

BRIEF INTERVENTION META-ANALYSIS: 2017 UPDATE CODING MANUAL

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ELIGIBILITY CRITERIA

This meta-analysis deals with the effects of brief alcohol interventions on alcohol use among adolescents and young adults. To be eligible for coding, a study must use an eligible intervention directed toward an eligible participant sample, report information on at least one eligible outcome variable, and employ an eligible research design.

1. INTERVENTIONS

- a. There must be a brief intervention program that involves actions performed with the expectation that they will have beneficial effects on participants' alcohol use or alcohol-related outcomes.
- b. Eligible brief interventions can be as short as 1 session with at least 5 minutes of total contact time, but no longer than 5 hours of total contact time between the first session and last session, excluding booster session length (e.g., follow-up phone calls, pamphlets). As long as an intervention meets the 'brief' criteria, it can be guided by any theoretical framework and conducted in any setting. If you have any questions about whether an intervention qualifies as "brief", please bring to the group for discussion.

2. SUBJECTS

- a. The research must investigate outcomes for adolescents and young adults, defined as individuals age 25 or younger. If the brief intervention is provided to a sample including participants over age 25, it will be eligible for inclusion only if it reports eligible outcome data separately for a qualifying adolescent/young adult population, or if the sample is comprised entirely of undergraduate college students. Eligible samples can include participants across all levels of the alcohol consumption spectrum (experimental users to alcohol dependent users).

3. RESEARCH DESIGNS

- a. An eligible study must use an experimental research design or a quasi-experimental design. Single group studies are not eligible. Studies that compare more than one treatment group to a single control group are eligible; in these cases, effect sizes should be calculated for each treatment group compared to the control group.
- b. Studies that use a quasi-experimental research design where participants are not randomly assigned or matched must include enough information to calculate a pretest effect size statistic for at least one **alcohol-use or alcohol-related problems** outcome.
- c. Treatment-treatment studies that compare two or more interventions to each other without a control group may be eligible if one of the intervention groups receives a 'sham' or 'straw-man' treatment that is equivalent to a control condition, or if one of the interventions is a practice as usual condition in which that practice is not a distinctive program delivered at a relatively high level.

NOTE: These should be set aside and brought to the attention of the group for discussion.

4. OUTCOME VARIABLES

- a. The study must assess intervention effects on at least one outcome variable that represents alcohol consumption or alcohol-consumption-related problems. Qualifying outcome variables are those that fall in or are substantially similar to the following categories:
 - Alcohol use;
 - Alcohol use disorder symptoms;
 - Alcohol use disorder diagnoses;

Other broad measures of alcohol-related problems (e.g., DUI arrests, work problems due to drinking, relationship problems due to drinking). General measures of life problems are not qualifying outcome variables unless they are explicitly measuring problems associated with alcohol consumption.

5. DATE OF PUBLICATION

- a. Eligible studies should be relatively modern, to be applicable to contemporary adolescents and young adults. Therefore, the date of publication or reporting of the study must be 2013 or later.

6. EFFECT SIZES

- a. The study must report sufficient information to make a statement about intervention effectiveness. If quantitative data are available to compute an effect size on an eligible outcome, the variables involved in the effect size must have a known direction of scoring, i.e., whether high or low values represent favorable or less favorable results. Studies that meet all eligibility criteria but for which an effect size cannot be calculated, should be identified and held separately for further consideration.

NOTE: If a study meets all other eligibility criteria except for this one, do not exclude, but bring to the attention of the group for discussion.

7. STUDY SITE and LANGUAGE

- a. The study can be conducted in any country, but must be reported in English.

BRIEF INTERVENTION PROJECT CODING MANUAL

STUDY LEVEL CODING

Step 1. Study Identifiers and Design Characteristics

STUDY IDENTIFIERS

The “unit” you will code here consists of a study, i.e., one research investigation of a defined subject sample or subsamples compared to each other, and the treatments, measures, and statistical analyses applied to them. Sometimes there are several different reports (e.g., journal articles) about a single study. In such cases, the coding should be done from the full set of relevant reports, using whichever report is best for each item to be coded; **be sure you have the full set of relevant reports before beginning to code.** Sometimes a single report describes more than one study, e.g., one journal article could describe a series of similar studies done at different sites. In these cases, each study should be coded separately as if each had been described in a separate report.

