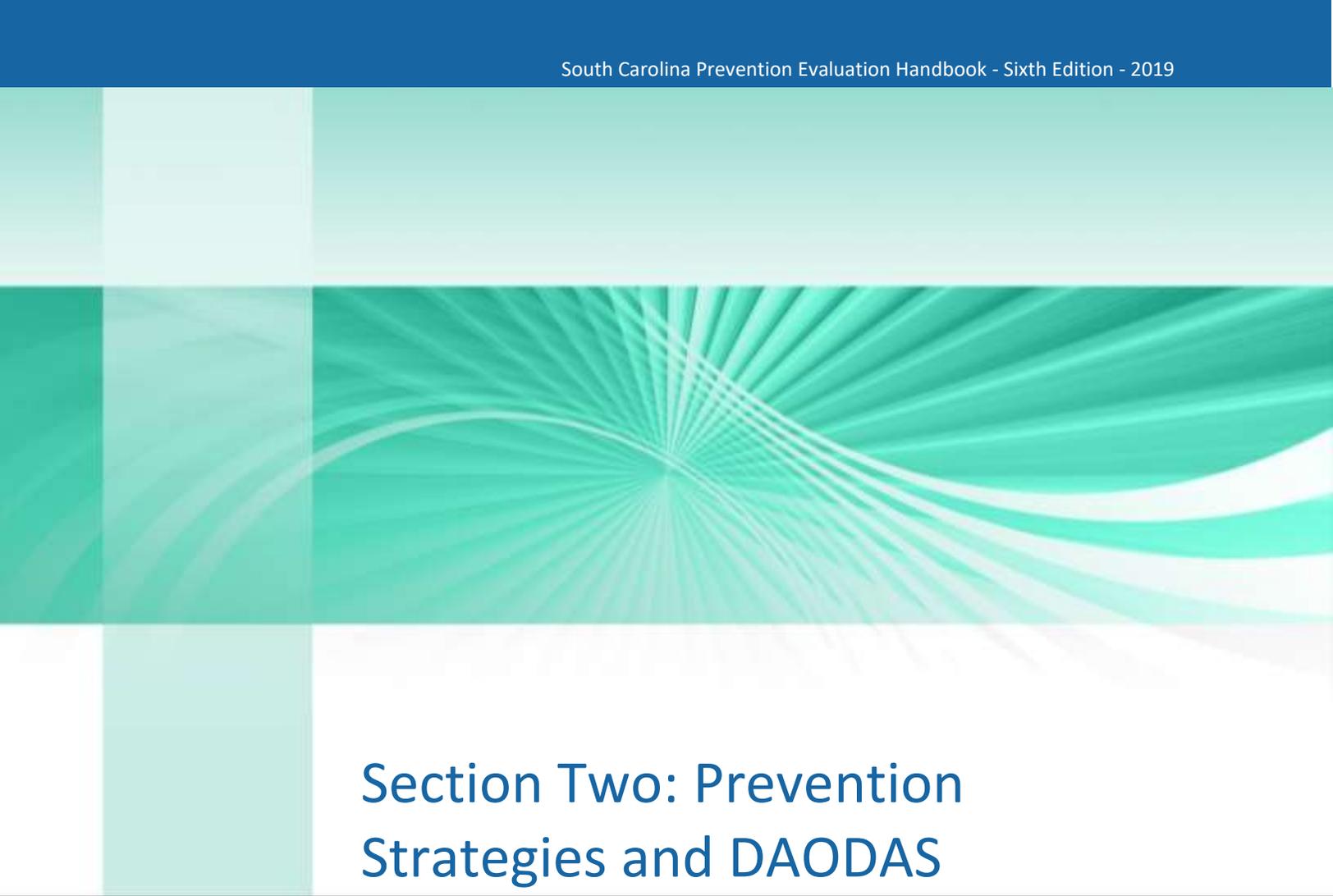
# Section Two: Prevention Strategies and DAODAS Reporting Systems

## Prevention Strategies

There are many ways to categorize prevention activities but because prevention funds in South Carolina primarily originate from the US Center for Substance Abuse Prevention (CSAP) within the Substance Abuse and Mental Health Services Administration (SAMHSA), we will use CSAP's categories. CSAP's strategies are categorized and defined as follows:

**Information dissemination** increases knowledge and changes attitudes through communications. This method of learning is mainly one-way, such as classroom speakers, health fairs, and media messages.

**Prevention education** is a two-way approach to teaching participants important skills. These skills can include resisting pressure to use drugs, looking at the intent behind advertising, or developing other skills used in making healthy choices. Prevention education often entails of the delivery of curriculum-based programs in a classroom setting.

**Positive alternatives** provide fun, challenging, and structured activities with supervision, so people have constructive and healthy ways to enjoy free time and learn skills. These alcohol- and drug-free activities help people—particularly young people— stay away from situations that encourage use of alcohol, tobacco, or illegal drugs. Classic examples of positive alternatives include midnight basketball and outdoor adventure activities.

**Environmental strategies** are aimed at the settings and conditions in which people live, work, and socialize. These strategies call for change in policies, law, and regulations—for example, zoning restrictions on alcohol outlets, high visibility law enforcement efforts to enforce underage drinking and smoking laws, and social host liability laws. Notably, environmental strategies to prevent substance abuse often have the goal of *restricting access* to alcohol, tobacco, and other drugs, and are often aimed at *community gatekeepers*, rather than those who may use the substances. For example, they may be aimed at alcohol and tobacco retail

merchants, law enforcement officers, or parents—all of whom have a role to play in restricting access. As these changes are carried out at the community level, they can have a sweeping impact.

**Community-based processes** strengthen resources such as community coalitions to prevent substance use and misuse. Organizing, planning, and networking are included in this strategy to increase the community's ability to deliver effective prevention and treatment services.

**Identification of problems and referral to services** are crucial to the prevention of substance use. This process includes determining when the behavior of people who are at high risk or who are using alcohol, tobacco, and other drugs requires education or other intensive interventions.

Most prevention strategies that fall within the six CSAP strategies can be subjected to some form of evaluation or monitoring effort. In nearly all cases, you can document the processes used to implement these efforts (e.g., who implemented them, where and why) and the outputs associated with implementation (e.g., the number and demographics of people who received the messages). Some of the strategies, however, are more conducive than others to outcome evaluation because they involve prolonged efforts to influence attitudes, beliefs, and behaviors. Efforts that are not prolonged (for example, a one-time health fair or broad information dissemination) are unlikely to have measurable influence on substance use behavior and, therefore, are not a good fit for an outcome evaluation.

## DAODAS Reporting Systems

DAODAS supports several different reporting tools to evaluate and monitor its funded prevention activities. Those include IMPACT, the DAODAS Standard Survey, and the Environmental Prevention Strategies Reporting System (EPSRS). It's always best to check in with DAODAS or PIRE to make sure you are using the right reporting tools for the right strategies. The tools are briefly described below and the *All Roads Lead to IMPACT* figure at the end of this section shows how the six strategies relate to the tools and how the tools relate to each other.

## IMPACT

Formerly known as Kit Solutions, IMPACT is the primary and most complete DAODAS reporting tool. **All** prevention-related data, across the six CSAP strategies must be reported in IMPACT. IMPACT largely is a tool for reporting prevention outputs, or counts, of prevention activities and people reached. It is also used for setting project goals and objectives, but here we are mostly concerned with data and evaluation.

(More details about using IMPACT for setting goals and objectives, and documenting implementation activities, can be found on the South Carolina Prevention Documents website. Although DAODAS encourages providers to enter data about their prevention events (e.g., group class, health fair, policy change, compliance check) *as the events occur,* at a minimum, DAODAS expects data to be entered monthly, with all data for a given month to be in IMPACT by the 8th business day of the following month.

| Features of IMPACT |
| --- |
| • Most of the data are outputs, or counts, of prevention activities and people reached. |
| • Data are entered by **event**. That is, any time a prevention event takes place, the details of that event must be entered. |
| • When entering data about the people reached, the group characteristics are entered (e.g., ages and races), not individual-level data. |
| • Data can be entered any time during the month and are expected to be entered by the 8th business day of the next month. |
| • A more complete set of instructions about IMPACT can be found on the SC Prevention Documents website. |

IMPACT categorizes services as Single or Recurring. A **Single Service** is a one-time event, such as a health fair or a compliance check. Even if an event occurs multiple times (e.g., an agency may have a series of health fairs or operate a series of compliance checks), the audience for each event is made up of different people and, therefore, each event is counted as one Single Service. Typically, the following strategy groups are documented as a Single Service:

- Information dissemination
- Positive alternatives
- Environmental strategies

- Community-based processes
- Identification of problems and referrals to service

Data to be entered for Single Services in IMPACT include the following:

- Institute of Medicine (IOM) Category
- Service population
- Location
- Target zip code
- Service start date
- Service end date
- Service duration
- Total number of attendees
- Number of attendees by age group (e.g., 0 – 4, 5 – 11, 12 – 14, 15 – 17, etc.)
- Number of attendees by gender
- Number of attendees by race
- Staff hours devoted to the service (direct and indirect)

A **Recurring Service** is a prevention service provided to a fixed group of people at risk for substance use or abuse, who are enrolled for a fixed period, in a planned sequence of events. These services are ongoing. The most common strategy-type associated with Recurring Services is **prevention education**—specifically, the delivery of a prevention curriculum to the same participants during multiple sessions (e.g., the delivery of the eight sessions of Life Skills Training to a class of middle school children, where the group of children does not change from session to session). Data to be entered for Recurring Services in IMPACT include the following:

- IOM Category
- Service date
- Service population
- Zip code
- Number of participants, with demographics entered for individual participants
- Staff hours devoted to the service (direct and indirect)

## DAODAS Pre-Post Survey

The DAODAS pre-post survey is the primary method for collecting individual-level data from prevention program participants (e.g., students participating in Life Skills). The survey is administered directly to program participants and it measures substance use attitudes, beliefs, and behaviors. Post-test data are compared to pre-test data to determine whether there were any changes in attitudes, beliefs, and behaviors

| Features of DAODAS Pre-Post- Surveys |
| --- |
| • Administered to program participants. <br> • Captures individual-level data about substance use attitudes, beliefs, and behaviors. <br> • Completed surveys are sent to DAODAS for processing. <br> • Data about the classes or groups that participate in programming should be entered in IMPACT. |

after program participation. There is more discussion about the pre- and post-test survey in Section Three, including how to administer the survey and how to interpret results.

## Environmental Prevention Strategies Reporting System

Formerly known as the AET Reporting System, the Environmental Prevention Strategies (EPS) Reporting System is designed for law enforcement officers to enter data about their environmental prevention operations. It is also designed for law enforcement officers to enter data directly from the field when the operations occur using an internet connection (either through mobile data services or a wifi hotspot). The environmental prevention operations that can be entered into the system are the following[1]:

| Features of EPS Reporting System |
| --- |
| • Focus is on environmental strategies involving law enforcement. <br> • Law enforcement operations-level data. <br> • Completed by officers in the field. <br> • Data can be entered into system by AET Coordinators, but the data must originate with the officers. <br> • Real-time reports available at the state, circuit, and county levels. |

---

[1] Appendix A includes more detailed information about environmental strategies and provides specific data fields that are required in the EPS Reporting System.

Compliance checks
- Bar checks/ID sweeps
- Saturation patrols
- Shoulder taps
- Party dispersals
- Checkpoints

Law enforcement officers can also report on other prevention activities in which they engage (e.g., media campaigns, community engagement/presentations, and alternative activities). In addition, AET Coordinators can report on AET-related media and enforcement data reported by local law enforcement activity not included on any environmental prevention activities listed previously that occurs during the month.

The environmental prevention operations could be conducted by local police departments, sheriff's offices, the South Carolina Law Enforcement Division (SLED), or the South Carolina Highway Patrol. And they may be supported by the DAODAS Alcohol Enforcement Team (AET) funds, discretionary grants (e.g., the Strategic Prevention Framework Partnerships for Success), Drug Free Communities grants, or local prevention funds. *The key is that the operations are coordinated efforts between substance abuse prevention agencies and law enforcement agencies.*

In 2016, DAODAS commissioned the development of an electronic reporting system, which was updated in 2018. The electronic system is designed to reduce the time between the implementation of operations and the availability of data reports. Ideally, law enforcement officials enter data in the Reporting System while they are in the field using a mobile device of their choosing (Android-tablet, iPad, or mobile phone). The data are then available for immediate aggregation and reporting at the state, AET circuit, or county level. AET Coordinators have password-protected access to the state-level data and data for their circuits, including the counties within their circuits. AET Coordinators can pull county-level reports from the EPS Reporting System and enter them into IMPACT each month.

# When to Use IMPACT, the Pre-Post Survey, and the EPS Reporting System

It may be confusing to know when to use the various reporting systems. In some cases, you may only need to enter data into one system. In other cases, unfortunately, you may need to enter data into multiple systems. The graph below provides guidance on where to report your prevention data.

Note that *all roads lead to IMPACT!* In other words, all data must be entered in IMPACT, at a minimum. In general, data for information dissemination, positive alternatives, community-based processes, and identification of problems and referral are entered in *IMPACT only*. For prevention education, in general, group-level data must be entered in IMPACT and individual-level data must be gathered from program participants using the DAODAS pre-post survey. Finally, data about environmental strategies should be entered into the EPS Reporting System by law enforcement officers; AET Coordinators should then pull those data and enter them into IMPACT. If you are unsure where to enter your data, please contact DAODAS or PIRE.

