

Guide to the Prevention Quarterly & Biannual Report

Alaska Division of Behavioral Health
(State Fiscal Years 2012-2014)

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Report Due Dates:

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

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

 State of Alaska Department of Health & Social Services Comprehensive Prevention Quarterly Report	
PROJECT INFORMATION	
Division of Behavioral Health Overarching Goal: <i>Promoting Healthy Communities Utilizing Effective Practices and Partnerships</i>	
1. Project Name	2. Coordinator
The contributing factors your project will address (identify no more than two, total)	
3. Risk Factors (select from drop down menu)	4. Protective Factors (select from drop down menu)
5. If you are using an evidence-based model identified by SAMHSA (described by NREPP) please list it below.	
1.	
2.	
3.	
Please click here to view SAMHSA's NREPP website.	

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

IOM Activities				Grant:	0	FY:	FY12 (2011-2012)	QT:	1st, July-Sept
List the activity information for each activity in your grant project. Please see "Guide to the Prevention Quarterly & Biannual Report" for further information on how to fill out this report or contact your program coordinator.									
Activity Information									
1. Activity Type (select from list)			2. IOM		3. Prevention Strategy (select from list)				
			Universal Direct						
4. Focus Population (select from list)			5. <u>Brief</u> Description of the selected Activity						
6. Communities Served			7. Times Offered		8. Total Contacts				

For assistance in filling out this information, please contact your state grant project coordinator.

Legend

- 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.)
- 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.)
- Prevention Strategies:** Select the prevention strategy that best fits your activity from the drop down menu. See "Guide to the Prevention Quarterly & Biannual Report".
- 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.
- Description of the Activity:** Provide a brief description of your activity.
- 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.
- 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)
- 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).



8. Total Contacts

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.

Universal	Age by Race Totals		Race												Ethnicity				Gender				
			Native Alaskan or American Indian		Black or African American		Asian		Native Hawaiian or Other Pacific Islander		White or Caucasian		Race Unknown or Other		More than One Race		Hispanic or Latino		Not Hispanic or Latino		All Participants		
	ALL	N/A	ALL	N/A	ALL	N/A	ALL	N/A	ALL	N/A	ALL	N/A	ALL	N/A	ALL	N/A	ALL	N/A	ALL	N/A	M	F	
Age Groups	0 - 4																						
	5 - 11																						
	12 - 14																						
	15 - 17																						
	18 - 20																						
	21 - 24																						
	25 - 44																						
	45 - 64																						
65 & Over																							
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.*)



8. Total Contacts

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.

Selective	Age by Race Totals		Race												Ethnicity				Gender				
			Native Alaskan or American Indian		Black or African American		Asian		Native Hawaiian or Other Pacific Islander		White or Caucasian		Race Unknown or Other		More than One Race		Hispanic or Latino		Not Hispanic or Latino		All Participants		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	N/A	N/A	
Age Groups	0 - 4																						
	5 - 11																						
	12 - 14																						
	15 - 17																						
	18 - 20																						
	21 - 24																						
	25 - 44																						
	45 - 64																						
65 & Over																							
Total Participants																							

Project Section: *Drop Down Menu Options ~* Contributing Factors

Risk Factors (see definitions for each factor at
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Academic failure beginning in grades 4-6 Lack of personal commitment to school
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> 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)
<ul style="list-style-type: none"> FASD: Having an alcohol related birth defect other than FAS FASD: Having an IQ above 70
Protective Factors (see definitions for each factor at
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Students are bonded/connected to their school Positive caring school climate Student participation in extra-curricular activities Early intervention and support services
<ul style="list-style-type: none"> 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 <i>in the community</i> for youth involvement
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> 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)

see pages 13-14 for definitions

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:

Bi-Annual Narrative Report



State of Alaska
Department of Health & Social Services
Comprehensive Prevention Bi-Annual Narrative

1. How many people are being reached through your prevention efforts?

This question will be answered by filling out the quarterly "population/demographic form" every quarter. Each of the major activities will be tracked by number of sessions or times offered as well as participants by age, gender and ethnicity. Additional output information on how much is being implemented can be included on the quarterly report form.