Each study has its own study identification number, or StudyID (e.g., 619). Each report also has an identification number (e.g., 619.01). The ReportID has two parts; the part before the decimal is the StudyID, and the part after the decimal is used to distinguish the reports within a study. (These two types of ID numbers, along with bibliographic information, are assigned and tracked using the bibliography.) When coding, use the study ID (e.g., 619) to refer to the study as a whole, and use the appropriate report ID (e.g., 619.01) when referring to an individual report.

[coder]

Coder's initials (select from menu)

[country]

Country in which study was conducted.

1. USA
2. Great Britain
3. Canada
4. Scandinavia: Denmark, Finland, Norway, Sweden
5. Australia/New Zealand
6. Other Western European Country: _____
7. Other: _____

[unit]

Unit of group assignment. The unit on which assignment to groups was based.

1. Individual (i.e., some youth assigned to brief intervention, some to comparison group)
2. Cluster (i.e., whole classrooms, therapy groups, facilities assigned to treatment and comparison groups)
99. Cannot tell

[clusteradj]

If participants are assigned to intervention/control groups in clusters, do the effect size statistics need cluster adjustments?

1. Yes
2. No

From the Cochrane Handbook:

In cluster-randomized trials, groups of individuals rather than individuals are randomized to different interventions. Cluster-randomized trials are also known as group-randomized trials. The groups may be, for example, classes, hospitals, medical practices, etc.

One of the main consequences of a cluster design is that participants within any one cluster often tend to respond in a similar manner, and thus their data can no longer be assumed to be independent of one another. Many of these studies, however, are incorrectly analysed as though the unit of allocation had been the individual participants. This is often referred to as a 'unit-of-analysis error' because the unit of analysis is different from the unit of allocation. If the clustering is ignored and cluster trials are analysed as if individuals had been randomized, resulting P values will be artificially small.

*Statistical methods exist that allow analysis at the level of the individual while accounting for the clustering in the data. The ideal information to extract from a cluster-randomized trial is a direct estimate of the required effect measure (for example, an odds ratio with its confidence interval) from an analysis that properly accounts for the cluster design. Such an analysis might be based on a 'multilevel model', a 'variance components analysis' or may use 'generalized estimating equations (GEEs)', among other techniques. Statistical advice is recommended to determine whether the method used is appropriate. **If the authors randomized at the cluster level, but analyzed the data at the individual level without using one of these methods, then the effect sizes will need "cluster adjustments".***

[design]

How participants/units were assigned to groups. This item focuses on the initial method of assignment to groups, regardless of subsequent degradations due to attrition, refusal, etc. prior to treatment onset. These latter problems are coded elsewhere.

1. Randomized experiment. This includes cases when every other person goes to the control group. This also includes cases where the entire sample is matched or blocked first, then assigned to treatment and comparison groups within pairs or blocks. This includes group randomized trials if the number of aggregates is adequate and properly analyzed.
2. Randomized experiments with units of analysis discrepancy or very small number of aggregates. This may include cases where groups were randomly assigned to conditions, but individuals were treated as the unit of analysis, or one group per condition.
3. Quasi-experiment, interrupted time series design.
4. Quasi-experiment, regression discontinuity design.
5. Quasi-experiment, matched group design (including propensity scores).
6. Quasi-experiment, non-equivalent comparison group design.
7. Other. Design that has both random assignment and self-selection into several groups.
99. Cannot tell

BRIEF INTERVENTION PROJECT CODING MANUAL

GROUP LEVEL CODING

Create one record in this database for each of the aggregate treatment and/or control groups that you selected earlier for coding. Studies with a treatment group and a control group will have two records, studies with two treatment groups and a control group will have three records, etc.

Group Identification and General Nature of Treatment

[groupid]

Number each group consecutively within a study, starting with 1.

[tvc]

Select the type of group you are coding.

1. Treatment group
2. Control group

[gtype]

What general type of “treatment” does this group receive?

