Guide to the Prevention Quarterly & Biannual Report
Alaska Division of Behavioral Health
(State Fiscal Years 2012-2014)

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Who to Contact:

<table>
<thead>
<tr>
<th>Juneau Staff: 877 - 393-2287</th>
<th>465-3370</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genevieve Casey</td>
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</tr>
<tr>
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</tr>
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<td></td>
</tr>
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</tr>
</tbody>
</table>

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Victoria Gibson                 | victoria.gibson@alaska.gov  | 465-4738 |
Cindy Tapp                     | cindy.tappe@alaska.gov      | 465-2835 |

Report Due Dates:

<table>
<thead>
<tr>
<th>Comprehensive Prevention Quarterly Report</th>
<th>Bi-annual Narrative Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Qtr – (July 1 - Sept 30)</td>
<td>Due Oct. 30</td>
</tr>
<tr>
<td>2nd Qtr – (Oct 1- Dec 31)</td>
<td>Due Jan. 30</td>
</tr>
<tr>
<td>3rd Qtr – (Jan 1 - March 31)</td>
<td>Due April 30</td>
</tr>
<tr>
<td>4th Qtr – (April 1 –June 30)</td>
<td>Due July 30</td>
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<tr>
<td></td>
<td>1st Bi-annual – July-Dec</td>
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<tr>
<td></td>
<td>Due Jan. 30</td>
</tr>
<tr>
<td></td>
<td>2nd Bi-annual - Jan-June</td>
</tr>
<tr>
<td></td>
<td>Due July 30</td>
</tr>
</tbody>
</table>

Additional information about Prevention Concepts and Terminology may be found in the Resource Guide for Comprehensive Prevention and Early Intervention Grantees
http://hss.state.ak.us/dbh/prevention/grants/default.htm
Project Section
Definitions for each box are below

Legend

1. **Project Name**: Name of your funded project

2. **Coordinator**: The project coordinator, the lead person who knows the most about the project overall. It may or may not be the same person that submits the fiscal reports.

3. **Risk Factors**: are characteristics within the individual or conditions in the family, school or community that increase the likelihood someone will engage in unhealthy behavior such as: the use of alcohol, tobacco and other drugs, violence, suicide, etc. Select from the drop down menu, (or see: http://hss.state.ak.us/dbh/prevention/publications/default.htm for definitions of each factor.)

4. **Protective Factors**: are characteristics within the individual or conditions in the family, school or community that buffer the impact of risk factors, help someone cope with challenges, and can prevent unhealthy behavior. Select from the drop down menu, (for definitions of each factor go to: http://hss.state.ak.us/dbh/prevention/publications/default.htm )

5. **SAMHSA Evidence Based Practices**: If your project is using an evidenced-based model as identified by the National Registry of Evidence-Based programs and practices, please list it. See website for more information: http://www.nrepp.samhsa.gov/
## Activity Pages

Definitions for each box or “cell” are below

**Legend**

1. **Activity Type**: Select the type of activity that best fits what you are proposing to do from the *drop down menu*, see page 6. (You will describe the activity in box 5.)

2. **IOM**: Choose one of the four Institute of Medicine (IOM) classifications from the *drop down menu*. See page 10 for more information. (Note: The IOM classification will determine what kind of demographic information you will need to collect about your participants.)

3. **Prevention Strategies**: Select the prevention strategy that best fits your activity from the *drop down menu*. See "Guide to the Prevention Quarterly & Biannual Report".

4. **Focus Population**: The specific people that the activities plan to reach. Select the group that fits best from the *drop down menu*, see page 6.

5. **Description of the Activity**: Provide a brief description of your activity.

6. **Communities served**: Identify the town/community where the prevention efforts/activities take place, from the *drop down menu*. Up to 6 communities may be listed. Note that the bottom two allow for you to enter other communities not listed.

7. **Times offered**: The number of times this activity was held throughout the quarter. (Example: 5 workshops, or 5 classes, or 100 times the PSA was aired on the radio)

8. **Total Contacts**: This will be answered differently, based on the type of IOM activity (box 2), selected and is further explained below.
“Universal Direct” or “Universal Indirect” IOM Activities
(Refer to question 2 or page 10 for more information)

Total Universal Contacts: “Total contacts” are the total number of “people contacts” made throughout the quarter for that activity. Sometimes this includes counting the same people more than once. This is called a “duplicated count” of participants.