**All Roads Lead to IMPACT!**
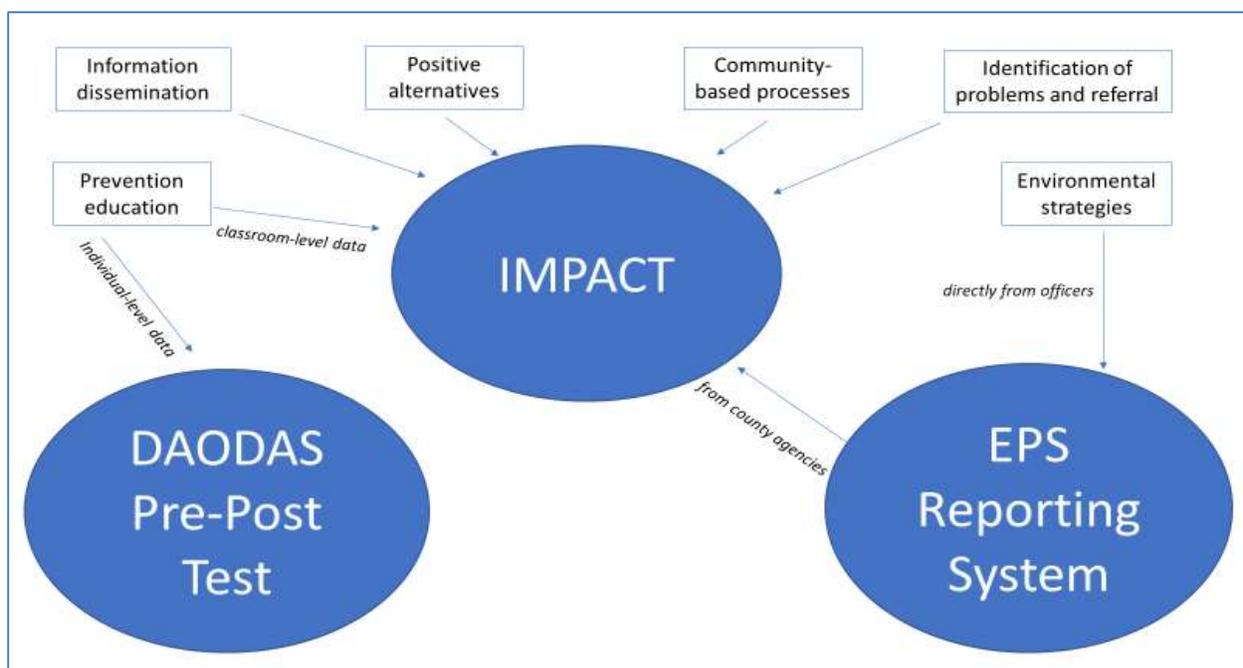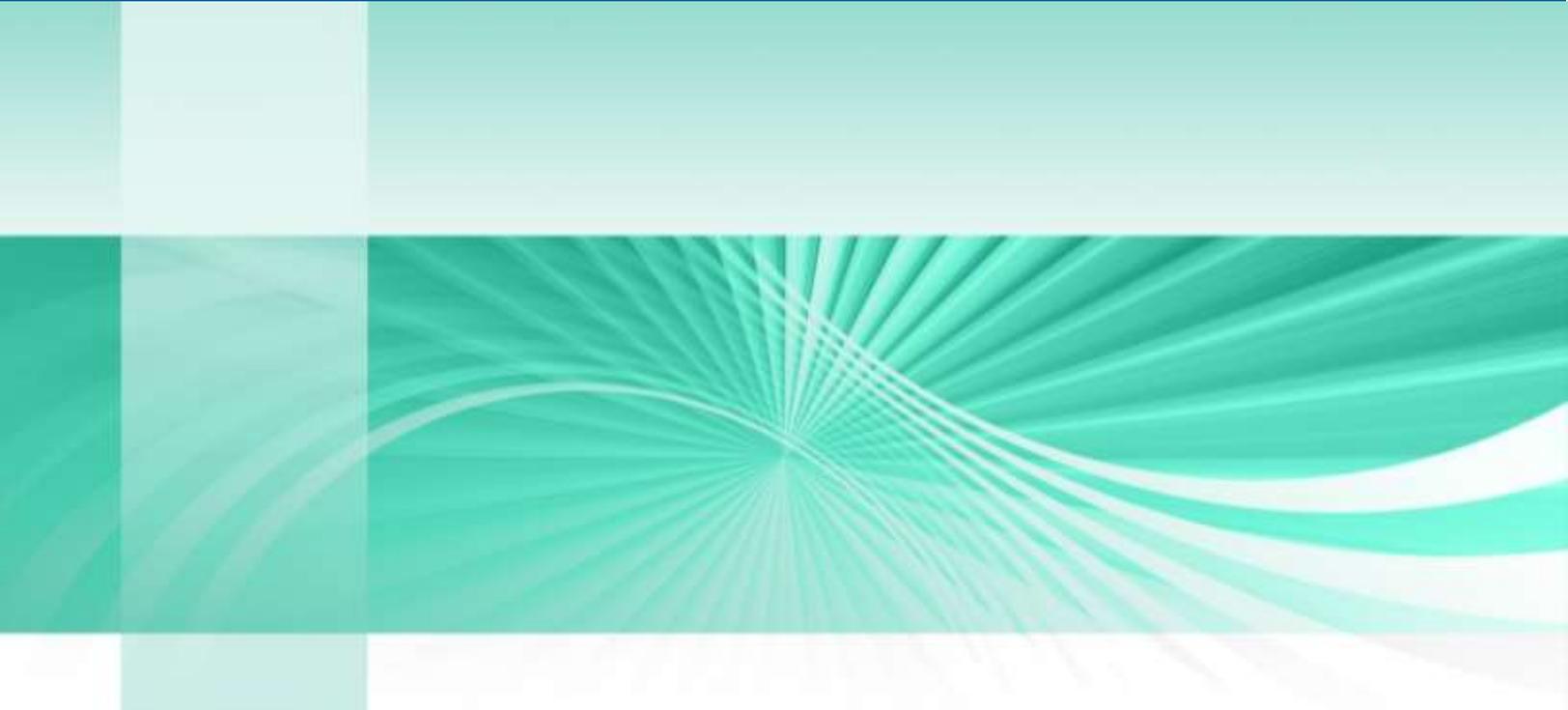
# Section Three: Understanding the DAODAS Standard Survey

# Description

The DAODAS Standard Survey is designed to be used with <u>Recurring Services</u> (i.e., substance abuse prevention programs consisting of multiple sessions delivered to the same group of participants) to middle- and high-school aged youth. (Some exceptions are described below.) The survey includes items that are relevant for most curriculum-based prevention education programs and are largely compatible with federal National Outcome Measures (NOMs) reporting requirements, as well as the Governor's Comprehensive Strategy for Youth Substance Abuse Prevention. The Standard Survey was updated in 2019 and is available in two versions—middle school and high school. Both surveys consist of the following measures:

- **Perceived risk/harm** of substance use. This measure lists several substances and different frequencies of use and asks participants to assess how much people risk harming themselves by using.

- **Disapproval** of substance use. This measure assesses how strongly participants think it is wrong for someone their age to use various substances.

- **Perceived parental attitudes** toward substance use. This measure asks for participants' perceptions of how wrong their parents think it would be if they (the child) used various substances.

- **Perceived peer attitudes** toward substance use. This measure asks for participants' perceptions of how wrong their friends think it would be if they (the child) used various substances.

- **Decision-making**. This measure assesses the extent to which participants make good decisions.

- **Past 30-day substance use.** These items assess whether participants used various substances in the past 30 days. The Middle School Survey asks about chewing tobacco, cigarettes, e-cigarettes, alcohol, marijuana, and prescription drugs without a doctor's prescription. The High School Survey includes these same substances plus prescription pain pills without a doctor's prescription, heroin or fentanyl, cocaine, and other illicit drugs (e.g., LSD, amphetamines, methamphetamines, or Ecstasy).

- **Past 2-week binge drinking.** The survey includes an item about binge drinking (having five or more drinks in a row) during the past two weeks.

- **Parent communication** about the dangers of substance use. This item asks participants whether they have talked with their parents about the dangers of substance use.

One or more of these measures may not apply to a program you implement, but most of them probably will. The above measures, combined with the four demographic questions (grade, gender, ethnicity and race) at the end, bring the number of items on the DAODAS Middle School Standard Survey to 36 and on the High School Survey to 44, which should be a manageable number for most middle- or high-school groups.

DAODAS has created exceptions that allow agencies to opt out of using the DAODAS Standard Survey, in addition to the target population falling outside the middle and high school age range. The following list is not exhaustive, so consult with DAODAS prevention staff if you have a different reason to request an exemption. In some of these cases, you may still choose to use the DAODAS Standard Survey, although it would not be required.

1. The program is three or fewer sessions in length.
2. The program is delivered, from first session to last, in less than 30 days.
3. The program is intended as a leadership-development program (e.g., a youth advisory board), rather than one designed to prevent or reduce substance use among participants.
4. The program has already begun a different evaluation process to attempt to attain "evidence-based" status (e.g., publication in a peer- reviewed journal).
5. The program developers offer evaluation instruments **and** analysis.
6. Participants have developmental-disability issues that would make them unable to understand the survey.
7. The school or other organization has forbidden use of the survey or will not allow you to implement proper consent procedures. This must be documented to DAODAS in writing.

## Using or Not Using Developers' Evaluation Instruments

Many evidence-based programs come with their own pre- and post-tests, and many practitioners feel an obligation to use these instruments. Of course, there are instances when that is the most practical approach. It is usually better to use the developers' instrument than to create one of your own.

There are also some common complaints, however, with developers' evaluation instruments. One pertains to their length; another to their lack of documentation on how to score participants' answers. Without this information, you have answers but no guidance on how to translate your results into useful conclusions. It is not unlike having a car but no keys. (Please note that this criticism does not apply to all evidence-based programs.)

**Programs that are required to use the DAODAS Standard Survey will most likely do so in place of using the developer's instrument**, if there is one available. While you do have the option of using both, you will want to consider the burden on the participants of using the DAODAS Standard Survey in addition to another, perhaps lengthy, instrument. Keep in mind that there is no real obligation to developers to use their instruments once you have paid them for the training and materials. If they are not providing you with analysis assistance or using your data as part of a research study, then you need to do whatever best meets your needs—not theirs.

Some practitioners have expressed concern that not using the developers' instruments will interfere with the programs' fidelity. This is not the case. Pre- and post-tests are almost never part of a program and, therefore, have nothing to do with the fidelity with which it is implemented.

# Survey Administration FAQs

**What processes to protect participant rights do we need to consider?** Among the first things you need to think through prior to using the DAODAS Standard Survey are consent and confidentiality issues, which are covered in more detail in the next section.

**Under what circumstances should the pre- and post-tests be administered?** *The DAODAS Standard Survey should be administered to middle and high school aged participants of a prevention program that is delivered during at least four sessions and over a period of at least 30 days.* Programs with three or fewer sessions or that last less than one month from pre- to post-test should consider a post-test-only format (or, with DAODAS approval, state that "outcomes cannot accurately be assessed"). The reason for this is that the length of time between the pre- and post-test would be so short that students could very likely remember many of their answers on the pre-test when they are taking their post-test. This is not good for ensuring valid answers. They may either feel inclined to repeat their answers from the first time or feel obliged to change answers because they feel they need to show they learned something. Either way, they would not be answering those questions as they truly feel or believe at that moment. In addition, the DAODAS Standard Survey asks respondents to reflect on the past 30 days for many of their substance use answers. If the program lasts less than 30 days, respondents will be including a pre-program period in their post-test answers, thus limiting the ability to demonstrate any post-program effects.

**When should the pre-/post-tests be administered?** *The pre-test should be administered to students no more than two weeks prior to the beginning of the content of the program.* It is entirely acceptable to give the survey at the beginning of the first session of the program. What you do not want to do is give students a pre-test at the beginning of the school year if your program is not beginning until, for example, November. By the time the program begins, the attitudes and use measures on the pre-test would be outdated. *The post-test should be administered to students within two weeks following the end of the content of the program.*

Again, it is entirely acceptable to give the survey at the end of the last session.

Booster sessions and multi-year programs complicate things. One possibility would be to give the pre-test at the beginning of the program, post-test at the end of the main set of sessions, and then post-test again after the booster sessions. To keep things simple, however, we recommend treating booster sessions and multi-year programs as distinct programs for which participants would receive a pre-test and a post-test at the beginning and end of each set of sessions.

**Who should administer the survey?** Ideally, the person administering the pre- and post-tests should be a "neutral" person to the participants. This means someone other than the person delivering the program or the classroom teacher. This is certainly not essential but recommended. The rationale is that participants may feel inclined to "reward" program deliverers because they like them and may give post-test answers that they think the deliverer would want them to give. With a consistent, neutral person administering the pre- and post-test, any potential bias should be reduced. If this is logistically impractical, then the program deliverer may administer the pre-/post-test.

**How should the survey be administered?** *The person administering the survey should read the directions to the students and then read each question* as the students all complete the survey at the same pace. Reading the questions out loud will (1) help account for low literacy levels by letting participants hear the questions as they read them and (2) ensure any questions about a confusing item are dealt with at one time. *The person administering the survey should try, however, to avoid any unnecessary clarification of any items* because that can influence participants' responses. If multiple students are truly confused, then minimal clarification can be made but try to avoid assuming they won't understand something and providing additional information prematurely.

**What should I say when I give out the survey?** We strongly recommend you read from the script provided on the Survey Administration Checklist. The script says the following:

*Today we would like you to answer some questions. We are interested in how students your age act, think, and feel. (AT POST TEST, add: We know that you answered some of these same questions a few weeks ago, but we want to know what your answers are to them at this time.*

*Before we begin, there are a few things to remember while completing this survey.*

*First, this is not a test; there are no right or wrong answers. What is important is that you give us your honest opinions.*

*Second, all the information you provide on the survey is confidential. That means that you do not put your name on any of the survey materials. None of your classmates or teachers have any list that says what names go with the code numbers. This way, nobody will find out any of your answers. And nobody will ever tell anybody or write down what one person said on the survey.*

*Third, please respect the privacy of others. This means you should never look at your neighbor's survey or talk about your answers. Each of you should give your own private opinions. If a question bothers you or you feel uncomfortable about answering it, skip that question and go to the next question. If you do not feel comfortable answering any of this survey, that is okay, too.  You can just return it blank.*

*Fourth, I will be reading each item aloud to you. Try to stay with me as I go and do not work ahead, so that we all end together. If you have any questions, just raise your hand.*

*Thanks for completing this survey for us.  Let's get started.*

**What should I do with the surveys once the students have completed them?** You should return your surveys to DAODAS according to the guidelines set forth by DAODAS and PIRE. Guidelines are posted on the [SC Prevention Documents](#) website.

## Consent Procedures

Asking participants about their beliefs, perceptions, and use of substances involves collecting personal information and potentially information about illegal behaviors; therefore, this information needs to be protected. In addition, these data cannot be collected until you have permission from the proper authorities to do so. Typically, this means that **parents must approve that you are going to be collecting this information from their children. Minors (that is, people under the age of 18) are not legally able to provide consent; consent must be obtained from a parent or guardian. Getting this consent is a process that should not be overlooked**.

Parental consent is typically obtained one of two ways. First is **active, written parental consent**. With active, written parental consent, parents are given information about the survey, including why the survey is being administered and the nature of the questions. The parents then return a signed consent form that explicitly grants permission for their child to complete the survey. **Only children who have documented active, written consent can then be given the survey.** A sample active, written parental consent form is included in the Confidentiality Packet on the SC Prevention Documents webpage.

The second way to obtain consent is through **parental notification with opt-out**. As with active consent, parents are given information about the survey, including why the survey is being administered and the nature of the questions. In this scenario, however, parents are provided with an opt-out form and told to return the form if they **don't** want their child to participate. In other words, the default is to have the child complete the survey unless the parent has opted out. This is the opposite of active consent, where the default is for the child to not complete the survey unless the parent has actively consented. If using parental notification with an opt-out, it is important to use multiple methods for reaching parents. It is typically not acceptable to send one notice home and assume it makes it to parents. You should consider sending multiple notices home with students, and sending notices through mail and email at least twice, to ensure that parents have multiple opportunities to be informed about the survey and to opt-out if they wish.

