

Obtaining valid response rates: Considerations beyond the Tailored Design Method¹

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Abstract

This study reports on the use of the tailored design method for survey response in two separate studies (i.e., the Retrospective Study and the TIP # 24 Study). Both studies used similar procedures to design and collect the data, but yielded vastly different response rates. Examination of these studies revealed factors that may have influenced the response rates beyond the proscriptions described by the Tailored Design Method (TDM). Six factors that may have influenced non-response were: (1) the extent of participants' interest in the study, (2) the degree the researchers had a comprehensive understanding of the participants, (3) the characteristics of the mailing lists obtained, (4) selection criteria from that list, (5) types of incentives used, and (6) name recognition of the study sponsor. This study provides researchers with lessons for future mailed surveys.

Keywords: Treatment Improvement Protocols (TIPs); substance abuse; substance abuse treatment; mailed surveys; Tailored Design Method; survey response rate; survey participation; substance abuse treatment providers; primary care providers; problems in survey research; use of incentives; participant recruitment

1. Introduction

In survey research, response rates are an important factor that influences the generalizability and the overall validity of the study's findings. To achieve high response rates, researchers may employ established procedures, such as the Tailored Design Method (Dillman, 2000)². The Tailored Design Method (TDM) provides guidelines for instrument development (i.e., surveys) and also specifies the type and timing for initial contact, follow-up mailings, telephone follow-up, and incentives. The TDM approach makes it possible to achieve response rates of 60 to 70 percent or higher. However, the use of TDM does not guarantee a high response rate. In some cases, despite the best efforts of researchers to follow the TDM procedures, the response rate may turn out to be less than adequate.

¹The opinions and assertions contained in this article are the private views of the authors and are not to be construed as official or as reflecting the views of the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, or the Department of Health and Human Services.

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²Dillman's (2000) Tailored Design Method is a revision to Dillman's (1978) first book titled *Mail and Telephone Surveys: The Total Design Method*. Both the Tailored and Total Design Methods are referred to by Dillman as TDM.

This article describes how the subtle differences in knowledge of and access to participants can significantly impact desired response rates, even when proven techniques such as TDM are used. An examination of two studies (i.e., the Retrospective Study and the TIP #24 Study) sponsored by the Center for Substance Abuse Treatment (CSAT) will show that both studies used participants with whom the researchers are familiar, as well as standard pilot testing work and TDM data collection procedures but yielded significantly different response rates.

The two studies were part of a 4-year evaluation of the dissemination of consensus-based best practice guidelines (i.e., Treatment Improvement Protocols [TIPs]) intended to provide salient and effective approaches to substance abuse (SA) treatment. Using diffusion of innovations theory (Rogers, 1995) as a framework, the overall evaluation was designed to determine the impact of TIPs on the substance abuse treatment field (Hubbard & Hayashi, in press).

The Retrospective Study (CSAT, 2000; CSAT 2001a; Hubbard & Mulvey, in press) was the first major study under the TIPs Evaluation Project. Data were collected in 2 waves. The Wave 1 survey focused on the TIP series in general by measuring awareness of, attitudes toward, and use of the 28 TIPs published at the time of the study. The Wave 2 survey collected data on the most useful and the least useful TIP as identified by the respondents. The goal of the Retrospective Study was to determine: (1) if TIPs are reaching their intended audiences; (2) if TIPs contain appropriate information for use by the target audiences; (3) how readers use information in TIPs, and (4) the impact of TIPs on changing substance abuse treatment practices. Using TDM data collection procedures, Wave 1 had an 80.1% response rate and collected data from 3,267 individuals affiliated with recognized SA-treatment programs (i.e., Single State Agency [SSA] Directors, Treatment Facility Program Directors, Clinical Supervisors, and Program Counselors). The Wave 2 survey was administered to a subset of those completing Wave 1 and also employed TDM data collection procedures. A 74.1% response rate was obtained from this group collecting data from 1,028 SA treatment professionals.