Example: your project sponsors three workshops, many of the same people attend -- count the total number of people that attend all the workshops (some will be counted more than once).

Demographic Data: Enter age, race, ethnicity and gender of contacts. Please note under “Ethnicity” if your contacts are “Hispanic or Latino” or “Not Hispanic or Latino” so the total under this column matches the total number of contacts.

<table>
<thead>
<tr>
<th>Universal</th>
<th>Age by Race Totals</th>
<th>Race</th>
<th>Ethnicity</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Native American or American Indian</td>
<td>Black or African American</td>
<td>Asian</td>
<td>Native Hawaiian or Other Pacific Islander</td>
</tr>
<tr>
<td></td>
<td>ALL</td>
<td>N/A</td>
<td>ALL</td>
<td>N/A</td>
</tr>
<tr>
<td>0 - 4</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>5 - 11</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>12 - 17</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>18 - 24</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>25 - 44</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>45 - 64</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>65 &amp; Over</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
</tbody>
</table>

Total Participants

“Selective” or “Indicated” IOM Activities
(Refer to question 2 or page 10 for more information)

Total (Selected/Indicated) Contacts: “Total contacts” in this case are the actual number of people reached by this activity throughout the quarter. Do not count the same person more than once! (Sometimes this is called an unduplicated count.)

Demographic Data: Enter age, race, ethnicity and gender of contacts. Please note under “Ethnicity” if your contacts are “Hispanic or Latino” or “Not Hispanic or Latino” so the total under this column matches the total number of contacts.

<table>
<thead>
<tr>
<th>Selective</th>
<th>Age by Race Totals</th>
<th>Race</th>
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<th>Gender</th>
</tr>
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<tbody>
<tr>
<td></td>
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<tr>
<td>0 - 4</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>5 - 11</td>
<td>M</td>
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<td>12 - 17</td>
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<tr>
<td>65 &amp; Over</td>
<td>M</td>
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</tbody>
</table>

Total Participants
### Project Section: *Drop Down Menu Options* ~ Contributing Factors

#### Risk Factors (see definitions for each factor at http://hss.state.ak.us/dbh/prevention/publications/default.htm)

- Experienced child abuse (physical, sexual) or other family violence
- Family history of substance use or problem behaviors
- Family management problems
- Family conflict
- Parental attitudes favorable to substance use
- Easy household access to harmful substances or guns
- Academic failure beginning in grades 4-6
- Lack of personal commitment to school
- Easy availability of alcohol and other drugs
- Easy availability of firearms
- Community laws and norms favorable toward drug use, firearms, and crime
- High rates of mobility (moving a lot) and transitions
- Low neighborhood attachment and community disorganization
- Poverty/Extreme economic deprivation
- Early initiation of the substances (before age 13)
- Feeling depressed or suicidal
- Loss of cultural identity and connection
- Presence of specific constitutional factors (FAS, or other biological or physiological conditions)
- Childhood media exposure to violence and alcohol
- Persistent antisocial behavior in children less than age 8.
- Friends involved in tobacco, alcohol and other drugs
- Favorable attitudes towards substance use (low perceived risk of harm)
- Older physical appearance than most of their same-age peers
- Paid work more than 20 hrs/week
- Perceived risk of an untimely death (before age 35)

**FASD:** Having an alcohol related birth defect other than FAS
**FASD:** Having an IQ above 70

#### Protective Factors (see definitions for each factor at http://hss.state.ak.us/dbh/prevention/publications/default.htm)

- Connected/bonded to parents and family
- Positive parenting style, supervision & high expectations
- Parents have high expectations for children's school success
- Parents have higher education
- Living in a two parent family
- Students are bonded/connected to their school
- Positive caring school climate
- Student participation in extra-curricular activities
- Early intervention and support services
- Youth are bonded/connected to other adults in the community
- Safe, supportive, connected neighborhood
- Strong community infrastructure (services for those in need)
- Local and state policies that support healthy norms and child/youth programs/services
- Range of opportunities *in the community* for youth involvement
- Youth engaged in meaningful activities
- Possessing life skills and social competencies (SE/EL)
- Maintaining cultural identity
- Positive self concept
- Positive peer role models
- Positive personal qualities
- Sense of religious identity
- High grade-point average

