Assessment Primer: Analyzing the Community, Identifying Problems and Setting Goals

Community Anti-Drug Coalitions of America
National Community Anti-Drug Coalition Institute

CADCA's National Coalition Institute, developed in 2002 by an Act of Congress, serves as a center for training, technical assistance, evaluation, research, and capacity building for community anti-drug coalitions throughout the U.S.

In 2005, the Institute initiated development of a series of primers aimed at providing guidelines for coalitions navigating the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's Strategic Prevention Framework. Each primer is designed to stand alone and work with the others in the series. While we have focused the planning process on SAMHSA's SPF, the steps can be applied by any community coalition.

This primer is designed to provide anti-drug coalitions clear guidelines for defining their communities and assessing the real needs within the community.

The information will enable your coalition to minimize duplication of effort, understand existing resources, and implement practices and policies to reduce substance abuse within the community.

You will find additional information on assessment and the other elements of the Framework on the CADCA website, www.cadca.org.

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INTRODUCTION

Drug-Free Communities Support Program

In 1997, Congress enacted the Drug-Free Communities Support Program (DFC) to provide grants to community-based coalitions to serve as catalysts for multi-sector participation to reduce local substance abuse problems. By 2009, nearly 1,600 local coalitions received funding to work on two main goals:

- Reduce substance abuse among youth and, over time, among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse.

- Establish and strengthen collaboration among communities, private nonprofit agencies, and federal, state, local, and tribal governments to support the efforts of community coalitions to prevent and reduce substance abuse among youth.

A word about words

What's your goal? Your aim? Your objective? Perhaps more importantly, what's the difference? At times, the terms are interchangeable. Often, the difference depends on who's funding your efforts.

To minimize confusion, we have added a chart (see page 40) that highlight terms that often are used to describe the same or a similar concept.

The public health model

Prevention programs traditionally have focused on approaches designed to affect the individual, peers, or families. Today, many coalitions work to reduce substance abuse in the larger community by implementing comprehensive, multi-strategy approaches.

Approaches that target individual users reach limited numbers of people. Community-based programs that provide direct services to individuals are important partners in a comprehensive coalition-led community-level response. Strategies that focus on the substance and the environment—although more difficult to implement—are likely to impact many more people. For example, information learned by teenagers who attend alcohol prevention classes at school, while important, is limited.

Chances of keeping youth from using alcohol are greater if those classes are part of a multi-strategy approach that includes a campaign to limit billboards near local schools and an education program for store owners to ensure they do not sell to minors. Such approaches might include strategies that target the sub-stance (e.g., raising the price of alcohol) and/or the environment (e.g., implementing policies to reduce youth access). To show communitywide change, your coalition needs multiple strate-gies focusing on multiple targets of sufficient scale and scope.

> **The public health model**
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> The public health model demonstrates that problems arise through relationships and interactions among an **agent** (e.g., the substance, like alcohol or drugs), a **host** (the individual drinker or drug user), and the **environment** (the social and physical context of substance use).
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> These more complex relationships compel coalitions to think in a more comprehensive way. Over time, the public health model has proven to be the most effective approach to creating and sustaining change at a community level.
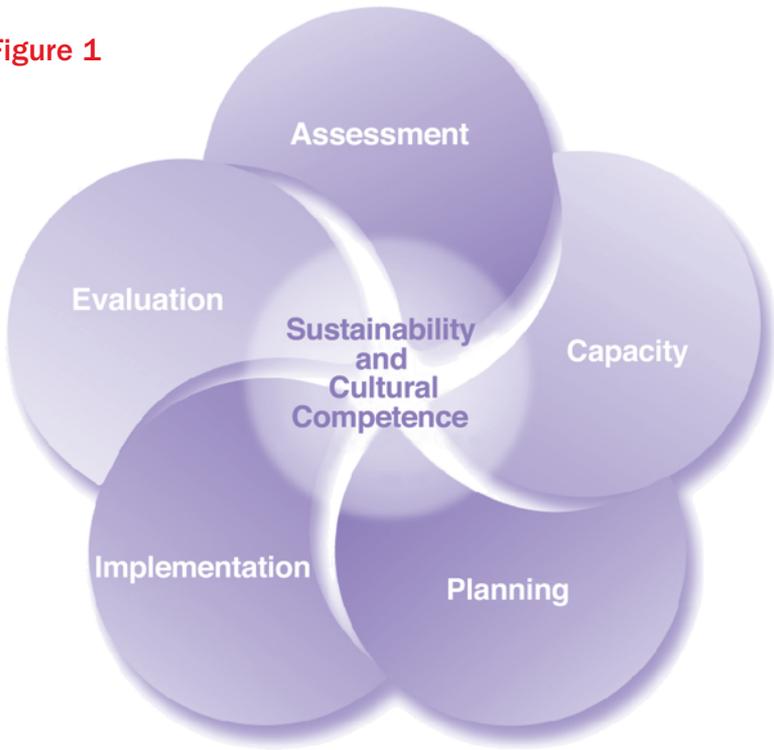
SAMHSA's Strategic Prevention Framework

The DFC initiative utilizes the **Strategic Prevention Framework (SPF)** developed by the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Adminis-tration (SAMHSA). The SPF's five elements assist coalitions in developing the infrastructure needed for community-based, public health approaches leading to effective and sustainable reduc-tions in alcohol, tobacco, and other drug (ATOD) use and abuse.

The five elements shown in Figure 1 include:

- **Assessment.** Collect data to define problems, resources, and readiness within a geographic area to address needs and gaps.
- **Capacity.** Mobilize and/or build capacity within a geographic area to address needs.
- **Planning.** Develop a comprehensive strategic plan that includes policies, programs, and practices creating a logical, data-driven plan to address problems identified in assessment.
- **Implementation.** Implement evidence-based prevention programs, policies, and practices.
- **Evaluation.** Measure the impact of the SPF and its implemented programs, policies, and practices.

Figure 1

Figure showing five overlapping circles labeled Assessment, Evaluation, Capacity, Implementation, and Planning, with Sustainability and Cultural Competence at the center.

A coalition is a coalition is a coalition...or is it?

There are four general types of local, community anti-drug coalitions that exist in communities throughout the U.S. They are:

Activity or event focused coalitions–conduct activities and/or events such as information and referral, poster contests, health fairs and resource directories.

Service/program delivery coalitions–focus on developing and carrying out programs that serve individuals and/or families, i.e., parenting classes, after-school and mentoring programs. Staff may be directly involved in the provision of services.

Community mobilization coalitions–organize their communities around single issues (or a set of issues) such as restricting alcohol and tobacco billboards near schools, eliminating the sale of drug paraphernalia in local stores or persuading elected officials to install street lighting.

Comprehensive community coalitions--respond to community conditions by developing and implementing multi-faceted plans that lead to measurable, population-level reductions in one or more substance abuse problems.

Frequently coalitions are developed because a funding organization or outside group provides resources, personnel or both. The external group may determine the goals of the coalition and how it will operate. In other cases, local community members and institutions determine goals, strategies and activities and then seek funds and resources to help carry out the plan.

It is not unusual for a coalition to change as it develops and responds to local conditions or external circumstances. Although this primer series will be useful for all types of coalitions, it is designed for comprehensive community coalitions with a special emphasis on coalitions funded by the DFC.

A word about cultural competence and sustainability

The SPF places cultural competence and sustainability at its center as these key concepts must be incorporated into every step. You will find recommendations for incorporating both from the earliest stages of coalition development through evaluation.

Cultural competence is a point on a continuum with several guiding principles that enable coalitions to have positive interactions in culturally diverse environments. Here are some key principles:

- **Each group has unique cultural needs.** Your coalition should acknowledge that several paths lead to the same goal.
- **Significant diversity exists within cultures.** Recognize that cultural groups are complex and diverse; do not view them as a single entity.
- **People have group and personal identities.** Treat people as individuals and acknowledge their group identities.
- **The dominant culture serves people from diverse backgrounds in varying degrees.** Coalitions must recognize that what works well for the dominant cultural group may not work for members of other cultural groups.