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.

2 a. How well are the prevention efforts being delivered? In the past 6 months, did you collect "How well" information?	
Indicators:	How will you measure this?
1. How well indicator:	
2. How well indicator:	
2 b. As a result of asking these questions, what did you learn? <i>Describe how the measurement information was used to improve or modify services, based on what was learned.</i>	
Words: 0	
2 c. If you did not ask any "how well" questions: please explain why not and your plans to collect this information in the future.	
Words: 0	

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 participants who attend most activities |
| % of coalition members who attend most meetings | % staff/participant ratio |
| % of staff retained or turn over after two years | % of staff fully trained or accredited |
| % of youth who feel respected & supported by staff | % 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.

3. *Is anyone better off? In the past 6 months, did you collect information for your Short Term Outcomes? If No, explain in the summary section below what data you did use or why you did not collect the information and what your plans are to collect it in the future. If Yes, provide a brief explanation how the measurement information is impacting your identified outcome(s) and or community conditions.*

Short Term Outcome #1

1.										
Current Baseline	n=		#		%	0.0%	of...			
Outcome Result	n=		#		%	0.0%	Increase or Decrease		% Change	0%
Brief Summary of Results										

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.

4. <i>Describe a success or accomplishment that occurred in your prevention efforts, during this time period, while using the SPF.</i>	Words: 0

Question 4. comments: Let your DBH program coordinator know what is working well. We like to hear about your success!.

<p>5a. Describe any barriers, challenges, and/or "lessons learned" that occurred in your prevention efforts, during this time period while using the SPF.</p>	<p>Words: 0</p>
Empty response area for 5a	
<p>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?</p>	<p>Words: 0</p>
Empty response area for 5b	

Question 5 comments:

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

- 5 b. This is a two part question: While it's important to deal with barriers and identify lessons learned; its 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.

<p>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.</p>	<p>Words: 0</p>
Empty response area for 6	

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

1. How much service or programming is being provided?

This relates to how much is being done. It's most often reported as a number (#).

Examples:

- # of participants (by age, ethnicity)
- # of activities offered (by activity)
- # of meetings held
- # of workshops held
- # of hours volunteered
- # of times PSA is aired
- # of locations information is posted

2. How well are programs/services being delivered?

This relates to how satisfied your participants are with your services. It also addresses the capacity, efficiency and infrastructure of your organization or coalition.

Examples of participant satisfaction measures:

- % of satisfied participants
- % of client suggestions implemented
- % of students who feel supported by staff
- % of youth who attend most activities

Examples of organizational capacity measures:

- % of staff who complete *Gatekeeper* training
- % staff turnover or retained after two years
- % staff/participant ratio

3. Is Anyone Better Off

What impact have you had on your target audience?

This relates to the measurement of your short term outcomes. What impact have you had on your target audience?

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.)

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 purport ion 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

This short term outcome associated with underage drinking is from your approved evaluation plan & is connected to your long term outcome.

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 and what your plans are to collect it in the future. If Yes, provide a brief explanation how the measurement information is impacting your identified population, 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...	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	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.

This summary helps to explain the 12 % decrease in minor consuming. Note the writer also acknowledged other factors that may have also influenced these rates.

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

This short term outcome is associated with building protective factors and increasing resiliency which is connected to one of the DBH long term outcomes.

Short Term Outcome #2

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

Current Baseline	n=	15	#	8	%	53.3%	of...	Youth Action members are confident in their problem solving and decision making skills.		
Outcome Result	n=	14	#	10	%	71.4%	Increase or Decrease	INCREASE	% Change	18%

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 plan. 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

This short term outcome is associated with suicide prevention and is also related to the long term outcome of Alaskans being mentally healthy and living successfully.

Short Term Outcome #1

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

Current Baseline	n=	450	#	85	%	18.9%	of...	community members knowledge of suicide risk factors, warning and where to get help.		
Outcome Result	n=	385	#	210	%	54.5%	Increase or Decrease	INCREASE	% Change	36%

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 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.

Focus group was helpful in identifying various themes and qualitative information to support the measured increase in knowledge.

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.