**FASD:** Living in a stable and nurturing home
**FASD:** Being diagnosed before the age of six years
**FASD:** Never having experienced violence against oneself
**FASD:** Staying in each living situation for an average of more than 2.8 years
**FASD:** Experiencing a good quality home from ages 8 to 12 years
**FASD:** Being eligible for Developmental Disability services
**FASD:** Having basic life needs met
### Drop Down Menu Options

#### TYPE OF ACTIVITY (select one that fits most closely)
- Information & resource sharing
- Wellness gatherings & health fairs
- Motivational speaker
- Education programs: presentations & trainings
- Parent classes/groups
- Life & social skills training
- Healthy recreational activities
- Community service or helping activities
- Peer leadership/helper or cross-age teaching
- Recognition efforts
- Mentoring
- Tutoring & homework supports
- Cultural activities
- Coalition building or program planning activities
- Needs assessments, community surveys or evaluations
- Community, program/service capacity building
- Changing attitudes, norms, policies, laws, or ordinances
- Media-based strategies
- Early intervention programs/services/activities
- Screening and referral activities
- Support groups
- Crisis hotlines
- Other: (Please briefly describe)

#### Prevention Strategies (select one)
- Dissemination of Information
- Education
- Community-Based Processes
- Alternative “Meaningful” Activities
- “Environmental” Approaches
- Individual Support and Referral

#### Long Term Outcomes (select one or more)
- Free from harmful effects of substance abuse
- Mentally healthy and living successfully
- Resilient, connected having basic life skills

#### Institute of Medicine (IOM) Prevention Classification (Select one)
- See page 10 for definitions
- Universal Direct
- Universal Indirect
- Selective
- Indicated

#### Focus Population (select one that fits most closely)
- Young Children (ages 0-5)
- Elementary-aged children (6-10)
- Youth (ages 11-18)
- All children & youth
- Young adults (ages 19-24)
- Seniors/Elders
- All adults
- Community-wide (all ages)
- Families (children & parents)
- Parents
- School staff & students
- School staff (only)
- Program staff
- Statewide audience
- Other:
Question 1 comments: No need to fill out this section. If you feel additional information needs to be captured or included, please go to #9 of the Comprehensive Quarterly Activity Report and provide this optional information in the space provided.

Question 2 comments:

2a. This question relates to the quality of your prevention efforts as well as the capacity and readiness of your staff and coalition. This requires attention to: whether services are culturally responsive and appropriate; the level of skill, experience and training among staff; or whether the program has a high level of buy-in or acceptance within the community and target audience. Finally, good supervision, management and leadership are essential to well run programs and services.

**Examples of “How well” indicators:**
- % of clients who report being satisfied by the services
- % of coalition members who attend most meetings
- % of staff retained or turn over after two years
- % of youth who feel respected & supported by staff
- % of participants who attend most activities
- % staff/participant ratio
- % of staff fully trained or accredited
- % of coalition members who complete the ___ training

Your evaluation tools may be formal or informal but all of them should provide some level of measurable feedback to your agency, coalition team and staff. A “How Well” evaluation offers a mid-way measure of how effective and successful your prevention efforts are (leading to your short term outcomes).

2b. Provide a summary of your “How Well” findings and describe how the information was/will be used to improve or enhance the quality or efficiency of your prevention efforts? Examples:
- Did you find that additional staff training and supervision/support is needed?
- Do you need to work more closely with the coalition or wellness team to promote and market your prevention efforts?

2c. If you didn’t do any evaluation in this area, please explain why. Also identify when you will conduct this part of the evaluation. IF YOU NEED ASSISTANCE, please contact your DBH program coordinator.
Question 3 comments: Have you completed any evaluation associated with your project’s short term outcomes, in the past six months? If so, please summarize. Within the table provided, identify the measures of your short term outcomes. (In most cases this will come from the evaluation plan you submitted to your DBH program coordinator.)

If you have not conducted any evaluation associated with your short term outcomes, when will you administer your evaluation? Please describe the steps you have taken to develop the tools or implement an evaluation that will measure your short term outcomes.

NOTE: We recognize that you may have specific timelines for data collection that do not meet our bi-annual reporting schedule. If you have yet to complete your evaluation, please indicate that information in the summary.

