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YouthAlert! (YA!) Violence & Bullying Prevention/Health Program
A Nonprofit 501 (c) (3) Organization and Public Charity

YouthAlert! (YA!) Violence & Bullying Prevention/Health Program Summary

"*Where Youth and Adults Meet Halfway to Reduce Violence & Bullying*"
Teaching Violence & Bullying Prevention and Healthy Lifestyles to Children and Youth
"Protecting the whole youth, and nothing but the youth"©

YouthAlert! (YA!) Violence & Bullying Prevention/Health Program is an in-school, out-of-school time, one to three-day, two to six-hour, live in-person presentation, whose purpose is to reduce violence and bullying and improve the overall health of children and youth of Elementary, Middle and High School age. This program is part of the **YouthAlert! (YA!) Eighteen Week School National Health Curriculum.**

YouthAlert! (YA!) Violence Prevention/Health Program includes, a live speaker, who give instruction and narration, over two-hundred video slides, over one-hundred public service announcements (PSA's) videos, important statistical information, important skills sets to learn, live role playing, question, and answer periods, open discussion, worksheets, reviews, surveys, local youth service contact information, free snacks and more. Twenty additional Breakout Sessions by subject are also available.

YouthAlert! (YA!) personnel present this program directly to any number of children or youth in a school, class, public, or community, environment. Extra attention during these presentations is given to male youth and U.S. minorities. The Program is not political, financial, religious, or *judgmental.*

YouthAlert! (YA!) Violence & Bullying Prevention/Health Program is, first, and foremost, a community outreach program. The program represents the voice of the entire community and all opinions are welcome from the community, educators, adults, and youth.

It is not fully known why people do violence but we do know one thing that prevents it, *education*. YouthAlert! (YA!) also believes when kids know better, they do better. When youth have *all* the information, they instinctively make good decisions. YouthAlert! (YA!) VBPHP is not only a comprehensive *health* program, following the *public health* approach to violence prevention, but also comprehensive *youth* program encompassing all important aspects in a youth's life. Empowerment, positive self-esteem, self-confidence, and positive and productive motivation, are the underlying themes in the **YouthAlert! (YA!) Violence & Bullying Prevention/Health Program**.

The program is continual and interactive both using current technology for out-of-school learning and lesson plans for in-school learning including sign up for text alerts at *www.YouthAlert.us*, posting survival stories to instragram *yasurvivalstories* and using our free mobile phone app. An important part of the program also helps youth connect to local and national support and intervention services.

The goal of the **YouthAlert! (YA!) Violence & Bullying Prevention/Health Program** is a Ten-Percent reduction in all violence, self-harm, bullying, substance abuse, school, board, and law, violations, truancy, and behavior events, in or out of school, with children, youth, and young adults who have gone through our program Specifically accomplishing this by people voluntarily using the power of their unique, personal, individual,

identity without compromising any of our common, fundamental principles. The program will also increase the grades of youth and schools in the areas of health and practical living.

YouthAlert! (YA!) VBPHP makes sure everyone gets this unified message that when people are being peaceful they are acting in their own self-interest without being selfish. YouthAlert! (YA!) VBPHP secret ingredients are *equality* and *kindness*. All voices and opinions are equal during our presentation and our presentation is a no-bullying zone. How YouthAlert! (YA!) acts and interacts with youths during the presentation is we believe is YouthAlert! (YA!)'s the greatest lesson. Although YouthAlert! (YA!) collects its own data, and does it own research, YouthAlert! (YA!) is applying the significant amount evidence-based information this is already out there, namely, *being there*, *caring*, and trying to reach each youth *individually.*

YouthAlert! (YA!) Violence & Bullying Prevention/Health Program's plan is to work *every semester* with schools we are working in their school-year. Preferably in their *Health* or *Physical Education (PE)* classes. We believe if we can reach Twenty Five-Percent of a school's student population within one school-year it can reduce all behavior events in, our out, of school Ten-Percent. When we teach the students simultaneously, they then teach their peers, and hopefully bring it home to their community. We also plan to concentrate on middle school youth so in just a few years there could be a new generation of peaceful and healthy high school students focused on positive and productive motivation and following their dreams.

YouthAlert! (YA!) Violence & Bullying Prevention/Health Program subjects include: domestic violence, dating violence, bullying, suicide/self-harm, gang violence, sexual abuse and violence, school violence, child abuse, neglect, elder abuse, safe surroundings, victimization, trauma, and more. Over half of the program deals with the subject of youth violence and bullying prevention. The remaining sessions cover all other youth health advocacy and prevention topics including, mental health, social health, physical health, substance abuse, unintentional injuries, diet, poverty, consumerism, and more.

YouthAlert! (YA!) Violence & Bullying Prevention/Health Program 18 week curriculum, lesson plans, and presentations are aligned with the National Health Education Standards (NHES), which is followed by most public schools in the U.S. Formative and summative assessments are done as well as pretest and posttest analysis. The program also includes instructor observation and youth self-reporting surveys at regular intervals. The program is overseen by a YouthAlert! (YA!) Advisory Board and follows an evidenced-based blueprint with outcome evaluations recommended by the Centers for Disease and Control (CDC).

YouthAlert! (YA!) has now completed two *back-to-back* years reaching over 3,300 middle and high school youths *each* year in schools with our in-school, multi-day, violence and bullying prevention/health program. 6,964 **students** total. **YouthAlert! (YA!)** has now reached over 10,000 youth with all its violence prevention initiatives including its six, free and public, *YouthAlert! (YA!) Youth Violence Prevention Event & Forums.*

YouthAlert! (YA!) is a Better Business Bureau Accredited Charity and are GuideStar Platinum Participants.

Our Mission: "To bring about a ten-percent reduction in youth violence and bullying through *volunteerism*, *education*, and *teamwork*."

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YouthAlert! (YA!) Violence & Bullying Prevention/Health Program
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Impact - YouthAlert! (YA!) Violence & Bullying Prevention/Health Program

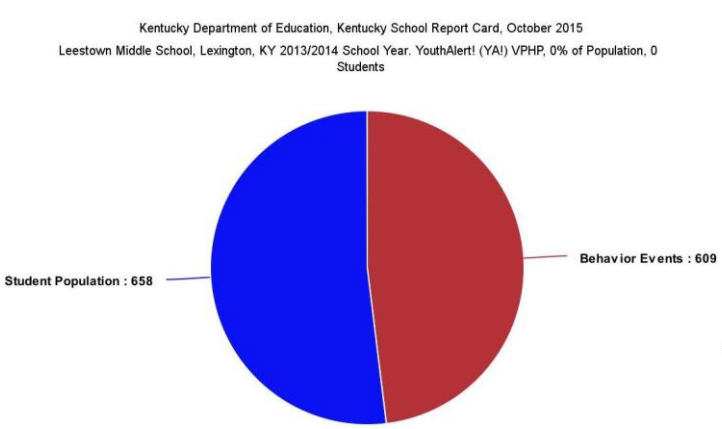
The first goal of our **YouthAlert! (YA!) Violence & Bullying Prevention/Health Program** is a Ten-Percent reduction in all violence, self-harm, bullying, substance abuse, school, school board, law, violations including behavior events, truancy, with youth who have gone through our program.

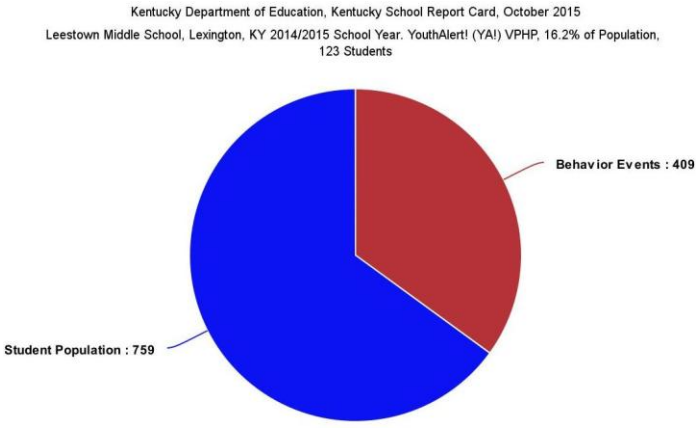
1. **Control Groups:** Public school report cards listed online which includes all behavior events to see how the statistics compare to how frequently many times we did our program in a particular school that school year. We are building "Model" schools where we do our multi-day program each semester at a school for at least three years in order
to reach the majority of the student population. That way we can have more of an impact on a school and more accurately measure our impact. The following are three of these comparisons for the last school-year.

YouthAlert! (YA!) Violence & Bullying Prevention/Health Program School Comparisons 2014/2015 vs. 2013/2014 (Source: Kentucky Department of Education, Kentucky School Report Card, October 2015)

Comparison One

Lassiter Middle School, 8200 Candleworth Drive, Louisville, KY 40214. In 2014/2015, Three, Three, Full-Days, YouthAlert! (YA!) Violence Prevention/Health Community Outreach Program, **9** full-days total, **205** students, **23.4 %** of the 2014/2015 Student Membership .





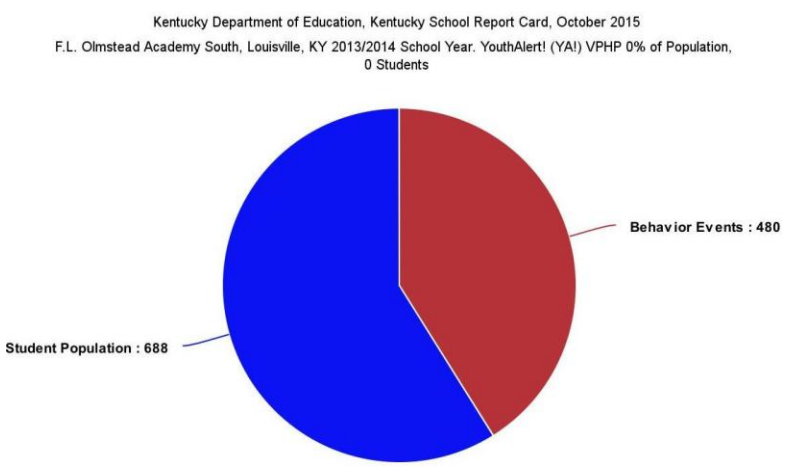
All Behavior Events *down* **7.1%** in 2014/2015 at Lassiter Middle School, from 1,658 to 1,540, despite a **1.4%** *increase* in Student Membership in 2014/2015, from 862 to 874. Lassiter Middle School has one of the highest levels of Behavior Events in Jefferson County Public Middle Schools.

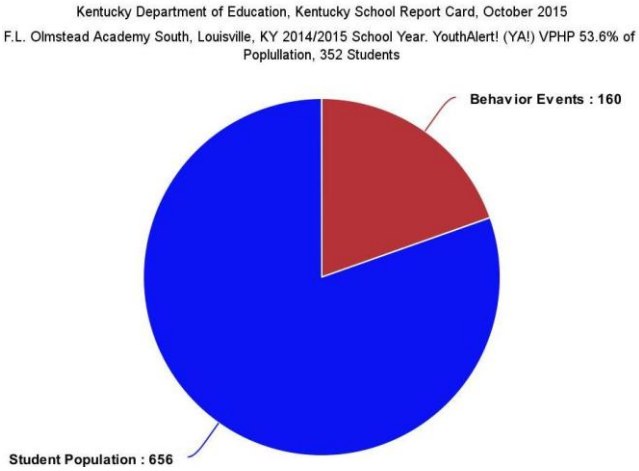
Similar School - Ramsey Middle School, 6409 Gellhaus Lane, Louisville, KY 40299. Behavior Events *up*

41.3 %, 339 to 479, from 2013/2014 to 2014/2015, with Student Membership up only **0.3%** , from 983 to 986. No YouthAlert! (YA!) Violence Prevention/Health Community Outreach Program sessions.

Comparison Two

Frederick Law Olmsted Academy South, 5650 Southern Parkway, Louisville, KY 40214. Two, Ninety-Minute YouthAlert! (YA!) Violence Prevention/Health Community Outreach Program, **352** students, **53.6%** of 2014/2015 Student Membership.





All Behavior Events *down* **66.6%** in 2014/2015 at Frederick Law Olmsted Academy South, from 480 to 160, despite only a **4.6%** *decrease* in Student Membership, 688 to 656.

Similar School - **Frederick Law Olmsted Academy North**, 4530 Bellevue Ave., Louisville, KY. Behavior Events *up* **47.3 %**, 1,417 to 2,088, from 2013/2014 to 2014/2015, although Student Membership was *down* **3.7%** in 2014/2015, from 653 to 628. No YouthAlert! (YA!) Violence Prevention/Health Community Outreach Program sessions.