- **Culture is ever-present.** Acknowledge culture as a predominant force in shaping behaviors, values, and institutions.
- **Cultural competence is not limited to ethnicity, but includes** age, gender, disability, sexual identity and other variables.

Sustainability requires creating a strong coalition that brings together a community to develop and carry out a comprehensive plan to effectively address a relevant problem. While long-term sustainability must include a focus on funding, it depends on much more than maintaining sufficient fiscal resources.

Sustaining an initiative over time also requires a combination of non-financial resources from the initiative itself and the broader community. Necessary internal resources include: leadership from management and board members; access to technical expertise from within the organization; and the existence of strong administrative and financial management systems. Critical external resources include: support from policymakers, the public, or other key stakeholders; access to technical expertise from outside the organization; and engagement of community-based organizations, parents, or other community members.*

A brief look at assessment

This primer focuses on the process that CADCA suggests community coalitions use to implement the first element—assessment—of the SPF. This includes creating and maintaining coalitions and partnerships, assessing community needs and resources, analyzing problems and goals, and developing a framework or model of change and a logic model. This process can, and should, be repeated regularly to ensure that your coalition is keeping up with changes in your community.

1. **Create and maintain coalitions and partnerships**
    - Identify, invite and include key collaborators for the initiative.

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* "Sustaining Comprehensive Community Initiatives: Key Elements for Success." Financing Strategy Brief. The Finance Project. (Apr 2002). The complete document is available online at http://www.financeproject.org/Publications/sustaining.pdf.

- Establish meeting and decision making processes that connect individuals and build trust.
- Facilitate brainstorming, encourage consensus, and promote shared decision making to create a vision and mission statement.

2. **Assess community ATOD needs and resources**
   - Define the coalition's community and boundaries (neighborhood, county, city, etc.).
   - Reconstruct and build on the relevant local history of community mobilization and anti-drug work.
   - Collect qualitative data via community forums, focus groups, listening sessions, key informant interviews, and surveys.
   - Collect quantitative data from partners and outside sources, including related archival and survey data.

3. **Analyze problems and goals**
   - Facilitate group problem analysis techniques including the "but why"—"but why here" technique illustrated in Chapter 4.
   - Include and incorporate the experience and expertise of coalition members to thoroughly name and frame problems and goals.
   - Apply a risk and protective factors framework or other overarching strategy that focuses on personal and environmental factors contributing to problem behaviors and settings.
   - Select objective criteria to facilitate the prioritization of problems.
   - Identify and make use of targets and agents of change. Construct functional problem or goal statements that reflect true community concerns and facilitate good problem analysis.

4. **Develop a framework or model of change and a logic model**
   - Create your coalition's common vision by developing a theory of change.
   - Use the "but why"—"but why here" conclusions to begin development of your coalition's logic model.

CHAPTER 1.   WHY DO A COMMUNITY ASSESSMENT?

You might wonder why it is important to assess substance abuse reduction needs and resources in your community—especially if you feel you already know what they are. Until you gather empirical and qualitative data—that which is based on factual information or observation—showing what is happening, where the problems occur, to whom, and why, the anecdotal evidence you have may be only one piece of a much larger picture.

A community assessment is a comprehensive description of your target community (however your coalition defines community). The assessment process is a systematic gathering and analysis of data about the community your coalition serves for the purpose of identifying and addressing local ATOD problems.

For some, this may include a risk and protective factor assessment. For others it may be a way to understand the types of substance abuse prevention, treatment, and recovery programs, practices and policies that exist within the community. It also can be an assessment of the demographic characteristics of your community. Think about community assessment as a way to get

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Community Assessment

What you need to know
- How to create coalitions and partnerships, assess community needs and resources, and analyze problems and goals.

What your community needs to do
- Analyze information about the problem, goals, and factors affecting them.

The product your community needs to create
- A community assessment that includes a demographic description of the community, data on the DFC core indicators, other relevant indicator data, and community resources.

Sample community assessment materials are available on the CADCA website, www.cadca.org.

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the "lay of the land" so your coalition can target real problems specific to your community, capitalize on existing efforts, and fully understand existing resources to implement desired practices and policies. A community assessment also documents gaps in existing resources—information that is critical to substance abuse reduction planning and to accomplishing your coalition's goals.

Undertaking a community assessment can provide many opportunities for the coalition and the community. A comprehensive assessment should

- **Create** community consensus about ATOD problems in the community.
- **Identify** underlying factors that contribute to those problems.
- **Identify and analyze** environmental, social, and individual factors that contribute to the problems.
- **Increase** the likelihood that your coalition will select and implement policies and practices that actually will reduce ATOD problems in the community.
- **Establish** baseline information to track the coalition's progress.

Normally community assessments are conducted at the beginning of a coalition's development. But they can, and should, occur as an ongoing process—like a regular check up. Communities and coalitions are not static, they change and develop over time. Understanding how community strengths, needs, resources, and make up change and evolve is critical to coalition effectiveness. This can occur through regular (annual or biannual) assessments so that your coalition can be responsive to the community in a proactive and effective manner.

At the beginning of the assessment process, your coalition should develop a functional problem statement describing the issue you plan to address. Look at the statement as a place to start and know that it may change as your coalition moves forward. See page 27 for more information on creating problem statements.

CHAPTER 2.   CREATE AND MAINTAIN COALITIONS AND PARTNERSHIPS

So why is it important to develop a coalition? The old saying: "Two heads—or in the case of coalitions, more—are better than one" applies. Coalitions made up of a cross section of community members bring diverse perspectives and expertise and help develop a strong *group IQ* in identifying problems, analyzing data, and developing relevant, culturally appropriate approaches and strategies. Coalitions should include a representative mix of the community—including parents, teachers, youth, law enforcement, health care, media, community leaders, religious and fraternal organizations, child welfare, AOD treatment and prevention providers, and others who reflect the community's diversity—racially, culturally, and linguistically. Indeed, DFC coalitions are required to include at least 12 prescribed community sectors on their coalitions.

Involving individuals and groups (sectors) who have access to and understand the data discussed in this primer not only builds coalition capacity, but also increases support for planning, implementation and sustainability.

Among the most important initial steps is developing an ongoing process to engage different parts of the community. Your

> ### Establish a data surveillance workgroup
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> Collecting data is a time consuming process. Before you begin, it is a good idea to bring a team together to help collect, analyze and report on data on an ongoing basis.
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> Members of the team should include individuals from agencies, such as law enforcement, schools, public health, social services, and treatment who are knowledgeable about and have access to their organization's data.
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> These individuals may already be members of your coalition and should be ready and willing to help in this effort. Your team also should include coalition staff and an outside researcher or epidemiologist with experience in indicator research.
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> Your data surveillance workgroup might naturally evolve into participating in the evaluation process, reporting to the community on general ATOD issues as well as the specific indicators on which the coalition is working.

coalition should recognize that each group has unique cultural needs and work to make room for several paths that lead to the same goal. Be mindful of cultural protocols, beliefs, values, and literacy needs. Because people are served in varying degrees by the dominant culture, coalitions need to recognize that what works well for the dominant cultural group may not work at all for members of other cultural groups.

Be aware that when and where you meet can affect participation. Are your meetings scheduled in the evenings so parents, teachers, and other working people can participate? Are meeting locations accessible to people with disabilities? Are your meetings held close to public transportation?

Community coalitions are sometimes formed around one problem and then seek funding for another because it may be the only available funding. For example, an existing coalition may identify neighborhood development as the problem on which they want to work, but decide to pursue alcohol and drug abuse reduction funding because it is available. Tension between the coalition and its funder can arise if the problem the coalition wants to address (neighborhood development) differs from the concerns of the funder (alcohol and drug prevention). A good coalition, however, can meet its own needs and that of its funder by researching ways in which the two interests or concerns coincide. For example, in what ways do alcohol and drug problems limit neighborhood development? What might be done to reduce these problems and encourage neighborhood development? By contrast, a coalition that operates too narrowly—considering only its own interests—is likely to fail, lose its funding or be unable to generate sufficient community support to sustain itself.