1. Focal intervention. There may be several focal interventions in a study, as when two different types of interventions, both of which could be expected to be effective, are compared.
2. “Straw man” alternate program or intervention, diluted version, less extensive program, etc., not expected to be effective but used as contrast for intervention group of primary interest. If the alternate intervention is not minimal and could realistically be expected to be effective, it is not a control condition and should be classified as a focal intervention instead.
3. Attention/sham treatment. Group gets some attention or sham treatment (e.g., watching Wild Kingdom videos while intervention group gets intervention)
4. Treatment as usual. Group gets “usual” handling instead of some special treatment.
5. No treatment control group. Group gets absolutely no treatment (although they may get pretested).

[progname]

Program name. Write in program or label for this group (e.g., Motivational Interviewing Group, waiting list control, etc.).

Participant Characteristics

[perwhite]

Percent white

[perblack]

Percent black

[perhisp]

Percent Hispanic

[peroth]

Percent other minority

[pernonwhite]

Percent non-white (only use this category if specific minority groups are not mentioned; if you use this category, there should only be numbers in the white and non-white categories)

[permale]

Enter percent male: _____ (use decimals, i.e., .42 NOT 42%)

[gendercomp]

Gender composition of group.

1. No males (<5%)
2. Some males (<50%)
3. 50% to 60% male
4. Mostly males (>60%)
5. All males (>95%)
99. Cannot tell

[age]

Enter the average age of the sample using number of years. Enter 9999 if you cannot tell.

[agelow] [agehi]

High and low age using years. Enter 9999 if you cannot tell.

[percoll]

Enter the percent of the sample enrolled in postsecondary education (college). Enter 9999 if you cannot tell.

[alclevel]

NOTE: THIS ITEM SHOULD BE REVISED BASED ON TEAM DISCUSSION AND CONSIDERATION

Indicate the overall modal level of alcohol use in the subject sample:

1. Abstainers (i.e., prevention program)
2. Low-experimenters (occasional, infrequent use)
3. Medium-regular users (sub-clinical use; frequent or consistent use below clinical or hazardous thresholds)
4. Hazardous users (sub-clinical use; binge drinkers with high volume drinking)
5. Abusers (DSM diagnosis or equivalent; use-related school, legal, familial, social, physical, or work problems, etc.)
6. Dependent (DSM diagnosis or equivalent; tolerance, withdrawal symptoms)
99. Cannot tell

[alctext]

Include description of information used to make alcohol severity decision along with report number and page number (when appropriate).

[perbinge]

Percentage of *past month* binge-drinkers in subject sample. Enter 9999 if you cannot tell.

INTERVENTION CHARACTERISTICS

[txttype]

NOTE: THESE DEFINITIONS SHOULD BE REVISED BASED ON TEAM DISCUSSION AND CONSIDERATION

First check all program types that apply to a given intervention (e.g., a program may include CBT, PET, and skills training components in combination).

Second, choose the **one** program type that can be considered the focal intervention characteristic. Most intervention will arguably deliver multiple service types, but do your best to narrow the focal type down to one category.

1. Behavioral therapy, contingency management: intervention based on principles of behavioral psychology focused on rewards and punishments. This will usually involve participants receiving rewards contingent on some behavior (e.g., receiving gift certificates or vouchers for abstinence).
2. Case management: intervention involves linking participants with other needed services, including mental health services, addiction health services, child care services, transportation, etc.
3. Cognitive behavioral therapy (CBT): intervention focuses on the importance of how individuals thoughts & cognitions affect their behavior. Intervention may focus on identifying cognitions and behaviors associated with substance use, and providing cognitive skills needed to cope with those situations. This might involve identifying problematic thoughts that lead to substance use or relapse, and using role playing to practice new thought patterns and behaviors in high risk situations.
4. Motivational enhancement therapy (MET)/motivational interviewing (MI): intervention goal is to address client ambivalence and enhance motivation for positive change through non-judgmental interactions. It is guided by the FRAMES acronym: FEEDBACK of personal risk/impairment; emphasis on RESPONSIBILITY for change; clear ADVICE to change; a MENU of alternative options; therapist EMPATHY; facilitation of client SELF-EFFICACY or optimism. Whereas MET attempts to get clients to recognize their strengths and motivate them to change, CBT focuses more on teaching and practicing behaviors and skills.
5. Motivational interviewing (MI)
6. CBT + MET: intervention uses both CBT and MET components. Includes MET components that focus on **why** patients may want to change their substance use; and CBT components that focus on **how** patients might change their substance use through teaching and practicing behaviors.
7. Psychoeducational therapy (PET): intervention that focuses mostly on educating participants about substances, harms associated with substances, etc. Primarily education focused with no personal reflection or insight.
8. Family focused therapy: intervention that focuses on identifying or addressing family processes that may be associated with substance use.
9. Feedback/information only: intervention that solely provides feedback to the participant on their drinking habits or provides a reminder to drink responsibly (ex: 21st birthday card mailed to college students). This should only be checked if no other intervention methodology is used.
10. Relapse prevention skills training
11. Skills training (non-relapse focused)

