



Evidence-based programs registry: Blueprints for Healthy Youth Development



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ABSTRACT

There is a growing demand for evidence-based programs to promote healthy youth development, but this growth has been accompanied by confusion related to varying definitions of evidence-based and mixed messages regarding which programs can claim this designation. The registries that identify evidence-based programs, while intended to help users sift through the findings and claims regarding programs, has oftentimes led to more confusion with their differing standards and program ratings. The advantages of using evidence-based programs and the importance of adopting a high standard of evidence, especially when taking programs to scale, are described. One evidence-based registry is highlighted—Blueprints for Healthy Youth Development hosted at the University of Colorado Boulder. Unlike any previous initiative of its kind, Blueprints established unmatched standards for identifying evidence-based programs and has acted in a way similar to the FDA – evaluating evidence, data and research to determine which programs meet their high standard of proven efficacy.

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1. Introduction

Prior to 1990, the general consensus in the research community about the effectiveness of prevention programs was that “nothing worked,” or to be more precise, nothing had been demonstrated in evaluations of programs and practices to be effective in preventing delinquency, antisocial behavior or dysfunctional, health compromising behavior (Martinson, 1974; Romig, 1999; Sechrest, White & Brown, 1979). However, over the last two decades, there have been major advances in both evaluation research and program design and development. This work has provided a rich body of evidence demonstrating that some programs and practices are effective, both for preventing the onset of problem behaviors and for successfully intervening with those caught up in these types of behavior (Greenwood, 2006; Institute of Medicine, 2008; Sherman, Farrington, Welsh, & McKenzie, 2002). Moreover, these programs often have positive effects on other important outcomes such as mental health, academic achievement, parenting practices and family wellbeing, and employment. This change in findings

about the effectiveness of prevention programs and practices is the result of both major improvements in the quality of evaluation research and improved program design and implementation.

We now have a better understanding of what does and does not work, and this has led to a new interest in identifying and implementing programs that have been demonstrated by rigorous evaluations to be effective. This current drive for proven, evidence-based programs has also been fueled by huge financial deficits at both the federal and state levels, leading to serious consideration of the high costs of violence, crime, drug abuse, school dropout and other problem behaviors and the efficiencies associated with investments in more cost-effective, proven programs and practices. In 2002, the White House encouraged all federal agencies to support evidence-based programs and to discontinue programs without evidence of effectiveness (Office of Management Budget, 2001; 2002), and it is now common practice that federal and state funding for prevention programs be restricted to evidence-based programs and practices.

This paper seeks to better inform policymakers, practitioners and citizens about the importance and advantages of using evidence-based programs to improve the life course of children, taking a closer look at the Blueprints for Healthy Youth Development registry as one source of important information on this topic.

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1.1. Defining evidence-based programs

An evidence-based program is a set of coordinated services/activities that demonstrate effectiveness [on some desired outcome] based on research (Children's Services Council, n.d.). Most researchers agree that the evidence of program effectiveness should minimally come from quasi-experimental or experimental evaluation. Randomized experiments are the "gold standard" for determining the effectiveness of a program (Campbell & Boruch, 1975; Shadish, Cook, & Leviton, 1991). Some argue that a higher standard should be placed on programs that will be taken to scale, such as requiring randomized controlled trials (Coalition for Evidence-Based Policy, 2014; Elliott, 2013) or evidence of sustained effects and replication (Elliott & Mihalic, 2004).

A number of agencies and groups have developed standards for assessing the research for the effectiveness of programs in order to designate them as evidence-based. However, the standards adopted by each agency differ, with some applying a more rigorous standard than others. For example, some agencies that rate programs will only accept a randomized controlled trial as sufficient evidence (<http://evidencebasedprograms.org>), while some will accept both randomized controlled trials and closely matched quasi-experimental designs (<http://blueprintsprograms.com>). The higher standards, such as randomization, replication, and sustainability, will result in fewer programs, but it is critical that there be a high degree of confidence in the effectiveness of a program before endorsing and taking a program to scale.