A good facilitator can devise a way to address the community's interests *and* the funder's needs. The coalition that is interested in economic development, for example, might want to focus on limiting the number of off-sale alcohol outlets and instituting con-ditions under which alcohol can be sold in newly developed areas of the city as part of their effort to build a healthier community.

Coalitions also may face a related dilemma. A coalition may come together for a particular problem in the community, such as methamphetamine use. After receiving funding, the coalition may undertake a more in-depth community assessment only to discover a different problem (e.g., underage drinking) is of greater concern and affects more people in the community. One way coalitions can deal with this issue is to carefully document the empirical data that has shifted the coalition's concerns and discuss these data with your funder.

The basic idea about coalitions is that "working together can move us forward." That said, collaboration among diverse systems and community members brings numerous challenges, including turf issues, personalities, group dynamics, power imbalances, and cultural differences. The sooner these issues are addressed—preferably with the help of a good facilitator—the sooner the coalition will be in a position to begin to collaborate effectively. (More information on building your coalition's capacity and developing leadership is available in the Institute's *Capacity Primer,* available online at www.cadca.org.)

CHAPTER 3:   ASSESS COMMUNITY ATOD NEEDS AND RESOURCES

The assessment process begins with defining your community, understanding its history, and collecting information about your community's ATOD problems. Be aware that, in large part, the kinds of data you collect will define the problems your coalition will address. For example, if you collect data only on individually-based indicators, like arrests, you will not learn anything about the settings or circumstances where alcohol and drug abuse problems are occurring—you need to collect environmentally-based data to learn that.

Defining the community

By now, your coalition will have defined the community that is the focus of the assessment. Funders sometimes specify the community, but if the decision is up to your coalition consider it carefully and develop criteria to use in your selection process. We traditionally think of *community* as a given geographical location and DFC coalitions are required to define the precise geographic boundaries of their community (i.e., place). However the term also can be broadened to mean any group sharing a common experience or interest. Therefore, community can repre-sent a place—a neighborhood, city, county, or tribal land; an experience—ethnicity (e.g., as an African) or gender (e.g., as a female); or an interest—concern about poverty, substance abuse, HIV, or the environment. How you define your community will dictate the types of data you collect.

Community history

Every community has a history of major events and forces that affect and help shape it. However, it is not uncommon for people in diverse ethnic or cultural groups to interpret the same event differently. Low income and communities of color often are asked to collaborate on grants—to legitimize seeking funds and meet requirements of funders. But lack of cultural competence on the part of funders and/or participating agencies, combined

with power imbalances and cultural differences can complicate and thwart effective coalition building and collaboration.

Being unaware of or insensitive to the community's history can lead to a variety of problems. For example,

- Not accounting for key events that help explain current conditions can result in misinterpreting what those events really mean to community members.
- Misunderstanding the context of a situation can result in a loss of credibility for the coalition.
- Failing to build on the community's past successes can result in duplication of efforts.
- Inappropriately claiming credit for progress attributable to other factors or historical trends can result in mistrust from the community.

Community assessment

The next step is to learn more about the nature and scope of local ATOD problems and where they are found in the community by collecting a variety of local data. This data should correspond as closely as possible to the coalition's geographic boundaries. Otherwise, it will be of limited value for assessment purposes.

Demographic data

Communities vary widely in terms of size, population, ethnic/cultural characteristics, political power, education, economic status, primary languages, and other factors that are essential as you work to set up coalition initiatives. Data that describes a place and the people living in it are called demographic data.

Start with basic demographic information of your community. Collecting demographic data over at least two census periods (e.g., 1990 and 2000) provides a way to see emerging population trends. Between official census periods, you also may be able to get annual estimates of some local demographic information that may be calculated by state or local planning departments (e.g., population growth by age, gender, race/ethnicity, etc.).

You can find the demographic variables listed below in the most recent U.S. Census data:

- Total population,
- Gender,
- Racial/ethnic breakdowns,
- Age groups,
- Average household income, size, and poverty data (so that you can understand the economic status of the community and what its available resources may be),
- Average educational level (to assess appropriate reading levels and message content for materials you develop), and
- Primary language to identify groups of non-English speaking residents and help determine the need to use alternate communication methods or media, such as newspapers or radio/television broadcasts in prevalent languages.

If your community is a specific neighborhood, ask your city or county planning or community development department to provide the demographic data you need through census track information. State and municipal agencies often have sophisticated geographic information systems (GIS) that can map census tracts and other data within the defined borders of your community.

It is helpful to collect and compare the same data from communities of similar size and/or from the city, county, and/or state. Comparison data are useful to determine how serious a problem may be in your locale, but will not help you plan your coalition's response—only local data can do that.

Core indicators

If you are a DFC grantee, you are required to collect local data on four core measures by grade level and to report this information at least every two years. These data, as well as the other ATOD indicators you will select, provide a baseline from which you will monitor the long-term goals of your coalition.

Some ATOD indicators

Availability/Environmental
- Alcohol outlets/problem outlets
- Smoke-free workplace and/or secondhand smoke regulations
- Alcohol advertising

Use
- Self-reported ATOD use among youth (school surveys)
- Self-reported ATOD use among adults (community surveys)
- Drug use among arrestees

Prevention
- Environmental policies
- School-based policies

Treatment/Support Activities
- People in treatment
- Screening and brief intervention data
- Treatment waiting list data
- Substance use hotline data

Criminal Justice
- AOD-related arrests
- Decoy stings of sales to minors
- Incident reports resulting from police calls for service

Harm
- AOD-related hospital/ER visits
- AOD related deaths
- Traffic fatalities
- Child welfare
- Drug-related HIV/AIDS
- Hepatitis C cases

Source: Join Together. *How do we know we are making a difference? A community alcohol, tobacco, and drug indicators handbook*. 2005 edition. See: www.jointogether.org.

The core measures are:

- **Average age of onset of any drug use.** This means the average age that youth report first trying alcohol, tobacco, or marijuana.
- **Past 30-day use.** The percent of youth who report using alcohol, tobacco, or marijuana in the past 30 days.
- **Perception of risk or harm.** The percent of youth who report feeling that regular use of alcohol, tobacco, or marijuana has moderate or great risk.
- **Perception of parental disapproval of use.** Percent of youth who report their parents feel that regular use of alcohol, tobacco, or marijuana is wrong or very wrong.

You need to decide at the beginning of your DFC initiative how you will collect data on these measures. Many coalitions find the best way to access this particular information is through student surveys that may already be conducted in local middle and high schools. In some areas where schools are not surveying students, coalitions have developed their own surveys and secured permission to administer them in local schools. If your coalition has not established a

student survey (or has been unable to access data from existing surveys), the sooner you decide how to collect these measures the better. This information is vital to know the extent to which certain substances are—or are not—problems among youth in your community.

The four core measures, along with the other ATOD indicators you decide to collect, should be monitored in an ongoing manner. This is important not only for your community assessment, but also to guide the coalition in making course adjustments along the way and to measure or evaluate progress toward your short- and long-term outcomes.

Choosing additional ATOD indicators

Alcohol, tobacco, and other drug indicators are used to identify trends and measure the impact of substance use/abuse and

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Community assessment resources

CADCA's National Coalition Academy
See: www.cadca.org

Community Anti-Drug Coalitions of America (CADCA)
CADCA Strategizer #6. Community Substance Use/Abuse Indicators.
See: www.cadca.org

SAMHSA's Prevention Platform
See: http://preventionplatform.samhsa.gov/

Join Together
How do we know we are making a difference? A community alcohol, tobacco, and drug indicators handbook. 2005 edition. See: www.jointogether.org

National Highway Traffic Safety Administration
Community How To Guide on...Needs Assessment and Strategic Planning. See: http://www.nhtsa.dot.gov/people/injury/alcohol/Community%20Guides%20HTML/Guides_index.

related issues in a given community. No single indicator can provide an adequate picture of substance abuse in a local community—what might be available and valid in one community might not be available in another.