Comparison Three

Leestown Middle School, 2010 Leestown Road, Lexington, Kentucky, 40511. Two, Three, Full-Days, YouthAlert! (YA!) Violence Prevention/Health Community Outreach Program, **6** full-days total, **123** students, **16.2%** of the 2014/2015 Student Membership .

All Behavior Events *down* **19.5%** in 2014/2015 at Leestown Middle School, from 609 to 409, despite a **15.3%** *increase* in Student Membership in 2014/2015, 658 to 759.

2. Health Curriculum: YouthAlert! (YA!) VBPHP is part of Yourht Alert has its own eighteen-week YouthAlert! (YA!) Health Ciricul. For Ellevmtary, Middle and High Shcoll. Our program is aligned with the National Health Education Standards-NHES which followed by most all Public Schools in the U.S.

3. School Statistics: Student's health grades and the Practical Living Program Review scores, submitted by schools, are also indicative of program progress. We have quite an extensive subject matter for youth for their health class and an extensive Program Review package for teachers in states that require this review/

4. <u>Formative Assessments</u>: We also use formative assessments and summative assessments using surveys taken after the presentation. These assessments have been extremely useful in evaluating our program. Our teaching model is where both youth and adults meet *halfway* to reduce violence since *youth* do half of all the violence and *adults* do half of all the violence. These assessments have also been very important in helping youth *form* opinions, *challenge* their beliefs, and give them a voice to *express* their opinions on these subject matters. Students' in-class participation and survey comments also aids in teacher assessments of students and helps expose potential problems with students, some which might require the need for an intervention.

YouthAlert! (YA!) has now completed two ***back-to-back*** years reaching over **7,383** students total with our in-school, multi-day, violence and bullying prevention/health program.

Our **<u>2015/2016</u>** School-Year <u>Survey *Summary Report*</u> of our in-school **<u>YouthAlert! (YA!) Violence & Bullying Prevention/Health Program</u>** for Kentucky is 24 pages and is dated **May 27, 2016**. It includes

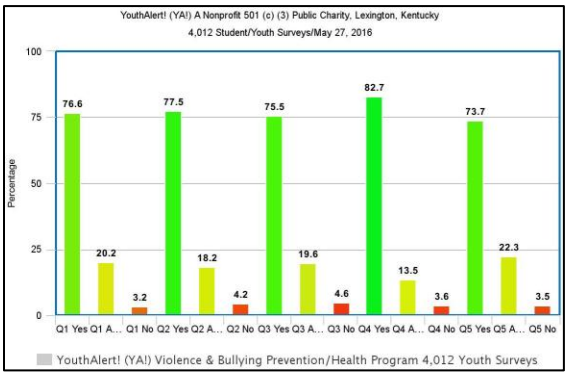
<u>4,012</u> Student/Youth surveys, and the **<u>65</u>** Teachers/Hosts surveys, for **<u>24</u>** public schools, and their **<u>40</u>** multi-day school presentations, **<u>90</u>** school-day presentations. **<u>360</u>** class presentations. Some results:

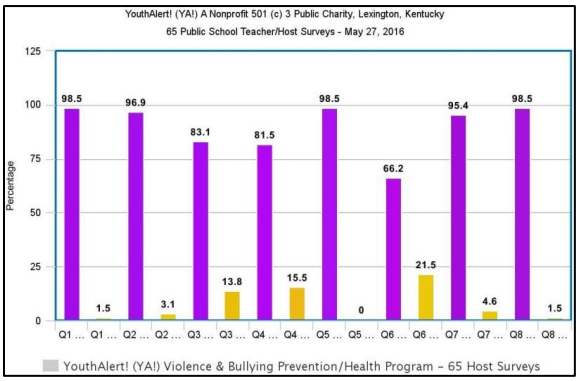
95.7 percent of students/youth said that they were <u>*more aware*</u> about the dangers of violence after this presentation.

96.2 percent of students/youth said this presentation will help <u>*prevent them*</u> from doing an act of violence.

100 percent of Teachers/Hosts said this Presentation could <u>*make a difference*</u> in a youth's life in a positive way when it comes to violence.

100 percent of Teachers/Hosts said they would <u>*recommend*</u> this Presentation to other youth groups, schools, or youth organizations.



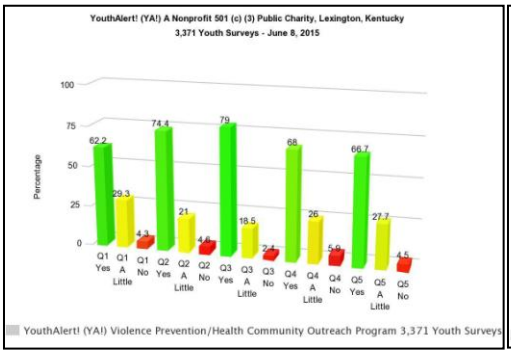


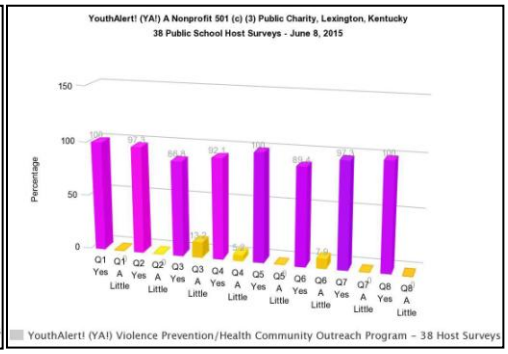
YouthAlert! (YA!) did presentations **51 Percent** of the school days this 2015/2016 school-year. There were **3.205** youth comments total, **79.9 Percent** of the 4,012 total surveys. Many youths who commented said the Presentation helped them, with the word "*help*" being used **747** times in the youth comments section, and many youths who commented said they learned a lot with the word "*a lot*" used **358** times in the youth comments section.

Our **<u>2014/2015</u>** School-Year Survey *Summary Report* is 10 pages and is dated **June 8, 2015**. It includes **<u>3,371</u>** Student/Youth Surveys, and **<u>38</u>** school Teacher/Host Surveys. Some results:

94.5 percent of Students/Youth surveyed thought the Presentation would help <u>*stop someone*</u> from doing violence, even if just a little.

100 percent of Teachers/Hosts said this Presentation *may stop some youth* from doing violence, even if just a little.

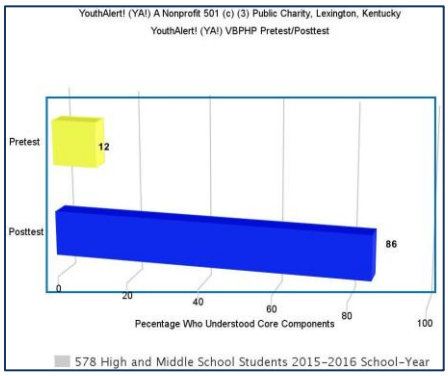




All **103** of the Teacher/Hosts surveyed in the **2014-2016** School-Years (two-years), *recommend* our in-school **YouthAlert! (YA!) Violence & Bullying Prevention/Health Program** to other youth groups, schools, or youth organizations.

5. Pretests and Posttests: YouthAlert! (YA!) VBPHP has a **74 Percent** *gain score* with **578** Middle, and High, School students with our completed five-question Pretest/Posttest assessment. This is well above the *30 percent* change score benchmark for pretest and posttest progress.

86 Percent of the *Posttest* answers taken immediately after the presentation, understood the *core components* in the program, where less than **12 Percent** of *Pretest* answers, were contained in the program. This indicates a highly successful method of instruction for our program, and also possibly, a high level of interest among students. The high gain score may also indicate the *newness* of the material presented to the students.



81 Percent, **468** of the **578** students, were high school students and **19 Percent**, 110 of the 578 students, were middle school students.

6. Public Statistics: Public statistics on crime, including, incarceration, arrests, self-harm and delinquency are also used to determine our programs' process in areas we have serviced the most. These public sources are from; law enforcement, the Centers for Disease Control and Prevention (CDC), and those who report on hospitalizations and coroner reports like the KY Injury Prevention and Research Center (KIPRC).

7. Testimonials: YouthAlert! (YA!) has several thousand testimonials from students and teacher attesting to the impact and success of **YouthAlert! (YA!) VBPHP.**

8. Summative Assessments and Self-Reporting Surveys: Summative assessments and Self Reporting surveys: and by students and teachers play a part in evaluating our impact.

9. Oversight by Advisory Board: The program is overseen by a YouthAlert! (YA!) Advisory Board of Health, Education, Law, and Business Professionals.

10. Consultation: YouthAlert! (YA!) meets and consults with Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control in Atlanta Georgia, and the Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice (USDOJ) in Washington, D.C. as well as other experts in violence prevention.

11. Future Design: One of the key goals of **YouthAlert! (YA!) Violence & Bullying Prevention/Health Program** to be the very first nationally certified violence prevention program in the U.S. This status to be certified by "Blueprints for Violence Prevention" developed by the Center for the Study and Prevention of Violence (CSPV) at the University of Colorado-Boulder or by the Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice (USDOJ). These are the two evidence-based leaders in the field of violence prevention. They each have separate evidence-based, outcome evaluations, policies, procedures, and guidelines to obtain their "Top Tier" or "Model" programs status. We are currently working toward these certifications. The only programs so far that touched on the area violence prevention that has reached these levels are mentoring programs.

Additional Impact - YouthAlert! (YA!) Violence & Bullying Prevention/Health Program

YouthAlert! (YA!) believes violence, including bullying and abuse, is the *number one* root cause of substance abuse. The violence is the head of the snake. And that comprehensive violence prevention program like YouthAlert! (YA!) VBPHP is the best anti-substance abuse program, and positive mental health program, especially for youth.

1. Between 55 and 99 percent of women who have substance abuse issues have been victimized at some point in their life (Moses, et al., 2003) and between 67 and 80 percent of women in substance abuse treatment are Intimate Partner Violence (IPV) victims (Cohen, et al., 2003; Downs, 2001). Approximately half of partnered men entering substance abuse treatment have battered in the past year (Chermack, Fuller & Blow, 2000; Fals-Stewart & Kennedy, 2005) (National Center on Domestic Violence, Substance Abuse and Intimate Partner Violence, Harrisburg PA, Retrieved January 2016)

2. National statistics estimate that 50 to 90 percent of women in substance abuse treatment have been or are currently victims of (Intimate Partner Violence) (IPV). (State of New York, Office of Alcoholism and Substance Abuse Services, Retrieved January 2016)

3. Authors indicate that there is overwhelming evidence that victims of sexual assault and rape are much more likely to use alcohol and other drugs to cope with the trauma of their victimization. For example, Rape victims are 5.3 times more likely than non-victims to have used prescription drugs non- medically. (Kilpatrick, Edmunds, and Seymour, 1992). Rape victims are 3.4 times more likely to have used marijuana than non-victims. (Ibid). Victims of rape are 6 times more likely to have used cocaine than their counterparts who were not raped. (Ibid). Compared to women who had not been raped, rape victims were 10.1 times more likely to

have used “hard drugs” other than cocaine. (Ibid).” (WCSAP, Research & Advocacy Digest Sexual Assault and Substance Abuse, October 2005)

4. The combination of childhood maltreatment and intimate partner violence exposure during adulthood substantially increase risks for the onset of substance use disorder (diagnosable substance abuse/addiction), new findings from a group of U.S. researchers indicate. In a study published in January 2015 in the journal Drug and Alcohol Dependence, researchers from Columbia University examined the effect that the combined experience of child maltreatment and IPV exposure has on the chances that an adult man or woman will develop an alcohol- or drug-related case of substance use disorder. The researchers concluded that the two forms of trauma have an additive impact on the risks for diagnosable substance problems. (California Alcohol and Drug Rehab, Promises Treatment Center, promises.com, May, 2015)

5. Adverse Childhood Experiences (ACE’s) contribute to stress during childhood and put individuals at higher risk for health problems such as alcoholism and alcohol abuse, depression, illicit drug use, intimate partner violence, and suicide attempts. The impact of ACEs is also cumulative, meaning the more ACEs a child is exposed to, the higher likelihood they will experience some of these health and social problems later in life. The life expectancy of people with six or more ACEs is 20 years shorter than those without any ACEs. (Centers for Disease Control and Prevention, CDC, Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence, July 2014)

6. The experience of being abused as a child may increase a person’s risk for alcohol-related problems as an adult. This relationship has best been demonstrated in women who had been victims of childhood abuse. Several factors most likely contribute to or influence this relationship, including coping skills; antisocial behavior; and psychological problems, such as posttraumatic stress disorder. (National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, U.S. Department of Health and Human Services, Alcohol Abuse as a Risk Factor for and Consequence of Child Abuse, Retrieved January 2016)