The TIP #24 Study (CSAT, 2001b) was a special study under the TIPs Evaluation Project. The purpose of this study was to examine primary healthcare professionals' (1) awareness of TIPs, including TIP #24: *A Guide to Substance Abuse Services for Primary Care Physicians*; (2) attitudes toward the alternative versions of the TIP #24 materials; (3) perceptions of the appropriateness of the TIP #24 materials; and (4) use of TIP #24 materials.

Using the same TDM data collection procedures, the TIP #24 Study had a 22.8% response rate and collected data from 137 individuals from a list of 600 primary care professionals. These 600 eligible participants were selected from a population of 2,508 leaders of 24 primary healthcare organizations. Like the Retrospective Study, the data collection procedure used for the TIP #24 Study was structured around the Tailored Design Method. Furthermore, experts were consulted in the study design and guidance was obtained regarding the use of primary healthcare organizations.

The large difference in response rates between these two studies despite the use of the same TDM procedures and the same study organization called for an examination of the factors that may have contributed to this discrepancy. One obvious difference is that these two studies

sampled from different populations. The target population in the Retrospective Study was SA treatment professionals while the TIP #24 Study targeted primary care physicians and related healthcare professionals who do not work exclusively in SA treatment programs. Although the use of similar procedures to design the studies and collect the data was expected to yield similar response rates, there may have been subtle differences between these populations that may have influenced the response rates.

This paper explores factors beyond TDM that may have influenced the response rates and could have an impact on future research efforts. Six factors are examined: (1) the extent of participants' interest in the study topic, (2) the degree researchers understand the participants, (3) the characteristics of professional organization mailing lists, (4) factors related to mailing surveys to individuals in leadership positions, (5) appropriate incentives, and (6) name recognition of the study sponsor. It is hoped that an examination of these issues will provide researchers with lessons learned for future mailed surveys.

2. Factors that impacted the response rates

Many factors can impact response rates, some of which may be unique to a particular project while others affect most studies. Comparing these two studies, including their study designs and pilot results, revealed systemic limitations that may have undermined the response rate for the TIP #24 Study. Although not foreseeable at the study's outset, the manner in which professional organizations maintain their lists, and the way gatekeepers restrict access to those in leadership roles, greatly diminished our ability to survey this population.

2.1. The extent of participants' interest in the study

The Treatment Improvement Protocol Series (TIP series), representing existing knowledge on best practices in substance abuse treatment, is one of the best known products developed by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment. Since 1991, 38 TIPs have been published and approximately 1.5 million copies of TIPs have been distributed to treatment facilities and individuals around the country. Each TIP contains evidence based practice guidelines developed with the input of a consensus panel made up of clinical, research, and administrative experts in substance abuse treatment.

Professionals who practice in the SA field are likely to have more exposure to the TIP series and to be more interested in how TIPs are implemented by others in the field. In the Retrospective Study, the participants were SA professionals who worked in substance abuse treatment facilities. The participants in the Retrospective Study were likely to be quite interested in knowing the knowledge, attitudes, and practice of others in the SA field with regard to the TIP series. Further, these participants would have learned something of value to them while completing the survey such as seeing a full list of all the TIPS.

In contrast, the participants in the TIP #24 Study were primary care providers who do not work in substance abuse treatment programs. This study focused specifically on TIP #24, *A Guide to Substance Abuse Services for Primary Care Physicians*, rather than more broadly on the TIP

series. For those professionals whose specialty is not specifically related to substance abuse and who do not typically view CSAT as an informational resource, it is likely that they would not be as interested in the study compared to SA treatment providers. Thus, a lack of interest in the study topic may have played a role in the poor response rate from primary care clinicians.