Since so many data are available, it is important to be strategic about the data you choose to collect. Excellent resources are available with ideas about community assessment indicators. Once you have reviewed these resources, your coalition should screen and rank a list of potential indicators according to whether they are sensitive, proximate and feasible using the following criteria.

Quantitative and qualitative data

Quantitative data are expressed in numerical terms, counted, or compared on a scale. These data help to answer the question "how many?" and can give your coalition perspective about the breadth of an issue, e.g., how many people are affected. When we see statistics about the percentage of people who smoke, binge drink, or are arrested for possession of methamphetamine, we are seeing quantitative data.

Qualitative data are non-numerical data rich in detail and description. These data are usually presented in narrative form, such as information obtained from focus groups, key informant interviews, and/or observational data collection. Qualitative methods can help make sense of quantitative/numerical data by exploring the question "what does it mean?" These data provide depth and texture about a situation and help us understand why there is an increase here or a decrease there.

- **Purpose.** What is your rationale about how the data you want to collect relate to your functional problem statement, ATOD problems, and to the work of your coalition? What will this data tell you about ATOD problems in your community and especially where (the settings) the problems occur?
- **Validity.** Does the indicator measure what it says it does? For example, to what extent do the number of DUI arrests measure the prevalence of drinking while driving as opposed to the aggressive enforcement of local laws by police?
- **Reliability.** Is the indicator reported the same way each year or are there variances that could affect totals and make data comparison impossible?

- **Availability.** Are the data available year to year and at the needed geographic level (neighborhood, city, county)?
- **Obtainability.** Can the data be collected easily? Will the agency that tracks the data release them?
- **Stability.** How long has the agency been collecting the data? It is most useful to use indicators that have been collected for at least five years to identify trends.
- **Cost.** Can data be provided at no cost, or will the agency charge a fee? Is the fee reasonable and affordable?
- **Relevance.** Does the coalition think that the indicator accurately represents a major aspect of the community's ATOD problem(s)?

When you have chosen a set of indicators and data sources, it is a good idea to create a monitoring and reporting system so you regularly can update the community on trends and progress.

Data types and collection

Two main types of data are collected in conducting a community assessment: primary data and secondary or archival data.

- **Primary data** include information that you collect and compile—such as counting the number of alcohol-related newspaper articles over a two-year period or the number of billboards in the community that advertise alcohol. It also may involve collecting data that are available but have not yet been compiled. For example, you might want to know how many children are removed from their homes when parental substance abuse is a factor. Or you might want to know how many and what percent of police calls for service involve alcohol or other drugs. You will need cooperation from the child welfare agency or police department allowing you to compile this information from their records.
- **Archival/secondary data** are already being collected and compiled by someone else (generally a local or state agency) on a regular basis and can be requested if you know where to look and how to ask. For example:

1) AOD-related arrests (from the local police department or state department of justice);
2) AOD treatment data (from the county or state);
3) Licensed retail alcohol outlets and problem outlets (from the state or local agency that licenses alcohol outlets);
4) Alcohol-involved traffic fatalities and injuries (from the state highway patrol); and
5) Intravenous drug-related HIV/AIDS data (from the county or state health department).

What's the denominator?

The denominator is the bottom number in a fraction that allows you to compare a part to the whole. For example, 1,000 arrests in your community (the denominator), and 450 involve drugs (the numerator).

Divide the numerator (450) into the denominator (1,000 arrests) you will find that 45 percent of all arrests involve drug use. This is important because you want to know to what extent drug-related arrests are consuming law enforcement resources.

The denominator provides a common point of reference and serves as a reality check about the significance of a piece of the whole picture (drug arrests compared to all arrests).

Collecting secondary data

It is important to clarify exactly what type of data you are seeking. Perhaps you want to collect arrest data. You would first ask for data related to all felony and misdemeanor arrests, and then for breakdowns of alcohol and other drug arrests by specific arrest category (e.g., DUI, felony drugs, public drunkenness); gender, age, race/ethnicity; and city and/or county. You also want to ask for at least five years of data so you can track changes and trends over time.

Contact state agencies whenver possible because they collect and "clean"* data from law enforcement agencies (e.g., local police departments, sheriff and the highway patrol) that make

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* When data are "cleaned" at the state level, it means all of the errors and inconsistencies have been identified and either fixed or removed.

arrests in your state. Getting data directly from the state also allows you to compare arrest rates between geographic areas with varying populations. These are called *per capita rates* because they are population-based, i.e., a rate per 1,000, 10,000 or 100,000 people. This is important because you might want to demonstrate that the problem (e.g., AOD arrest rate) is much higher in your community than in the state as a whole, or is higher in your city compared to a larger one.

If your community is not a city or county, but a neighborhood or school district, it is unlikely that you will be able to get specific data from the state, which generally collects data only at the city and county level. In that case, your best option is to go to your local police or law enforcement agency. Ask to speak with a crime data analyst or information technician who can help you get neighborhood-specific information. Then you can compare alcohol and other drug arrests in your area to the city as a whole.

> ## What to ask when collecting data from a secondary source
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> - What is the most current year for which data are available?
> - How often are data updated?
> - Are county- or city-specific data available?
> - Are the data available online?
> - What types of breakdowns are available (e.g., gender, age, race/ethnicity)?
> - Is there a cost to obtain these data?
> - How long will it take to get them?

Data collection methods

Community assessments with the richest information use multiple sources for data collection. Those may include surveys, mapping, key informant interviews, focus groups, and observational data collection. Be sure your data collection is culturally responsive and appropriate, e.g., consider whether questions might be seen as too personal or inappropriate. Consider appropriate translation and make sure that the interviewers or group facilitators reflect the composition of the group(s).

- **Surveys.** Conducting or reviewing local community and/or school-based surveys can provide quantitative data about how a particular group or groups think, behave or react.

Surveys can be a good tool to describe populations, show prevalence of behaviors, and assess the level of knowledge about specific issues.

- **Mapping.** Geographical Information Systems (GIS) software can help you create a map of your community showing, for example, the concentration of alcohol outlets, problem outlets, the proximity of police calls for AOD-related problems and arrests, and location of alcohol-related traffic crashes.

- **Key informant interviews.** One-on-one interviews are conducted by a skilled interviewer who asks open-ended probing questions of individuals who have particular knowledge or experience with the problems being assessed. Key informant interviews can help inform your quantitative data. For example, you find that there is an increasing trend in DUI arrests and want to know whether it is due to increased enforcement or because more people who are driving under the influence are getting into traffic accidents. Interviewing someone from the local police department who can explain what is influencing the trend can help your coalition better understand what is happening and why, and thus make a more informed and strategic decision about its approach.

- **Focus groups.** Focus groups are facilitated discussions of 5-10 individuals from similar backgrounds led by a trained moderator who guides the group into increasing levels of focus and depth on key issues. Like key informant interviews, focus groups can help you go beyond quantitative data and allow you to learn more about a particular problem. For example, a survey of 9th and 11th grade students reveals high levels of binge drinking. You want to understand more about settings in which youth are binge drinking and how and where they have access to alcohol, so you conduct a series of focus groups of 9th and 11th graders from the community.

- **Observational data collection.** This method involves documenting visual data in the community. For example, you could recruit volunteers—youth and adults—to record the number and placement of alcohol and tobacco advertisements in neighborhood stores or billboards prominently displayed to attract children and youth.

Collecting environmental data

To really understand an ATOD problem in your community, you need to know not only that there is a problem and who is most affected, but also what settings or circumstances contribute to the problem. These are often referred to as *environmental indicators*. Alcohol outlet density is an example of an environmental indicator. Since studies have found a relationship between crime in neighborhoods and a high density of alcohol outlets you might want to analyze these data in your community. To analyze this, you would contact your state or local agency (typically Alcoholic Beverage Control) that licenses off-sale (supermarkets, convenience stores) and on-sale (bars and restaurants) alcohol outlets and request a list of outlets arranged by zip code. Get the latest census data (or population estimates) and calculate per capita rates. This will show you which zip codes have the highest per capita concentration of outlets. You also can look at other characteristics in these zip codes such as poverty levels, high concentrations of households with children under five years old and types of crime being committed in areas surrounding outlets.