7. In 2004, 17% of state prisoners and 18% of federal inmates said they committed their current offense to obtain money for drugs. In 2002 about a quarter of convicted property and drug offenders in local jails had committed their crimes to get money for drugs, compared to 5% of violent and public order offenders. (Bureau of Justice Statistics, Office of Justice Programs, U.S. Department. Of Justice, Drug and Crime Facts, Retrieved January 2016)

8. Conclusion. In face of problematic evidence, it is impossible to say quantitatively how much drugs influence the occurrence of crime.” (Bureau of Justice Statistics, Office of Justice Programs, U.S. Department. Of Justice, Fact Sheet: Drug Related Crime, NCJ-149286, September 1994)

Violence and Homelessness:

9. Domestic violence is the third leading cause of homelessness among families, according to the U.S. Department of Housing and Urban Development. (Safe Horizon, NYC, 2016)

Violence and Obesity:

10. Fear of violence leads to weight problems for some young women. Young African-American women who live in fear of the violence in their neighborhoods are more likely to become obese when they reach their 20s and 30s, new research from the University of Michigan shows. (Medicalexpress.com May 13, 2016)

YouthAlert (YA!) Violence & Bullying Prevention/Health Program
Student Worksheet One – Pretest/Posttest – Return to Presenter

Name _____ **Date** _____ **Class** _____

Before Presentation

1. What is Violence?

2. How can I avoid being a victim of violence?

3. How can I get out of a dangerous situation?

4. What is Bullying?

5. How can I help stop teen suicide?

YouthAlert (YA!) Violence & Bullying Prevention/Health Program
Student Worksheet One – Pretest/Posttest – Return to Presenter

****************************AFTER PRESENTATION***************************

6. What is Violence?

7. How can I avoid being a victim of violence?

8. How can I get out of a dangerous situation?

9. What is Bullying?

10. How can I help stop teen suicide?

YouthAlert! (YA!) Violence & Bullying Prevention/Health Program Worksheet for Student to Keep

YouthAlert! (YA!) Violence & Bullying Prevention/Health Program - Presentation Chapters

Who Are We? Why Are We Here? What Is Violence? Shadow Violence, Believing in Peace, World Violence, Why do People Do Violence? Who Does Violence? Who Are the Victims of Violence? What Is Consent? Identity Stations, The High Five Principals, Family/Close Unit, Anger, Media, What Is Bullying? Hitting/Stealing, Gossip, Ridicule, Shunning, Cyber-Bullying, #1 Rule of Violence, Justice, Youth Power, Weapons, What Is A Man? How Did We Get Here? Your Independence, Attitude, Kindness, Principle Sharpening Test, Justified Violence, Self Defense, How Not to be a Victim of Violence, Worst Case Scenario, Dreams, Inner City, Suicide Prevention, Research, The Next Leader, USA, Religion, Summary, Free Help! Contacts, Continuing Education.

YouthAlert! (YA!) VBPHP Vocabulary Words: Volunteerism, Equality, Minority, Maiming, Harassment, Stalking, Consent.

Match the YouthAlert! (YA!) VBPHP Word Associations (Left to Right)

Most People	Pain Explosion
Name of the Game	True Choice
Youths Job	Do Not Underestimate
Self Defense	Peaceful
Being Human	Power Demagnetizers
Bullying	Don't' Over Do It
Kindness	Respect
Justice	Very , Very, Bad Pain
Violence	Survival
Youths Destiny	Survive Your Youth
Media	The Real Deal
Suicide/Self Harm	Forever
Guns	To Live and Long and Healthy Life

----------**F R E E H E L P !**----------

1-800-273-8255 National Suicide Prevention Lifeline http://www.suicidepreventionlifeline.org/

1-800-784-2433 National Hopeline Network http://www.hopeline.com/

1-800-422-4453 Childhelp National Child Abuse Hotline http://www.childhelp.org/pages/hotline

1-800-799-7233 National Domestic Violence Hotline http://www.thehotline.org/

1-888-743-5754 The Domestic Abuse Helpline for Men and Women http://dahmw.org/

1-800-656-4673 National Sexual Assault Hotline http://apps.rainn.org/ohl-bridge/

1-800-786-2929 National Runaway Switchboard http://www.1800runaway.org/

1-800-366-8288 Self Abuse Information Line S.A.F.E. Alternatives http://www.selfinjury.com/

YouthAlert! (YA!) VBPHP Word Puzzle

W W J X U L T R C E X L M G I I J A S R C H Y E Y Q L M B S A K U K U U R J R I
H Z T P L A H A D F B C H Z D L A O F E R Q T T C R E Z F N F K F B H D U L H Y
I N H L P Q I P S R L R I E P T D H W J L Y A O F B D Z C P B T V J B S C O Y E
K H F N F I W K G R U W N K Q F H K O G U F N V A X I V X X C H U J T U T S D B
G N C F W T I D R S X T O M O R C P F R L A H A I N C W I D F V Z I D B B N S U
A R J O T K R J N G I G G O J J B D S G S L D A F S I A X Q F M C X T V B H O U
C W D I U S X O L T M U M P U B O Y F R E T B P R D U Z M H P E D R E A M S G S
R I W V N M P J Y S J X N B O Z L V P F M G O N A M S P C O F E S O S K F V X Z
F X O T X A Z S H Y E N S N I Q B P U G O H G J U G U T Y B U Y A F R O S R Q S
F L V Y E L T N Z A P L X I U K T M T J G N I Y L L U B R E B Y C L X F A N X T
Z B K W M A Q K D V H S P P K X B B T W H N D R M J V H S U K F D A I D I U L Z
Q R N L T B D D Y Z J S S I T N E S N O C G F S J M X M S A Z P Q Q G P L Y J R
L Q I I S K N V P U R S B L C O F B Y E L I O H L O H B M P Z Z X A A Z T B F R
B I O Z X X E Q U A D O K E W N Y S Y V U S K C H T B N L K C H L O P O U E O D
U N F U T E X T F E Y N C X T M I T Q R K D W X J R H T T G U Y F Q O G X F X Y
S T D F I I Y D F R F X L V L O W R N S R H U K R S N Z S F D R F G N K P S P O
L T T Y B W S L N Z D W L X J K F M P K M I V L N K I K E K Q K G D E D K S D D
X Y T X D J H F E L O R X W Q Y G R U D S G E U S M V F O S B F D W C I D G C P
H E E G B V T E N G G O X S N D F V F I G H E C Z M B Y H N N M H U R J E U X R
G O P Y W Y C R E M E R V A M Z I I G B F F O C C T L F N H K E T Z X X I M G Z
J Q H W B S I O S T T C C E E D H S D N E I B N M O Q V U C R C F Y Y P F Z P D
N W G U E K I U X J B S A R L Y K N J D G V Z C S H U B W Z J Q R E F Z I L N X
J X Q L L T B S K B U S W M F N M S P H P E D D P L R I D I C U L E D U T Y X E
P R Q Q U X Z W P E K H B D C G Q C H O B W A P N A F B G W A C B Z G V S X P E
A U T N B Y W S B D Q N O K C P W V Z U I V D B J K Q H Y W N X L S L Y U G U A
G J N U C O W F W H V B C L Z Z T T N F S C D W P F T C R U V T G M O F J D N S
I J H I Z G K Z L S T E J Q D Y U T V Q K T P J H G X B O Q I H P P I C J G A D
T K R E V Z Y O L Y P F A E O S R U Z U M Q X V F D S W V D H S B K A H E W M I
A Z E O O C E J E M R E E P H M Y M D Y B A N F D I C I Q M R N K J S H O V W O
V Z T H Z Y A D K M S V R F G G J L Z F I I I N Y F O D Z K F Y V K B J Y G C N
S L I Q J T U M K E I D G Y L C S N W O M F B L O U G F T L F G X J Z R O C E C
M W W G N U E X D D M T T B K Y K X W X U Z X F W G Z E A O P B V D W J T W H O
X O C P S X F H Y I O F I V A T M L D W A H J Y N L A H E M R I U J E S C E S L
B D K V X C T N E A V R P N F H N P I A G X P I F M E Y B B I W H C I N K V V V
F O O F M R U E T I O A K G H M A Q Y G T N Y B A O F E I U C L S J Z R S F C V
G B M F S Z Y F Q V D V M G Z C H Q C X U L N R V K Q M C V E V Y L Y J X S T J
U K Y G R N T D O N F V K E R C Q S U Z L O H X E U R L L P V M B V D W L H F J
W K X L P U M Y M D G C Y K L R Z E V U U U N V Z B H T R W O H L V J X J W B S
W D H G O A W D N R K E S P N J P N B C X I N X K Q M H I P S O X C V Y C W U K
U T N L K B I B Q I X G K G N K F Y F I R G Q D C Q X S T X P E Y S H W P T G G

BULLYING
CONSENT
CYBERBULLYING
DEFENSE
DREAMS
FAMILY
HIGHFIVE
IDENTITYSTATIONS
JUSTICE
JUSTIFIED
MEDIA
PRINCIPLES
RIDICULE
SELFHARM
SUICIDE
TEAM
WEAPONS

Youth Alert!

Circle One **Name**_____**(Optional)**

1. **Did you Learn *Anything New* about Violence in this Presentation?**

   Yes **A Little** **No**

2. **Did this Presentation make you *More Aware* about the Dangers of Violence?**

   Yes **A Little** **No**

3. **Will this Presentation Help You Avoid *Being a Victim* of Violence in the Future?**

   Yes **A Little** **No**

4. **Will this Presentation Help *Prevent You* from Doing an Act of Violence?**

   Yes **A Little** **No**

5. **Could this Presentation Help Stop *Someone Else* from Doing an Act of Violence?**

   Yes **A Little** **No**

Comment on the Presentation:

Youth Alert!

Circle One **Name**_____**(Optional)**

1. **Did you Learn *Anything New* about Violence in this Presentation?**

   Yes **A Little** **No**

2. **Did this Presentation make you *More Aware* about the Dangers of Violence?**

   Yes **A Little** **No**

3. **Will this Presentation Help You Avoid *Being a Victim* of Violence in the Future?**

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   Yes **A Little** **No**

Comment on the Presentation:

YA!

YouthAlert (YA!) Violence & Bullying Prevention/Health Program

Student/Youth Ending Self-Reporting Survey

Student Name: **School** **Survey Date**

Age **Grade** **Gender**

1. The Presentation was a positive experience.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

2. I have been more aware of bullying and violence since the Presentation.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

3. I have avoided bullying and violence more since the Presentation.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

4. I am leading a more peaceful life since the Presentation.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

5. I have helped others who were being bullied since the Presentation.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

6. I have put into practice what I learned in the Presentation.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

7. I have more self-esteem since the Presentation.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

8. I could learn more and support what I already know if I saw the Presentation again.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

9. I remember many positive things about the Presentation.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

10. I have felt and acted more equal and kind since the Presentation.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

11. I have been more focused on surviving my teen years since the Presentation.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

12. I have seen a positive change in my peers who have also seen the Presentation.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

Comments:

Instructor Help List for YA! VBPHP Presentation

1. **Complete student/class demographic form**
2. **Complete instructor presentation survey after the YA! presentation.**
3. **Video of Instructor with comment on the YA! presentation**
4. **Help take photos and videos of the presentation with YA!'s phone.**
5. **Help hand out student worksheet, pretest-posttest, quizzes and surveys**

YA! only collects the quizzes and survey's if the all the quiz answers and the survey comments, at the bottom of the survey, are complete.

6. **Review student surveys on the last day of each presentation after the surveys have been sorted by YA! By those who have commented and those who have not, and after the surveys have been numbered**
7. **Help with role playing. Bullying and bystander intervention**
8. **Like YouthAlert! (YA!) on school facebook accounts and if possible mention YouthAlert!(YA!) in any other school social media sites**
9. **If possible get their students to like YouthAlert! (YA!) on school facebook accounts and mention YouthAlert!(YA!) in any other social media sites they might have**
10. **Help hand out treats**

YA!

YouthAlert (YA!) Violence & Bullying Prevention/Health Program

Student/Class Demographic of Presenation

Instructor_____ **Location/Class**_____ **Dates**_____

Period	Grade	Males	Females	Minorities	Non-Minorities	Total

YA!

YouthAlert (YA!) Violence & Bullying Prevention/Health Program

Instructor/Host Eight Question Survey (Circle One Answer)

Name_____ **Location**_____ **Dates**_____

1. Was the Session/Program presented and performed in a professional manner.

Yes **A Little** **No** **Don't Know**

2. Do you think the Session/Program could make a difference in a youth's life in a positive way when it comes to violence.

Yes **A Little** **No** **Don't Know**

3. Do you think the Session/Program may stop some youth from doing violence?

Yes **A Little** **No** **Don't Know**

4. Was there new and different information in the Session/Program for youths that was new to youths or information they would otherwise not receive.