The choice of using active, written consent or opt-out may affect your sample. Because it is more difficult to obtain active, written consent, your sample size may be more limited. It may also be biased because certain groups of people may be more, or less, likely to return the active consent. Whether you use active, written consent or the opt-out is primarily dependent on the policies of the entities involved in the project. For example, your agency may have policies about obtaining consent. Similarly, schools or school districts may have policies about obtaining consent. It is critical—and your responsibility— that you learn about and follow whatever

processes these organizations might have. This approval process may have a name, such as an Institutional Review Board (IRB). In many cases, working under these organizations' guidelines will be an advantage, because many schools have parents sign a blanket permission slip at the beginning of the year that approves most of the surveying that will take place during the year.

To protect yourself from any potential negative consequences, **make sure that you are proactive about ensuring that you have followed all proper consent procedures**. If a child tells their uninformed parent that they answered questions about how much they have used drugs, the parent may envision all sorts of negative consequences and make things very difficult for you or the school.

## Confidentiality

A key element of the consenting procedure—and indeed of protecting the rights of human subjects—is to ensure data **confidentiality.** That is, you will want to assure parents that their child's data and privacy will be protected. One way to enhance confidentiality is to avoid using names on surveys. It may be important, however, to link the pre-tests with the post-tests, so instead of using names, the DAODAS Survey asks that you assign each student a unique ID number. Procedures for assigning unique ID numbers and keeping the list of names and numbers safe and protected are provided in detail in the "Confidentiality Packet" document found in the Evaluation Documents section of the SC Prevention Documents website. Using unique ID numbers instead of names—and taking steps to protect the ID numbers—should alleviate most participants' concerns about a classmate or teacher knowing their answers.

Some parents or students may still be highly suspicious, but in that case, there may be little you can do to convince them that their information is safe.  Regardless of consent procedures, **at testing time, any students who choose not to take the survey should be allowed to opt out; they also must be told that they can decline to answer any question they would prefer not to answer**.

There may be situations in which you may need an even stronger protection for participants. **Anonymity** procedures are ones in which no names or other identifying information are collected, so there is no way to link participants' answers to them. However, this can also complicate efforts to link pre- and post-tests. PIRE can advise you on this, if needed.

# Administering the Surveys

When preparing the surveys to be completed by the students, keep in mind that these pages must ultimately be entered into the DAODAS scanner for the responses to be read and imported into a database for analysis. Therefore, there are certain steps that need to be taken to ensure this process works smoothly.

A detailed overview of how to prepare, proctor, review, handle, and return the surveys can be found in the "Scanned Standard Survey Overview" document in the Evaluation Documents section of the SC Prevention Documents website, so we will not repeat that information here. It is important that you review all those guidelines carefully to ensure that you collect useable data and that we do not have to return survey batches back to you to be corrected.

# Data Analysis

If you are using the DAODAS Standard Survey, once you send the surveys to DAODAS, PIRE will scan them, clean the data, and analyze the data. If you are using a different survey (approved by DAODAS) and need guidance on how to analyze the data, please contact DAODAS or PIRE staff for assistance. For the Standard Survey, PIRE scores the survey in the manner described below (question numbers listed are from pre-test).

**Question 1: Perceived risk/harm of ATOD use.** These items are scored as follows: No Risk = 0; Slight Risk = 1; Moderate Risk = 2; Great Risk = 3. These scores are averaged for an overall perceived risk/harm score between 0 and 3, with higher scores being more favorable.

**Question 2: Disapproval of substance use**. These items are scored as follows: Not at All Wrong

= 0; A Little Bit Wrong = 1; Wrong = 2; Very Wrong = 3. These scores are averaged for an overall disapproval score between 0 and 3, with higher scores being more favorable.

**Question 3: Perceived parental attitudes toward substance use**. These items are scored as follows: Not at All Wrong = 0; A Little Bit Wrong = 1; Wrong = 2; Very Wrong = 3. These scores are averaged for an overall parental disapproval score between 0 and 3, with higher scores being more favorable.

**Question 4: Perceived peer attitudes toward substance use**. These items are scored as follows: Not at All Wrong = 0; A Little Bit Wrong = 1; Wrong = 2; Very Wrong = 3. These scores are averaged for an overall peer disapproval score between 0 and 3, with higher scores being more favorable.

**Question 5: Decision-making**. These items are scored as follows: Never = 0; Sometimes but Not Often = 1; Often = 2; All the Time = 3. These scores are averaged for an overall decision-making score between 0 and 3, with higher scores being more favorable.

**Question 6: Past 30-day substance use.** These items are treated individually with YES indicating use and NO indicating no use during the past 30 days.

**Question 7: Past 2-week binge drinking.** This is a YES/NO item, with YES indicating binge drinking and NO indicating no binge drinking during the past two weeks.

**Question 8: Parent communication about the dangers of substance use**. This is a YES/NO item, with YES indicating communication with a parent and NO indicating no communication with a parent about the dangers of substance use.

# ■ Data Reports

You can receive up to two evaluation reports per program each year. One will be a year-end report, which does not need be requested because they will be completed for all programs. An agency may also request one evaluation report per program at any time during the year. The PIRE evaluation report typically contains information for the program in the county of interest, the same program aggregated across all counties, and all programs aggregated across all counties. This format allows program staff to compare the performance of the program with the same program in other counties and with prevention programs overall across the state. The following information is typically provided in each report:

- The number of participants with valid pre- and post-tests;
- A measure-by-measure breakdown of the average pre-test score, average post-test score, and percent change from pre- to post-test;
- Whether the change for each measure was statistically significant;
- A bar chart depicting the percent of pre-test non-substance-users (that is, those who reported not using a given substance during the past 30 days) that remained non-users at post-test;
- A bar chart depicting the percent of pre-test substance users (that is, those who reported using a given substance on at least one day during the past 30 days) that reduced use (that is, reported using on fewer days), though not necessarily stopped entirely, by post-test;
- Bar charts depicting the pre- and post-test scores for each measure;
- Bar charts depicting the results for items on the pre-test only (i.e., age of first use, whether they talked with their parents about ATOD dangers in the past year, and whether they have been exposed to prevention ads in the past year);
- A summary of overall program findings as observed by PIRE staff;
- Sub-group data tables broken down by gender, race, ethnicity and implementation group (but only when the number of participants in the subgroup is at least 25);

- A discussion of differences between sub-groups; and

- A brief description of some of some methodology issues.

A typical data table is presented below.  These are the columns headers in the table:

- **Risk Factor Scores/Substance Use:** Identifies the measures in that section. **Range** shows the possible low and high scores for that measure. **% Users in Past 30 Days** identifies that what is displayed in the Substance Use section is the percentages of participants that reported any use in the past month.

- **Your County, This Program:** These columns show results for your local program, identified on the cover page. "N" is the number of matched participants in this dataset.

- **All Counties, this Program:** These columns show results for all counties using the same program. "N" is the number of matched participants in this dataset.

- **All Counties, All Programs:** These columns show results for all counties using the DAODAS Standard Survey for any program in this Fiscal Year. "N" is the number of matched participants in this dataset.

- **Pre Average:** For the risk factor measures, the average pre-test score for those participants with a valid pre- and post-test. For substance use measures, the percent of participants that reported any use during the past 30 days at pre-test.

- **Post Average:** For the risk factor measures, the average post-test score for those participants with a valid post- and post-test. For substance use measures, the percent of participants that reported any use during the past 30 days at post-test.

- **% Change:** The rate of change from pre-test to post-test expressed as a percentage. The

formula to calculate percent change is: (post-test - pre-test)/pre-test. Keep in mind that for the 30-day use measures, negative change scores are preferred because they reflect less use.

At the bottom of the sample data table there are notes about statistical significance tests. These tests are used to determine the probability that values observed at pre-test and post-test (for example, pre- and post-test risk factor scores or substance use rates) are truly different from one another. When we implement prevention programs, we typically hope to see differences in pre-test and post-test scores that are truly different from each other (and in the desired direction, of course) as an indication that the program may have had an effect. For instance, we would like to see risk factors scores become more favorable (or increase, given the way we code the data) and substance use rates go down. Several factors influence tests of statistical significance, including sample size, pre-test score, amount of change from pre-test to post-test, and variability in scores. It is not possible to determine whether differences in pre- and post-test scores are statistically significant by simply looking at them—sometimes scores that differ by a wide margin are not significantly different from one another and sometimes scores that seem very similar to each other are significantly different. It is necessary to conduct appropriate statistical tests to make this determination.

There are many kinds of tests for statistical significance, but most of them use a *p-value* to determine the probability that the observed results are significant. P-values can range from 1.0 to 0.0, with the values indicating the probability that an observed difference is random (or by chance). Scientists have typically set the threshold for significance to be a p-value of .05—that is, p-values below .05 are considered statistically significant. The .05 p-value means that the probability of the observed difference being random (or simply by chance) is only 5%. (Stated conversely, the probability that the difference is real is 95%).  In the evaluation reports, we indicate whether p-values are less than .05 (statistically significant) or .10 (marginally statistically significant).

## Sample Data Table

| Risk Factor Scores, Range (Positive score is favorable) | Your County, This Program N=55 | | | All Counties, This Program N=145 | | | FY18 All Counties, All Programs N=545 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Pre Average | Post Average | % Change | Pre Average | Post Average | % Change | Pre Average | Post Average | % Change |
| Perceived Risk, 0-3 | 2.38 | 2.43 | 1.81* | 1.96 | 2.16 | 10.11** | 1.92 | 2.07 | 7.61** |
| Disapproval of Substance Use, 0-3 | 1.95 | 1.88 | -3.79** | 1.86 | 1.91 | 3.16** | 1.81 | 1.85 | 2.18** |
| Perceived Parental Attitudes, 0-3 | 2.76 | 2.76 | 0.00 | 1.88 | 2.01 | 6.73 | 1.58 | 1.62 | 4.5** |
| Perceived Peer Attitudes 0-3 | 1.95 | 1.88 | -3.79** | 1.82 | 1.83 | 0.90 | 2.38 | 2.43 | 1.81* |
| Decision-Making Skills, 0-3 | 2.85 | 2.85 | -0.12 | 2.82 | 2.87 | 1.61** | 2.83 | 2.84 | 0.28 |

| Substance Use, % Users in Past 30 Days (Negative change is favorable) | Pre Average | Post Average | % Change | Pre Average | Post Average | % Change | Pre Average | Post Average | % Change |
|---|---|---|---|---|---|---|---|---|---|
| Other Tobacco | 5.06 | 3.13 | -38.14 | 2.42 | 1.91 | -21.07 | 3.23 | 3.52 | 8.98 |
| Cigarettes | 10.13 | 7.81 | -22.90 | 3.35 | 1.91 | -42.99 | 4.45 | 3.36 | -24.49 |
| E-Cigarettes or Vapes | 17.72 | 17.19 | -2.99 | 7.27 | 5.14 | -29.30 | 9.48 | 7.85 | -17.19** |
| Alcohol | 6.36 | 0.74 | -88.36 | 4.73 | 2.63 | -44.40 | 4.30 | 3.13 | -27.21* |
| Marijuana | 1.9 | 0 | -100 | 2.31 | 1.67 | -27.71 | 1.80 | 1.31 | -27.22 |
| Non-Medical Prescription Drug Use | 4.13 | 6.62 | 60.29 | 3.46 | 4.06 | 17.34 | 3.55 | 3.01 | -15.21 |
| Prescription Pain Pills (OxyContin, Vicodin, etc.) | 2.18 | 2.21 | 1.38 | 2.31 | 2.15 | -6.93 | 2.44 | 2.22 | -9.02 |
| Heroin or Fentanyl | 2.91 | 4.17 | 43.30 | 2.42 | 1.91 | -21.07 | 1.80 | 1.88 | 4.44 |
| Binge Drinking (past 2 weeks) | 0.98 | 0.98 | 0.00 | 6.36 | 0.74 | -88.36 | 1.73 | 1.68 | -2.89 |

*Pre- and post-test averages are approaching being statistically significantly different (significant at the p<.10 level, but not p<.05 level)

** Pre- and post-test averages are statistically significantly different (significant at p<.05 level)

# Interpreting Your Data Reports

There are different ways that you can look at each result in your outcome evaluation report.

We'll use some sample sections for our examples.

**Example A**

Total cases = 30

| Measure | Avg. Pre-test Score | Avg. Post-test Score | % Change |
|---|---|---|---|
| Perceived Parental Attitudes (0-3) | 2.83 | 2.83 | 0.00 |

**Example B**

Total cases = 243

| Measure | Avg. Pre-test Score | Avg. Post-test Score | % Change |
|---|---|---|---|
| Perceived Risk (0-3) | 1.92 | 2.07 | 7.61** |
| 30-day Marijuana Use* | 10.00 | 0.00 | -100.00 |
| Heroin or Fentanyl | 1.13 | 1.11 | -1.77 |

* Negative change scores indicate desired change.
** Indicates statistically significant at $p < .05$.

**Example C**

Total cases = 12

| Measure | Avg. Pre-test Score | Avg. Post-test Score | % Change |
|---|---|---|---|
| Perceived Risk (0-3) | 1.82 | 2.30 | 26.37 |
| 30-day Cigarette Use* | 16.7 | 0.00 | -100.00 |

* Negative change scores indicate desired change.

Here are some of the things you may want to consider when interpreting the results in your report:

1. **How much change took place?** The "% Change" column provides the amount of change from pre- to post-test as a percentage. For the risk factor measures, you want the change to be positive. For substance use, however, you are hoping for negative change. One way to use this information is to compare it to your program objectives. For example, you may have an objective to reduce marijuana use by 5%. The "% Change" provides you with the information you need to determine whether you've met your objective.

2. **Was the change statistically significant?** The asterisks in the final column in the data table tell you whether the differences between pre-test scores and post-test scores are significantly different or marginally statistically different.

3. **Where was the pre-test number on the possible scale?** This is important for two reasons. First, pre-test numbers are a form of needs-assessment data. Knowing how your group started on certain measures can give you an indication of what other types of programming they may need. High percentages of users at pre- test may mean that, regardless of post-test results, the participants need to be considered for selective or even indicated programming.

   The second reason to look at pre-test numbers is so that you can take them into consideration when looking at the % change and significance results. High pre-test numbers on variables you predict will increase at post-test can limit potential improvement through what is called a "ceiling effect." In Example A, the pre-test score for perceived parental attitudes is 2.8 on a scale of 3.0. This means that there was virtually no room for improvement. Unfortunately, there was even a decline on that measure, which is common when there is a ceiling effect.

To use a more common example, these numbers would be analogous to a student answering 97% of the questions on a test at school correctly and being expected to do better a second time. It would be very difficult. Looking at the bar charts provided on your PIRE evaluation reports may help put this in perspective for some measures.

Similarly, low pre-test scores on variables you predict will decrease at post-test can limit potential improvement because of what is called a "floor effect." In Example B, the pre-test prevalence rate for heroin or fentanyl is 1.13%, which is quite low. This means that there was virtually no room for improvement.