Another type of information you might want to know about is where underage youth convicted of drunk driving got their last drink—from bars, parents, friends, or parties—to help you decide what kind of intervention is needed. Surveying youth attending a

mandatory Drinking Driver Program is a good place to collect this data. If you find that youth are accessing alcohol from bars, you might decide to educate bar owners by instituting a Responsible Beverage Service training program, or increase the enforcement of existing underage drinking laws. If you found that youth were accessing alcohol from house parties, you might try to pass a Social Host Ordinance to discourage such events.

Resource assessment

A resource assessment describes current resources and resources that could be directed toward addressing the community's ATOD problems. This assessment could, for example, look at who is being serviced by existing prevention initiatives, treatment capacity, 12-step programs, neighborhood councils, local businesses, parent groups, faith community, senior centers, and other existing resources.

A resource assessment is important because it

- **Provides** a way for the community to use its existing capacity.
- **Accounts for** community assets and resources.
- **Describes** the community by focusing on positive rather than negative aspects.
- **Identifies** ways that build member capacity.
- **Expands** the identification of assets and resources to include more than just programs and agencies.
- **Identifies** community members who might be willing to participate in the coalition or support the coalition's efforts.

Disaggregating data

Whenever possible, you should try to get data that are disaggregated by gender, age, and race/ethnicity so that you can determine which groups are more affected by ATOD problems. This is no easy job. Disaggregated data often are not available.

For example, the more than 30 ethnic groups falling into the general category of "Asian" are categorized as "other" in some databases. In other cases, Asians are delineated as a group but not by ethnicity.

This can present problems. For example, your community may have a proportionately small group of Cambodian refugees who are disproportionately affected by a particular problem. Because Cambodians are included in the general category of "Asian" (most of whom are not affected by the same problem) that problem will be masked.

CHAPTER 4.   ANALYZE PROBLEMS AND GOALS

Before you can really address a problem in your community you need to learn as much as you can about that problem. It is like focusing the lens of a camera—each time you ask more in-depth questions about the problem, the subject in your camera lens becomes clearer. A good coalition is one that has a spirit of inquisitiveness—a willingness to look beyond the obvious and try to understand more about what is really going on with a given problem. Where is the problem occurring? What are the high-risk settings? Who is affected? By continuing to ask these questions (and analyzing data related to them) your coalition is more likely to develop a complete picture of the problem—and therefore develop more effective community solutions.

The following example will help you work through the process of analyzing a problem by asking specific questions to bring the root causes to the surface. This process can help move a coalition from treating symptoms to changing the underlying reasons that youth are using alcohol, tobacco, and other drugs in your community—in short, to real substance abuse reduction.

It is critical that when your coalition analyzes the data, you ensure your group has representation from affected populations and the agencies responsible for collecting the different data sets. For example, if you are analyzing crime data from neighbor-hoods with high crime rates, you should include the police depart-ment and neighborhood residents on your coalition.

Once identified, problems should be presented in a manner that is respectful of the community. Problems should be analyzed to discover root causes and local conditions that make these causal factors (often called risk or protective factors) more prevalent.

Crafting your coalition's functional problem statement (The problem is...)

Some coalitions never develop strong strategic plans because the members never create a sound problem statement during the assessment phase. Sooner or later the coalition loses steam

because the members and partners never clearly articulated and agreed upon the problem(s) they were trying to reduce.

Developing a clear problem statement for your coalition should occur early in the assessment phase. This will set the stage for a community assessment that is anchored to the problem your coalition wants to address and will help focus the lens of your coalition's camera. It also will help your coalition build capacity and gain community support to sustain your efforts by clarifying how your coalition intends to make a difference.

Survey different segments of the community to find out how the broader community "names and frames" what they believe are the community's most significant substance abuse problems. A good problem statement will meet each of the following criteria:

A) **Identify one issue or problem at a time.**
B) **Avoid blame.** *(e.g. the problem is "young people in our neighborhood do not have enough positive activities" rather than "the kids here have nothing to do and are trouble makers.")*
C) **Avoid naming specific solutions**. *(e.g. the problem is not "we don't have a youth center"—the problem may be "young people in our neighborhood are getting into trouble during after-school hours" for which a youth center may be one element of an overall solution.)*
D) **Define the problem by the behaviors and conditions that affect it.** Good problem statements frame the issue as either not enough good conditions/behaviors or too many bad conditions/behaviors (*e.g., "Too many young adults are using methamphetamine drugs."*).
E) **Are specific enough to be measurable.**
F) **Reflect community concerns as heard during the assessment process.**

As the community assessment process progresses, the coalition will gather information to help identify the root causes of a problem ("But why?") and, most importantly, how a root cause manifests itself locally ("But why here?").

Sometimes, a coalition decides to change its original problem statement based on information gathered during the assessment

process. For example, a coalition might start out defining the problem as "Kids are using prescription drugs," but then discover during the community assessment that the vast majority of youth are using alcohol and marijuana. In fact, as the coalition's planning process moves forward, it will be necessary to revisit the problem statement frequently.

But why?

Like a doctor, the goal of a coalition is to understand the cause of the symptoms and attack the source—remember crime and drug abuse are symptoms. We analyze problems and goals to surface root causes. A great coalition exercise for identifying root causes is called the *but why technique*.

To conduct a but why session:
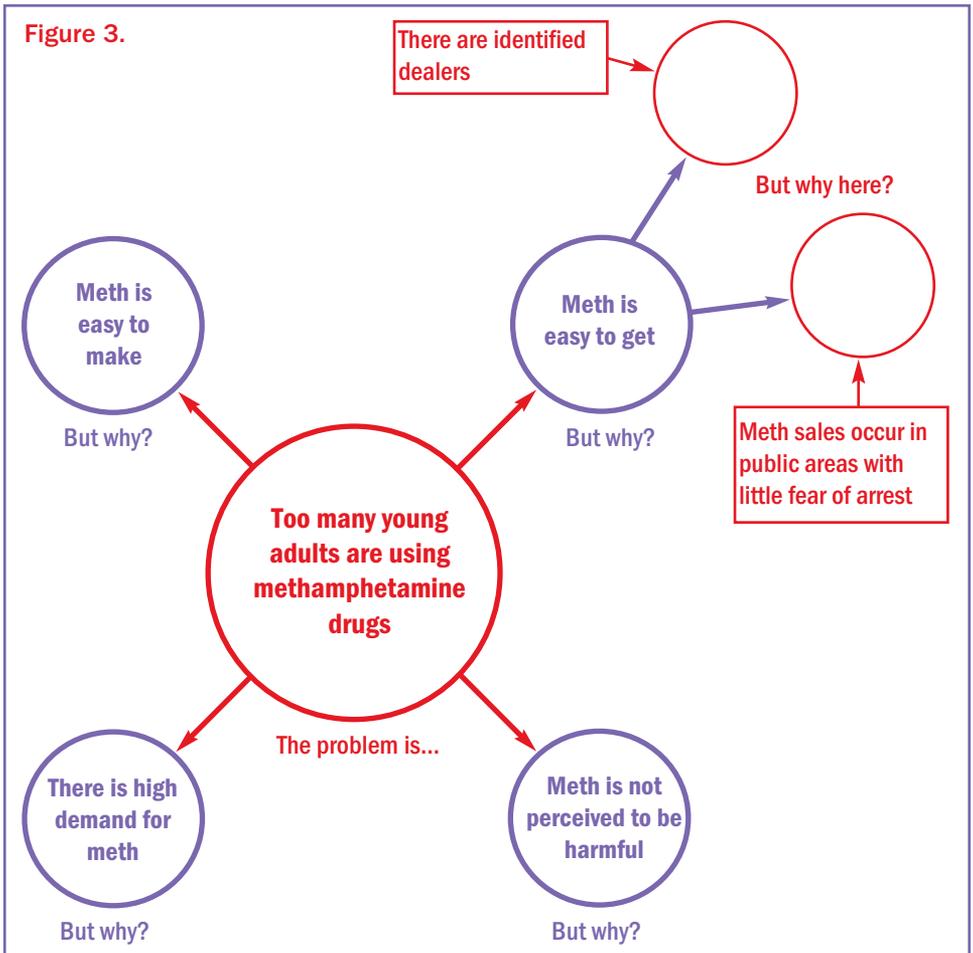- Put the problem statement in the middle of a large piece of flip chart paper.
- Ask the group to brainstorm reasons the problem exists by asking, "But why?"
- Write the answers the group generates around the problem statement with arrows.