Dillman (2000) cited a study by Heberlein and Baumgartner (1978), which found that the salience of a survey is a significant determinant of response rates. Respondents were more likely to respond to surveys dealing with topics of importance to their behavior or current interest. Although questions can be added, ordered, and displayed to make them appear more interesting, Dillman (2000) concedes that in practice, there are limits to how much content can be modified in order to improve salience. The 22.8 percent response rate from primary care professionals in the TIP #24 Study would suggest that this survey dealt with a topic that had limited salience for the primary care physician.

2.2. The importance of obtaining a more comprehensive understanding of the participants

A comprehensive understanding of the target population is important to the design of a study and may have direct implications on response rates. While CSAT has considerable knowledge of the composition and characteristics of the four target populations (i.e., SSA Directors, Facility Directors, Clinical Supervisors and Program Counselors) in the Retrospective Study, the agency has little information on primary care clinicians who do not typically use CSAT as an informational resource. During the design phase of the TIP #24 Study, a pilot test was conducted with nine physicians, physician assistants, and nurses. These nine individuals were representative of the TIP #24 target audience. Pilot study participants were asked to complete the TIP #24 questionnaire, comment on the clarity of the questions, and identify problems with the questions and format of the survey. Minor changes were made to the questionnaire based on pilot participants' feedback.

In addition, pilot participants were asked to discuss any problems they experienced or other similar respondents might experience in completing the questionnaire. However, no one mentioned the fall lecture circuit between October and November when many physicians are traveling and lecturing around the country. Consequently, the respondents' schedule conflicts presented a serious barrier to obtaining a high response rate. The TIP #24 Study was implemented in the late summer of 1999 and follow-up calls began in mid October 1999. Since the fall is lecture season for many medical professionals, those who participated in the lecture circuit could not be reached for follow-up. Those who were reachable explained that they were extremely busy, with "piles" of paperwork, surveys, and other reports backlogged on their desks. A busy professional life, coupled with the demands of a lecture circuit, made it difficult to retrieve completed questionnaires from these individuals. If the schedule conflicts had been revealed at baseline, changes to the study could have been made to improve the study's response rate. For example, a change in the study's start date could have ensured that follow-up calls began after these professionals returned from lecturing. A second aspect of primary care providers we discovered is that they are exceedingly busy and receive multiple surveys every year. These providers do not have the time to respond to every survey they receive and thus will likely only attend to one that is exceptionally attractive and "stands out." Had we known how

busy these individuals are, changes to the materials could also have been made to make them easier to identify, understand, and complete. To make the TIP #24 survey stand out amidst a sea of other paperwork, the materials could have been sent with a brightly colored cover page containing a clear, simple, message that explained who the survey was for, and why it should be completed.

2.3. Considerations for using mailing lists provided through professional organizations

The ability to reach or access the study population is a critical determinant in study implementation. Mailing lists provide a convenient way to get contact information to survey individuals. In the Retrospective Study, the researchers were able to rely on the National Facility Register to reach the Facility Directors who then provided the names of the Clinical Supervisors and Program Counselors who were solicited to participate in the study. It was not necessary to rely on other mailing lists or other sources of information to reach potential respondents.

Conversely, the TIP #24 Study was not able to access potential respondents as easily. Significant challenges in reaching the target population were experienced for several reasons most of which stemmed from the fact that the study required the use of mailing lists maintained by professional primary healthcare associations. Many professional associations had incomplete mailing lists and their efforts to screen materials being sent to their membership to “protect the members from junk mail” posed serious problems in reaching the sample.

The TIP #24 Study relied on professional primary healthcare associations to obtain names and telephone numbers of their leadership. Since the researchers were interested in testing the targeted dissemination of relevant TIPs to audiences outside the substance abuse treatment field, an initial dissemination plan intended to reach primary healthcare clinicians was prepared. This plan called for reaching clinicians through their primary healthcare associations. Originally, 24 professional primary healthcare associations with a combined membership of nearly 3 million were identified for inclusion in the study. In attempting to gather the names and telephone numbers of this substantial membership, it was learned that the mailing lists of healthcare associations were prohibitively expensive. The original dissemination plan needed to be revised since paying for membership lists was not feasible under the limited budget of the TIP #24 Study.