The problem is that a lower standard comes with a greater risk of failure when programs are subsequently implemented on a wide scale. For example, evaluations conducted with RCTs have, in a number of instances, invalidated earlier findings from studies with quasi-experimental comparison group designs. Examples include hormone replacement therapy which was once a recommended treatment for postmenopausal women, based upon comparison group studies, until two large-scale randomized controlled studies showed that it increased the risk of coronary heart disease, stroke, and breast cancer; dietary fiber to prevent colon cancer was shown to have no effect; and an oxygen-rich environment for premature infants was shown to increase blindness (Baron, 2007).

A number of "design replication" studies have been carried out to examine whether and under what circumstances comparison-group studies can replicate the results of randomized controlled trials. These studies test comparison-group methods against randomized methods by first comparing the outcomes of the program group to a randomly assigned control group, and next comparing the same program participants with a comparison group selected through methods other than randomization. Twelve of these studies have been summarized by Cook, Shadish, and Wong (2008). Their review suggests that comparison group studies without close matching often produce inaccurate estimates of an intervention's effects. This is true even when statistical techniques are used to adjust for observed differences between the two groups. Often studies match only on demographic variables, and these studies consistently fail to reproduce the results of experiments. Comparison group designs are more likely to produce valid results when there is careful matching of the treatment and comparison groups at pretest, especially on the pretest measures of the outcome and geographic location.

The evidence used to inform policy decisions must be scientifically valid. Randomized controlled trials are first and foremost in generating this evidence, followed closely by matched comparison designs. Non-equivalent comparison group designs or methods that fail to use a control group do not provide an acceptable standard of evidence, as they often produce

erroneous results. Other factors in design and implementation of an evaluation must also be considered to ensure that the evaluation is producing valid results. These include, but are not limited to: adequate sample size, baseline equivalence, low attrition, lack of differential attrition, valid outcome measures, appropriate unit of analysis, intent to treat analysis, and appropriate statistical techniques. The Society for Prevention Research has adopted a similar set of standards that must be met if a program or policy is to be called tested and effective (Society for Prevention Research, n.d.).

The quality of evidence is not the only consideration in defining an evidence-based program. If these programs are to be replicated, there must be specificity in the program description that clearly shows how its theoretically grounded components produce the intended impact. It is, therefore, important to identify the outcomes the program is designed to change and the specific risk, protective, and promotive factors that will mediate that change. It is also important to designate the targeted population, which should not be based upon assumption, but upon evidence of the program's success with that population. Theoretically driven programs also involve detailed instructions on how to deliver the intervention, duration of the intervention, and amount of training required. Failure to implement the program within the specified guidelines often results in smaller or null effects (Mihalic, 2004). While some may question the importance of using theoretically driven programs, recent studies indicate that interventions which make extensive use of theory tend to have larger effects on behavior than interventions that make less or no use of theory (Taylor, Conner, & Lawton, 2012; Webb, Joseph, Yardley, & Michie, 2010).

Widespread dissemination of programs with evidence of effectiveness from poorly designed studies, as well as implementation of programs with poor fidelity, is a waste of limited funds and undermines the public confidence in prevention science when the outcomes that were promised are not achieved.

2. Why has policy changed over the last decade to support evidence-based programs?

Budget shortfalls at national and local levels have created a need for greater efficiency and accountability in systems working with children and youth. Despite tremendous outlays of money each year for support services to families and youth, research is not being used with sufficient frequency, intensity and quality to impact human services and has not provided the full potential benefits to consumers and communities (Baron, 2012; Sawhill & Baron, 2010). Baron (2012) uses as an example Department of Education data showing that "reading and math achievement of 17-year-olds—the end product of our K-12 educational system—has not improved over 40 years, despite a 90 percent rise in public spending per student (adjusted for inflation)." In the same report, he also states that "in education, although the college graduation rate has risen, the high school graduation rate peaked around 81 percent in the early 1970s. Since then, it has been stuck between 75 and 80 percent."

However, there are examples showing that when evidence-based programs are integrated into these systems, taxpayers enjoy cost savings and youth benefit from better outcomes. In 2004, the Florida Legislature voted to initiate the Department of Juvenile Justice's Redirection project to address the growing number of juvenile offenders who were being committed to residential facilities for non-legal violations of probation. The Redirection project diverted, or redirected, these youth from residential placement to evidence-based, community-based treatments, relying on three programs (Functional Family Therapy, Multi-systemic Therapy, and Brief Strategic Family Therapy). During the

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