Figure 2.

But why?

But why?

The problem is...
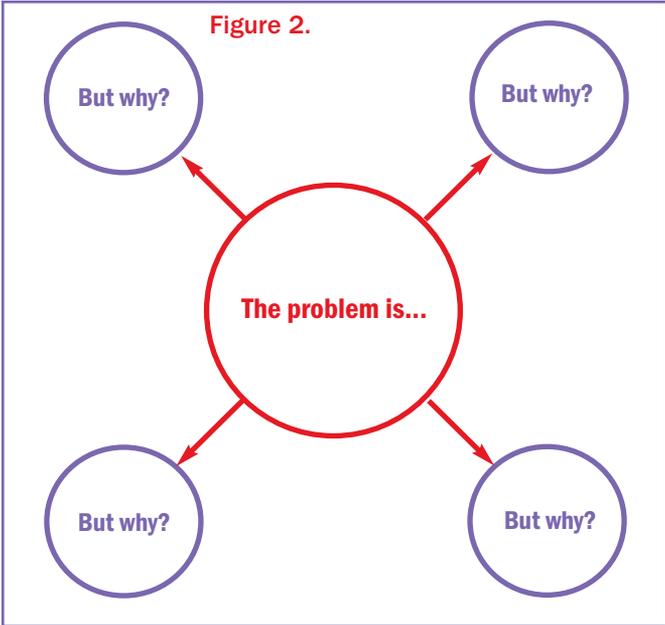
But why?

But why?

But why here?

You will note that most answers to the but why exercise could be equally applied to any community—these are generic causes. By asking "but why here?" your coalition can better identify and address how a *root cause* manifests itself in your community.

- **Take** the results of the "But why?" exercise just completed and select an identified root cause.
- **Ask** the group to determine "But why here?" for the root cause they selected.
- **Repeat** for additional root causes that surfaced in the "But why?" exercise.

Figure 3.

There are identified dealers

But why here?

Meth is easy to make

But why?

Meth is easy to get

But why?

Meth sales occur in public areas with little fear of arrest

Too many young adults are using methamphetamine drugs

The problem is...

There is high demand for meth

But why?

Meth is not perceived to be harmful

But why?

Only local people or those familiar with the local context can truly answer the "But why here?" portion of this exercise. This technique requires your community to examine the data and information gathered during the assessment process and helps them identify what additional data are needed. If the underlying factors were the same in every community, there would be no need for local community coalitions.

The "but why here" exercise will compel your coalition to select strategies and initiatives that get to the unique root causes of substance abuse in your community.

What data sources can we use?

Remember, finding and collecting data is like playing detective. Be creative and imaginative in thinking of ways to fill gaps. Some possible data sources include:

❑ Ask your local police department for data on methamphetamine arrests to see how widespread the problem is and who is involved (remember to ask for data that is as broken down as much as possible, e.g. by gender, race, and age).

❑ Look at county treatment admission data.

❑ Look at school surveys to see how often meth is used, by whom, age of first use, frequency of use, and attitudes.

❑ Conduct focus groups among high school students and/or youth in treatment programs to find out how they get methamphetamine, what it costs, where and with whom they use it, and how harmful they believe using it is.

❑ Contact the local child welfare agency to get estimates about the percentage of families in the system affected by in methamphetamine use.

❑ Check with the county environmental protection office for information about clean-up costs and exposure to toxic chemicals from living in and around labs.

❑ Do a content analysis of local newspapers to determine whether the problem has been reported and, if it has, how widely and accurately.

Prioritizing the solutions

Now it is time to finalize the selection of the problem or problems on which your coalition will work. It is sometimes helpful to frame prioritization by acknowledging that while your efforts to gather data have revealed $100 worth of problems, it is likely you only have $10 to spend. So, if you cannot do everything, how do you spend your $10 wisely? Asking and answering a series of questions can help increase your understanding of the problem so that the strategies you select and the evaluation plan you develop are more focused.

The following questions can facilitate the prioritization process:

- Are other groups in the area working on this issue? If so, who are they and will they become partners?
- Are local data sources available to get information?
- How can the coalition get access to the data?
- If there are no existing data, is the coalition willing to spend some resources conducting firsthand data collection, i.e., interviewing key people and conducting focus groups?
- Can the coalition get data that covers the grant period in a timely fashion?
- Is the problem related to the goals of your DFC grant or other funding?

CHAPTER 5.   DEVELOP A FRAMEWORK OR MODEL OF CHANGE AND A LOGIC MODEL

Now that you have created your functional problem statement, done your community assessment and analyzed and prioritized the approaches you will take, the next steps are to identify a *theory of change* and create a *logic model*. This chapter gives a brief description of those processes. A more in-depth look at these topics is presented in the the Institute's *Planning Primer.*

Develop your theory of change

A *theory of change* describes the types of strategies used by the coalition that lead to accomplishing its goal. Many coalition stakeholders like using a theory of change as part of planning and evaluation because it creates a commonly understood vision of the problem being addressed and defines over-arching, evidenced-based strategies or approaches proven to address that problem.

Your coalition should identify the assumptions behind the evidence-based strategy or approach that has been selected. Assumptions explain the connections between short-term (early), intermediate, and long-term outcomes and expectations about how your strategies will work. These assumptions also should demonstrate the evidence-based approach your coalition has selected to accomplish its goals.

You might think about this process as a series of **if—then** relationships. Assume your coalition wants to reduce the number of young adults who use meth.

- **If** the coalition invests time and money decreasing meth production in the local community through inhibiting access to meth precursor chemicals/drugs and increases community/police surveillance of potential meth labs, **then** local meth production is likely to decrease.
- **If** local meth access is inhibited, **then** the use of meth will decrease.

- **If** youth receive the social norm messages from a credible source, **then** they will be more likely to believe the messages and delay initiation of methamphetamine use.

Even this very simple series of statements contains a number of assumptions about the problem, how the strategy will work, and what it can achieve. For example, it assumes that:

- A community can change access to meth precursor chemicals/drugs;
- Reducing availability of meth is an effective strategy to combat meth use;
- Increasing the number of teens who receive messages from people they trust that most young people do not use meth will lead to decreased meth use in young adults.