4. **How many participants were there?** The number of participants has a large impact on % change and statistical significance. Small numbers of participants can lead to much greater % changes because each individual participant has a much greater impact on the group scores. One participant who goes from no alcohol use to using will have relatively little impact on the post-test numbers for a group of 200 but can have major impact on a group of 15.

In Example C, we see a 100% reduction in the number of cigarette users, which is wonderful from any perspective. However, we also see that there were just 12 participants in the group. With a low pre-test percentage of 16.7%, we can do the math to determine that at pre-test there were two participants who had used. At post- test, those two participants had not smoked. While this is positive change, it certainly may strike some differently than the idea of a 100% reduction in cigarette use, which may conjure up images of dozens of participants suddenly tossing aside their packs of cigarettes after sitting through a program.

Low pre-test numbers also influence statistical significance because the number of participants is one of the factors used when calculating significance. So, again in Example C, the 100% reduction in 30-day cigarette use is not statistically significant. Obviously, with a pre-test percentage of 16.7% and 12 participants, there is no way the

program could have achieved a statistically significant reduction if even 0% at post-test didn't achieve it. Also, in Example C, even a 26% improvement in perceived risk was not significant because there were only 12 participants. In contrast, Example B's perceived risk scores were significant for an 7.6% change because more than 200 participants were involved. The most important lesson from this may be that if you have few participants, you may not want to focus too heavily on your results until you have reached a larger number of participants.

5. **How did groups do in comparison to one another?** Your evaluation report may include data tables broken down by gender, race group, or implementation group. There are often striking differences between these groups that may cause you to think. For example, if females generally had much better scores than males in a program, how could you adapt the program to be more effective with males? What about if White participants had better results than Black or African American participants? What if one school did much better than another school? Would you want to look at the quality of the delivery of the program? Would you want to look at differences in the way it was administered? Would you decide to adapt the program at the less effective school, or would you decide to stop doing it because it just doesn't work with those kids? There are rarely right or wrong answers to these questions, but data results can give you some help in determining what you should consider.

On most evaluation reports, PIRE has looked through your data and tried to point out some observations related to the questions described above but remember that these are **your** outcomes. It is worth the time for you to think through your results and decide what they mean to you.
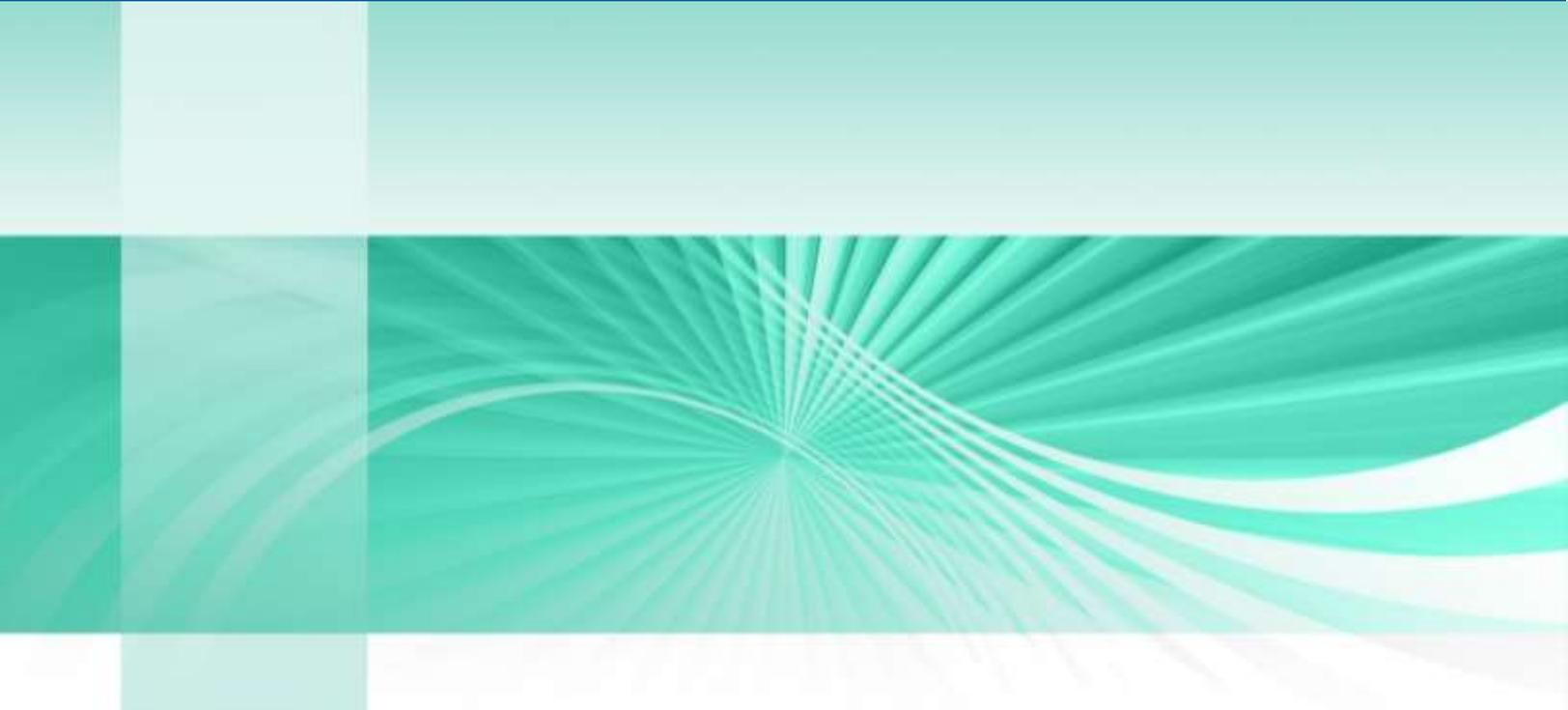
# Section Four: Other Evaluation Issues

## ■ Fidelity Checklists

One of the most common debates in prevention is the discussion of the value of fidelity versus adaptation. **Fidelity** is the agreement (concordance) of a replicated program model or strategy with the specifications of the original. The primary argument for fidelity is that the developer generated the positive outcomes required to be an evidence-based program by doing the program a certain way, and if the program is not implemented in that way, the likelihood of replicating those positive results is diminished. Indeed, most evaluative evidence suggests that programs that are not administered with fidelity will achieve weaker effects.

**Adaptation** refers to modifications made to a chosen intervention, which may be intentional or unintentional. The primary argument for adaptation is that every community is different, so the implementers must be trusted to make decisions about how the program can work best with their audience.

There is no easy answer to reconciling these two viewpoints. It is reasonable to argue that perfect fidelity is impossible because all the conditions of the original implementation by the developer cannot be recreated because the communities, participants, presenters, and other factors will not be the same. At the same time, however, there is general agreement that intentional adaptations should not be made frivolously and would work best when planned and determined with input from multiple stakeholders, including community members. There is also general agreement that, if adaptations are to be made, they generally should be in the form of thoughtful *additions* to the program, rather than deletions of program components.

Monitoring fidelity is as important as monitoring outcomes. And, unlike outcomes, delivering a program with fidelity is much more in your control. One important tool for monitoring fidelity is a fidelity checklist. Fidelity checklists can take many forms. One kind is a checklist generated directly from the content of an evidence-based program. For example, if All Stars Session 1 is supposed to comprise activities A, B and C, your fidelity checklist would list those activities under the heading "Session 1" and have a space to check off whether each activity was

presented. The checklist should also have an area for each session to record if there were any changes made from the way the developer recommends the program be delivered. By the end of the program, it should be clear exactly where the deliverer diverted from the developer's plan. One copy of the checklist would be completed for each group (perhaps a classroom) of students receiving the program.

A second kind of fidelity checklist has the person delivering the program fill out a pre-implementation plan. Each session would be a row in a table and the columns could include details such as date of the session, number of anticipated students, person delivering the session, and content of the session. A similar table would be filled out after each session is completed. This is the post-implementation plan.  At the end of the program, these two plans can be viewed side-by-side and should reveal where there were deviations from the original plan. The difference between this type of plan and the one described above would be that, in the case of an evidence-based program, your pre-implementation plan might not match the developer's recommendation if the deliverer had already decided in advance to make adaptations.

While major adaptations are not likely to be forgotten by implementers, smaller ones are easy to forget about, especially considering that you will often be analyzing your outcome results months after implementation and there may have been multiple groups that received the program simultaneously. In most cases, a fidelity checklist will be a better record of what took place than your memory.

There are several ways that fidelity results can be useful for program improvement. If your overall results exceed your expectations, then you have reason to believe that the way you implemented your program was successful and should perhaps be repeated.

If your results were less than you expected, your fidelity checklist may hold some answers. If there were instances where implementation was altered substantially, this might account for

your disappointing results. In this case, you might conclude that it was the implementation that went wrong rather than concluding that the program does not work with your population.

The findings from your fidelity checklists may be more specific. If results were disappointing for only one or two measures, you may want to go back to the fidelity records for the sessions where that content was addressed most heavily and see if explanations are available. Perhaps a fire alarm on the day you were addressing the risk of drugs disrupted the session, and that might explain the poor results for perceived risk.

Fidelity checklists may also help make use of the finding that you had varying results between different implementation groups like schools or classrooms. It could be that the program simply was more effective with one group than another, but it also could be that there were variations in the way the program was implemented that could account for the differences. If there were variations in implementation and one group did much better, you may want to emphasize replicating that implementation in the future. If one group did poorly, you may want to ensure that the program is not implemented in that way in the future.

There is no guarantee that fidelity checklists will help make sense of outcome results, but without them, you will be unable to make those possible connections. Also, fidelity checklists can help keep you accountable to your plans, even if they do not help explain outcome results.

## Follow-Up Designs

One unfortunate reality of prevention programs is that they often have the desired effects from pre-test to post-test, but these effects begin to "wear off" after the program ends. A program that can demonstrate positive effects even months after the program has ended is worthy of attention. To demonstrate whether a program has these lasting effects requires a **follow-up design**. A follow-up design is rather simple because it only involves adding a follow-up test to the basic pre- and post-test design. The follow-up test would be administered to program participants typically three to six months, or perhaps a year, after the program ends.

The follow-up test is typically the same test as the post-test. With this third point in time, participant responses can be compared from pre-test to follow-up test or post-test to follow-up test to see what effects are intact.

The primary obstacle to a follow-up design is typically locating program participants that long after a program has been completed. But if there is a structure in place that makes this feasible, you may want to consider the follow- up design. Our current scanned survey system was not conceived with follow-up surveying in mind, but PIRE could work with you to figure out the best way to handle the collection and analyses of follow-up data. You would use the post- test version of the survey in most cases.

## ■ Comparison Groups

It is not unusual for an evaluation of a prevention program to produce ambiguous results that leave the implementer uncertain as to how to interpret them. For example, some data will reveal "flat change," meaning the scores look mostly the same at pre- and post-test. Sometimes data will even show slight declines on measures that were intended to increase. Many will interpret this to be an unsuccessful program.

However, that may not always be the case. One thing we know about youth drug use is that it typically increases over time, especially for adolescents. Therefore, during a typical prevention program we might see noticeable increases in drug use between the times of the pre-test and post-test. For most substances, it is certainly more likely to increase than to decrease. The longer the program runs, the more likely an increase in use could be expected. So, if drug use were likely to increase with no intervention, could flat change be considered a prevention success?

Questions like these are difficult to answer from a one-group pre- post-test design.  This design will never answer the question, "What would have happened if we had not done this intervention?"  One way to answer this question is to use a comparison-group design.  A

comparison group is a group of individuals (or schools or communities) whose characteristics are like those of the program group but who do not receive the program services, products or activities being evaluated. When using a comparison group, you simply pre- and post-test that group at the same time that you pre- and post-test the group getting the program. Comparing the results between the two groups allows you to see the difference in outcomes and determine whether your program accounted for any change (or lack of) that was generated. Referring back to the scenario above, you may find that the measure you were looking at did not change for the intervention group but actually declined for the comparison group. With this additional information, the flat change can be interpreted as a success (i.e., the decline experienced by others was <u>prevented</u>).

The most difficult aspect of the comparison group is identifying an appropriate group that is relatively similar to the intervention group. Typically, these groups are matched on demographic characteristics such as race, ethnicity, gender, age, socioeconomic status, and location. Matches do not have to be perfect, but the closer the match, the more reliable the conclusions that you can draw from the results. The other barrier is convincing the comparison group to take the pre- and post-test even though they are not getting any intervention. Often, incentives are used for the institution involved. Alternatively, you could offer the comparison group the intervention *after* they have provided pre- and post-test data. Thus, initially, the group is a pure comparison for the intervention group. They then receive the intervention after you have collected the data you need for the intervention group. This is referred to as a delayed-intervention comparison group.