Yes **A Little** **No** **Don't Know**

5. Did the Session/Program match the age of youths attending?

Yes **A Little** **No** **Don't Know**

6. Do you think if the Session/Program was to be repeated to the same youths every year, it would be more effective?

Yes **A Little** **No** **Don't Know**

7. Did it the Session/Program meet your expectations?

Yes **A Little** **No** **Don't Know**

8. Would you recommend the Session/Program to other youth groups, schools, or youth organizations?

Yes **A Little** **No** **Don't Know**

Comments_____

_____

_____

Compliment_____

_____

_____

YA!

YouthAlert (YA!) Violence & Bullying Prevention/Health Program

Quiz – Multiple Choice (Circle One)

Name_____ **Teacher**_____ **Grade**_____ **Date**_____

1. **Violence is:**

very, very, bad pain fun happens only to other people sometimes works

2. **Attitude is Everything:**

if you're tough when you ignore people if your attitude is kindness if people respect you

3. **My First Purpose is:**

to have fun to do well in school to make friends to survive my youth

4. **All People are Equal Because:**

It's what adults believe no one has a special view or angle It's what kids believe people are not equal

5. **Bullying is:**

necessary sometimes can't be stopped only when someone hits you forever

6. **You Should Always Recognize:**

a true choice that you don't always have choices that you have no choice choice is only for some people

7. **Most People are Already:**

violent peaceful mean happy

8. **The Rule of Violence:**

you get away with violence sometimes only criminals do violence

only men do violence doing violence brings violence to you

9. **You are a Youth Until you:**

graduate High School have a boyfriend/girlfriend are 24 years of age get into a fight

10. **Violence is Only Allowed When:**

they had it coming I do it someone insults me it's real self-defense

---

11. A Youth's Destiny is:

doomed | to live a long and happy life | die young | win over other people

12. The Root of Evil is:

money | men | politics | selfishness

13. Most Youth Get Hurt by:

family | themselves | friends | strangers

14. How to Escape a Violent Situation:

walk away | make some noise | do nothing | all three | none of these three

15. One of the Best Ways to be an Upstander is to:

keep a journal | keep it a secret | bully them back | tell someone

16. Most Victims of Violence are:

girls | boys | children | adults

17. Adults like to:

ignore kids | be the hero | tease kids | be the enemy

18 Youth Need to Learn How to Juggle things to:

become independent | enjoy more drama in school | be superior | to impress teachers

19. The Number One Age Group for doing Violence is:

12-18 | 19-24 | 25-30 | 31 or older

20. When People Disrespect you:

it's their gift | it's their flaw | disrespect them back | get your friends against them

YA!

YouthAlert (YA!) Violence & Bullying Prevention/Health Program
Instructor Ending Self-Reporting Survey on Students

Instructor: **School:** **Date:**

1. The Presentation was a very positive experience for my students.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

2. Some of my students have been more aware of bullying and violence since experiencing the Presentation.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

3. Some of my students who experienced the Presentation have behaved better since the Presentation.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

4. Some of my students have spoken about parts of the Presentation since the Presentation.

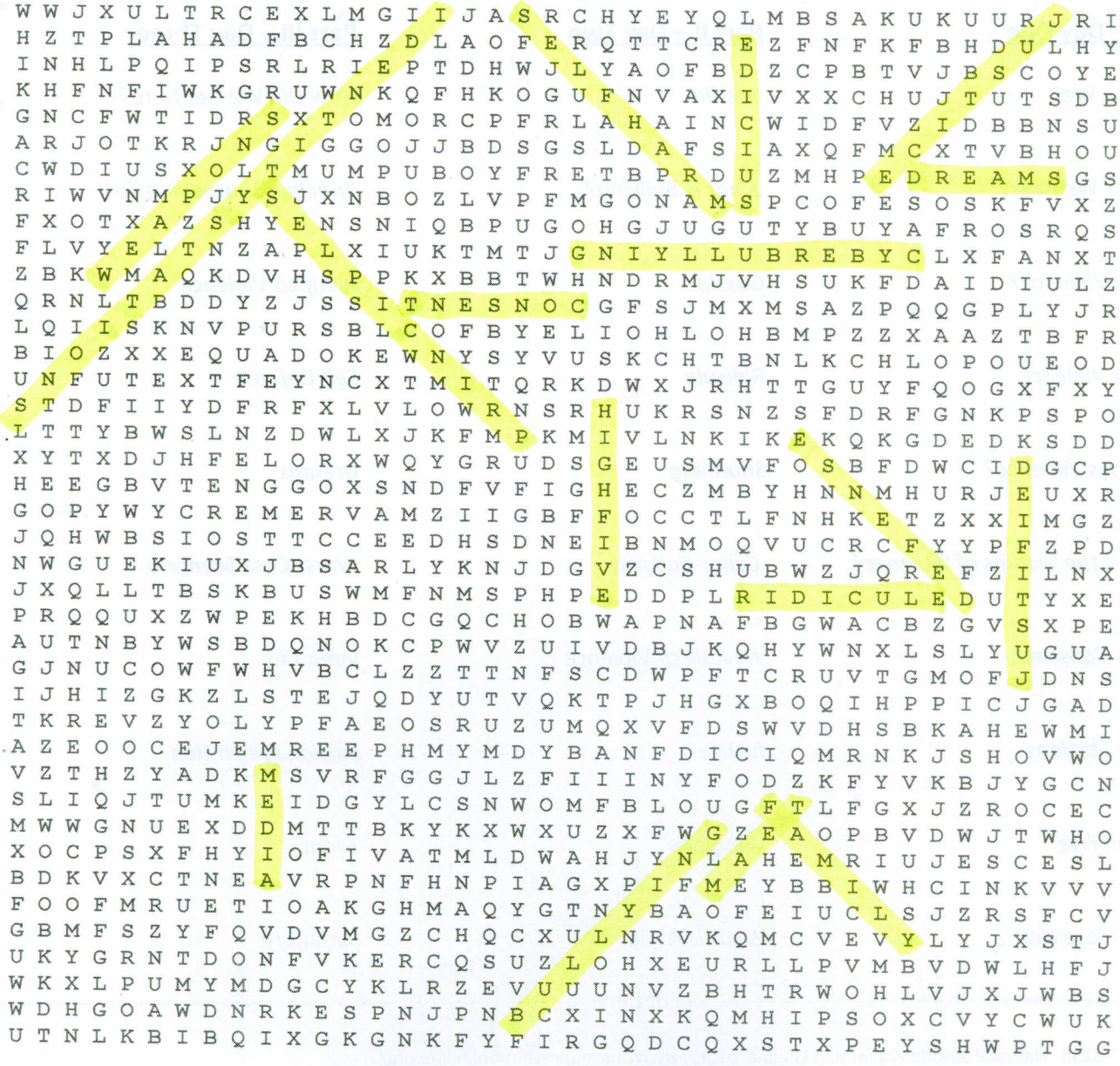
☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

5. The Presentation has assisted in the education of my students on the subjects in the Presentation.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Don't Know

Comments:

YouthAlert! (YA!) Word Puzzle

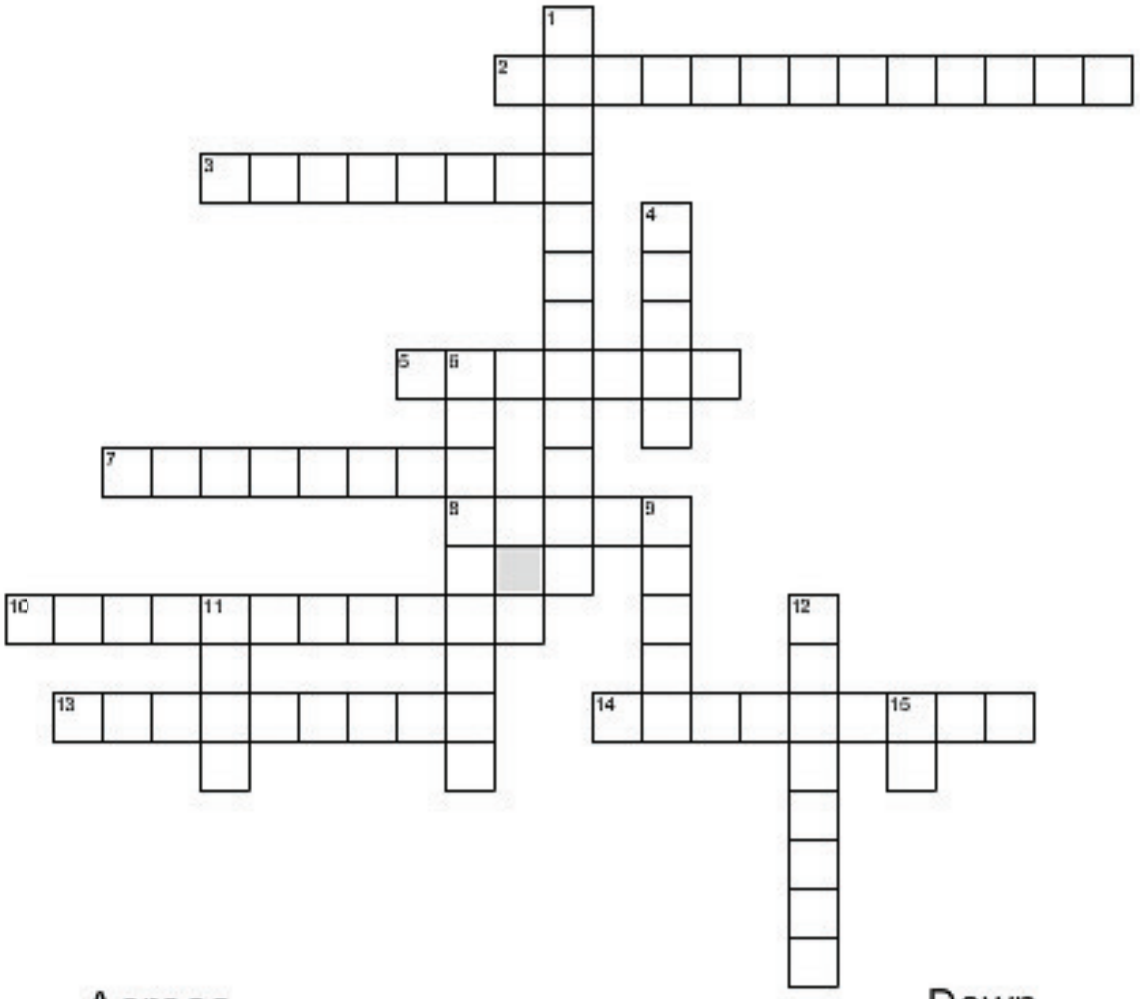


BULLYING
CONSENT
CYBERBULLYING
DEFENSE
DREAMS
FAMILY
HIGHFIVE
IDENTITYSTATIONS
JUSTICE
JUSTIFIED
MEDIA
PRINCIPLES
RIDICULE
SELFHARM
SUICIDE
TEAM
WEAPONS