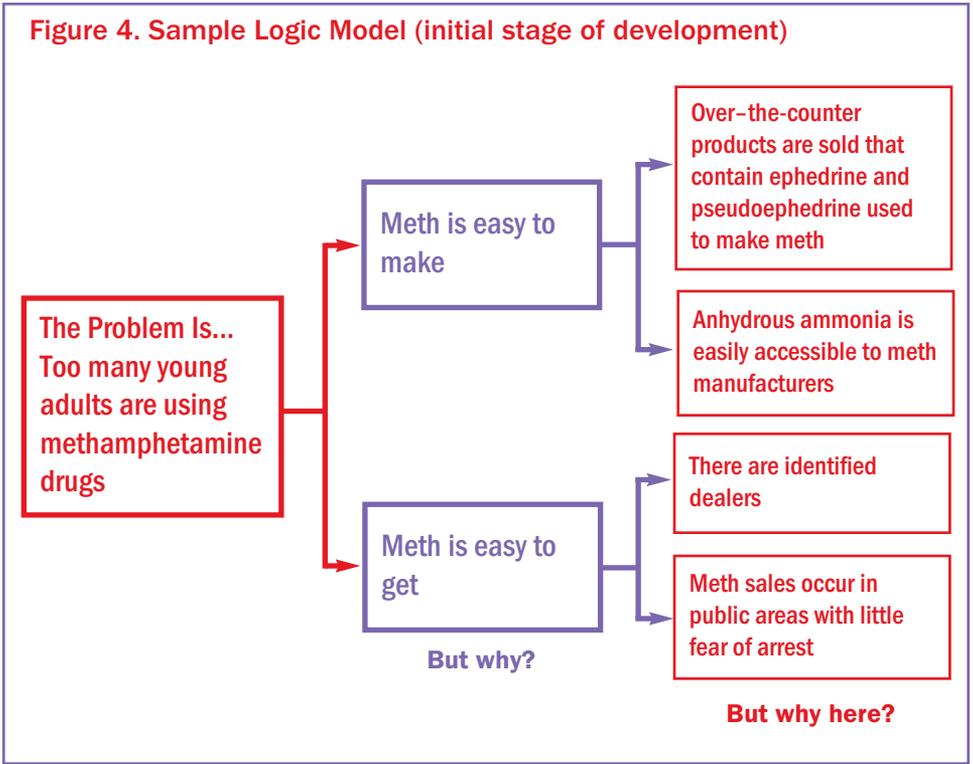Based on this example, the theory of change would be as follows:

> *When a community comes together and implements multiple strategies to address young adult use of methamphetamines in a comprehensive way, young adults will be more likely to use less.*

What is a logic model?

A logic model is like a "road map" that lets everyone know you are on the right path. It presents a picture of how your initiative is supposed to work. It is a straightforward, graphic approach to planning that ensures no vital step will be overlooked—from goal setting to measuring outcomes—and explains why the strategy you have chosen is a good solution to the problem. A logic model is a succinct, logical series of statements linking the needs and resources of your community to strategies and activities that address the issues and what the expected result will be.

If your coalition conducted the *"the problem is, but why, but why here"* exercise outlined on pages 28-32, you already have completed the first steps in constructing your logic model. This is shown in the example on the following page:

Figure 4. Sample Logic Model (initial stage of development)

```
                                    ┌─────────────────────────┐
                                    │ Over–the-counter        │
                                    │ products are sold that  │
                      ┌──────────┐  │ contain ephedrine and   │
                      │ Meth is  │  │ pseudoephedrine used    │
                      │ easy to  │──│ to make meth            │
                      │ make     │  └─────────────────────────┘
                      └──────────┘
┌───────────────┐                   ┌─────────────────────────┐
│ The Problem   │                   │ Anhydrous ammonia is    │
│ Is...         │                   │ easily accessible to    │
│ Too many young│                   │ meth manufacturers      │
│ adults are    │                   └─────────────────────────┘
│ using         │
│ methamphetamine│                  ┌─────────────────────────┐
│ drugs         │                   │ There are identified    │
└───────────────┘  ┌──────────┐     │ dealers                 │
                   │ Meth is  │     └─────────────────────────┘
                   │ easy to  │
                   │ get      │     ┌─────────────────────────┐
                   └──────────┘     │ Meth sales occur in     │
                      But why?      │ public areas with little│
                                    │ fear of arrest          │
                                    └─────────────────────────┘
                                              But why here?
```

Draft the logic model

A logic model identifies short-term, intermediate, and long-term outcomes. It tells you the kind of information to collect and document for your coalition and funder(s) to show that you are on the right track, moving in the right direction, and likely to accomplish your longer-term objectives. As mentioned earlier, there are a number of different forms that can be used to develop a logic model. Figure 5 on pages 38-39 is an example of a simple logic model that includes a theory of change, problem, strategies, activities, and short-term, intermediate, and long-term outcomes. This example is presented in greater detail in the Institute's *Planning Primer* from this series. This sample is intended to outline the basics of constructing a logic model for a community anti-drug coalition.

The following scenario illustrates the logical sequence presented in Figure 5. Assume that your community assessment found that a high percentage of young adults (age 18-25) are using methamphetamine drugs. Your coalition decides to select this as its high priority issue. Over time, the coalition wants to see a significant decrease in the percent of young adults who report using meth, the percent of young adults in treatment for meth addiction, percent of meth-related drug arrests and percent of meth-related hospital visits.

The coalition decides to use strategies including:
- **Decrease access** to precursor chemicals;
- **Build skills and provide information**;
- **Pass public policy/legislation and increase barriers** to manufacture of meth;
- **Delay initiation** of use; and
- **Increase** treatment availability.

Your coalition is now ready to continue the development and refinement of your logic model. This is covered in greater detail in the Institute's *Planning Primer.*

**Remember: if you are a DFC coalition, your coalition is charged with addressing alcohol, tobacco, marijuana, and any other drug problems in the community—not just focusing on a single substance as shown in Figure 5.

CONCLUSION

By now you have brought a lot of people to the table and are well under way in assessing ATOD problems in your community. This is a good time to check and see if anyone is missing and be sure they are invited to become a coalition member/partner. If representatives from these groups do not show up at meetings, it is worth a visit from a persuasive and influential coalition member to try to identify any barriers that might preclude their participation. Are your meetings productive? Do coalition members extend themselves and welcome new members? In order to develop and maintain a diverse coalition, it is important for the coalition members to ask themselves these questions periodically, and make adjustments where needed.

A final word about cultural competence as it relates to assessment: Community anti-drug coalitions have much to gain by committing to increase their cultural competence. A coalition's ability to communicate effectively within a diverse cultural environment brings new perspectives, ideas, and strategies to the table and can deepen trust and cooperation among community members. An authentic community assessment validates indigenous knowledge and includes feedback from and the involvement of those who are most affected by the problem. Culturally competent coalitions are more likely to be effective coalitions.

A final word about sustainability as it relates to assessment: Sustainability goes well beyond finding funding sources to support your prevention efforts. Sustainability is a process, not a result, denoting action, not maintaining the status quo. Your coalition is the backbone of your prevention efforts, and needs to be tended to. Building a strong coalition infrastructure to support prevention initiatives is crucial. Sustaining the interest of coalition members as time goes on means working on current problems and continuing to collect and assess current data and trends in the community. Working toward sustainability as you progress through each phase of the SPF takes a lot of intentional effort but is well worth the effort, and can make all the difference in the success of your efforts.

Figure 5. Sample Logic Model**

Theory of Change

When a community comes together and implements multiple strategies to address young adult use of methamphetamines in a comprehensive way, young adults will be more likely to use less.

Problem Statement			Strategies
Problem	**But Why?**	**But Why Here?**	
Too many young adults are using methamphetamine drugs	Meth is easy to make	Over–the-counter products are sold that contain ephedrine and pseudoephedrine used to make meth Anhydrous ammonia is easily accessible to meth manufacturers	Decrease access to precursor chemicals
		Labs are plentiful, easily hidden, hard to locate	Build skills and provide information Increase barriers to manufacture meth
	Meth is easy to get	There are identified dealers Meth sales occur in public areas with little fear of arrest	Provide education Increase barriers and pass policy
	There is high demand for meth	There is a demand for meth among young adults that feeds the supply	Delay initiation
		Meth users do not have access to treatment in our community	Increase treatment availability

	** See note on page 36		

Activities	Outcomes		
	Short-term	**Intermediate**	**Long-term**
Develop and enforce policies Increase barriers to meth production Change the physical environment	50% of public report support of policy changes Decrease in OTC precursor product sales/thefts Change the physical environment	Decrease in perceived availability Increased busts of meth labs by law enforcement % of house fires related to meth decreases	% of young adults reporting meth use decreases % of young adults in treatment for meth addiction decreases % of meth arrests as a proportion of all drug-related arrests decreases % of meth related ER/Hospital visits decreases
Increase barriers to meth production	Public reports possible meth labs		
Increase barriers and pass policy Increase surveillance and enforcement	Public reports possible meth dealers Public reports possible meth sales locations	% of meth sale busts decreases Decrease in perceived availability	
Change community practices/systems to engage in comprehensive meth prevention Build skills	% of all community members (children, parents, organizations, citizens, etc.) that participate in prevention programs	Increase in perceived harm Increase in age of initiation	
Enhance access/remove barriers Change community practices/systems	Treatment services are developed/ expanded to address meth use	% of young adults referred to treatment for meth decreases	

A word about words

As noted at the beginning of this primer, there are a number of terms that sometimes are used interchangeably. Often, the difference depends on who is funding your efforts or the field from which you come. The following chart highlight terms that often are used to describe the same or similar concept.