PIRE can help advise you on a comparison-group design if you are interested in using one.
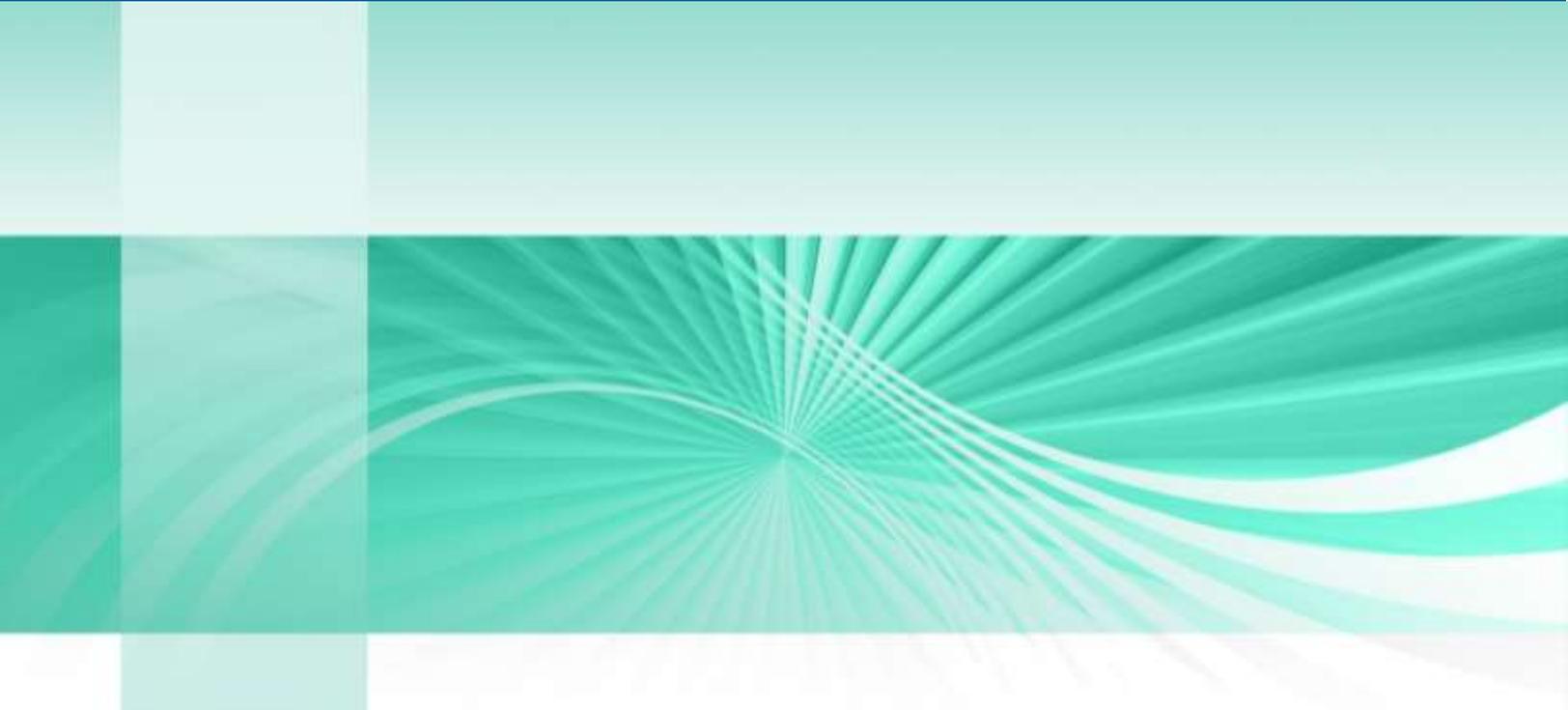
# Section Five: Conducting Community Surveys

# ■ Why You Might Consider Community Surveys

Surveys are an excellent way to gather data to assess behaviors, attitudes, and beliefs in your community. They allow you to collect information from a lot of people that is not readily available from other sources. Before you decide to conduct your own survey, however, you should do some research to make sure there are no existing surveys that could provide you with the information you want. The table below lists a few prominent surveys relevant for substance abuse prevention that are conducted in South Carolina.

| Survey Name | Sponsoring Agency | Target Population | Frequency | Level of Estimates | Website |
|---|---|---|---|---|---|
| Behavioral Risk Factor Survey (BRFS) | SC Department of Health and Environmental Control (DHEC), in conjunction with the CDC | Adults ages 18 and older | Annual | State Nation | https://www.scdhec.gov/health/sc-public-health-statistics-maps/behavioral-risk-factor-surveys |
| Communities That Care (CTC) | DAODAS | High School students | Biannual (even years) | County (a subset of counties participates in this survey) | https://www.communitiesthatcare.net/ |
| National Survey on Drug Use and Health (NSDUH) | SAMHSA | Persons ages 12 and older | Annual | State Nation | https://nsduhweb.rti.org/respweb/homepage.cfm |
| Monitoring the Future (MTF) | National Institute on Drug Abuse (NIDA) | Grades 8, 10, 12 | Annual | National | http://www.monitoringthefuture.org/ |
| Youth Risk Behavior Survey (YRBS) | SC Department of Education (DOE), in conjunction with the US Centers for Disease Control and Prevention (CDC) | High School students | Biannual (odd years) | State Nation | https://ed.sc.gov/districts-schools/school-safety/health-safety-surveys/sc-youth-risk-behaviors-survey-yrbs/ |

One problem with existing surveys is that they often are designed to provide prevalence estimates (i.e., estimates of substance use behaviors, attitudes, and beliefs) at the state level, meaning that data may not be available that are specific to your county or community. In fact, you may have noticed in the table that only one survey provides estimates below the state level—the CTC Survey sponsored by DAODAS. And you may also have noticed that not all

counties participate in this survey. We highly encourage you to work with DAODAS, your county substance abuse prevention agency, and your local school district to administer the CTC survey because it is a valuable source—and the only systematic source—of information about youth substance use, attitudes, and behaviors at the county level in South Carolina. That said, if your county currently does not participate in the CTC you may want to administer your own survey that allows you to gather data about substance use behaviors, attitudes, and beliefs among students in your community.

Even if your community does participate in the CTC, there are several reasons why you might consider conducting your own supplemental community survey. First, you may be interested in gathering data from adults in your community, which the CTC does not do, or from specific subpopulations which may not be adequately represented in the CTC. Second, you may want to ask different questions than those that are included in the CTC. Third, you may want to gather data more frequently than the CTC. Fourth, you may want to have more control over the data collection process and not rely on the willingness of the school district to agree to participate in the CTC. Regardless of the reason for wanting to conduct a community survey, there are several points you should consider before making the decision to do so.

## Making the Decision to Conduct Surveys

The decision to conduct supplemental community surveys should not be made without carefully weighing the anticipated costs and benefits. Consider how important the information that you would expect to gain from the survey would be for your work. How likely is it that the information would change what you do in the community and how you allocate your resources?  If you conclude that it would be very important, then be sure that you have the resources to conduct the survey in an appropriate manner to answer your questions, and, presumably, that you anticipate having the resources to repeat administration to assess community changes across time. If you conclude that the survey information would be nice to have, but that it is not essential, consider whether there are simpler, less costly ways to help answer your questions.

We suggest that you consult with experts to make sure that you understand the true costs that would be associated with gathering the information that you are seeking—including developing, administering, analyzing, and reporting findings—and to help you think about whether there are more cost-effective ways to meet your needs (e.g., archival data sources that you have not considered, key informant interviews, or focus groups). PIRE, or other resources available to you through DAODAS, can help you with this, and you would be wise to investigate whether expertise on these issues exists within your community. Is there a college or university in your area? If so, there may be a social science researcher at the school in fields like public health, sociology, and psychology who would provide guidance (and perhaps more) for free. If you are contemplating using funding from DAODAS to support conducting surveys, it would be prudent to touch base with them for guidance, as well as confirmation about what would, and would not, be allowable, and information about any requirements that you must meet to comply with State policies.

## Design Considerations

Planning a survey is not difficult, but there are many things to consider if you want to collect information with the best chance of meeting your needs. As mentioned above, if you do not hire or otherwise engage experts to lead this process for you, we recommend at least consulting with people who have community surveying experience to guide you in the right direction. And,

| Design Considerations |
|---|
| • What is the goal of the survey and does it fit the needs of your community? |
| • Do surveys exist that include items and constructs that meet your needs? |
| • Are your items clear and concise? |
| • What is your analysis plan? |
| • What demographic questions do you need to ask? |
| • Can you pilot test your survey? |

especially if you are planning to administer your survey with a community that you do not know well, you would be wise to consult and plan with those who do know this population—you can waste time planning a survey in a way that makes sense to you, but that is not a good fit with your intended population of respondents. Many of the more important issues to consider are

noted here, and more detailed information about many aspects of surveying is available from the resource websites listed at the end of this section.

The goal for your survey should be to ask the right questions to meet your needs. This means that each question should be as clear and concise as possible, and you should avoid including any questions that are not necessary to meet your goals. Respondents appreciate when their time is respected, and the questions are easy to understand; they will be less likely to participate and provide complete, useable responses when a survey is very long, items seem redundant, or the questions are not clear.

A good way to begin identifying items for your survey is to specify the general issues that you want to know about and then do a little bit of research (e.g., an internet search) to identify commonly-used survey questions relevant to these issues. For example, if you are interested in learning about substance use behaviors you would be wise to consider the relevant items from the U.S. Center for Disease Control and Prevention's (CDC's) Youth Risk Behavior Survey, the National Institute on Drug Abuse's Monitoring the Future survey, SAMHSA's National Survey on Drug Use and Health, and the Communities that Care survey. (See the table at the beginning of this chapter for commonly used national surveys.) The items on these surveys have been carefully developed to measure substance use behaviors in a consistent, accurate manner, and estimates from administration of these surveys across the country are readily available as comparisons for your analyses. For similar reasons, if you are interested in learning about respondent attitudes, it would be wise to identify items (often multiple items that together form a scale) that have been tested and found to measure these attitudes in a reliable and valid manner. Common scales include perceptions of the risk of harm from using substances and perceived peer approval of substance use.

One of the easiest ways to help ensure that you are asking the right questions is to develop your analysis plan as you develop the content of the survey. For each possible survey question, ask yourself how you will use the response information (What analyses will you do?), what this

information will tell you (Is the question worded to get at exactly what you want to know about?), and whether you should be asking additional questions to learn more about this topic (What else do you want to know?). An important analysis issue to consider is whether you would benefit from being able to make comparisons with existing data about the same issue in other communities (e.g., assessing how your community compares to the state as a whole). If that is the case, it will benefit you to use the exact same question(s), or at least questions that address the same conceptual issue and match up as closely as possible. If you are unsure how you would analyze a possible question or unsure how this response information would be helpful to meet your goals, you should consider omitting that question.

You also should consider what respondent demographic questions to ask on the survey. One reason to ask these questions is to understand how closely your sample of respondents matches the full population that you want to know about. Generally, the more closely your sample resembles important characteristics of the full population, the more you can be confident that the survey responses will help you plan to serve that population. A second important reason would be to allow you to do analyses concerning important sub-sets of the respondents. Which groups of people do you want to know about in particular? If you do not have a way to identify responses from members of that sub-population, you will not be able to analyze them independently.

Once you have a draft of your survey, it is wise to pilot test it to confirm that you have made the best possible choices about the design. To do this, you will want to have a manageable number of people who are reasonably representative of your intended respondent population complete the survey. As a general recommendation, we suggest asking 10 people to pilot test the survey. This can be a two-step process in which they first complete the draft survey in the manner that you are intending and then have your pilot test participants answer additional questions that reflect on that process. The additional questions can ask them about issues that might be of concern, such as whether it seemed too long, whether the completion instructions on the form were clear, and whether there were any survey questions that were not clear. You

could also talk with them about the goals for your survey, ask them if they think it is designed well to answer those questions, and ask if they have suggestions about how to ensure survey participation by a representative sample of the target population. Your goal is to understand knowledge, attitudes, and behaviors of people like your pilot test group, so you would be wise to consider their perspectives about how to do this well.

In addition to asking pilot test participants about their experiences responding to the survey, you should review the data from the pilot test to see if any items stood out as being problematic. Were all the surveys complete or did the participants fail to respond to certain questions? Were all the responses clear and informative? Are there any inconsistencies in the response patterns indicating that a pilot test participant may have been confused by a question or an instruction on the survey? Based on the information from your pilot testing, you can make appropriate adjustments to the survey and feel confident that you have taken appropriate steps to help ensure that the information from your survey respondents will be useful.

## Administration Considerations

Please note that many of the topics discussed earlier in Section 3 concerning administration of the DAODAS Standard Survey may also be relevant for your community survey, particularly concerning parental consent. We suggest that you review that information because we will not be covering those topics in as much detail in this section.

| Administration Considerations |
| --- |
| • Method of administration (online or paper and pencil). |
| • Timing (season, relation to specific programming). |
| • Number of respondents, target population, and recruitment. |
| • Target population. |
| • Consent procedures. |

A central administration issue that you will want to consider from the start is the method or methods that you will use to collect the information. A fundamental question is whether

respondents will complete surveys on paper or electronically (or both)? Generally, paper-and-pencil surveying provides more flexibility in development and administration, while computer-based surveying is likely to provide greater uniformity, fewer steps between completion and analyses, and greater ability for people to respond without a person interacting with them. If you are planning to have people complete the survey on paper, you may need to pay attention to the steps you will be taking to protect the anonymity of respondents (see the relevant steps of the DAODAS Standard Survey administration protocol in Section 3). For questions about sensitive issues, participants will be more likely to respond truthfully if they are confident that their responses will not hurt them in the future (you obviously want to be confident of this as well). You also will want to have a clear plan for how you will process the written responses to enter them into a format/database for your analyses. If you anticipate that the collection will be completed online, you will want to review and select an appropriate platform (e.g., SurveyGizmo or SurveyMonkey) with careful consideration of factors such as whether the platform will allow you to ask all of the questions that you want in a manner which allows participants to respond in the way that you want (e.g., Are there any restrictions on the number of questions, the types of response categories, or the length of responses to open-ended questions?), and the way in which you will be able to access the quantitative and qualitative responses to the surveys (e.g., Can you download the dataset(s) in a format that you can easily use?).

There are timing issues to consider when you plan for administration of your community survey. If you are doing a one-time needs assessment about your community, then most likely it is the case that the sooner you have the information, the better. If you are assessing whether the community changes from a point prior to implementing a program to a point after (a pre-post assessment), then you will want to administer the survey at appropriate times relevant to program implementation (probably just before and after program implementation, and perhaps at later points in time to assess longer-term changes). If you will be administering the survey in your community on a periodic basis (e.g., annually) to assess changes across time, you will want to administer it at a time of the year that is most appropriate to repeat across time

periods.  In all cases, you should think about whether there are any important reasons to adjust the timing of your data collection plans to collect more helpful information.  Are respondents from your target population less likely to be available at certain times of the year?  Are their responses likely to be influenced by events or other things that only happen at certain times of the year?  In the worst-case scenario, how long do you think it could take to gather the number of surveys that you need?  You will want to take all relevant factors into consideration when planning for the timing of administration.

A particularly important step in implementation planning is determining the number of respondents you need to reach, including any sub-populations that are important for your analyses.  In general, having more participants is better, but there are diminishing returns as your numbers increase.  As an example, there is always a benefit to having 100 additional surveys, but this benefit is likely to be much greater if this gives you a total of 200 participants than if it gives you a total of 1,100 participants. It is also the case that the representativeness of your sample is likely to be more important than the size of your sample (quality > quantity). If you have a very large number of respondents, but they are only representative of a sub-set of your target population, then you have learned quite a bit about that sub-set but very little about your full target population. *As a general guideline, you will probably want <u>at least</u> 300-400 respondents to be able to calculate reasonably accurate estimates for your full population.* Note that if the full population that you want to know about is quite small (say 100 people), and you collect surveys from most of these people (say 90), then these represent a nearly-complete census of your target population and thus should give you reasonably accurate estimates for the full population.

In addition to the participant target number, there are many other issues to consider pertaining to the selection of your participants. At a broad level, how will you be selecting your sample of respondents from the target population?  Will you be recruiting people randomly from the full population, using a convenience sampling strategy to keep the process simple and inexpensive, or targeting specific groups of respondents to help ensure that you have a sample that reflects

the diversity of your target population (this is particularly important if you want to analyze information about sub-groups which are less numerous or less likely to be a part of your sample unless you take specific steps to include them)? You want to avoid inadvertently winding up with a biased sample, and you will want to understand any distinctive characteristics of your sample relative to what you might expect for a typical sample of your target population.

To implement your sampling strategy, you will want to have a plan to ensure adequate participation to reach your target number of participants within your administration timeframe. Is your target population readily available and willing/able to participate, or will you need to recruit each participant? If the latter, you would be wise to consider which community partners can help you with this process (e.g., recruiting from their social networks, providing staff and volunteers to help with administration, etc.), and whether formal recruitment advertising in the community could be helpful (e.g., posters and social media ads). Will it be adequate and appropriate to ask people to participate voluntarily or will you be offering any incentives to help you reach your participation goals? An incentive might be something of relatively small value (e.g., a coupon), or it could be the opportunity to participate in a drawing (or series of drawings) to win a much more significant prize. Even a small incentive can help get people's attention and convey that you value and appreciate their time responding to the survey, which can be particularly important when they do not have other clear reasons to participate.