Key

YouthAlert! (YA!) VBPHP

Crossword



Across

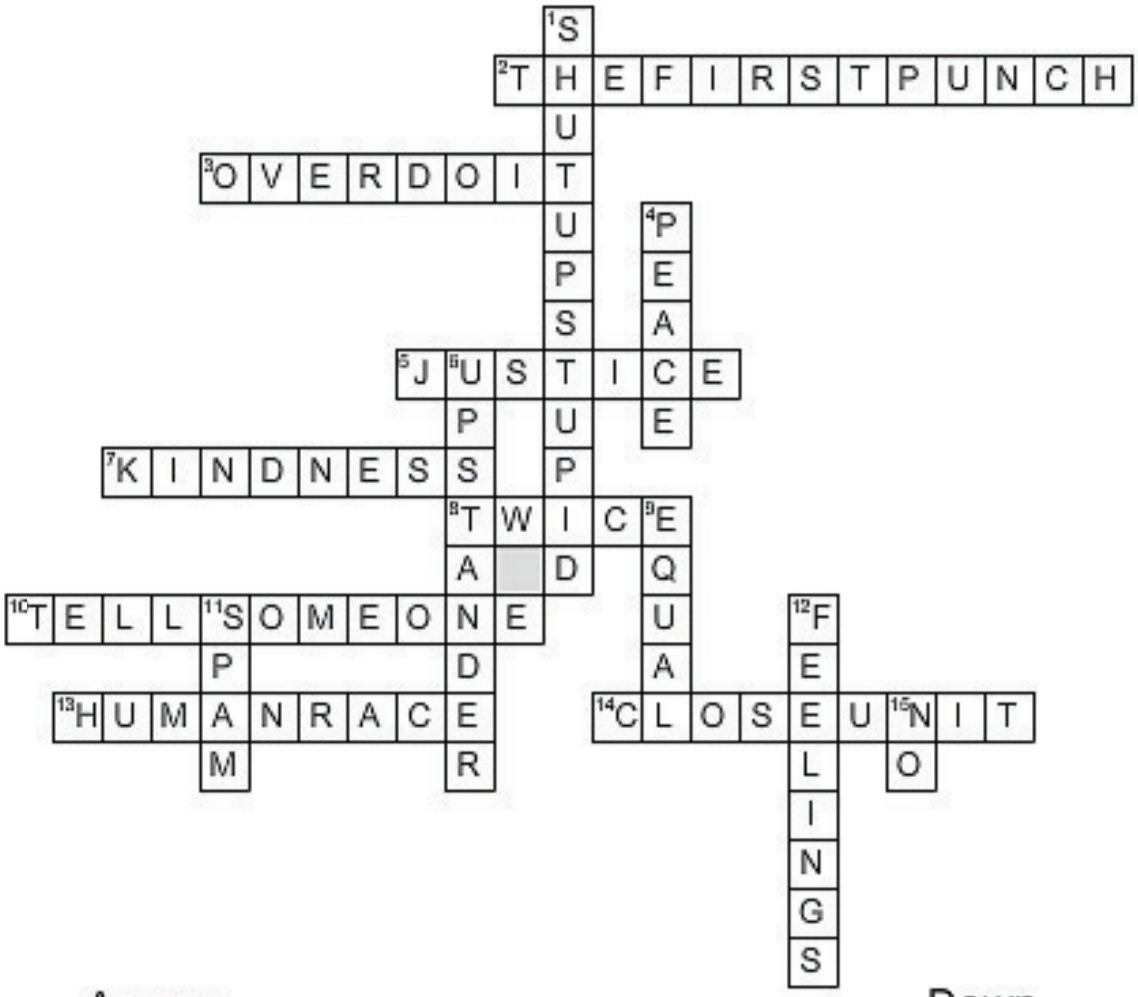
2. In a dangerous situation do not throw
3. One of the secrets of a long life is not to
5. Do not under estimate this
7. If you haven't learned this you have learned anything
8. It is bullying and harassment when it happens
10. Do this when you are being bullied
13. Some believe that humans have already won the
14. Another word for family is

Down

1. The two worst bullying words
4. The first principle of everything
6. The opposite of being a passive bystander
9. All humans are
11. When you are being cyber-bullied hit block or this button
12. Everyone has got these
15. Learn to say this politely

YouthAlert! (YA!) VBPHP

Crossword



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YouthAlert! (YA!) Violence & Bullying/Health Program

Presentation Certificate

www.YouthAlert.us

This Certificate is a recognize that **YouthAlert! (YA!) Violence Prevention & Bullying /Health Program** has been performed at the following location.

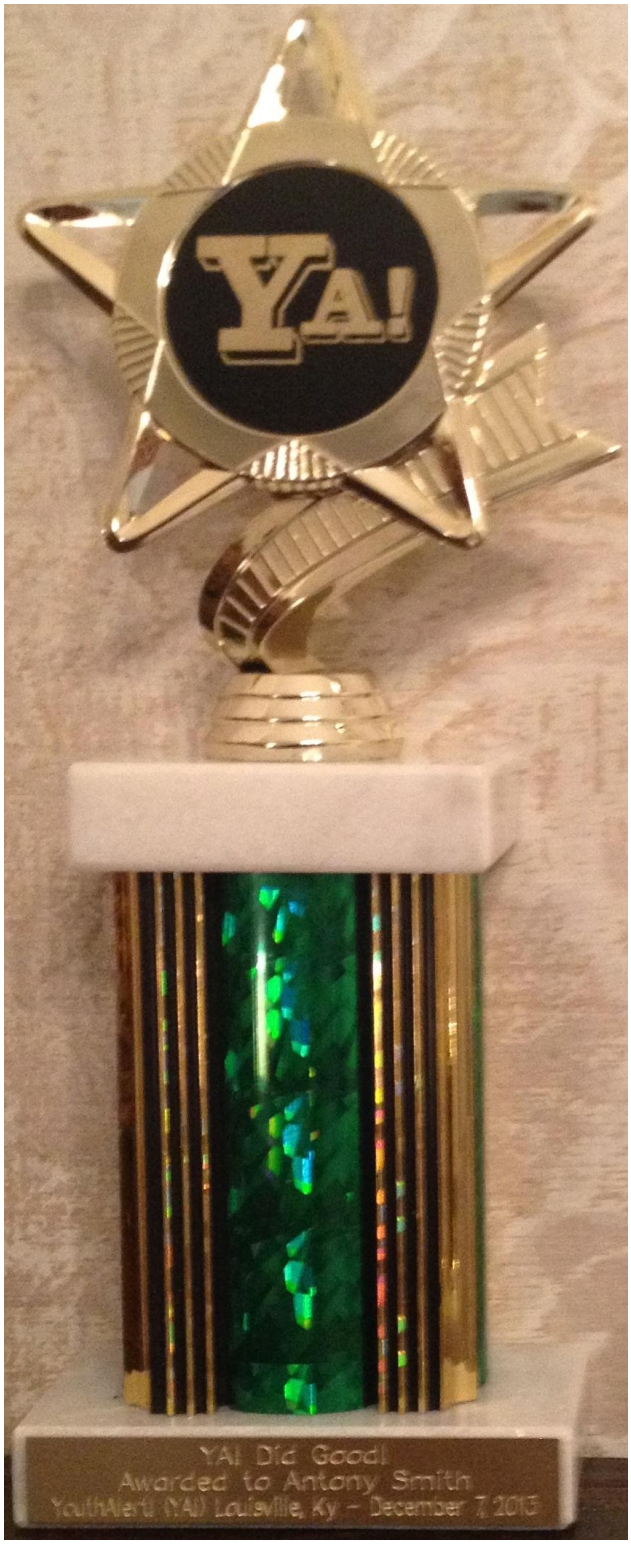
ABC Middle & High School
Anywhere Main Street
Anytown, Kentucky

August 1, 2016

Douglas A. Wain, C.E.O./Executive Director, YouthAlert! (YA!)
www.YouthAlert.us info@YouthAlert.us

YouthAlert (YA!) Violence & Bullying Prevention/Health Program

YouthAlert! (YA!) Participation Trophy



Invitation to Adults to Join Us!

YouthAlert! (YA!)

Violence & Bullying Prevention/Health Program

"Where Youth and Adults Meet HALFWAY in the Classroom to Reduce Violence & Bullying"

One Day, Two Day, and Three Day, Programs

Subjects Include: Dating Violence, Bullying, Gun Violence, Suicide/Self Harm, Gang Violence, Justice, Sexual Violence, School Violence, Child Abuse, Neglect, Domestic Violence, Media, Safe Surroundings, Gender & Gender Identity Violence, Victimization, Mental & Social Health, Physical Health, Substance Abuse, Unintentional Injuries, Diet, and more.

When ***Where***

info@YouthAlert.us www.YouthAlert.us

YA!

YouthAlert (YA!) Violence & Bullying Prevention/Health Program

Instructor/Host Letter of Interest

From:

We are interested in having the **YouthAlert! (YA!) Violence & Bullying Prevention Program** to our School/Event.

We hope you may be interested in sponsoring this program at our school/event to bring this important information to our students/audience.

Thank you for your support.

_____

Dates:

YouthAlert (YA!) Violence & Bullying Prevention/Health Program

List of Other Schools Who Might Have Interest in the Program

YouthAlert! (YA!) Violence & Bullying Prevention/Health Program

"*Where Youth and Adults Meet Halfway to Reduce Violence & Bullying*"
Teaching Violence & Bullying Prevention and Healthy Lifestyles to Children and Youth
"Protecting the whole youth, and nothing but the youth"©

YouthAlert! (YA!) Violence & Bullying Prevention/Health Program is an in-school, out-of-school time, one to three-day, one to six-hour, presentation, whose purpose is to reduce violence and bullying by a ten-percent and improve the overall health of children and youth of Elementary, Middle and High School age. This program is part of **YouthAlert! (YA!)'s Eighteen Week National Health Curriculum.**

YouthAlert! (YA!) personnel present this program directly to any number of children or youth in a school, class, public, or community, environment. Extra attention during these presentations is given to male youth and U.S. minorities. The Program is not political, financial, religious, or judgmental.

YouthAlert! (YA!) Violence & Bullying Prevention/Health Program is, first, and foremost, a community outreach program. The program represents the voice of the entire community and all opinions are welcome from the community, educators, adults, and youth. The program also helps youth connect to local and national support and intervention services.

Volunteer Description for Sponsors, 2016

Assist with classroom management.

Assist calling on students with questions with hands raised.

Assist handing out treats for student participation.

Engaging students on the subjects.

Providing feedback to students.

Testimonials, stories, of the volunteer's personal experiences on violence, bullying a health.

Assist in live role-playing with students.

Assist in distributing and collecting, YouthAlert! (YA!) handouts, surveys, participation papers and notes, and data collection including class demographics.

Assist in taking videos and photos. Videos and photos are taken of all participants throughout the presentation.

Assist with social media postings for YouthAlert! (YA!)'s intsagram, twitter, facebook, Flickr, Pinterest, youtube, accounts.

Other volunteer special interests, or sponsorship initiatives, volunteers would like to share with students.

Contact: Douglas A. Wain, Executive C.E.O./Executive Director

YouthAlert! (YA!) Violence & Bullying Prevention/Health Program

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Guest Speakers from Sponsors, 2016

YouthAlert! (YA!) VBPHP is where youth and adults meet HALFWAY to reduce violence, bullying, and live health lifestyle so in addition to support and educational content, live *Guest Speakers from Sponsors* in the classroom during our presentation will always be a integral part our program.

Sponsors are very much welcome to speak in-person to students during our in-school presentation, during class time. Guest Speakers can choose whether they want to speak to one class or many classes within our one, to three, full- day Presentation. Guest Speakers from Sponsors are welcome to speak live at the schools, events, and days that they are sponsoring.

Guest Speakers from Sponsors are free to talk about any subject matter they want in any manner they would like. Subjects can be:

Any special subject, campaign, or initiative, the Sponsors are involved in. We can arrange that the Guest Speaker speaks at a time which coincides on when their subject matter is presented in the program.

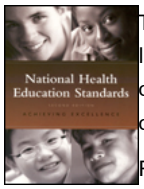
Any personal experiences, lessons, testimonials, stories, of the Guest Speakers experience on violence, bullying a health.

Guest Speakers from Sponsors are recommended to speak to children and youth from ten to twenty minutes. We also recommend a ten minute question and answer period with the Guest Speaker once the speaker finishes.

YouthAlert! (YA!) records videos and photos of all Guest Speakers and participants throughout the presentation. Many of these videos and pictures are posted publicly on our web site and social media sites including intsagram, twitter, facebook, Flickr, Pinterest, youtube, accounts. These videos and photos of Guest Speaker may also be used in our program at other presentations.

Contact: Douglas A. Wain, Executive C.E.O./Executive Director

National Health Education Standards



The National Health Education Standards (NHES) were developed to establish, promote and support health-enhancing behaviors for students in all grade levels—from pre-Kindergarten through grade 12. The NHES provide a framework for teachers, administrators, and policy makers in designing or selecting curricula, allocating instructional resources, and assessing student achievement and progress. Importantly, the standards provide students, families and communities with concrete expectations for health education.

First published in 1995, the NHES were created in response to several model standards being developed for other areas of education by educational leaders across the United States in the early 1990's. With support from the American Cancer Society (http://www.cancer.org) , the Joint Committee on National Health Education Standards was formed to develop the standards. Committee members included

- American Public Health Association (http://www.apha.org)
- American School Health Association (http://www.ashaweb.org)
- SHAPE America (Society of Health and Physical Educators) (http://www.shapeamerica.org/explorehealth.cfm)

Over the last decade, the NHES became an accepted reference on health education, providing a framework for the adoption of standards by most states. A review process begun in 2004 resulted in revisions to the NHES that acknowledged the impact and strength of the original document and took into account more than 10 years of use nationwide. The 2nd edition *National Health Education Standards—Achieving Excellence* promises to reinforce the positive growth of health education and to challenge schools and communities to continue efforts toward excellence in health education.

Standards and Performance Indicators

The NHES are written expectations for what students should know and be able to do by grades 2, 5, 8, and 12 to promote personal, family, and community health. The standards provide a framework for curriculum development and selection, instruction, and student assessment in health education.

Standard 1 Students will comprehend concepts related to health promotion and disease prevention to enhance health.

Standard 2 Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.

Standard 3 Students will demonstrate the ability to access valid information, products, and services to enhance health.

Standard 4 Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.

Standard 5 Students will demonstrate the ability to use decision-making skills to enhance health.