10. Other (please specify): any other intervention that does not fall into the categories above.

[txcomp]

Intervention components (check all that apply)

2. Advice (normative prescriptions for behavior change): this involves providing youth with normative prescriptions or explicit directive instructions for behavior change.

3. Feedback (personalized feedback on use levels): this involves providing youth with some form of personalized feedback regarding their alcohol/drug use. Usually this involves summarizing youth's assessment results, so it provides individual level information that is relevant to that specific youth. Feedback does not necessarily include advice (i.e., directive advice) but can be purely factual information.

4. Goal-setting: this involves encouraging or helping youth set goals for making behavior change.

5. Norm referencing: this involves comparing the youth's alcohol/drug use to some normative reference group (usually compared to other youth in the same school/grade/university, or to some national norms).

6. Education/information: this involves the provision of very broad, generic education or information (e.g., information on the characteristics of certain drugs, alcohol effects on the brain, etc).

7. Decisional balance (pros/cons): this involves outlining or discussing the pros and cons of drinking or using drugs, or any situations associated with alcohol/drug use.

8. Expectancy challenges: this involves experimental settings where youth are 'set up' in ways that will make them challenge their expectations. Generally this involves experimental research settings where participants think they or other participants have received alcohol, but some have not; and the researchers measure the effects on their expectations of behavior (See Study 2644.01 for an example of a classic expectancy challenge experiment).

9. Identifying high risk situations: this involves identifying the social situations or other situations in which the youth is most likely to use alcohol/drugs, or use them heavily. The goal is generally to identify those high risk situations so that the youth can try to minimize these situations, or learn ways to cope with those situations to minimize their alcohol use.

10. Provided materials: use this component only if the intervention component cannot be encapsulated in any other component category. This involves youth receiving some form of materials – including pamphlets, CD-ROMS, postcards, etc.

11. Moderation strategies discussion: this involves **discussions that focus on identifying or coming up with strategies the youth can use to drink less alcohol. This might involve using smaller shot glasses, drinking water in between alcoholic drinks, etc.**

13. Peer pressure refusal skills: this involves teaching youth skills or strategies to resist peer pressure. This might include discussing options for resisting peer pressure, or practicing/role-playing situations where the youth resist peer pressure.

1. Assessment
2. Advice
3. Feedback
4. Goal-setting

5. ~~Norm-referencing~~
6. ~~Education/information~~

[site]

Intervention Site. Nature of the site in which intervention generally delivered: (select one)

1. School/university health center
2. University, self-administered
3. University, other (i.e., not self-administered, not in campus health center)
4. Primary care setting (doctor's office), not on school campus
5. Emergency room, trauma center
6. Other setting (please specify)
7. High school setting
8. OBGYN/prenatal care setting
9. ~~Police station~~
10. ~~School~~
11. ~~Mental health agency (public or private)~~
12. ~~Research setting, university, or research organization~~
13. ~~Other (please specify)~~
99. Cannot tell

[manual]

Did this group receive a manualized intervention program?

1. Yes. Do not infer that the treatment was manualized. Select 'yes' only if the report specifically indicates that the treatment was manualized.
2. No, but some indication of a written curriculum/script/protocol that is not called 'manualized'.
3. No, no indication of a manualized treatment or written curriculum/script/protocol.

[delmode]

Primary delivery mode of intervention.

1. Face to face with provider
2. Pen and paper; little to no interaction with physical provider (e.g., pamphlet)
3. Computerized
4. Other _____
5. Mixed, no predominant mode
6. 99. Cannot tell

[format]

Check all of the formats used in the intervention sessions

1. Subject alone (self-administered treatment, e.g., computer course)
2. Subject and provider(s), one on one (e.g., individual interviews)
3. Subject group and provider(s)
4. Subject with family/parents and provider(s)
5. Other _____

[txdur]

Duration of intervention. Approximate number of **minutes** subjects received the brief intervention, from first treatment event to last excluding follow-ups designated as such. Multiply hours by 60. Code 999 if cannot tell. Estimate for this item if possible.