When considering your sampling and recruitment strategy, you also will need to think about whether there are any participation consent issues (especially if your respondents might be under 18), whether you need any institutional permissions to implement your collection plan, whether there are any language issues (Will all participants need to respond in the same language?), and what steps you will be taking to prevent someone from responding more than once. It is worth taking the time to carefully consider your choices because they effect the ease of implementation and the usefulness of the information that you collect. You will want to document all relevant factors about the process that you follow so that you and others can understand your sample of respondents and replicate this process in the future.

## ■ Analysis and Use Considerations

When you have completed data collection or are at a point when you think you might stop collecting data, it is prudent to review the raw data to identify and remove any responses that are unusable or problematic (note that you will be creating a new dataset as you do this – always keep your raw data in one file and create new files as needed for your analyses). Do you have reason to believe that any observations (completed surveys) in your database are duplicates (e.g., entered into the database more than once)? Are there observations that are not completed to a full-enough extent to be useful (e.g., only a few initial questions were answered)? Are there any item response patterns that are illogical or highly improbable, and thus a sign that the respondent was not providing carefully-considered, truthful answers? When you have completed this data cleaning process, you can then review the demographic profile of this dataset to determine if you might need to collect further information to ensure that you have enough respondents with enough target population representativeness to answer your questions. When the analysis dataset is finalized, reviewing the demographics also will help you understand the makeup of the population sample that you will be analyzing, including making final decisions about how you might weight the data to generate more precise population estimates that account for important under- and over-representation of sub-groups in your sample.

If you followed our guidance when developing the survey, you know how you will analyze the responses to each question and you now can implement this analysis plan. If you have not thought this through before arriving at the analysis stage, you would be wise to think about what you hope to learn from your analyses and determine your approach before proceeding.

As you complete your analyses and move to the stage of sharing your findings with other people, you will again want to take time to consider your options before proceeding. Who is the audience for your findings, or do you have different audiences that may call for different approaches? What are the main things that you want each audience to understand about your

findings?  What would be the most effective way to ensure that they learn all that they need to know to understand the most essential findings? In any format (e.g., presentation, print, online), you should consider whether data can be displayed visually (e.g., tables, charts, and graphs) in a way that will help people understand the information more quickly.  This process is about sharing the story of what you learned about your target population, and thus you should consider including information from other sources that helps relate this story effectively (e.g., comparison with findings in other communities and anecdotal information that brings your story to life).  Although your focus is on sharing what you learned, it is also important to acknowledge the limitations of your findings – that is, to be clear about what the survey information <u>does not</u> tell you as well as what it does tell you.

## ◼ Resources

**Communities That Care**

Information on their approach, including their Youth Survey

https://www.communitiesthatcare.net/

**Community Tool Box**

Information on conducting surveys

https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/conduct-surveys/main

**Harvard University Program on Survey Research**

Tip Sheet on Question Wording

http://psr.iq.harvard.edu/files/psr/files/PSRQuestionnaireTipSheet_0.pdf

**Questionnaire Design: Asking Questions with a Purpose from the University of Wisconsin**

http://learningstore.uwex.edu/assets/pdfs/G3658-02.pdf

**Search Institute**

Information on their approach, including their Developmental Assets Profile

https://www.search-institute.org

**Survey Monkey**

Surveys 101

https://www.surveymonkey.com/mp/survey-guidelines/

# Appendix A: Key Data Fields for the Environmental Prevention Strategies (EPS) Reporting System

**Compliance Checks**

Compliance checks refer to the organized use of an under-aged person attempting to purchase alcohol or tobacco from an establishment to see if the seller properly follows the law and refuses to allow the purchase. A comprehensive compliance check intervention, however, is broader than a simple compliance check in that it includes (1) development of community support for compliance checks, (2) use of media or other means to publicize the upcoming compliance checks, (3) frequent compliance checks involving law enforcement administering penalties to the seller and license holder, and (4) offering comprehensive merchant education. Compliance checks may be conducted with on-premise establishments where alcohol is sold and consumed at the same location (e.g., bars, restaurants, and clubs) or off-premise establishments where alcohol is sold, but not consumed on-site (e.g., convenience stores and grocery stores). Key EPS Reporting System data fields include the following:

- Funding source

- Alcohol or tobacco check

- Location of check

- Type of business

- On- or off-premise

- The product that was attempted to be purchased

- Whether the sale was completed

- Whether the following was present:
    - The buyer's age asked
    - Age check equipment used
    - ID requested
    - ID studied
    - ID signage available

- Clerk's demographics

- Buyer's demographics

- The fine, if the sale was completed

- Whether the clerk had taken a responsible alcohol sales class

**Controlled Party Dispersal**

One common way that young people gain access to alcohol is at parties, gathering at different venues (e.g., home, hotels, beaches, and parks). A Controlled Party dispersal is a proactive law enforcement strategy aimed at identifying and safely dispersing underage drinking parties when the social gatherings occur.[2] The intent with controlled party dispersal is to change community perceptions and promote joint law enforcement and community efforts. Major components of party dispersal should include the following: the establishment of law enforcement units or specialists; community calls and hotlines to inform law enforcement of underage parties (planned or in-progress) and establishments that may sell to underage customers; and media to create news releases and hold press conferences to educate community about the incidence of underage drinking.  Key EPS Reporting System data fields include the following:

- Location of party

- Agencies involved

- Individuals at party and demographics

    o Gender

    o Age

    o Race/Ethnicity

- Primary alcohol type confiscated (e.g., beer, alcopops, liquor, etc.)

- Total number of tickets by offense (e.g., underage alcohol violation, fake ID, alcohol transfer, etc.)

- Sources of party location information

---

[2] When DAODAS teaches controlled party dispersal techniques, it emphasizes that officers may gain information about a party that will occur at some point in the future at an underage person's home (e.g., the parents may be planning a trip out of town for the weekend and the youth may plan a party with friends). Officers are encouraged to talk to the youth's parents. This effort is meant to end the party before it has an opportunity to begin. A party dispersal form is not used in this case; however, the prevented party is tracked on the miscellaneous enforcement monthly report.

**Shoulder Tap**

Shoulder tap operations, conducted by law enforcement personnel and an underage decoy, are designed to reduce the problem of adults providing alcohol in and around licensed alcohol establishments by holding adult providers of alcohol to a minor responsible for their illegal behavior. The shoulder tap is also called a third-party transfer. The underage decoy stands outside an alcohol establishment and approaches an adult going into an establishment to buy alcohol by tapping the adult's shoulder and asking the adult to purchase alcohol for them. If the adult makes the purchase for the underage decoy, the adult provider can be arrested, cited, or booked for providing alcohol to the underage decoy. Shoulder tap operations can be implemented as an active enforcement detail or an educational opportunity. Key EPS Reporting System data field include the following:

- Location and time of operation
- Number of adults approached
- Number of alcohol transfers
- Other related offenses
- Demographics
  - Gender
  - Age
  - Race/Ethnicity

**Bar Check/Fake ID Sweep**

Bar check/Fake ID sweeps are law enforcement operations that involve uniformed officers entering on-premise alcohol outlets (e.g., bars and restaurants) and observing for illegal alcohol-related activities including the use of fake IDs by patrons and overserving by owners, managers, and bar tenders. This enforcement operation is not an on-premise compliance check because an underage confidential informant (CI) is not used. Key EPS Reporting System data field include the following:

- Type of establishment
- Number fake IDs identified
- Other violations
- Demographics
  - Gender
  - Age
  - Race/Ethnicity

**Public Safety Checkpoints**

Public Safety Checkpoints (also known as roadblocks) are conducted by law enforcement agencies to check for public safety issues such as impaired driving, equipment violations, and other law violations that affect public safety. Public Safety Checkpoint locations are determined by data analyses that review traffic crash data, citizen complaints, arrest/citation data, and other pertinent data. Officers are stationed at a location to check drivers for signs of Impairment, underage drinking, and other violations (e.g., open containers, suspended licenses, drug possession, and fake IDs). The most effective preventive checkpoints are highly visible and publicized through local media. Key EPS Reporting System data field include the following:

- Location
- Date and time
- Total number of tickets by offense (e.g., underage alcohol violations, DUI, suspended/revoked licenses)
- Number of cars
- Demographics
  - Gender
  - Age
  - Race/Ethnicity

**Saturation Patrol**

Saturation patrol involves the deployment of officers to targeted roadways during select time periods to detect and apprehend impaired drivers. Saturation patrols are also described as "roving public safety checkpoints" and determined by data analyses using the same data points as with public safety checkpoints. Saturation patrols are most effective for prevention when implemented as high visibility enforcement—i.e., when they are announced in advance and accompanied by media coverage. Saturation patrols are used for 'hot spot' crime reduction, and are likely to result in other traffic related violations such as speeding, not wearing seat belt, no child restraint, and littering. This strategy can be effective in apprehending hard core alcohol impaired drivers who often stay clear of checkpoints and deter crime inside and outside the actual patrol location. Key EPS Reporting System data field include the following:

- Location
- Date and time
- Law enforcement activities (e.g., underage alcohol violations, DUIs, suspended/revoked licenses)
- Number of cars
- Demographics
  - Gender
  - Age
  - Race/Ethnicity

**AET Miscellaneous Law Enforcement Monthly Report**

This form should be completed by AET Coordinators each month to document miscellaneous law enforcement activities that have not been captured elsewhere in the EPS Reporting System. That is, the data in this report should not be reported on any of the specific operation forms. Key EPS Reporting System data field include the following:

- Achievements for the month

- Number of violations by type (e.g., underage alcohol violations, DUIs, and fake IDs)

- Type of law enforcement operations

**AET Prevention Activity**

This form is used to report substance abuse prevention efforts by law enforcement agencies are not direct law enforcement operations. Examples of prevention efforts include media campaigns, community engagement/presentations, and alternative activities (e.g., midnight basketball). Key EPS Reporting System data field include the following:

- Program title
- Service data and duration
- Service population
- Service location
- Staff hours
- Demographics
    - Age
    - Gender
    - Race/Ethnicity

**Monthly Media Report Form**

This form is used to report all AET-related media activity for the month including television, radio, and print ads; community meetings attended; brochures distributed; and social media activity.
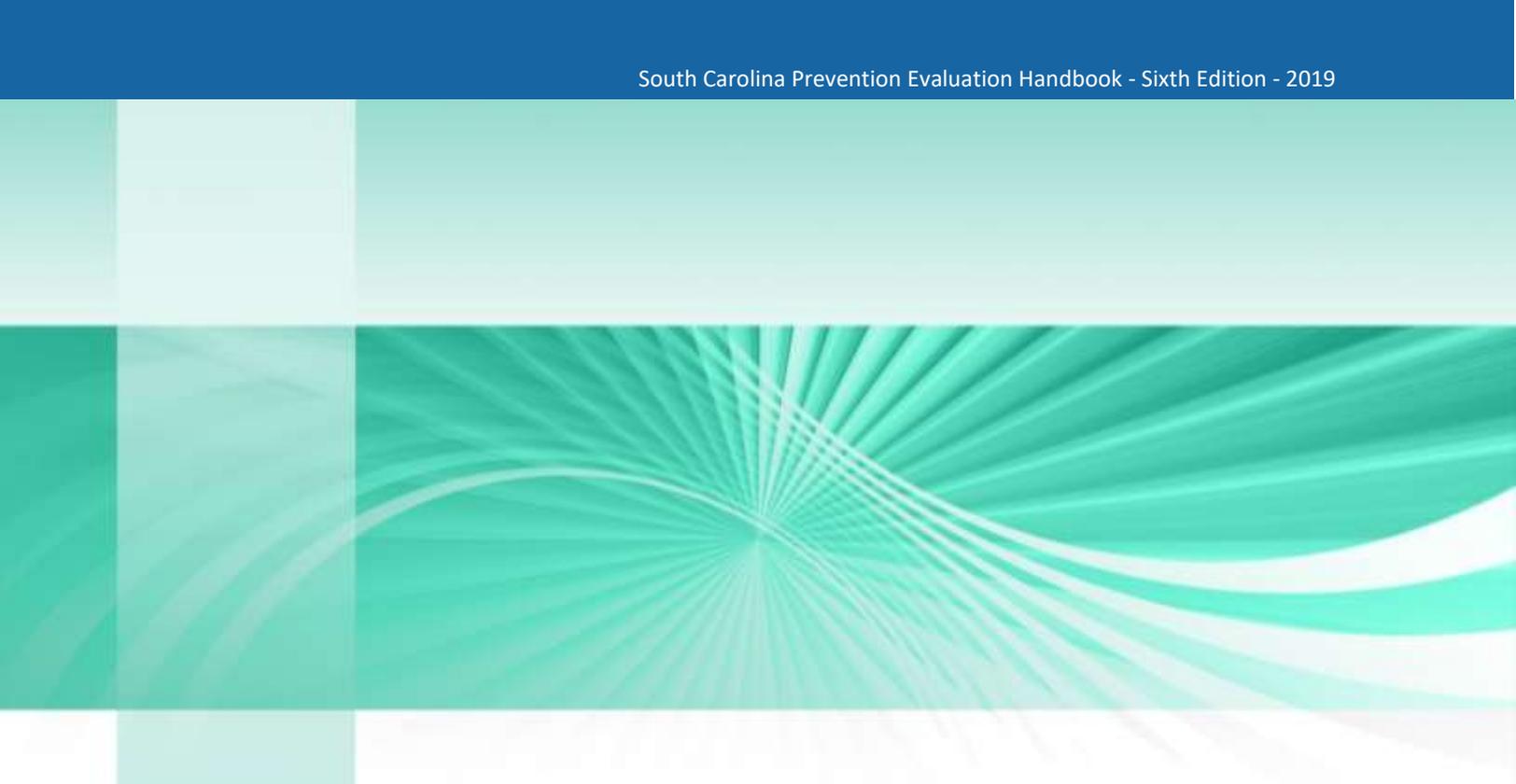
# Appendix B: Prevention and Evaluation Terms

**Abuse** – Occurs when alcohol or other drug use adversely affects the health of the user or when the use of a substance imposes social and personal costs.

**Active Consent** – A process of written approval gaining parental or guardian permission for a student to take part in an intervention or data-collection activity. (*South Carolina Prevention Evaluation Handbook*)

**Activities** – What a program does with its resources to produce outcomes.

**Activity Code** – A unique identifier used as a means of linking each session of a recurring program.

**Adaptation** – Modification made to a chosen intervention, particularly related to both what is presented and how it is administered. Adaptations may constitute both deletions and additions to, as well as modifications of, program content.