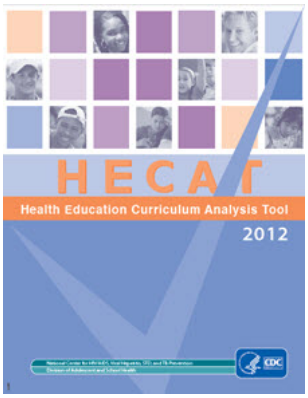
Standard 6 Students will demonstrate the ability to use goal-setting skills to enhance health.

Standard 7 Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.

Standard 8 Students will demonstrate the ability to advocate for personal, family, and community health.

Page last reviewed: August 18, 2016
Page last updated: August 18, 2016
Content source: Division of Population Health (/NCCDPHP/dph), National Center for Chronic Disease Prevention and Health Promotion (/chronicdisease) (/)

Health Education Curriculum Analysis Tool (HECAT)



The Health Education Curriculum Analysis Tool (HECAT) can help school districts, schools, and others conduct a clear, complete, and consistent analysis of health education curricula based on the National Health Education Standards and CDC's Characteristics of an Effective Health Education Curriculum .

Results of the HECAT can help schools select or develop appropriate and effective health education curricula and improve the delivery of health education. The HECAT can be customized to meet local community needs and conform to the curriculum requirements of the state or school district.

HECAT Brochure [PDF - 242 KB]

The HECAT features:

- Guidance on using the HECAT to review curricula and using the HECAT results to make health education curriculum decisions
- Templates for recording important descriptive curriculum information for use in the curriculum review process
- Preliminary curriculum considerations, such as accuracy, acceptability, feasibility, and affordability analyses
- Curriculum fundamentals, such as teacher materials, instructional design, and instructional strategies and materials analyses
- Specific health-topic concept and skills analyses
- Customizable templates for state or local use

Download the HECAT

Chapters | Modules | Appendices

- HECAT Cover [PDF - 155 KB]
- Table of Contents and Acknowledgments [PDF - 169 KB]
- Overview [PDF - 391 KB]
- Chapter 1: General Instructions [PDF - 211 KB]
- Chapter 2: General Curriculum Information [PDF - 121 KB]
- Chapter 3: Overall Summary Forms [PDF - 135 KB]
- Chapter 4: Preliminary Curriculum Considerations [PDF - 377 KB]
- Chapter 5: Curriculum Fundamentals [PDF - 229 KB]
- Chapter 6: Overview of Modules [PDF - 101 KB]

File Formats Help:

How do I view different file formats (PDF, DOC, PPT, MPEG) on this site? (https://www.cdc.gov/Other/plugins/)

(https://www.cdc.gov/Other/plugins/#pdf)

Page last reviewed: April 22, 2016
Page last updated: September 1, 2015
Content source: Division of Adolescent and School Health (/healthyyouth/), National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (/nchhstp/)

The Public Health Approach to Violence Prevention

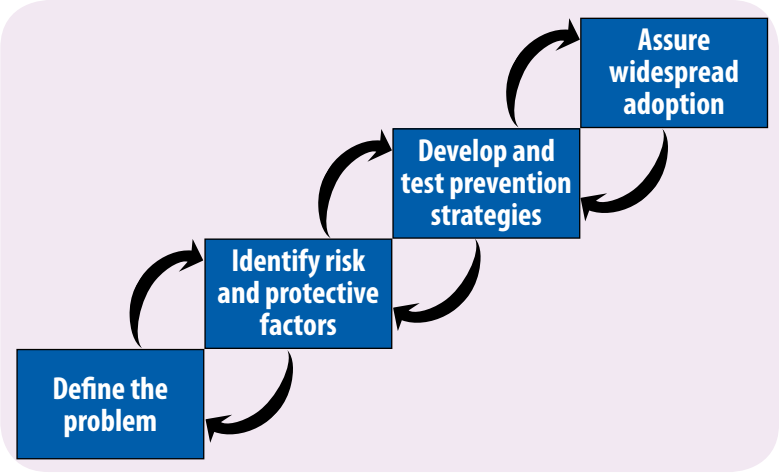
The public health perspective asks the foundational questions: Where does the problem begin? How could we prevent it from occurring in the first place? To answer these questions, public health uses a systematic, scientific approach for understanding and preventing violence[1]. While violence prevention practitioners may not be involved in all steps, understanding each step and why they are necessary to assure the desired impact on community health is helpful in selecting and/or developing prevention strategies.

The Public Health Approach

There are multiple steps in the public health approach, with each step informing the next. Many people, organizations, and systems are involved at each step along the way. Think of it as a relay team for prevention. The prevention practitioner usually takes up the baton in the fourth step, but overall success depends upon all of the other teammates and how they run their legs of the race

The Public Health Approach

In **step one**, the problem is defined. This involves systematically collecting data to determine the "who", "what, "where," "when," and "how." Data are typically gathered from a variety of sources such as death certificates, medical or coroner reports, hospital records, child welfare records, law enforcement or other records. Data can also be collected using population-based surveys or other methods.



In **step two**, the reasons why one person or community experiences violence while another does not are explored. Scientific research methods are used to identify the factors that increase the risk for violence (risk factors). Factors that may buffer against these risk factors are also identified; these protective factors decrease the likelihood of violence in the face of risk. The goal of violence prevention is to decrease risk factors and increase protective factors.

In **step three**, prevention strategies are developed and rigorously tested to see if they prevent violence. This information is shared with others, usually through activities related to step four.

Step four is where the rubber meets the road. The strategies shown to be effective in step three are disseminated and implemented broadly. While many prevention practitioners may not have the skills or resources necessary to conduct steps one, two, and three, knowing where to look for the findings of others, such as registries for evidence based practice in the field, will satisfy similar goals for implementation. Training and/or technical assistance often is offered to practitioners when implementing effective strategies or programs to ensure that the strategies are implemented as they were intended. Though this is considered the final step of the public health model, it doesn't mean that the process is complete. Additional assessments and evaluation are done to assure that all components of the strategy fit within the particular community context and have the desired effect of preventing violence.

Putting it all together

So what does this mean for the decision making process on the ground? How does knowing about the four steps help in selecting prevention strategies? One way to look at it is that the Public Health Approach offers a framework for asking and answering the right questions. The tool on the next page will help you to do just that.

1. Mercy, J., et. al. (1993). Public Health Policy for Preventing Violence. Health Affairs. 12(4), 7-29.

National Center for Injury Prevention and Control
Division of Violence Prevention

CS221239B

Use the tool below to think through a violence-related problem you would like to impact in your community or organization. The issue of Shaken Baby Syndrome, one form of abusive head trauma, is used as an example to demonstrate the tool. Fill in the shaded areas on the table with examples from your community or organization.

Using the Public Health Approach			
Steps	**Guiding Questions**	**Potential Resources**	**Example/Exercise**
Step One Define the Problem	What (violence-related) problem do I want to prevent? What data are available to describe the scope and burden of the problem? • How many people are affected by the identified problem? • Who is experiencing the problem? • When and where is the problem occurring?	National Violent Death Reporting System - http://www.cdc.gov/ViolencePrevention/NVDRS/index.html Web-based Injury Statistics Query and Reporting System (WISQARS) - http://www.cdc.gov/injury/wisqars/index.html Kids Count Data Center - http://datacenter.kidscount.org/?gclid=CMHYql_7oqMCFcpd2godz3wZ4Q ALSO: State and local crime statistics, health statistics, child welfare data, etc.	*Example: Abusive head trauma (AHT), including Shaken Baby Syndrome (SBS) is a leading cause of child abuse deaths in the United States. According to a study of North Carolina AHT cases, as many as three to four children a day experience severe or fatal head injury from child abuse in the United States.* *Your turn:*
Step Two Identify Risk and Protective Factors	Where do I find research to answer: • What are the risk factors for the problem? • What are the protective factors for the problem?	Division of Violence Prevention (NCIPC/CDC) - http://www.cdc.gov/ViolencePrevention/index.html	*Example: Caregiver frustration or anger resulting from inconsolable crying and limited social supports are primary risk factors for shaking a baby.* *Your turn:*
Step Three Develop and Test Prevention Strategies	Where do I find information to answer: • Are there existing, effective strategies based on best available evidence? • If none exist, what resources do I need to develop a new strategy based on what was learned in steps one and two? • Where can I find research partners to help evaluate the selected strategy? • Is the strategy effective – did it do what was intended?	The Community Guide to Prevention Services - http://www.thecommunityguide.org/about/methods.html Blueprints for Violence Prevention - http://www.colorado.edu/cspv/blueprints/ California Evidence-Base Clearinghouse http://www.cachildwelfareclearinghouse.org/scientific-rating/scale Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence - http://www.nrepp.samhsa.gov/about-evidence.asp	*Example: A promising or model home visitation program. http://ibs.colorado.edu/cspv/blueprintsquery* *Your turn:*
Step Four Assure Widespread Adoption (Dissemination and Implementation)	• Who would benefit from this strategy (parents, educators, policy makers, etc.)? • How do I get this strategy to the people who need it? • Where can I find assistance and support for implementing an effective strategy and on-going monitoring and evaluation of the strategy?	National Implementation Research Network - http://www.fpg.unc.edu/~nirn/ FRIENDS National Resource Center - http://www.friendsnrc.org/ University of Kansas Community Toolbox - http://ctb.ku.edu/en/default.aspx	*Example: Implementation of a home visitation program that includes a focus on specific parental behaviors and modifiable environmental conditions associated with adverse outcomes for children.* *Your turn:*

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The Effectiveness of Universal School-Based Programs for the Prevention of Violent and Aggressive Behavior

A Report on Recommendations of the Task Force on Community Preventive Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

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CONTENTS

The Effectiveness of Universal School-Based Programs for the Prevention of Violent and Aggressive Behavior

A Report on Recommendations of the Task Force on Community Preventive Services*

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Summary

Universal school-based programs to reduce or prevent violent behavior are delivered to all children in classrooms in a grade or in a school. Similarly, programs targeted to schools in high-risk areas (defined by low socioeconomic status or high crime rates) are delivered to all children in a grade or school in those high-risk areas. During 2004–2006, the Task Force on Community Preventive Services (Task Force) conducted a systematic review of published scientific evidence concerning the effectiveness of these programs. The results of this review provide strong evidence that universal school-based programs decrease rates of violence and aggressive behavior among school-aged children. Program effects were demonstrated at all grade levels. An independent meta-analysis of school-based programs confirmed and supplemented these findings. On the basis of strong evidence of effectiveness, the Task Force recommends the use of universal school-based programs to prevent or reduce violent behavior.

* Points of view expressed are those of the contributors and the Task Force on Community Preventive Services and do not necessarily reflect those of CDC, the National Institutes of Health, the National Institute of Justice, the U.S. Department of Justice, or the U.S. Department of Health and Human Services. Author affiliations reflect author's location while this research was being conducted.

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Background

Youth violence is a substantial public health problem in the United States. In a representative national survey conducted in 2003, U.S. adults reported approximately 1.56 million incidents of victimization by perpetrators estimated to be aged 12–20 years, representing a rate of approximately 4.2 incidents per 100 persons in this age group (*1,2*). Two thirds of reports by victims concerned "simple assaults" (i.e., attacks without a weapon and not resulting in an injury requiring >2 days of hospitalization). The remaining victimizations were "serious violent crimes" (i.e., rape, sexual assault, robbery, or aggravated assault).

Because survey respondents were crime victims, murder was not included. Since the 1980s, youths aged 10–17 years, who constitute <12% of the U.S. population, have been involved as offenders in approximately 25% of serious violent victimizations (*3*). Homicide and suicide are the fourth and fifth leading causes of death respectively among children aged 5–14 years and the second and third leading causes of death among persons aged 15–24 years (*4*).

Risk factors for youth violence include low socioeconomic status (SES), poor parental supervision, harsh and erratic discipline, and delinquent peers (*3*). Delinquent youths commonly have additional problems (*5*), including drug abuse, difficulties at school, and mental health problems (as indicated by being in the top 10% of the distribution of externalizing and internalizing symptoms in the Child Behavior Checklist) (*6*). These youths are threats not only because of the direct harm they cause but also because of the role they might play in the socialization of other potential delinquents (*7*).

The prevention of youth violence and aggression is of value in itself and also because early violent and aggressive behavior is a precursor of later problem behaviors (*8*). Researchers categorize risk factors for early childhood delinquency, including violent behavior, as individual, family, peer, school, neighborhood, and media. Factors in all categories are thought to contribute to the development of early and chronic violent behavior, and all are thought to provide opportunities for intervention to reduce the development of these behaviors (*9*).