In contacting the primary healthcare associations, the researchers learned that although full membership mailing lists cost money, mailing lists of the associations’ leadership were, in most cases, public knowledge and free. Assuming that the leaders of each of these organizations (1) communicate with their respective memberships, (2) are in positions to influence their members (and thus disseminate the TIP #24 materials to their networks), and (3) are elected to represent their members’ interests, a decision was made to target the leadership of the primary healthcare associations as a first step in reaching their membership. In order to reach primary care clinicians through the leadership of their professional associations, a listing of the key administrative staff, Board Members, Division Directors, and regional representatives of the original 24 professional associations was assembled by accessing the information through association web sites or by calling the associations directly. In assembling this list, it was discovered that a number of associations did not keep complete and current mailing lists of their leadership. Of the 24

associations identified at the beginning of the study, only 19 had complete listings of their leadership.³

Once mailing lists for the leadership from the various organizations were obtained, the TIP #24 Study found that many of the addresses were incomplete or incorrect. Some lists were business addresses, while others were home ones, and still others were the association's headquarters. The variability in addresses also made follow-up calls more difficult since the paths to find some people were rather circuitous. For example, a national representative had a telephone number listed in Washington D.C. at the association's headquarter. An assistant assigned to this representative was at a different number in the Washington D.C. area. In order to reach the representative, the assistant had to "track down" a telephone number for him at his "day job" in the State where the representative lived. Since many assistants were not willing to spend the time tracking down the leadership needed for the study, many potential respondents were not reached by the follow-up call procedure.

The inability to reach prospective respondents at follow-up was problematic for three reasons. First, it could not be confirmed that these individuals received the original TIP #24 materials and questionnaires. Second, if they did receive the original materials, the inability to contact them at follow-up meant any questions or concerns that they may have had could not be addressed. Finally, the inability to reach these individuals prevented them from receiving replacement questionnaires should they have needed them. Since appropriate follow-up is necessary for high response rates (Dillman, 2000), the inability to directly contact many of the participants may have lowered the response rate.

2.4. Factors impacting the delivery of mailed surveys to individuals in leadership positions

In the Retrospective Study, all surveys were mailed directly to the prospective respondents. In the TIP #24 Study, delivery of the mailed surveys often took a more circuitous route. Potential respondents often had gatekeepers (assistants/support staff) whose job it is to screen the mail and telephone calls. These gatekeepers often did not consider the survey an "important matter" and so our attempts at securing a response were fruitless

Several associations would not allow mail to go directly to their members. All mail had to be reviewed, and approved, by board members or other association committees. Therefore, the TIP #24 Study was dependent upon this review process, and then on particular association staff, to forward mail to the participants. Follow-up calls to the associations revealed that, in some cases, the survey packets were not forwarded to the leadership as promised. In fact, when pressed for a response, many association directors explained that they did not forward the packages to the predetermined leadership, but instead distributed the materials to individuals whom they felt were more "qualified" to read the materials and answer the questions. Since the organizations did not keep listings of the individuals to whom they distributed the materials, it could not be confirmed that the materials were actually forwarded; nor could these individuals be contacted at

³Complete lists included mailing information for all individuals in the 2 types of leadership positions defined for this study: Board of Directors and Division Directors.

follow-up. Again, the ability to take the steps needed to obtain completed questionnaires from them was hampered because many people could not be contacted directly.