[sessions]

Number of intervention sessions. Approximate (or exact) number of unique **sessions** over which the participants received the intervention. Code 999 if cannot tell. Estimate for this item if necessary, and if you can come up with a reasonable order of magnitude number.

[txdays]

Number of **days** covered by the intervention period. Approximate (or exact) number of days over which the entirety of intervention sessions spanned. Code 999 if cannot tell. Estimate for this item if necessary, and if you can come up with a reasonable order of magnitude number.

[impmon]

Monitored intervention implementation. Was the implementation of the program monitored by the author/researcher or program personnel to assess whether it was delivered as intended?

1. Yes, with no indication of feedback to treatment providers. Do not infer that monitoring happened. Select "yes" ONLY if the report specifically indicates that implementation was monitored.
2. Yes, with indication of feedback to providers.
3. No indication that service delivery was monitored.
99. Cannot tell

[impprob]

Was there any uncontrolled variation or degradation in implementation or delivery of treatment, e.g., high dropouts, erratic attendance, treatment not delivered as intended, wide differences between settings or individual providers, etc.? Assume that there is no problem if one is not specified.

1. Yes (describe below)
2. Possible (describe below)
3. No, apparently implemented as intended

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OUTCOME LEVEL CODING

[dvdes]

Describe construct. Provide a brief description of the outcome measure, its operational definition, and what type of scale it originated from (if applicable).

[dvmacro]

Select the broad outcome construct group

1. Substance Use
2. Substance Use Disorder Diagnoses
3. Substance Use Related Problems

[dvmicro]

Select the specific outcome construct group

100. Alcohol use
200. Alcohol abuse diagnosis
201. Alcohol dependence diagnosis
202. Alcohol use disorder (abuse OR dependence) diagnosis
300. DUI/DWI
301. Arrests due to alcohol use
302. Work problems due to alcohol use
303. Relationship problems due to alcohol use
304. Risky sexual behavior due to alcohol use
305. Other negative consequences associated with alcohol use
306. Mixed negative consequences associated with alcohol use

[dvdays]

Time period covered by this dependent variable. Total number of days over which the information presented in this dependent variable was counted. This question applies mainly to variables like alcohol consumption that are continuously counted and thus might be presented in study reports as: number of drinks in the past month (you would code 30 days for this). Measures like alcohol use disorder diagnoses, which are measured at discrete time points and do not cover a certain time period, should be coded as 888 for not applicable.

If you have two measures of the same construct (such as alcohol use) that have *different time period coverage*, then you must create two separate dependent variables.

BRIEF INTERVENTION PROJECT CODING MANUAL

EFFECT SIZE CODING

This portion of coding requires familiarity with some basic statistics, including means, standard deviations, proportions, t-tests, chi-squares, ANOVA (or F-tests), and the like.

Step 1. General Information

[reportid]

Report ID for this effect size. Indicate the report number (e.g., 2098.01) for the report in which you found the information for this effect size. This is important so that we can find the source information for the effect sizes later on, if necessary, and is especially important for studies with multiple reports.

[pagenum]

Page number for this effect size. Indicate the page number of the report identified above on which you found the effect size data. If you used data from two different pages, you can type in both, but use a comma or dash between the page numbers.

[estype]

Type of effect size:

1. Pretest. This effect size measures the difference between an intervention and comparison group before the intervention (or at the beginning of the intervention) *on the same variable* used as an outcome measure, e.g., alcohol use measured before the intervention begins is used as a pretest for alcohol use measured the same way after the intervention ends.
2. Posttest. This effect size measures the difference between two groups *after intervention* on some outcome variable.

[wave]

Wave number. Pretest effect sizes always get a 1; each wave thereafter gets numbered consecutively, beginning with 1. Some studies involve more than one posttest measurement on the same dependent variable, and we need to be able to distinguish one from another. Give the first posttest after treatment a 1, the second a 2, and so on.