The most serious forms of violent crime (i.e., rape, sexual assault, robbery, aggravated assault, and homicide) rarely occur in schools (*10*). During July 1992–June 2000, an annual average of 29 homicides and five suicides occurred throughout U.S. schools, representing <1% of the homicides among youths aged 5–19 years and <0.5% of suicides among youths away from schools during the same period (*10*). However, a disproportionate amount of nonfatal crime occurred in school facilities or on the way to or from school. Although rates of violent crime declined during 1993–2003, in 2003, approximately 740,000 violent crimes were committed at schools against adolescents aged 12–18 years (rate: 1.3 per 100 persons) (*10*). Of these crimes, approximately 150,000 (20.3%) were classified as "serious."

The Task Force review assessed the effectiveness of universal school-based programs in reducing or preventing violent and aggressive behavior among children and adolescents. These programs teach all students in a school or school grade about the problem of violence and its prevention or about one or more of the following topics or skills intended to reduce aggressive or violent behavior: emotional self-awareness, emotional control, and self-esteem; positive social skills; social problem solving; conflict resolution; and team work.

As used in this report, "universal" means that programs are administered to all children in classrooms regardless of individual risk, not only to those who already have manifested violent or aggressive behavior or risk factors for these behaviors. Although meriting separate review because youths who manifest violence or aggressive behavior at young ages are at greater risk for later violence, programs that target youths who already have manifested problems of violence or are considered at high risk for violence were not evaluated in this review.

Universal programs might be targeted by grade or school in high-risk areas (defined by residents' low SES, commonly indicated by the proportion of school children receiving subsidized lunches, or high crime rates, as noted by study authors describing the school community). Programs are delivered to all children in those settings. Programs also might be implemented in special schools (e.g., schools for children with specific disabilities). Prekindergarten, kindergarten, elementary, middle, and junior and senior high school settings were included in this review.

Universal school-based programs are founded on multiple theoretical approaches (*11,12*). Theories of behavior change vary in their focus on individuals; interpersonal relations; the physical and social environment, including social norms; and combinations of these. Certain programs focus on providing information about the problem of violence and approaches to avoiding violence, on the assumptions that providing this information to students will lead to its application and subsequently to reduced violence and that information is necessary, if not sufficient, to change behavior. For example, the Violence Prevention Curriculum for Adolescents (*13*) is designed to teach students about the causes of violence; knowledge of violence resistance skills is taught through discussion. Other programs (*14*) assume that self-concept and self-esteem derive from positive action and its rewards, so if children's behavior can be made more positive and sociable, they will develop better attitudes toward themselves and then continue to make positive choices. In the Second Step program (*15*), teaching and discussion are accompanied by role playing, modeling, skill practice, feedback, and reinforcement.

Certain programs (e.g., Responding in Peaceful and Positive Ways [*16*] and Students for Peace [*17*]) cite social learning theory (*18*) as the foundation for their intervention design. Other programs are founded on the theory that they will be most effective if they modify the broader

environment of the child. In the elementary school PeaceBuilders program, in addition to the classroom curriculum, the entire school is involved, both outside and inside the classroom, together with parents and the community; in the school setting, conditions that provoke aggressive behavior are mitigated, and the following of simple positive behavioral rules, such as "praise people" and "right wrongs," is encouraged and rewarded (*19*). The Safe Dates Program includes a 10-session classroom curriculum, a theatrical production performed by students, a poster contest, community services for adolescents in abusive relationships (e.g., support groups and materials for parents), and training for community service providers (*20*). School antiviolence programs often are associated with manuals, which facilitate reliable implementation; manuals often are available commercially.

Introduction

The independent, nonfederal Task Force on Community Preventive Services leads work on the Guide to Community Preventive Services, a resource that includes multiple systematic reviews, each focusing on a preventive health topic. Work on the Community Guide is supported by the U.S. Department of Health and Human Services (DHHS) in collaboration with public and private partners. Although CDC provides staff support to the Task Force for development of the Community Guide, the recommendations presented in this report were developed by the Task Force and are not necessarily the recommendations of DHHS or CDC.

Community Guide findings are prepared and released as each is completed. Reports of systematic reviews have already been published on improving coverage with universally recommended and targeted vaccines, tobacco use prevention and reduction, reducing motor-vehicle–occupant injury, increasing physical activity, diabetes management, improving oral health, skin cancer prevention, other aspects of violence prevention, and the effects of the social environment on health. A compilation of Community Guide systematic reviews has been published in book form (*22*). Additional information regarding the Task Force and the Community Guide and a list of published articles are available on the Internet at http://www.thecommunityguide.org.

The interventions reviewed might be useful in reaching certain objectives specified in *Healthy People 2010* (*23*), which outlines the disease prevention and health promotion agenda for the United States. These objectives identify certain important preventable threats to health and focus the efforts of public health systems, legislators, and law enforcement officials on addressing those threats. Universal school-based programs and their proposed effects on violence-related outcomes are relevant to multiple *Healthy People 2010* objectives regarding injury and violence prevention (Table 1).

Methods

Community Guide systematic reviews summarize evidence on the effectiveness of interventions in improving selected health-related outcomes. Positive or negative effects of the intervention other than those assessed for the purpose of determining effectiveness (including positive or negative health and nonhealth outcomes) also are considered (*24,25*). When an intervention is shown to be effective in changing a selected outcome, information also is included on the applicability of evidence (i.e., the extent to which available effectiveness data might apply to diverse population segments and settings), the economic impact of the intervention, and barriers to implementation.

As with other Community Guide reviews, the process used to conduct a systematic review of the evidence and to develop conclusions involved 1) forming a systematic review development team, 2) developing a conceptual approach to organizing, grouping, and selecting interventions, 3) selecting interventions to evaluate, 4) searching for and retrieving evidence regarding each intervention, 5) assessing the quality of and abstracting information from each study, 6) assessing the quality of and drawing conclusions about the body of evidence on effectiveness, and 7) translating the evidence on effectiveness into recommendations.

The present review was produced by the systematic review development team (the team) and a multidisciplinary team of specialists and consultants representing various perspectives on violence. This review included studies that assessed directly measured violent outcomes, specifically self- or other-reported or observed aggression or violence, including violent crime. The review also included studies that examined any of five proxies for violent outcomes that include not only clearly violent behavior but also behavior that is not clearly violent:

- measures of conduct disorder (the psychiatric condition, in which the rights of others or major societal norms or rules are violated) (*26*);
- measures of externalizing behavior (i.e., rule-breaking behaviors and conduct problems, including physical and verbal aggression, defiance, lying, stealing, truancy, delinquency, physical cruelty, and criminal acts) (*27*);

TABLE 1. Selected *Healthy People 2010 objectives related to school-based violence prevention programs**

Objective no.	Population	Baseline		2010 objective
		No.	Year	
Injury Prevention				
15-1: Reduce hospitalization for nonfatal head injuries per 100,000 population	All	60.6†	1998	45.0
15-2: Reduce hospitalization for nonfatal spinal cord injuries per 100,000 population	All	4.5†	1998	2.4
15-3: Reduce firearm-related deaths per 100,000 population	All	11.3†	1998	4.1
15-5: Reduce nonfatal firearm-related injuries per 100,000 population	All	24.0†	1997	8.6
15-12: Reduce hospital emergency department visits per 1,000 population	All	131.0†	1997	126.0
Violence and Abuse Prevention				
15-32: Reduce homicides per 100,000 population	All	6.5†	1998	3.0
15-33a: Reduce maltreatment of children per 1,000 children aged <18 years	Children	12.9§	1998	10.3
15-33b: Reduce child maltreatment fatalities per 100,000 children aged <18 years	Children	1.6§	1998	1.4
15-34: Reduce rate of physical assault by current or former intimate partners per 1,000 persons aged ≥12 years	Adolescents/adults	4.4	1998	3.3
15-35: Reduce annual rate of rape or attempted rape per 1,000 persons aged ≥12 years	Adolescents/adults	0.8	1998	0.7
15-36: Reduce sexual assault other than rape per 1,000 persons aged ≥12 years	Adolescents/adults	0.6	1998	0.4
15-37: Reduce physical assaults per 1,000 persons aged ≥12 years	Adolescents/adults	31.1	1998	13.6
15-38: Reduce physical fighting among adolescents (students in grades 9–12) during previous 12 months¶	Adolescents	36.0	1999	32.0
15-39: Reduce weapon carrying by adolescents (students in grades 9–12) on school property during past 30 days¶	Adolescents	6.9	1999	4.9

* **Source:** US Department of Health and Human Services. Healthy people 2010. 2nd ed. With understanding and improving health and objectives for improving health (2 vols.). Washington, DC: US Department of Health and Human Services; 2000.
† Age-adjusted to year 2000 standard population.
§ Target rate objective 15-33a is expressed per 1,000 children aged <18 years, compared with 100,000 children aged <18 years for objective 15-33b. Comparable objectives would be reduction of child maltreatment to 1,290 per 100,000 children aged <18 years and reduction of child maltreatment fatalities to 1.6 per 100,000.
¶ Per 100 adolescents.

- measures of acting out (i.e., aggressive, impulsive, or disruptive class behaviors) or conduct problems (includes talking in class, stealing, fighting, lying, not following directions, teasing, and breaking things);
- measures of delinquency (which might include violent behavior and behavior not regarded as violent); and
- school records of suspensions or disciplinary referrals.

The purpose of this review was to assess the effectiveness of school-based programs in reducing or preventing violent behavior. Thus, studies of school-based programs were included only if they assessed violent outcomes or proxies for violent outcomes and if the reduction of violent or aggressive behavior was an objective of the program (although it need not have been the only or principal objective). The effects on other outcomes were not systematically assessed, but are reported if they were addressed in the studies reviewed.

Electronic searches for literature on universal school-based programs were conducted during June–July 2002 and updated in December 2004. Databases searched included MEDLINE, EMBASE, Education Resources Information Center (ERIC), Applied Social Sciences Index and Abstracts, National Technical Information Service (NTIS), PsycINFO, Sociological Abstracts, National Criminal Justice Reference Service (NCHRS), and Cumulative Index to Nursing and Allied Health Literature (CINAHL).†

The team also reviewed the references listed in retrieved articles, and specialists on the systematic review development team and elsewhere were consulted. Studies reported in journal papers, governmental reports, books, and book chapters were eligible for review.

Articles published before December 2004 were considered for inclusion in the systematic review if they evaluated a universal school-based program, assessed at least one of the violent outcomes specified previously, were conducted in countries with high-income economies,§ and compared persons exposed to the intervention with persons who had

† These databases can be accessed as follows: MEDLINE: http://www.ncbi.nlm.nih.gov/sites/entrez; EMBASE: DIALOG http://www.embase.com (requires subscription); ERIC: http://www.eric.ed.gov; Applied Social Sciences Index and Abstracts: http://www.csa.com (requires subscription); NTIS: http://www.ntis.gov; PsycINFO: http://psycinfo2.apa.org/psycinfo (requires subscription); Sociological Abstracts: http://www.csa.com (requires subscription); NCJRS: http://www.ncjrs.gov/index.html; and CINAHL: http://www.cinahl.com (requires subscription).

§ High-income economies as defined by the World Bank are Andorra, Antigua & Barbuda, Aruba, Australia, Austria, The Bahamas, Bahrain, Barbados, Belgium, Bermuda, Brunei, Canada, Cayman Islands, Channel Islands, Cyprus, Denmark, Faeroe Islands, Finland, France, French Polynesia, Germany, Greece, Greenland, Guam, Hong Kong (China), Iceland, Ireland, Isle of Man, Israel, Italy, Japan, Republic of Korea, Kuwait, Liechtenstein, Luxembourg, Macao (China), Malta, Monaco, Netherlands, Netherlands Antilles, New Caledonia, New Zealand, Norway, Portugal, Puerto Rico, Qatar, San Marino, Singapore, Slovenia, Spain, Sweden, Switzerland, Taiwan (China), United Arab Emirates, United Kingdom, United States, and U.S. Virgin Islands.

not been exposed or who had been less exposed. Studies with a sample size <20 students were excluded because results from such studies were not considered reliable. While searching for evidence on violent outcomes, the team also sought information about effects on other outcomes not related to violence (e.g., changes in school performance and drug abuse).

Each study that met the initial inclusion criteria became a candidate for the review and was read by two reviewers who used standardized criteria (available at http://www.thecommunityguide.org/methods/abstractionform.pdf) to assess the suitability of the study design and threats to validity (*24,25*). Disagreements between the reviewers were reconciled by consensus of the development team members. The team's classification of the designs of studies reviewed is in accord with standards of the Community Guide review process and sometimes differs from the classification used in the original studies. Studies with the greatest design suitability are those in which data on exposed and control populations are collected prospectively. Studies with moderate design suitability are those in which data are collected retrospectively or that have multiple pre- or postmeasurements but no concurrent comparison population. Studies with least suitable designs are those with no separate comparison population and only a single pre- and postmeasurement in the intervention population. On the basis of the number of threats to validity, studies were assigned a number of penalties and characterized as having good, fair, or limited execution for the purposes of this review (*24*). Studies with good or fair quality of execution and any level of design suitability (greatest, moderate, or least) were included in the body of evidence.