A related barrier to gaining access to the organization leaders who were supposed to participate in the TIP #24 Study, was the confusion as to who should complete the survey. A number of measures were taken to specify that it is the leadership who is to complete the survey and they included the following: (1) the cover letter sent with the TIP #24 survey asked the respondent to answer the survey as “a leader of an organization serving primary care clinicians;” (2) the cover of the TIP #24 survey stated that this is a “Questionnaire for Leadership of Professional Primary Care Organizations;” and (3) the first page of the questionnaire reinforced the fact that the questionnaire was for the *leadership* of a particular organization (the respondent’s organization was written in a space provided). However, despite these efforts, follow-up calls revealed that many participants did not have a clear understanding as to who should fill out the questionnaire. In part, this confusion among participants may have come from the terms used in the title of the TIP # 24 and companion documents. The title of the TIP #24 and the TIP #24 Concise Desk Reference was *A Guide to Substance Abuse Services for Primary Care Clinicians*. Similarly, the pamphlet’s title was *Identifying Substance Abuse in the Primary Care Setting*. It appears that the terms “primary care clinician” and “primary care setting” confused many leaders who received the survey (and materials). Although this confusion was not revealed in pilot tests, participant calling to the toll-free number and follow-up calls to potential respondents revealed that many Board of Directors and Division Directors were administrators only and did not consider themselves as primary care clinicians. Some were trained as clinicians but were not actively practicing. For example, there was a primary care clinician who had switched to veterinary medicine but remained a member of his primary healthcare organization. Calls further revealed that some of the people on the leadership lists were neither Board of Directors nor Division Directors but were rather administrative assistants to these members or membership directors, or other association staff. Since the majority of participants contacted through participant and follow-up calls did not consider themselves to be “primary care clinicians,” they indicated that they did not feel that they were appropriate and/or qualified to complete the survey. Although most of the people said that they passed the survey on to someone they considered to be an appropriate “clinician,” some recipients acknowledged that they threw the survey away. Several commented that as soon as they received the TIP #24 materials (the original materials were sent before the survey), they passed them on to a colleague who could use them. Finding the original survey and tracking down the clinician who ultimately received the survey became a major hurdle. In some cases, the survey has been passed on several times which made follow-up contacts very difficult.

2.5. Determining truly appropriate incentives

Effective and appropriate incentives may vary with the respondent population. In the Retrospective Study, non-monetary incentives were offered to encourage responses and to increase the response rate. For returning the Wave I Questionnaire the respondents were offered the following: (1) any TIPs requested, (2) placement on a mailing list to receive notice of future TIPs, and (3) one of five videos available through National Clearinghouse for Alcohol and Drug Information (NCADI). The usual NCADI charge of \$12 for each video was waived. For

returning the Wave 2 Questionnaire, respondents could select 1 of 10 videos offered through NCADI and respondents who returned their questionnaires within the specified period selected 2 of the 10 videos. SSA Directors received all five of the new videos.

The incentives for returning the TIP #24 Study may not have been particularly motivating or meaningful to the respondents, despite contrary feedback received during the pilot study. In the TIP #24 Study, respondents could select and receive any of the TIPs, or related substance abuse treatment information. In addition, their name would be placed in a drawing for \$250.00 toward membership in their professional association or toward attendance at a conference. Since all members of primary healthcare associations must pay membership dues and conference fees, some of which are quite expensive, it was believed that payment for association dues or conference fees would be appreciated and would serve as an incentive to return the questionnaire. When this incentive idea was pilot tested, it was well received by the physicians, physician assistants, and nurses who participated in the pilot study. However, when this incentive was offered in the actual study, follow-up calls to the participants revealed that it was not particularly appealing to respondents. Primary care clinicians, especially physicians, often receive gifts/incentives from pharmaceutical firms and other companies along with various surveys. It is likely that the TIP #24 incentives were not sufficiently enticing to these healthcare professionals. Thus, the incentives offered to providers in the retrospective study were perhaps more immediate and tangible while payment of association membership dues for the primary care professions though of more value, was less immediate and appealing.