Important Information on Baseline: What is the baseline information, by which you will gage your project’s success. To measure a change in knowledge, attitudes, skills and behaviors or conditions, we must have a place to start.

n= This is a common symbol used in social science research that represents the total number of people in a particular population sample. If you are measuring rates, (typically identified as a percentage), you must calculate that information into a percentage, based upon a total population. If you have data that does not identify an “n” or the total population that was included in the sample, then let us know so we can help to establish this for you.

Question 4. comments: Let your DBH program coordinator know what is working well. We like to hear about your success!
5a. Describe any barriers, challenges, and/or “lessons learned” that occurred in your prevention efforts, during this time period while using the SPF.

5b. How have you addressed this barrier, challenge, and/or “lesson learned”? How have you used this information to make changes or adaptations to improve or enhance your project in the future?

Question 5 comments:

5a. Let your DBH program coordinator know what you may be struggling with or areas that you feel may need improvement.

5b. This is a two part question: While it’s important to deal with barriers and identify lessons learned; it’s equally important to use the information to modify, adjust and improve your prevention efforts in some way. Please provide an example or describe how you have used the information learned to make changes.

6. Please identify any technical assistance you would like to receive from your DBH Program Coordinator over the next six months. Examples: Help with evaluation, assessment, maintaining a coalition, recruitment strategies, reporting requirements, etc.

Question 6. comments: Your program coordinator may already have a technical assistance plan with you. If not, this information can help steer support for your project in the right direction.
Institute of Medicine (IOM) Prevention Classifications

The National Academy of Science, Institute of Medicine has classified prevention efforts into four areas. After you describe your activity, choose one of the four Institute of Medicine (IOM) classifications from the drop down menu. The four classifications are as follows:

Universal activities
Universal efforts target the general public or a whole population group that has not been identified on the basis of individual risk.

1. **Universal Direct**: Activities that directly serve people who have NOT been identified at risk of having or developing problems (e.g., health education for all students, after school program, staff training, parenting class, community workshop).

2. **Universal Indirect**: Activities that provide information to a whole population who have NOT been identified at risk of having or developing problems (e.g., media activities, community policy development, posters/pamphlets, internet activities).

Other IOM activities identify individuals or subgroups of a population that are at greater risk.

3. **Selective**: Activities targeting people or a subgroup of the community living in high risk environments or are at risk of developing a substance abuse or mental health problem (e.g., classes for children of alcoholics, enrichment activities for FASD children, support group for friends and family of someone who has died by suicide.)

4. **Indicated**: Activities targeting individuals who have signs or symptoms of a substance abuse or mental health problem. The person may not have developed a diagnosable substance use disorder or mental illness. (e.g., crisis lines, depression screening, smoking cessation or student assistance programs)
Sample Evaluation Plan Measures or Indicators

<table>
<thead>
<tr>
<th>1. How much service or programming is being provided?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This relates to how much is being done. It’s most often reported as a number (#).</td>
</tr>
<tr>
<td><strong>Examples:</strong></td>
</tr>
<tr>
<td># of participants (by age, ethnicity)</td>
</tr>
<tr>
<td># of activities offered (by activity)</td>
</tr>
<tr>
<td># of meetings held</td>
</tr>
<tr>
<td># of workshops held</td>
</tr>
<tr>
<td># of hours volunteered</td>
</tr>
<tr>
<td># of times PSA is aired</td>
</tr>
<tr>
<td># of locations information is posted</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. How well are programs/services being delivered?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This relates to how satisfied your participants are with your services. It also addresses the capacity, efficiency and infrastructure of your organization or coalition.</td>
</tr>
<tr>
<td><strong>Examples of participant satisfaction measures:</strong></td>
</tr>
<tr>
<td>% of satisfied participants</td>
</tr>
<tr>
<td>% of client suggestions implemented</td>
</tr>
<tr>
<td>% of students who feel supported by staff</td>
</tr>
<tr>
<td>% of youth who attend most activities</td>
</tr>
<tr>
<td><strong>Examples of organizational capacity measures:</strong></td>
</tr>
<tr>
<td>% of staff who complete Gatekeeper training</td>
</tr>
<tr>
<td>% staff turnover or retained after two years</td>
</tr>
<tr>
<td>% staff/participant ratio</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Is Anyone Better Off</th>
</tr>
</thead>
<tbody>
<tr>
<td>What impact have you had on your target audience?</td>
</tr>
<tr>
<td>This relates to the measurement of your short term outcomes. What impact have you had on your target audience?</td>
</tr>
<tr>
<td>Short term outcomes identify change in either: attitudes/perception, knowledge, skills, behavior or conditions, as a result of your prevention work. (It’s typically reported as a percentage.)</td>
</tr>
</tbody>
</table>