[postwks]

Timing of measurement. Approximate (or exact) number of weeks after the intervention when measure was taken. Divide days by 7; multiply months by 4.3. Enter 999 if cannot tell, but try to make an estimate if possible. Enter 0 if pretest. If posttest measurement occurred during an ongoing treatment, use 888 here.

Step 2. Group Selection

[groupid1]

Group 1. If you are coding a treatment-control effect size, select the appropriate *treatment* group here. If you are coding a treatment-treatment effect size, select the focal treatment group here or, if neither is focal, select one here and the other as Group 2 below.

[groupid2]

Group 2. If you are coding a treatment-control effect size, select the appropriate *control* group here. If you are coding a treatment-treatment effect size, select the second of the two treatment groups here.

Step 3. Dependent Variable Selection

[varno]

Select the dependent variable for this effect size.

Step 4. Effect Size Calculation and Data Entry

You need to determine what effect size format you will use for each effect size calculation. There are two general formats you can use, each with its own section in the database:

- Compute ES from means, sds, variances, test statistics, etc.
- Compute ES from frequencies, proportions, contingency tables, odds, odds ratios, etc.

Also note that within each of the above effect size formats, effect sizes can be calculated from a variety of statistical estimates; to determine which data you should use for effect size calculation, please refer to the following guidelines in order of preference:

- Compute ES from descriptive statistics if possible (means, sds, frequencies, proportions).
- If adequate descriptive statistics are unavailable, compute ES from significant test statistics if possible (values of t, F, Chi square, etc.).
- If significance tests statistics are unavailable or unusable but p value and degrees of freedom (df) are available, determine the corresponding value of the test statistic (e.g., t, chi-square) and compute ES as if that value had been reported.

Note that if the authors present both covariate adjusted and unadjusted means, you should use the covariate adjusted ones. If adjusted standard deviations are presented, however, they should not be used.

[favor]

Which group is favored? Select the group that has done “better”:

1. Treatment
2. Control
3. Neither, Exactly Equal
4. Cannot tell

For treatment-control comparisons, the treatment group is favored when it does “better” than the control group. The control group is favored when it does “better” than the treatment group.

Remember that you cannot rely on simple numerical values to determine which group is better off. For example, a researcher might assess the attendance and report this variable in terms of the average number of absences in the last semester. Fewer absences are better than more, so in this case a lower number, rather than a higher one, indicates a more favorable outcome.

Sometimes it may be difficult to tell which group is better off because a study uses multi-item measures in which it is unclear whether a high score or a low score is more favorable. In these situations, a thorough reading of the text from the results and discussion sections usually can bring to light the direction of effect – e.g., the authors will often state verbally which group did better on the measure you are coding, even when it is not clear in the data table. Note that if you cannot determine which group has done better, you will not be able to calculate a numeric effect size. (You will still be able to create an effect size record—just not a numeric effect size.)

[esdata]

Effect size derived from what type of statistics?

1. Means and SDs; means and variances; means and standard errors
2. N successful/unsuccessful (frequencies)
3. Proportion successful/unsuccessful (percentage successful or not)
4. Multi-category (polychotomous) frequency or %
5. Independent t-test
6. One-way ANOVA (2 groups, 1 degree of freedom)
7. One-way ANOVA (>2 groups, >1 degree of freedom)
8. Covariance Adjusted (ANCOVA)
9. Chi-square statistic (1 degree of freedom; from 2x2 table)
10. Correlation coefficient (zero-order)
11. Hand calculated ES
12. Effect sizes as reported directly in the study
13. Other (please specify)

[esadj]

For this effect size, did you use adjusted data (e.g., covariate adjusted means) or unadjusted data? If both unadjusted and adjusted data are presented, you should use the adjusted data for the group means or mean difference, but use unadjusted standard deviations or variances. Adjusted data are most frequently presented as part of an analysis of covariance (ANCOVA). The covariate is often either the pretest or some personal characteristic such as socioeconomic status. If you encounter data that is adjusted using something other than a covariate, please see Sandra or Mark.