2.6. Name recognition of the study sponsor

The name recognition of the study sponsor often determines whether one can get past the potential respondents' gatekeepers. It was learned through follow-up calls for the TIP #24 Study that many gatekeepers did not consider the TIP #24 *survey* "important" enough to warrant a conversation with their employer. However, changing the word *survey* to *study*, and emphasizing that CSAT was a Federal agency, seemed to work with some gatekeepers. On the other hand, for the Retrospective Study, potential respondents valued CSAT and identified with its mission, and would not attach more importance to a "study" rather than a survey.

According to Dillman (2000), government sponsorship of surveys is likely to improve response because they can often appeal to legitimate authority as a basis for responding. In both studies, emphasizing that this study is a federal government effort sponsored by the Center for Substance Abuse Treatment raised the legitimacy of the survey for some gatekeepers. However, many gatekeepers had been instructed to inform callers that the doctor (or other healthcare professional) would not participate in research studies. As with the other barriers to accessing the target population, if the follow-up caller could not get past the gatekeeper, then the target person was never reached. If the target person could not be reached by telephone, then it is unlikely that gatekeeper conveyed the package containing the TIP #24 materials to their employer. In either case, name recognition of the study sponsor could open some doors and improve response rates.

3. Lessons learned

Certain limitations to the TIP #24 Study design presented the research team with many barriers to obtaining high a response rate. Tackling these barriers and the information gathered while trying to overcome them, led to several “lessons learned” regarding factors that might affect response rate beyond the TDM. In an attempt to help others avoid similar problems, these lessons are discussed below. These lessons can be group into the following areas: 1) understanding relevant universe to be sampled from, 2) understanding the population being studied and 3) the variability in mailing lists.

3.1. Obtain a clearer understanding of what target audience is appropriate

The TIP #24 Study attempted to obtain primary healthcare professionals’ perception of the information contained in TIP #24 and the utility of the three different alternative versions. To obtain these perceptions, leaders (i.e., Board of Directors and Division Directors) of professional primary healthcare associations were contacted and asked to review the materials and complete a survey. Using a diffusion of innovations interpretation, the original belief was that this leadership group represented the opinion leaders of their primary healthcare networks. The association directors informed the authors that these leaders would be able to comment on the utility of the TIP #24 materials for their respective membership. The researchers were also told that these leaders could act as dissemination agents for the TIP #24 materials so that the materials could be used in the field. However, follow-up calls to potential respondents, and to the associations that provided their names, revealed that this information was incorrect.

Follow-up calls revealed that the assumption that the Board of Directors and Division Directors of each professional association were the opinion leadership of their associations was in error. Although these individuals were well respected in their organizations, these individuals did not function as opinion leaders in their organizations and would not be good change agents for TIP #24. Even when the association leadership consisted of appropriate role models (i.e., not solely an administrator) many of these individuals had increasing taken on administrative roles. In such cases, the individuals would often feel too out of touch with current practice to comment on the utility of the materials. On a more positive note, in cases where the Board of Director or Division Director felt he/she was not qualified to respond to the survey, he/she usually passed (i.e., disseminated) the survey to someone who was a practicing clinician.

3.2. Know the study population

Primary care clinicians were the study population for the TIP #24 Study. Typically, these clinicians do not refer to a substance abuse agency for information; therefore, the funding agency has little information on them as a potential audience. Since this agency has little information on primary care clinicians, the TIP #24 Study had to rely on (1) information about primary care clinicians that is published in the research, (2) information that was obtained through the study’s pilot work, and (3) information from sources who were consulted by the agency and who worked in the primary healthcare field.

In the future, when working with an unfamiliar study population pilot work must extend beyond the usual testing of the study's instrumentation and brief interviews with participants. More probing questions designed to gain an understanding of how the community functions should be asked. Much of the information that was gained through follow-up calls to participants could not have been obtained through the published research. Longer pilot interviews—interviews especially designed to elicit information on how information is disseminated and used by individuals in a targeted profession—will allow the researchers to acquire a more complete understanding of the population. This information will allow the agency that funded this study to be more effective in developing and disseminating information targeted to professionals working outside their field.