**Examples of short term outcomes and their indicators:**
- Increase youth perception of the harmful consequences of alcohol use
  
  *Indicator: % of youth who believe alcohol use by teens, is harmful, compared to baseline*
- Decrease youth perception that most of their peers regularly use alcohol
  
  *Indicator: % of youth who believe most of their peers are not using alcohol, compared to baseline.*
- Increase participant’s knowledge of FASD.
  
  *Indicator: % of participants who increased their post-test score by, at least 10%*
- Increase a school’s positive school climate *(conditions)*
  
  *Indicator: % of students who feel connected to their school.*
- **Other examples**
  - Increase community’s awareness of suicide intervention/prevention services
  - Decrease the perception that most other youth are using alcohol regularly *(norms)*
  - Decrease the number of injuries resulting from driving while intoxicated *(behavior)*
  - Increase workshop participants decision making and problem solving skills
  - Improve students social/emotional skills
  - Reduce the proportion of retail outlets that sell liquor to people underage *(conditions)*
  - Increase the percent of youth who have 3 or more supportive adults *(behavior)*
  - Increase the percent of adults who reach out and support youth *(behavior)*
  - Decrease youth access to alcohol *(conditions)*
Short Term Outcome “Is Anyone Better Off”
Reporting Examples

Short Term Outcome Example #1

3. Is anyone better off? In the past 6 months, did you collect information for your Short Term Outcome? If No, explain in the summary section below what data you did use or why you did not collect the information. If Yes, provide a brief explanation how the measurement information is impacting your identified needs and or community conditions.

Short Term Outcome #1

1. Decrease the overall percentage of youth who receive repeat Minor Consuming charges in Cordova. (AS04:16.050)

| Current Baseline | n=37 | # | 6 | 16.2% | Of all youth who received repeat minors consuming out of the total of youth who received MCAs.
| Outcome Result   | n=22 | # | 1 | 4.5%  | Increase or Decrease
|                 |      |   |    |       | % Change | 12%

Brief Summary of Results

Our organization has been providing supports to youth who receive repeat MCA’s in our community. We provide each youth the PRIME For Life program as well as follow up mentoring through an effort with the local youth service organization. As you read in the How Well section, we believe the program parts of this effort are going well, as evidenced by the responses of youth and families receiving these supports. While we cannot take full responsibility for the decrease in the repeat minors consuming in the total population of youth receiving MCA’s, we believe our efforts have helped to contribute to this 12% decrease in the past year. Our baseline measure was taken from the FY 2009 Alaska Court System Minor Consuming Charges and the follow up measure from the FY2010 Alaska Court System Minor Consuming Charges.

NOTES:
In this case example, the grantee had already identified a baseline measure based on Alaska Court System Minor Consuming Charges (MCA) data from their local community. The grantee may also have recognized in their planning that the Prime For Life model measure may have some limitations because it only accounts for youth who are driving while intoxicated and does not identify a decrease in other risk drinking behaviors among youth who are not or do not drive a vehicle. Therefore, additional measures such as the Youth Risk Behavior Survey or other evaluation tools such as implementing youth focus groups on the topic may help to show increased effectiveness of the program.
### Short Term Outcome Example #2

**2. Increase youth decision-making and problem-solving skills.**

<table>
<thead>
<tr>
<th>Current Baseline</th>
<th>Outcome Result</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>n= 15</em></td>
<td><em>n= 14</em></td>
</tr>
<tr>
<td>#</td>
<td>#</td>
</tr>
<tr>
<td>8</td>
<td>10</td>
</tr>
</tbody>
</table>

*Youth Action members are confident in their problem solving and decision making skills.*