**Addiction** – A compulsive physiological craving for a habit-forming substance. Addiction is a chronic and progressive disease usually characterized by physiological symptoms upon withdrawal. The term "dependence" is often used synonymously to avoid the pejorative connotations of addiction.

**Age of Onset** – In substance abuse prevention, the age of first use. (*Achieving Outcomes*, 12/01)

**Alcohol Purchase Surveys** – A variation of compliance checks that do not involve penalties. Alcohol purchase surveys are one evaluation method for alcohol compliance checks and are conducted before and after the actual compliance checks. They are not, however, regular alcohol compliance checks minus the law enforcement presence, because youth cannot purchase alcohol by law except in coordination with law enforcement.

**Alternatives Approach** – One of the strategies mandated by the Substance Abuse Prevention

and Treatment (SAPT) Block Grant regulations, the alternatives approach is based on the observation that providing opportunities for drug-free leisure activities may prevent or reduce substance abuse. Alternative programs include a wide range of activities that appeal to children and youth: athletics, art, music, movies and community service projects. Youth who live in high-risk communities need safe alternative environments, such as Boys or Girls Clubs, and opportunities to develop relationships with non-substance-using peers.

**Anecdotal Evidence** – Information derived from a subjective report, observation or example that may or may not be reliable but cannot be considered representative of a larger group or of conditions in another location. (*Achieving Outcomes*, 12/01)

**Anonymity** – The collection of data that cannot be linked by anyone to individual respondents. (*South Carolina Prevention Evaluation Handbook*)

**Archival Data** – Relative to the collection of data for needs-assessment purposes, information that is collected and stored on a periodic basis. For example, most public agencies collect data that can be used directly or indirectly for an overall picture of substance use or abuse within the geographic area served by that agency (e.g., emergency room statistics, school surveys on substance abuse trends, suspensions and truancy rates, crime reports). Once collected, the data can be cross-referenced in various combinations to identify individuals, groups and geographic areas that are most appropriate for prevention or reduction purposes. (*Achieving Outcomes*, 12/01)

**Assignment** – The process by which researchers place study subjects in an intervention or comparison group. Experimental-design studies randomly assign study subjects to both intervention and control conditions. In quasi-experimental studies, study subjects are non-randomly assigned to intervention and comparison conditions. Random assignment increases the likelihood that the intervention and control groups are equal or comparable and have similar characteristics.

**At Risk** – For individuals, the condition of being more likely than average to develop an illness or condition (e.g., substance abuse) because of some predisposing factor such as family history or poor environment.

**ATOD** – Alcohol, tobacco and other drugs.

**Attendee** – An individual receiving a single prevention service. Demographic data (age, race/ethnicity and gender) are typically collected for attendees.

**Attribution** – The ability to link a particular effect with a specific event or characteristic.

**Attrition** – An unplanned reduction in size of a study sample due to participants' dropping out of the evaluation (e.g., they moved away from the study location).

**Attrition Bias** – Differences between intervention and comparison groups due to attrition (drop-out) of participants from a study or intervention. For example, participants may drop out of an intervention study for a number of reasons. This attrition of participants may affect the results in determining the effectiveness of the intervention.

**Baseline Data** – Initial information collected prior to the implementation of an intervention, against which outcomes can be compared at strategic points during and at completion of an intervention. (*Achieving Outcomes*, 12/01)

**Bias** – The extent to which a measurement, sampling or analytic method systematically underestimates or overestimates the true value of something. For example, bias in questionnaire data can stem from a variety of other factors, including choice of words, sentence structure and the sequence of questions. Bias is also created when a significant number of respondents do not answer a question. If those responding and those not responding have different characteristics, the responding cases may not be representative of

the entire group. Bias can be caused by a multitude of factors both recognized and unrecognized; the task of the evaluator is to design, implement and honestly report the results of a study that is as free from bias as possible.

**Cause** – Something that brings about an effect or a result. Establishing causal relationships is almost impossible in the social sciences because many variables affect human behavior. For example, young people whose parents are critical or abusive are at higher risk for using drugs. However, it would be difficult to prove that parental criticism and abuse actually caused a teenager to abuse drugs.

**Center for Substance Abuse Prevention (CSAP)** – Under the umbrella of the Substance Abuse and Mental Health Services Administration (SAMHSA), CSAP is the lead federal agency for supporting substance abuse prevention practice and the federal sponsor of this Decision Support System. CSAP makes grants to state and local governments and private organizations to engage in a wide variety of prevention activities. The mission of CSAP is to decrease substance use and abuse and related problems among the American public by bridging the gap between research and practice. CSAP fosters the development of comprehensive, culturally appropriate prevention policies and systems that are based on scientifically defensible principles and target both individuals and the environments in which they live.

**Change Score** – A measure of difference (often from one time to another).

**Coalition** – A union of people and organizations working for a common cause.

**Collaboration** – The process by which people/organizations work together to accomplish a common mission. (*Achieving Outcomes*, 12/01)

**Community** – A group of individuals who share cultural and social experiences within a common geographic or political jurisdiction.

**Community Mobilization** – One of the six prevention strategies mandated by the SAPT Block Grant. This strategy tries to enhance the ability of the community to provide prevention services, and includes such activities as organizing, planning, inter-agency collaboration, coalition building and networking. The strategy also includes community and volunteer training, systematic planning, multi-agency coordination and collaboration, funding procurement, and community team building.

**Community Readiness** – The community's awareness of, interest in, and ability and willingness to support substance abuse prevention initiatives. (*Achieving Outcomes,* 12/01). More broadly, connotes readiness for changes in community knowledge, attitudes, motives, policies and actions.

**Comparison Group** – A group of individuals whose characteristics are similar to those of the program participants but who do not receive the program services, products or activities being evaluated.

**Component Logic Model** – Shows how the activities that make up a prevention program link together to achieve immediate and intermediate outcomes or objectives.

**Confidential** – A level of participant information protection in which the individual's information can be linked to his/her identity, but access to the file that provides this linkage is strictly limited to the evaluation team, and where no information is ever published that could permit the identification of any individual participant's responses. (*South Carolina Prevention Evaluation Handbook*

**Consent** – The approval of a participant's parent or guardian to take part in an intervention or data-collection activity, such as a survey or focus group. (*South Carolina Prevention Evaluation Handbook*

**Construct** – An attribute, usually unobservable (such as socioeconomic status) that is

represented by a measure.

**Continuous Quality Improvement (CQI)** – The systematic assessment, feedback and use of information relevant to planning, implementation and outcomes. (*Achieving Outcomes*, 12/01)

**Control Group** – In experimental evaluation design, a group of participants that is essentially similar to the intervention (i.e., experimental) group but is not exposed to the intervention. Participants are designated to be part of either a control or an intervention group through random assignment.

**Core Measures** – As used in SAMHSA terminology, a compendium of data- collection instruments that measure underlying conditions – risks, resources, attitudes and behaviors of different populations – related to the prevention and/or reduction of substance abuse. Core Measures are no longer actively discussed by CSAP, but they can be accessed.

**Cultural Competence** – The capacity of individuals to incorporate ethnic and cultural considerations into all aspects of their work relative to substance abuse prevention and reduction. Cultural competence is maximized with implementer/client involvement in all phases of the implementation process, as well as in the interpretation of outcomes. (*Achieving Outcomes*, 12/01)

**Data** – Information collected according to a methodology using specific research methods and instruments.

**Data Analysis** – The use of statistical and/or classification procedures to assess, interpret and/or appraise of systematically collected information. (*Achieving Outcomes*, 12/01)

**Data Driven** – A process whereby decisions are informed by and tested against systematically gathered and analyzed information. (*Achieving Outcomes*, 12/01)

**Data Source** – The entity (person or device) providing responses to measurement devices *(see "Respondent").*

**Data Targets** – The "who" or "what" that is being evaluated.

**Demographics** – The characteristics of a human population, including sex, age, socioeconomic status (SES) and so forth.

**Design** – An outline or plan of the procedures to be followed in scientific experimentation and research studies in order to reach valid conclusions.

**Domain** – Sphere of activity or affiliation within which people live, work and socialize (e.g., self, peer, school, workplace, community, society). (*Achieving Outcomes*, 12/01)

**Early Intervention** – Identifying persons at high risk prior to their having a serious consequence, or persons at high risk who have had limited serious consequences related to substance use on the job; or having a significant personal, economic, legal or health/mental health consequence, and providing these persons at high risk with appropriate counseling, treatment, education or other intervention.

**Education** – One of the six prevention strategies mandated by the SAPT Block Grant. This strategy involves two-way communication between an educator or facilitator and participants. The strategy focuses on improving critical life and social skills such as decision-making, refusal, critical analysis of media messages, and improved judgment. Examples include classroom sessions for all ages, parenting and family-management classes, and peer-leader programs.

**Effect** – A result, impact or outcome. (*Achieving Outcomes*, 12/01). In evaluation research, attributing an effect to a prevention program or intervention requires establishing, through careful evaluation, logical relationships among factors internal and external to the program or

intervention.

**Effectiveness** – The ability to achieve stated goals or objectives, judged in terms of outcomes and impact.

**Environment** – The social and physical context in which individuals live, work and go to school. The environment includes many factors and characteristics that encourage or inhibit the use of alcohol, tobacco and other drugs. (*South Carolina Prevention Handbook*)

**Environmental Analysis** – An assessment of the formal and informal policies and the social, physical or cultural conditions affecting an individual or a community. (*Achieving Outcomes*, 12/01)

**Environmental Strategies** – One of the six strategies mandated by the SAPT Block Grant regulations. This strategy establishes or changes community standards, codes and attitudes, and thus influences incidence and prevalence of substance abuse. Approaches can center on legal and regulatory issues or can relate to service and action-oriented initiatives. Examples include providing technical assistance to communities to maximize enforcement of laws governing availability and distribution of legal drugs, product-pricing strategies and modification of practices of advertising alcohol and tobacco.

**Epidemiology** – The study of the determinants and distribution of disease with respect to person, place or time. It is the basic science of developing and applying disease prevention and control.

**Ethnicity** – Belonging to a common group – often linked by race, nationality and language – that shares a cultural heritage and/or origin.

**Evaluation** – The systematic collection and assessment of information to determine the results of some effort or activity. (South Carolina Prevention Evaluation Handbook)

**Evaluation Instruments** – Specially designed data-collection tools (e.g., questionnaires, survey instruments, structured observation guides) to obtain measurably reliable and valid responses from individuals or groups pertaining to their attitudes, abilities, beliefs or behaviors. (Achieving Outcomes, 12/01)

**Evaluation Plan** – The systematic blueprint detailing all the evaluation aspects of the project.

**Evaluation Questions** – Questions designed to guide an evaluation. Also, the questions that the evaluator wants the data to answer. These questions may require process, outcome or other types of data.

**Evidence-Based Practices Resource Center** – A SAMHSA website with information and tools to help incorporate evidence-based practices into communities: https://www.samhsa.gov/ebp-resource-center.

**Evidence-Based Program** – A program that is theory-driven, has activities/interventions related to the theory of change underlying the program model, has been well implemented, and has produced empirically verifiable outcomes that are assumed to be positive.

**Experimental Design** – A research design involving random selection of study subjects, random assignment of them to control or intervention groups, and measurements of both groups. Measurements are sometimes conducted before, and always after, the intervention. The results obtained from such studies typically yield the most definitive and defensible evidence of an intervention's effectiveness.

**Fidelity** – Agreement (or concordance) of a replicated program model or strategy with the specification of the original. On a continuum of high to low, where high represents the closest adherence to the developer's design, the degree of fit between the developer-defined components of a substance abuse prevention intervention and its actual implementation in a

given organizational or community setting. In operational terms, the rigor with which an intervention adheres to the developer's model. (*Achieving Outcomes*, 12/01)

**Fidelity/Adaptation Balance** – A dynamic process that addresses both the need for fidelity to the original program model and the demonstrable need for local adaptation. (*Achieving Outcomes*, 12/01)

**Focus Group** – A group of people questioned together about their opinions, usually in a controlled setting. Focus groups are widely used as a method of gathering qualitative data. When created and implemented skillfully, they can bring an evaluator or evaluation team "inside" the issue of interest. (*Achieving Outcomes,* 12/01)

**Follow-Up Design** – An evaluation design that adds a follow-up test to the pre- and post-test design. The follow-up test is given to program participants a set amount of time (perhaps three to 12 months) after the program has ended and allows implementers to see whether the positive effects of the program last beyond the end of the program. (*South Carolina Prevention Evaluation Handbook*)

**Goal** – Statement of the ultimate outcome of a program.

**Health Fair** – Generally, a school or community-focused gathering, such as a carnival or bazaar, traditionally held for barter or sale of goods, often for charity. These events offer an opportunity to disseminate materials and information on substance abuse prevention and health-related issues. Examples are school health-promotion gatherings, health-screening programs in shopping malls, church fairs or carnivals.

**Implementation Assessment** – In general, a synonym for process evaluation. Process evaluation focuses on how a program was implemented and operates.

**Indicated Preventive Interventions** – Strategies designed for persons who are identified as having minimal but detectable signs or symptoms or precursors of some illness or condition, but whose condition is below the threshold of a formal diagnosis of the condition.

**Indicator** – A variable that relates directly to some part of a program goal or objective. Positive change on an indicator is presumed to indicate progress in accomplishing the larger program objective. For example, a program may aim to reduce drinking among teens. An indicator of progress could be a reduction in the number of drunk-driving arrests or the number of teens found to be drinking underage in clubs. It can also be a substitute measure for a concept that is not directly observable or measurable (e.g., prejudice, substance abuse). For example, an indicator of "substance abuse" could be "rate of emergency room admissions for drug overdose." Because of the imperfect fit between indicators and concepts, it is better to rely on several indicators rather than just one when measuring this type of concept. (*Achieving Outcomes*, 12/01)

**Information Dissemination** – One of the six prevention strategies mandated by the SAPT Block Grant.  This strategy focuses on building awareness and knowledge of the nature and extent of substance use, abuse and addiction, and their effects on individuals, families and communities, as well as dissemination of information about prevention programs and resources. The strategy is characterized by one-way communication from source to audience, with limited contact between the two. Examples include clearinghouses, resource directories, media campaigns, speaking engagements and health fairs.

**Instrument** – An ordered set of measures or a device researchers use to collect data in an organized fashion, such as a standardized survey or interview protocol.

**Integrity** – The level of credibility of study findings based on peer-consensus ratings of quality of implementation and of evaluation methods.

**Internal Validity** – Refers to the ability to make statements about causal relationships between

variables. Internal validity threats may diminish the truthfulness of those statements.

**Intervention** – An activity or set of activities to which a group is exposed in order to change the group's behavior. In substance abuse prevention, interventions are used to prevent or lower the rate of substance abuse or substance abuse- related problems.

**Item** – A question or query accompanied by a response-measurement system.

**Key Informant Interview** – Interview with a member of, or someone who is knowledgeable about, the social phenomena you wish to study.

