



The Evaluation of Positive Potential in Rural Northwest Indiana

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| Grantee | PATH, Inc. Project Director, Donna Golob, donna@pathblazer.org |
| Evaluator | ITMESA, LLC Harry Piotrowski, MS, zhp@sprynet.com |
| Intervention Name | Positive Potential |
| Intervention Description | <p>The Positive Potential instruction is a stand-alone, longitudinal, and developmental whole-child program for adolescents. Positive Potential was developed for primarily white middle school youth in rural communities. The curriculum focuses on positive youth development, with emphasis on a child’s possible self and future self, goal orientation, positive school performance, and risk-reduction and risk-elimination behaviors with sexual activity and other adolescent risk behaviors (such as alcohol, tobacco, drugs, violence, pornography, and bullying). Students are encouraged with risk-avoidance and developmental health-promotion strategies.</p> <p>Positive Potential is a supplemental program provided to the students in addition to the health/physical education curricula they already receive as part of their regular school education. The program replaces instruction occurring in other core academic or health/physical education classes. Students attend five 45- to 50-minute sessions on consecutive days in grades 6 (Be the Exception), 7 (Push the Limits), and 8 (Unstoppable). Instruction is provided by a male–female facilitator team and features engaging and participatory interactions and multimedia presentations. Students also attend a 45-minute assembly at the end of each grade and at the start of grade 9. The assemblies, presented by program facilitators, are multimedia events reviewing content and reinforcing the instruction for that year in middle school curricula and over the three years at the beginning of grade 9.</p> |
| Counterfactual | Business as usual |
| Counterfactual Description | The control school youth continue to participate in the usual health education instruction, after-school activities, or other community activities and instruction about risk behaviors and health. The school general health curriculum usually includes one lesson on sexually transmitted disease/HIV prevention. Control group students also attend assemblies at the same times as the treatment group students; however, the assemblies focus on topics not related to the Positive Potential instruction, such as general health and exercise. Nationally recognized speakers present to the assembly each year and avoid any content that is presented in the treatment groups. |
| Primary Research Question(s) | What is the impact of the Positive Potential instruction relative to business as usual health instruction on the occurrence of sexual intercourse activity one year after the end of treatment? |
| Additional Outcomes | Reduction in sexual activity; reduction in sexual risk activity (use of condom and other birth control, alcohol, or drugs); risk avoidance (initiated sexual intercourse); reduction in violent behaviors; decrease in substance use such as alcohol, tobacco, and drugs; enhanced school performance; and positive change in attitudes about sexual activity, healthy choices, and future goals |

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| Sample | Elementary and middle schools were selected by demographic criteria (rural, low-income, and high risk based on adolescent birth rates and rates of sexual activity) from five northwest Indiana counties. Schools with established relationships were contacted first, followed by additional schools. Meetings were held with school administrators to introduce and describe the project, discuss the feasibility of participating, gain their cooperation with a letter of invitation, and secure a memorandum of agreement. Two cohorts of 6th-grade students from 16 schools were recruited in 2011 and again in 2012. Youth were eligible if they were in the 6th grade, able to read and comprehend English at least at a 5th-grade level, and provided parental consent and student assent. Two schools dropped from the study, leaving a total of 1,776 youth enrolled (970 treatment and 806 control). The sample size in the first cohort was 827 youth (421 treatment and 406 control) and the size of the second cohort was 949 (549 treatment and 400 control). |
| Setting | Public middle and elementary schools with a 6th grade in five northwestern Indiana counties participated in the four-year longitudinal research study. The setting represents predominantly rural farming and largely white communities. |
| Research Design | <p>The evaluation is a cluster randomized controlled longitudinal trial with recruitment of students in 16 schools. Sixteen schools, pair-blocked by grade 6 size to avoid highly skewed groups, were randomized into treatment or control groups. Either a classroom teacher or health educator distributed consent packets to 6th-grade youth to take home to obtain parental permission to participate in the study. After collection of parental consent and student assent and administration of a baseline questionnaire, students were then notified of their schools' assignment. Data collection occurs at seven points in time: pre-instruction and 3 months post-instruction follow-up each year (6th, 7th, and 8th grade), and a 12-month post-instruction follow-up in 9th grade. Youth completed self-report paper-and-pencil questionnaires. If a student was not present during the group administration of the questionnaire, arrangements were made to have the student complete the questionnaire using a computer, a paper-and-pencil questionnaire, or by telephone.</p> <p>Quantitative and qualitative data were also collected on program implementation to assess fidelity or quality of youth-facilitator interactions and youths' self-reported perceived outcomes for each of three curricula in grades 6, 7, and 8.</p> |
| Impact Findings | To be determined when data collection and analysis are complete. |
| Implementation Findings | To be determined when data collection and analysis are complete. |
| Schedule/Timeline | Sample recruitment for all youth ended in December 2012. Across both cohorts, pre-6th-grade instruction data collection ended in December 2012, 3-month post-6th-grade instruction data collection ended in March 2013, pre-7th-grade instruction data collection ended in November 2013, 3-month post-7th-grade instruction data collection ended in February 2014, pre-8th-grade instruction data collection ends in December 2014, and 3-month post-8th-grade instruction ends in March 2015. For the first cohort only, 12-month post-8th-grade instruction (fall of grade 9) ends in December 2014. A final report, which focuses on 12-month post-instruction follow-up data for the first cohort, will be available to the Office of Adolescent Health in 2015-2016. |