**Brief Summary of Results**

The Youth Action Committee started in September with 16 members, lost 5 throughout the year and gained 3 new members in the spring. Throughout the year our Youth Action Committee planned a series of activities for their peers, and service events for the community. The activities were primarily youth planned, led and evaluated. When one of the events was not well attended, the group brainstormed a list of what happened and what we could do differently. The list of suggestions was used in planning our next event. Some of our members taught younger students a class “Making decisions to keep you safe and strong!” Our group had fun and learned along the way. We adapted the YLAPQ survey for our evaluation tool, as we shared in our evaluation tool. After reviewing our survey results and talking with the youth, we believe the teens increased their resiliency and life skills, through our program, as reflected in the numbers reported above. We are also thrilled to learn the YAC participants also reported “Our group has improved the quality of life in my community” and many of them felt “This group helps me feel useful to my community.” We were also pleased to learn that as a result of our efforts 43% (6 out of 14) youth agreed, “My friends are less likely to use alcohol or other drugs,” compared to 33% (5 out of 15) from the baseline survey.

More information about the overall results of our evaluation plan can be found in our end of year evaluation report. This will be completed in June 2012.

**Note:**

The reference to the year end evaluation report. This may also serve as the report that can be disseminated to your agency, coalition or wellness team to demonstrate the results of your efforts which will also help to inform future assessments and planning.

**Sharing additional findings helps to support your overall strategies and activities as a whole.**

**NOTE:**

This example also spoke to the larger outcomes associated with resiliency and life skills. The specific questions asked in the YLAPQ were related to their increased “confidence” which is a subjective measure of their self worth and also increases in their “problem solving” with is based on their skills and abilities. Based on all the findings in the summary, it appears this grantee is also making connections between quality of life, feeling useful in the community and other factors related to the short term outcome. They all appear to be interrelated factors in decision making and problem solving. This summary helps to strengthen the 18% increase shown here.
### Short Term Outcome Example #3

#### Short Term Outcome #1

1. Increase knowledge of youth suicide risk factors, warning signs and where to get help.

<table>
<thead>
<tr>
<th></th>
<th>Current Baseline n=450</th>
<th>Outcome Result n=385</th>
</tr>
</thead>
<tbody>
<tr>
<td>#</td>
<td>85</td>
<td>210</td>
</tr>
<tr>
<td>%</td>
<td>18.9%</td>
<td>54.5%</td>
</tr>
<tr>
<td>Of…</td>
<td>community members knowledge of suicide risk factors, warning and where to get help.</td>
<td></td>
</tr>
<tr>
<td>Increase or Decrease</td>
<td>INCREASE</td>
<td>% Change 36%</td>
</tr>
</tbody>
</table>

**Brief Summary of Results**

Based on our community Suicide Prevention Awareness Survey (SPAS) that was given in March, of those surveyed, there was a 36% increase in their knowledge of risk factors and where to get help. This was based on our public information campaign, PSA's radio spots, theatre advertising, bus ads, and the high school poster contest "Celebrate Life" event and health fair. Community members were also asked follow-up questions during a focus group on what they thought was most significant risk factors in the community and they identified "relationship problems", "lack of jobs" and also "drugs and alcohol abuse" as a problems people are experiencing. When asked who they would go for help, 36% said a "counselor", 32 percent said they would "call 911", 8% said a "psychiatrist", 5% said their "friends" and 9 % said "other".

The Suicide Prevention Awareness Survey (SPAS) was given approximately 6 months when the initial baseline survey was implemented in the fall during the initial implementation phase of the grant project. The web-based anonymous survey was distributed at area high schools and also encouraged students to forward survey to parents to be entered into a drawing to win a Kindle. Next survey will be given in September. The coalition will then reassess the findings and begin to identify specific groups or other target populations that have frequent access to those who are higher risk in the community so the campaign can be targeted to those groups.

Even though some of this information is included in your evaluation plan, the writer added some rationale on how they are using the information for future planning. Since they now have over 50% of the population (high school students and their parents) knowledgeable about suicide and where to get help, the coalition may adjust their campaign to focus on other groups, i.e. primary care providers, church groups, the workplace etc... This may also require they change their campaign strategies to reach these groups.

**NOTE:**
This example is using a universal public information campaign directed at the entire community, but was only able to survey high school students and their parents. Even though 36% is a significant increase, it does not speak to the community as a whole. It appears in this situation the grantee developed a survey that was manageable for them to implement and collect the data and did provide a representative sample of youth and their parents which is a good start. It appears they also have future plans to target specific groups that have stronger contact with higher risk groups in this community as identified in their needs assessment.