**Likert Scale** – A form of response options in which the choices are ordered in a continuum such as "strongly agree" to "disagree" or "never" to "all of the time."

**Logic Model** – A graphic depiction of the components of a theory, program, initiative or activity that shows the program's components and plausible linkages between the program components.

**Matched Sampling** – Pairing (or blocking) of two units because they are similar, followed by the random assignment of one unit to one intervention and the other to another intervention or comparison group.

**Measure** – An assessment item or ordered set of items *(see "Outcome Measure" and "Process Measure")*. Measures are one of the tools used to obtain the information or evidence needed to answer a research question. They are similar to indicators, but more concrete and specific. Often, an indicator will have multiple measures. Indicators are statements about what will be measured; measures answer the question exactly how will it be measured.

**Media Campaigns** – Structured activities that use print and broadcast media to deliver prevention information or health-promotion messages relative to substance abuse. In contrast

with public service messages, campaign messages are usually more than five minutes long. Examples include media promotion of Red Ribbon, Project Graduation, or other similar events; printing of ads with "no- use" messages; distribution of signs to stores and businesses; distribution of bumper stickers, posters, etc.; use of national substance abuse prevention media materials tagged to a state or community (e.g., Partnership for a Drug-Free America); and prevention ads and messages in newspapers.

**Methodology** – A procedure for collecting and analyzing data.

**Minimum Data Set** – An agreed upon collection of measures to be collected as the core of a cross-site or multi-state evaluation plan.

**National Prevention Network (NPN)** – An organization of state alcohol and other drug abuse prevention representatives and an affiliate of the National Association of State Alcohol and Drug Abuse Directors (NASADAD) that provides a national advocacy and communication system for prevention. State prevention representatives work with their respective state agency directors to ensure the provision of high-quality and effective ATOD abuse prevention services in each state. The NPN, in collaboration with the NASADAD Prevention Committee and staff, implements its mission at the national level. NPN's mission is to support and enhance national, state, and local ATOD abuse prevention efforts that will reduce the incidence and prevalence of such abuse.

**National Survey** – Most often, a data-collection effort conducted among a specially selected sample of people who are, at the least, statistically representative of a larger population or group. National surveys are generally free from regional biases because they cover every region of the country and are typically sponsored by a federal agency interested in determining national trends on a selected issue. (*Achieving Outcomes*, 12/01)

**Needs Assessment** – Needs-assessment activities include surveys of various targeted populations and communities, assessment of prevention resources within the state, studies of

current outcome indicators, geographic and demographic analyses of social-marketing data, and household and school surveys.

**Norms** – A behavior or belief that is considered typical of a community.

**Objective** – Specific results or effects of a program's activities that must be achieved in pursuing the program's ultimate goals (e.g., a treatment program may expect to change participants' attitudes [objective] in order to ultimately reduce recidivism [goal]). As used in the *Achieving Outcomes Guide*, measurable statements of the expected changes in risks, assets or other underlying conditions as expressed in the program's guiding theory of change. (*Achieving Outcomes*, 12/01)

**Objectivity** – As used in the *Achieving Outcomes Guide*, refers to the expectation that data collection, analysis and interpretation will adhere to standards of research that protect outcomes or results from the influence of personal preferences or loyalties. (*Achieving Outcomes*, 12/01)

**Outcome Evaluation** – The systematic assessment of the results or effectiveness of a program or activity. It is a type of evaluation used to identify the results of a program's effort. It seeks to answer the question, "What difference did the program make?" It yields evidence about the effects of a program after a specified period of operation.

**Outcome Measures** – Assessments that gauge the effect or results of services provided to a defined population. Outcomes measures include the consumers' perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity and health status.

**Outcome Objectives** – Specific statements describing the change you hope to accomplish. (*South Carolina Prevention Evaluation Handbook*)

**Outcomes** – The extent of change in targeted attitudes, values, behaviors or conditions between baseline measurement and subsequent points of measurement.

**Outlier Data** – Extremely high or low values of a variable of interest.

**P Value** – The chance that the result could have been produced by random sampling fluctuations rather than being actual (*MedicalBiostatistics.com Glossary of Terms*).

**Participant** – An individual formally enrolled or registered in a recurring prevention service.

**Post-Test** – The test administered at the end of the data-gathering sequence of an evaluation (usually after the program or activity being evaluated has been completed).

**Pre-Test** – The collection of measurements before an intervention to assess its effects.

**Prevalence** – The number of instances of a given disease or other condition in a given population at a designated time. If the period is not mentioned, the concept usually refers to the situation at a specified point in time, that is, point prevalence. The numbers of people using or abusing substances during a specific period. (*Achieving Outcomes*, 12/01). In general epidemiological terms, the number of **new plus old cases** existing at or during a specified time.

**Prevention** – The use of evidence-based approaches to create or enhance environmental conditions within communities, families, schools and workplaces that protect individuals from substance abuse and that help them develop personal decision-making skills to reduce the risk of ATOD-related problems. (*The Governor's Comprehensive Strategy for Youth Substance Abuse Prevention*)

**Prevention Best Practices or Model Programs** – Many agencies that sponsor prevention programs are attempting to identify the best of these programs (sometimes called "model programs") so that they can be replicated in other sites.

**Prevention Strategies** – The SAPT Block Grant regulations require that each state receiving a block grant adopt a comprehensive prevention program that includes a broad array of prevention strategies for individuals not identified to be in treatment. These strategies (defined separately in this glossary) include information dissemination, education, alternatives, problem identification and referral, community-based process, and environmental approaches.

**Primary Prevention** – Prevention activities designed to prevent substance abuse before any signs of a problem appear. Also, strategies designed to decrease the number of new cases of a disorder or illness.

**Problem Identification and Referral** – A prevention strategy mandated by the SAPT Block Grant regulations. It aims to identify those who indulged in illegal or age-inappropriate use of tobacco or alcohol, and identify first use of illicit drugs in order to reverse their behavior in the early stages. Examples of activities include employee and student assistance programs and driving under the influence/driving while intoxicated programs.

**Process Evaluation** – Focuses on how a program was implemented and operates. It identifies the procedures undertaken and the decisions made in developing the program. It describes how the program operates, the services it delivers, and the functions it carries out. It addresses whether the program was implemented and is providing services as intended. However, by additionally documenting the program's development and operation, it allows an assessment of the reasons for successful or unsuccessful performance, and provides information for potential replication.

**Process Measures** – Measures of participation, "dosage," staffing and other factors related to implementation. Process measures are *not* outcomes, because they describe events that are inputs to the delivery of an intervention. (*Achieving Outcomes*, 12/01)

**Process Objectives** – Specific statements describing ways that you intend the intervention to be

implemented. (*South Carolina Prevention Evaluation Handbook*)

**Program** – A structured intervention, including environmental initiatives, that is designed to change social, physical, fiscal or policy conditions within a definable geographic area or for a defined population. (*Achieving Outcomes*, 12/01)

**Protective Factors** – Conditions that build resilience to substance abuse and can serve to buffer the negative effects of risks. Also referred to as "assets." (*Achieving Outcomes*, 12/01)

**Qualitative Data** – Information that is not measured, counted or expressed in numerical terms (e.g., a statement about how safe a resident feels in his/her neighborhood). In an evaluation, qualitative data provides contextual information that describes participants and interventions. These data are often presented as text. A strength of qualitative data is their ability to illuminate findings derived from quantitative methods. Qualitative research typically uses observation, interviewing and document review to collect data.

**Quantitative Data** – Information that can be expressed in numerical terms, counted or compared on a scale (e.g., the number of 911 calls received in a month). In substance abuse prevention evaluation, quantitative data can be used to measure changes in targeted outcomes (e.g., substance use) and intervening variables (e.g., attitudes toward substance use). The strength of quantitative data is their use in testing hypotheses and determining the strength and direction of effects.

**Quasi-Experimental Evaluation Design** – This design uses subjects found in non-equivalent intervention and comparison groups (sometimes randomly selected but not randomly assigned).

**Random Assignment** – The process through which members of a pool of eligible study participants are assigned to either an intervention group or a control group on a random basis,

such as through the use of a table of random numbers.

**Recurring Prevention Service** – A prevention service provided to a fixed group of people at risk for substance use or abuse, who are enrolled for a fixed period of time in a planned sequence of activities. The activities, through the practice or application of recognized prevention strategies, are intended to inform, educate, develop skills, alter risk behaviors, deliver services and/or provide referrals to other services (e.g., a parent-education group where the same group meets once a week for six weeks).

**Reliability** – The consistency of a measurement, measurement instrument, form or observation over time. The consistency of results (similar results over time) with similar populations, or under similar conditions, confirms the reliability of a measure. (*Achieving Outcomes*, 12/01)

**Representative Sample** – A segment of a larger body or population that mirrors the characteristics of the larger body or population.

**Respondent** – An individual from whom data are collected via questionnaire, interview or other means. Respondents may be members of the target population, but they also include others from whom information is gathered. For prevention programs, respondents often include program staff, social service providers, educators, parents and others.

**Risk Factor** – Conditions for a group, individual or defined geographic area that increase the likelihood of a substance use/abuse problem occurring. (*Achieving Outcomes*, 12/01)

**Sample Size** – Reflects the number of subjects from a population in your study. Determining the sample size involves using certain techniques and procedures in selecting elements of a population for study.

**Secondary Prevention** – Prevention activities designed to intervene when risk factors or early

indicators of substance abuse, such as marital strife or poor school performance, are present. Also, prevention strategies designed to lower the rate of established cases of a disorder or illness in the population (prevalence).

**Selection Bias** – A bias in the estimate of a program effect that arises from the inability to separate the impact of the program on an outcome of interest from the impact of other factors that are correlated with program participation and outcome measures. Such bias often occurs in nonrandomized or poorly randomized settings, resulting in treatment and comparison groups that differ on measurable and immeasurable factors. For example, self-referral to (or self-selection into) a substance abuse program may result in substantial differences between substance abusers who participate in the program and those who do not. These differences, along with participation status, may influence observed outcomes.

**Selective Preventive Interventions** – Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

**Single Prevention Service** – A one-time activity that, through the practice or application of recognized prevention strategies, is intended to inform or educate general and specific populations about substance use or abuse (e.g., a one- time student assembly).

**Single State Agency (for substance abuse treatment and prevention)** – Each state has a designated agency for substance abuse treatment and prevention that is the recipient of a federal block grant *(see "Substance Abuse Prevention and Treatment Block Grant," below)*. These agencies may be freestanding entities or bureaus of the state's Department of Health and Human Services. They may also be part of the Office of the Governor.

**Standardized Instruments** – An assessment, inventory, questionnaire or interview that has been tested with a large number of individuals and is designed to be administered to program participants in a consistent manner. Results of tests with program participants can be compared to reported results of the tests used with other groups.

**Statistical Power** – The ability to accurately detect differences between groups or relationships between variables.

**Statistical Significance** – A relationship is said to be statistically significant when it occurs so frequently in the data that the relationship's existence is probably not attributable to chance.

Statistical Testing – A type of statistical procedure that is applied to data to determine whether the results are statistically significant (that is, the outcome is not likely to have resulted by chance alone).

Strategic Planning – A disciplined and focused effort to produce decisions and activities to guide the successful implementation of an intervention. (Achieving Outcomes, 12/01)

**Substance Abuse** – Abuse of or dependency on alcohol, tobacco and other drugs. There are many definitions. The definition in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, is "the maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following occurring within a 12-month period:

- recurrent substance use resulting in a failure to fulfill major role obligations;
- recurrent substance use in situations in which it is physically hazardous;
- recurrent substance-related legal problems;
- continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of the substance."

**Substance Abuse and Mental Health Services Administration (SAMHSA)** – SAMHSA is an operating division within the federal Department of Health and Human Services, and the umbrella agency housing the Centers for Mental Health Services (CMHS), Substance Abuse

Prevention (CSAP), and Substance Abuse Treatment (CSAT).

**Substance Abuse Prevention and Treatment (SAPT) Block Grant** – This is authorized under Section 501 of the Public Health Services Act, which is now expired. Funding continues each year under a continuing resolution. The SAPT Block Grant is the primary funding vehicle for substance abuse prevention; 20% of all funds allocated to states must be spent on substance abuse primary prevention services as outlined in Block Grant legislation. (Federal Register, 58:60, March 31, 1993, 17062 ff., 45 CFR Part 96)

**Survey Data** – Information collected from specially designed instruments that provide data about the feelings, attitudes and/or behaviors of individuals. (*Achieving Outcomes*, 12/01)

**Sustainability** – The likelihood of a program to continue over a period of time, especially after grant monies disappear. (*Achieving Outcomes*, 12/01)

**Synar Amendment** – The SAMHSA regulation implementing the Synar Amendment requires the state to have in effect a law prohibiting any manufacturer, retailer or distributor of tobacco products from selling or distributing such products to any individual under the age of 18; enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18; conduct annual random, unannounced inspections in such a way as to provide a valid sample of outlets accessible to youth; and develop a strategy and timeframe for achieving an inspection failure rate of less than 20% of outlets accessible to youth.

**Target Population** – The group of persons (usually those at high risk) whom program interventions are designed to reach.

**Technical Assistance (TA)** – Services provided by professional prevention staff intended to provide technical guidance to prevention programs, community organizations and individuals to conduct, strengthen or enhance activities that will promote prevention. Services recorded

under this service-type code should be viable technical assistance that will lead to a final product. Examples are addressing cultural competence, developing an action plan/capacity building, ensuring quality assurance and improvement, conducting evaluations, adding programs and services, developing funding and resources, and providing professional expertise and organizational development.

**Tertiary Prevention** – Intervention, also known as treatment, that seeks to address symptoms of substance abuse and prevent further problems. Also, strategies designed to decrease the amount of disability associated with an existing disorder or illness.

**Testing Bias** – Testing bias is introduced to participants as a result of their participating in repeated administrations of a data-collection instrument. The experience of participating in the first test may affect their subsequent reactions to the program or to retesting (e.g., responding to a similar questionnaire).

**Treatment** – Services for people diagnosed with a substance use or other behavioral health disorder (*SAMHSA's Behavioral Health Continuum of Care Model*).

**Triangulation** – Triangulation is the process of combining methods to study the same aspect of a program. Comparing [more than one] data source (e.g., interviews, observations and program documentation) helps to ensure that the information used to assess the program is accurate.

**Unit of Analysis** – Level at which data will be analyzed (e.g., individual, group) or other higher collective level (e.g., classroom, school, school district).

**Universal Prevention** – Prevention designed for everyone in the eligible population, both the general public and all members of specific eligible groups. Also, activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

**Validity** – The extent to which a measure of a particular construct/concept actually measures what it purports to measure. For example, is "years of schooling" a valid measure of education? (*Achieving Outcomes*, 12/01)

**Validity Threats** – Plausible alternative explanations for measured program effects (e.g., history, maturation, selection, attrition, measurement).

**Variable** – A factor or characteristic of an intervention, participant or context that may influence or be related to the possibility of achieving intermediate or long-term outcomes.