3.3. Avoid using professional associations' mailing list

One of the biggest limitations to the implementation of the TIP #24 Study was the necessity of using mailing lists of professional associations. Not only were these lists found to be incomplete, out of date, and not uniform, they added a layer of bureaucracy to the study. Consequently, access to the population was severely hampered. If professional association mailing lists must be used, only those associations that allow direct access to their membership should be included in the sampling universe. In addition, only those members who have home and/or current business telephone numbers and addresses should be included in the sample. By limiting the sample to those individuals with whom follow-up contact can be made, many of the barriers associated with gaining access to a population can be eliminated.

4. Conclusion

Achieving a high response rate is very important in survey research but many different factors can have an influence on response rates in survey research. Researchers often employ proven techniques such the Tailored Design Method (TDM) to increase the response rate. However, using TDM does not necessarily lead to high response rates. Two studies, the Retrospective Study and the TIP #24 Study, used the same TDM techniques but yielded very different response rates. An examination of these studies revealed some of the factors that may have led to the varied response rates.

Although the Retrospective Study targeted a population of substance abuse treatment professionals and the TIP #24 Study targeted primary care clinicians, the use of similar procedures to design the study and collect the data was expected to yield similar response rates. However, the Retrospective Study obtained response rates of 80.1% and 74.1%, while the TIP #24 Study yielded a response rate of only 22.8%.

Six factors were found that might have influenced the varied response rates between these two studies. These include: (1) the extent of participants' interest in the study, (2) the degree the researchers had a comprehensive understanding of the participants, (3) the characteristics of the mailing lists obtained, (4) selection criteria from those lists, (5) types of incentives used, and (6) name recognition of the study sponsor. A brief summary of these factors are presented below:

- The interest of the participants in the study topic is likely to vary but the salience of the topic to the prospective participant can be an important determinant of participation.
- It is important to know the population being studied. It is necessary to understand the basic socio-demographic characteristics and also to know their availability, schedules, and day-to-day activities. Such information may not be available from published research but require longer pilot interviews and even ethnographic observation designed to elicit the needed information.
- Direct access to the study population is essential in survey research. Using mailing lists provided through professional organizations can be problematic because they are often incomplete, not current, and not uniform. If such mailing lists must be used it is advised that only those associations that allow direct access to their membership be included in the sampling universe and to include only those member who have a current home and business telephone number and address listed. One may try conducting a screening call to check the accuracy of the addresses and contact information. The ability to make follow-up contacts rests upon having accurate, current, and direct contact information on each participant.
- It can be difficult to reach people in leadership positions because they often employ gatekeepers to screen their mail and telephone calls. In addition, leadership with clinical background and leadership with administrative background have different expertise.
- A lack of meaningful and enticing incentives can affect the response rates. Effective and appropriate incentives vary with the respondent population and may depend on what other incentives the participants have received in the past. Incentives that are more immediate and tangible may be more effective than incentives that are more remote.
- The name recognition of the study sponsor often determines whether one can get pass the gatekeepers. Changing the word “survey” to “study” and emphasizing that the sponsor of the study is a Federal agency seem to open some doors and improve the response rates.

An understanding of these factors served as the basis for “lessons learned” including (1) obtain a clearer understanding of what target audience is appropriate, (2) know your target audience, and (3) avoid using professional associations’ mailing list. It is hoped that these lessons will serve as guidance to future research efforts.

This study has shown that following the TDM approach will not guarantee a high response rate. We have outlined factors that extend beyond TDM that also affect survey participation and warrant consideration by researchers in future studies. To be sure, the TDM is an extremely helpful guide, and enabled us to obtain a high response rate in the retrospective study. The TIP #24 Study, however, was less than successful. While many of the lessons we learned seem obvious in hindsight, at the time of the study we expected our past successes to be replicated. The TIP #24 Study was a sobering development, but one which, in retrospect taught us valuable lessons about how to conduct better survey research in the future.

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