1. Unadjusted data
2. Pretest adjusted data (or other baseline measure of an outcome variable construct)
3. Data adjusted on some variable other than the pretest (e.g., socioeconomic status)

4. Data adjusted on pretest plus some other variables

Assigned and Observed N

Assigned N, Observed N. These fields refer to the number of subjects who were originally assigned to the group(s) involved in this effect size (Assigned N) and to the number of subjects who were actually “observed” or “measured” (Observed N). If you cannot tell how many subjects were originally assigned to a group, look at the number of subjects (Observed N) at pretest; you can frequently use pretest sample sizes for assigned N. However, in cases where the authors have removed the subjects who do not have both pretest and posttest measures (such that the pretest N and the posttest N are the same), do not assume that the number of subjects at pretest is the correct number for Assigned N and, instead, leave this field blank. In cases where there is no attrition, the Assigned N is the same as the Observed N. Only use the same numbers for Assigned N and Observed N when you are SURE that there is no attrition.

[n_txas]

Assigned N for the treatment group (or pretest, if this is a pretest-posttest effect size)

[n_ctas]

Assigned N for the comparison or second treatment group (or posttest, if this is a pretest-posttest effect size; if this is a pretest-posttest effect size, this value should be the same as the assigned N for the pretest).

[n_tx_ob]

Observed N for the treatment group (or pretest, if this is a pretest-posttest effect size)

[n_ct_ob]

Observed N for the comparison or second treatment group (or posttest, if this is a pretest-posttest effect size)

Other Effect Size Data Fields

[mean_tx]

Mean for treatment group

[mean_ct]

Mean for comparison group

[sd_tx]

Standard deviation for treatment group

[sd_ct]

Standard deviation for comparison group

[nsucc_tx]

N successful for treatment group

[nsucc_ct]

N successful for comparison group

[nfail_tx]

N failed for treatment group

[nfail_ct]

N failed for comparison group

[tvaldep]

Dependent t-value

[tvalind]

Independent t-value

[chisq]

χ^2 (df=1)

[esauth]

Effect size reported by authors

[orauth]

Odds ratio reported by authors

Final Effect Size Determination

[es21]

Effect size value- standardized mean difference; calculated automatically in database

[es81]

Effect size value- odds ratio; calculated automatically in database

Remember that you cannot rely on simple numerical values to determine which group has done better. For treatment-control comparisons, a positive effect size should indicate that the treatment group did “better” on the outcome measure than the comparison group, while a negative effect size indicates that the comparison group did “better” than the treatment group, and a zero effect size means that the two groups are exactly equal on the measure. For single-group pretest-posttest comparisons, a positive effect size indicates that the group did better at posttest than at pretest, while a negative effect size indicates that the group did better at pretest than at posttest, and a zero effect size means that the group’s performance was exactly equal at the two time points.

You must make sure that the sign of the effect size matches the way we think about direction, such that the effect size is positive when the treatment group (or posttest) is better and negative when the comparison group (or pretest) is better.

Standardized mean difference effect sizes can range anywhere from around –3 to +3. However, you will most commonly see effect sizes in the –1 to +1 range.

Odds ratio effect sizes can range anywhere from around 0 to $+\infty$. However, you will most commonly see effect sizes in the 0 to 5 range.

Note: If the authors report an effect size, include that in your coding and use it for the final effect size value if no other information is reported. However, if the authors also include enough

information to calculate the effect size, always calculate your own and report it in addition to that reported in the study.

[ES39] Any problems coding this effect size?

LITERATURE SEARCH STRATEGY

Main Databases

Host	Database(s)	Search String	Search Date
PubMed	PubMed		
ProQuest	ERIC IBSS PsycARTICLES PsycINFO ProQuest Dissertations & Theses Social Services Abstracts Sociological Abstracts		
CINAHL	CINAHL		

Supplementary Searches

Source	Description	Search String	Search Date
<i>Addiction</i>	Journal handsearch		
<i>Addictive Behaviors</i>	Journal handsearch		
<i>ACER</i>	Journal handsearch		
Campbell Collaboration	Journal handsearch		
Chestnut Health Systems	Website		
Cochrane Collaboration	CENTRAL		
CPDD	Conf. presentations		
Google Scholar	Google Scholar		
International Clinical Trials Registry	Clinical trials registry		
<i>JSAD</i>	Journal handsearch		
<i>Psychology of Addictive Behaviors</i>	Journal handsearch		
Research Society on Alcoholism	Conf. presentations		
Society for Prevention Research	Conf. presentations		