A word about words			
Assess	**Plan/Implement**	**Evaluate**	
"The problem is... But why? But why here?"			
What you want	**What you do to get there**	**Are you getting there?**	**Did you get there?**
• Aim • Goal • Objective • Target	• Activity • Approach • Initiative • Input • Method • Policy • Practice • Program • Strategy	• Benchmark • Indicator • Intermediate Outcome • Input/Output • Measure • Milestone • Short-term Outcome • Output	• Impact • Outcome • Results
←------------------------- Build Capacity -------------------------→ ←------------------------- Sustain the Work -------------------------→ ←----------------- Increase Cultural Competence -----------------→			

GLOSSARY

Activity. Things that you do—activities you plan to conduct in your program

Agent. In the public health model, the agent is the catalyst, substance, or organism causing the health problem. In the case of substance abuse, agents are the sources, supplies, and availability.

Aim. A clearly directed intent or purpose, an anticipated outcome that is intended or that guides your planned actions, the goal intended to be attained

Approach. The method used in dealing with or accomplishing: a logical approach to the problem.

Assumptions. Assumptions explain the connections between immediate, intermediate, and long-term outcomes and expectations about how your approach is going to work.

Benchmark. Measure of progress toward a goal, taken at intervals prior to a program's completion or the anticipated attainment of the final goal.

Community assessment. A comprehensive description of your target community (however your coalition defines community). The assessment process is a systematic gathering and analysis of data about your community.

Community-level change. This is change that occurs within the target population in your target area.

Demographic data. Data that describes a place and the people living in a community. Commonly collected demographic data include size, population, age ethnic/cultural characteristics, socio-economic status, and languages spoken.

Denominator. The bottom number in a fraction. This fraction is what you need to compare a part to the whole. The denominator or total numbers provides a common point of reference

Empirical data. Relying on or derived from observation or experiment. Information derived from measurement made in "real life" situations (e.g., focus groups, one-on-one interviews).

Environment. In the public health model, the environment is the context in which the host and the agent exist. The environment creates conditions that increase or decrease the chance that the host will become susceptible and the agent more effective. In the case of substance abuse, the environment is the societal climate that encourages, supports, reinforces, or sustains problematic use of drugs.

Framework. A framework is a structure that is used to shape something. A framework for a strategy or approach supports and connects the parts.

Goal. A goal states intent and purpose, and supports the vision and mission statements. For example: "To create a healthy community where drugs and alcohol are not abused by adults or used by youth."

Group IQ. The ability to engage collectively in strategic thinking to plan for and implement effective community-level strategies.

Host. In the public health model, the host is the individual affected by the public health problem. In the case of substance abuse, the host is the potential or active user of drugs.

Impact. The ultimate influence or effect a program has on a targeted problem or condition.

Incidence. The rate at which new events occur in a population, i.e., the number of new cases of a disease in a specific period of time, divided by the total population at risk of getting the disease during that period. It is often expressed as rates per million population.

Indicator. A measure that helps quantify the achievement of a result, outcome, or goal.

Initiative. A fresh approach to something; a new way of dealing with a problem, a new attempt to achieve a goal or solve a problem, or a new method for doing this.

Input. Organizational units, people, funds, or other resources actually devoted to the particular program or activity.

Intermediate outcome. Results or outcomes of program activities that must occur prior to the final outcome in order to produce the final outcome. FOR EXAMPLE, a prison vocation program must first result in increased employment (intermediate outcome) before it may expect to reduce recidivism (final outcome).

Logic model. Presents a diagram of how the effort or initiative is supposed to work by explaining why the strategy is a good solution to the problem at hand and making an explicit, often visual, statement of activities and results. It keeps participants moving in the same direction through common language and points of reference. Finally, as an element of the work itself, it can rally support by declaring what will be accomplished, and how.

Measure. n. The value assigned to an object or an event; v. express as a number or measure or quantity.

Methodology. The means and logical procedure by which a program plan or approach is implemented.

Milestone. A significant point of achievement or development, which describes progress toward a goal.

Objective. Objectives are the specific, measurable results a coalition plans to accomplish and serve as the basis by which to evaluate the work of the coalition. Each objective should have a timeframe by which it will be accomplished. "To reduce the number of youth in our community who smoke at age 15 from 18.5 percent to 10 percent by 2007."

Observational data. A method that documents visual data in the community.

Outcome. Outcomes are used to determine what has been accomplished, including changes in approaches, policies, and practices to reduce risk factors and promote protective factors as a result of the work of the coalition. An outcome measures change in what you expect or hope will happen as a result of your efforts.

Outcome evaluation. Evaluation that describes and documents the extent of the immediate effects of coalition strategies, including what changes occurred.

Output. The product or service delivery/implementation targets you aime to produce.

Per capita rates. Rates per unit of population; per person.

Policy. A governing principle pertaining to goals, objectives, and/or activities. It is a decision on an issue not resolved on the basis of facts and logic only. For example, the policy of expediting drug cases in the courts might be adopted as a basis for reducing the average number of days from arraignment to disposition.

Practice. A customary way of operation or behavior.

Prevalence. The number of people with a disease at a given time, or at any time in a specified period, divided by the number of people at risk from that disease. It is often expressed as rates per million population.

Primary data. Information you collect and compile.

Process evaluation. Evaluation that describes and documents what was actually done, how much, when, for whom, and by whom during the course of the project.

Program. Any activity, project, function, or policy with an identifiable purpose or set of objectives.

Protective factors. The factors that increase an individual's ability to resist the use and abuse of drugs, e.g., strong family bonds, external support system, and problem-solving skills.

Qualitative data. Non-numerical data rich in detail and description, usually presented in a textual or narrative format, such as data from case studies, focus groups, or document review.

Quantitative data. Information that can be expressed in numerical terms, counted, or compared on a scale.

Readiness. The degree of support for, or resistance to, identifying substance use and abuse as a significant social problem in a community. Stages of community readiness for prevention provide an appropriate framework for understanding prevention readiness at the community and state levels.

Resource assessment. Both describe the resources currently being used and the resources that could be directed towards addressing identified problems in the community.

Resources. A resource is any or all of those things that can be used to improve the quality of community life   the things that can help close the gap between what is and what ought to be.

Results. The consequences and outcomes of a process or an assessment. They may be tangible such as products or scores, or intangible such as new understandings or changes in behavior.

Risk factors. Those factors that increase an individual's vulnerability to drug use and abuse, e.g., academic failure, negative social influences and favorable parental or peer attitudes toward involvement with drugs or alcohol.

Secondary/archival data. Data that is already being collected and compiled on another organization or group.
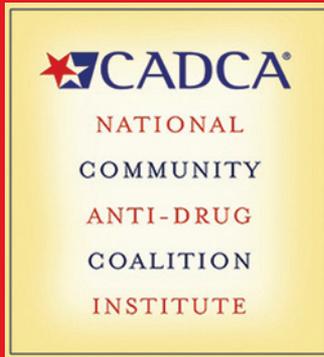
Short-term outcome. Changes expected to occur either immediately or very shortly after implementation of activities.

Strategy. The strategy identifies the overarching approach of how the coalition will achieve intended results.

Sustainability. The likelihood of a strategy to continue over a period of time, especially after specific funding ends.

Targets. Defines who or what and where you expect to change as a result of your efforts.

Theory of change. A theory of change creates a commonly understood vision of the problem being addressed and defines the evidenced-based strategies or approaches proven to address that problem.