Baselines and relative percentage change were calculated using the following formulas:

- For studies with before-and-after measurements and concurrent comparison groups:

$$\text{Effect size} = (I_{post} / I_{pre})/(C_{post} / C_{pre}) - 1$$

where: I_{post} = last reported outcome rate in the intervention group after the intervention, I_{pre} = reported outcome rate in the intervention group before the intervention, C_{post} = last reported outcome rate in the comparison group after the intervention, and C_{pre} = reported outcome rate in the comparison group before the intervention.

- For studies with post measurements only and concurrent comparison groups:

$$\text{Effect size} = (I_{post} - C_{post}) / C_{post}$$

- For studies with before-and-after measurements but no concurrent comparison:

$$\text{Effect size} = (I_{post} - I_{pre}) / I_{pre}$$

To report effect sizes from multiple studies, the team used the median and, if seven or more effect sizes existed, the lower quartile, Q_1 (the 25th percentile), and the upper quartile, Q_3 (the 75th percentile). Q_1 and Q_3 provide information on the range of the middle 50% of the study effect sizes and therefore can be interpreted as reflecting the range of typical effects.

The strength of the body of evidence was summarized on the basis of the number of available studies, the strength of their design and execution, and the size and consistency of reported effects (*24*). When the number of studies and their design and execution quality were sufficient by Community Guide standards to draw a conclusion on effectiveness, the results were summarized statistically and graphically.

If an intervention was determined to be effective, evidence was assessed regarding its applicability in diverse settings, populations, and circumstances, noting whether it had been applied specifically in different conditions (e.g., to white and minority populations or to younger and older children). The goal of this assessment was to determine the conditions under which the intervention was effective and thus the known limits of its application.

As noted, this review did not systematically assess the effects of a violence prevention intervention on other outcomes (e.g., drug abuse, school achievement, truancy, or psychological adjustment). However, some of the benefits of the intervention mentioned in reviewed studies are noted. The potential harms of school-based violence prevention programs also are noted if these harms were mentioned in the effectiveness literature or were judged by the team to be of importance.

Barriers to implementation are summarized only if an intervention was demonstrated to be effective. Similarly, economic evaluations of interventions were conducted only when evidence of effectiveness was identified. Methods used in Community Guide economic evaluations have been described previously (*28,29*).

Systematic reviews in the Community Guide identify existing information on which to base public health decisions about implementing interventions. An additional benefit of these reviews is identification of areas in which information is lacking or of poor quality. To summarize these research gaps, the team identifies remaining research questions for each intervention evaluated.

Results

The team identified 53 studies (*14,15,20,30–79*) of universal school-based programs that met the criteria to be included in the review. Of these, seven (*32,41,45,49,50, 52,64*) were of greatest design suitability and good execution, 32 (*15,20,30,31,34–40,43,46–48,51,53–56,59, 60,63,65,66,70,71,74,75,77–79*) were of greatest design suitability and fair execution, five (*14,33,44,68,76*) were of moderate design suitability and fair execution, one (*42*) was of least suitable design and good execution, and eight (*57,58,61,62,67,69,72,73*) were of least suitable design and fair execution. This intervention was well-suited for an experimental design, in certain cases using randomization of classes, grades, or schools to the antiviolence program or to a control condition. The comparison population often received no intervention rather than an alternative intervention. Study sample sizes varied widely (range: 21–39,168 students; median: 563). Follow-up time from the conclusion of the intervention to the final assessment ranged from none (i.e., assessment was conducted immediately after the end of the intervention) to 6 years (median: 6 months).

Characteristics of school programs differed by school level. In lower grades, programs focus on disruptive and antisocial behavior. At higher grade levels, the focus shifts to general violence and specific forms of violence (e.g., bullying and dating violence). The intervention strategy shifts from a cognitive affective approach designed to modify behavior by changing the cognitive and affective mechanisms linked with such behavior to greater use of social skills training. With increasing grade level, interventions might focus less on the teacher as the primary program implementer than on other personnel (e.g., student peers or members of the team conducting the research study). Because this review assessed only universal programs, the classroom was the principal setting of these programs at all grade levels. No clear trends in frequency and duration of programs were apparent by school level.

Comparison of program characteristics and populations served at different school levels indicated substantial heterogeneity by level and intercorrelation among characteristics. For this reason, bivariate analysis of program effects by program characteristics might suggest incorrectly a causal association of these characteristics with effect size differences when the associations actually are confounded by other associations. Recognizing the potential for other program characteristics to confound apparent associations, the team provided bivariate associations of program characteristics with effect sizes.

For all grades combined, the median effect was a 15.0% relative reduction in violent behavior among students who received the program (interquartile interval [IQI]: -44.1%, -2.3%). The effects of school programs were identified at all school levels, from a 7.3% relative reduction in violent behavior (i.e., an effect size of -7.3%) among middle school students who received the program (15 study data points; IQI: -35.2%, 2.3%) to a median effect size of -32.4% in prekindergarten and kindergarten programs (six study data points; percentiles not calculated). In elementary school programs, the median reduction of violent behavior was 18.0% (34 study data points; IQI: -44.8%, 2.5%). Among high school students, the median reduction in violent behavior was 29.2% (four study data points; percentiles not calculated) (Table 2). The team next explored associations between various program characteristics and effect size to develop hypotheses that might explain the heterogeneity of program effects. Because of the intercorrelation of program characteristics noted previously, this bivariate presentation should be regarded as simply reporting empirical associations rather than the assessment of causal explanations for effect variability.

All school antiviolence program strategies (e.g., informational, cognitive/affective, and social skills building) were associated with a reduction in violent behavior. All program foci (e.g., disruptive or antisocial behavior, bullying, or dating violence) similarly were associated with reduced violent behavior. With the exception of programs administered by school administrators or counselors, a reduction in violent behavior was reported in programs administered by all personnel, including students and peers; however, certain effect sizes were based on a small number of study data points.

The team compared the effects of programs delivered in school environments defined by the presence of lower SES or high rates of crime or both with environments that did not have these characteristics. For 14 studies, these characteristics were not described. In environments with lower SES or high crime rates or both, effectiveness was consistent with overall study results (15 studies; median: -29.2%; IQI: -42.5%, -6.7%). These programs appeared to be similarly effective in settings in which lower SES or high crime rates or both were noted to be absent (24 studies; median: -21.0%; IQI: -50.0%, -5.2%). Nonreporting of class and crime characteristics in certain studies might have occurred because these characteristics were not remarkable (i.e., in neighborhoods that have low crime and higher SES). If results from these studies are combined with those for which

TABLE 2. Effect sizes* and number of study data points,† by population and program characteristics

Characteristic	Median	25th and 75th percentiles
Grade		
All grades combined (65)	**-15.0**	**-44.1, -2.3**
Prekindergarten/Kindergarten (6)	-32.4	—§
Elementary (34)	-18.0	-44.8, -2.5
Middle (21)	-7.3	-35.2, 2.3
High (4)	-29.2	—
Intervention strategy		
Information conveyed (10)	-8.6	-22.9, 18.3
Cognitive/affective (6)	-14.0	—
Social skills (30)	-19.1	-35.2, -2.1
Environmental change, classroom (3)	-15.0	—
Environmental change, school (12)	-11.7	-63.6, -1.7
Peer mediation (2)	-61.2	—
Behavior modification (0)	—	—
Program focus		
General violence (19)	-10.3	-50.0, -1.7
Disruptive or antisocial behavior (33)	-19.1	-44.3, -2.8
Bullying (10)	-6.7	-64.8, 17.2
Gang activity (2)	-5.3	—
Dating violence (1)	-29.2	—
Primary program personnel		
Students/peers (4)	-41.6	—
Teachers (49)	-17.5	-44.3, -2.3
Administrators/counselors (3)	34.4	—
Nonschool personnel (2)	-5.3	—
Researchers (7)	-7.3	-42.5, 2.3
Community environment		
Not stated (14)	-1.6	-10.3, -3.3
Not low SES¶/not high crime (24)	-21.0	-50.0, -5.2
Not stated and not low SES/not high crime (38)	-11.2	-44.4, -1.4
High crime/low SES (15)	-29.2	-42.5, -6.7
Majority race/ethnicity		
Black (15)	-16.8	-44.3, -5.2
White (22)	-20.4	-40.2, -5.0
Hispanic (6)	-0.5	—
No information provided (13)	-30.9	-44.4, 8.0
No clear majority (8)	-10.3	-87.5, -1.4

* Relative % change in intervention compared with control population.
† Number of outcomes assessed for each characteristic.
§ Interquartile intervals not calculated with six or fewer studies.
¶ Socioeconomic status.

crime is specified as low and/or SES as higher, the combination is associated with a relative reduction of 11.2% (38 studies; IQI: -44.4%, -1.4%), which is still consistent in direction with overall study results.

Finally, the team explored the effects of universal school programs by predominant race and ethnicity of the study school population. In schools in which the population was >50% black, the median reduction in violent behavior was 16.8% (11 studies; IQI: -44.3%, -5.2%), compared with 20.4% in schools in which the population was >50% white (22 studies; IQI: -40.2%, -5.0%) and 0.5% in schools in which the population was >50% Hispanic (six studies; percentiles not calculated). Given the limited number of studies, the last estimate might not be reliable. To determine whether the magnitude of the reduction in violent behavior diminished with longer intervals following the end of the intervention, the team assessed the association between length of follow-up time and effect size (data not presented). Longer follow-up was associated with smaller effect size.

Universal school-based programs were determined to be effective at all school levels and across different populations. The reviewed studies assessed the effects of programs in communities characterized by the presence of lower SES or high rates of crime or both, compared with communities characterized by the absence of both of these factors.

Other benefits of universal school-based programs have been noted, with supporting evidence for some of these effects (*15,46,49*). Improvements were reported for social behavior more broadly, including reductions in drug abuse, inappropriate sexual behavior, delinquency, and property crime. Substantial improvements in school attendance and achievement also were reported (*54,80,81*).

The majority of economic studies identified in this review reported the costs of programs, but only one study reported economic summary measures based on both costs and benefits. Cost estimates ranged from $15–$45 per student for the PATHS program (*30,82*) to <$200 per student for the PeaceBuilders program (*81*). The only study that estimated both costs and benefits (*83*) was based on the Seattle Social Development Project (*31*). This study was rated as good according to the Community Guide's quality assessment criteria for economic studies. The average effect size for this program, which focused on elementary schools in a high-crime urban area, was a relative decrease of 13% in basic crime outcomes. The total benefits per project participant, including cost savings to taxpayers because of reduced expenses for the criminal justice system and reduced personal and property losses for crime victims, were estimated to be $14,426 in 2003 dollars. Net savings per participant amounted to $9,837. In terms of cost-benefit ratio, this program indicated a benefit of $3.14 for every dollar invested in the program. Although the effect size found in the study is near the median effect size of other school programs, this program is more comprehensive, more intensive, and of longer duration than many programs, in addition to being more costly. Thus, the cost benefit of other programs might differ from that determined for the Seattle Social Development Project.

Schools and their curricula are subject to multiple requirements and demands. Because schools might not recognize the need for instruction in the reduction of violence

and aggression, introducing effective programs into school curricula and schedules might be difficult. The need for teacher training for these programs also might make acceptance and implementation difficult. However, the benefits of many programs for traditional academic outcomes such as attendance and school performance might enhance the interest of school policy makers, administrators, and teachers in these programs.

In summary, study results consistently indicated that universal school-based programs were associated with decreased violence. Beneficial results were found across all school levels examined. On the basis of the limited amount of available economic data, universal school-based programs also appear to be cost-effective.

Discussion

The findings of this review were compared with a recently updated meta-analysis (*84*) with a similar approach to intervention definition and outcomes assessed, although certain differences existed in the literature and methods used. Expanded versions of both reviews, including a detailed exploration of similarities and differences, have been published (*85*). The meta-analysis indicated that the associations reported in the present review were not greatly confounded. School-based programs for the prevention of violence are effective for all school levels, and different intervention strategies are all effective. Programs have other effects beyond those on violent or aggressive behavior, including reduced truancy and improvements in school achievement, "problem behavior," activity levels, attention problems, social skills, and internalizing problems (e.g., anxiety and depression).

Although this review established the effectiveness of universal school-based programs for the prevention of violent and aggressive behavior, important research issues remain. These include determining 1) whether the characteristics of the programs, or perhaps of the settings in which they are implemented, differentiate those programs that are more effective from those that are less effective; 2) whether school programs are equally effective and cost effective for high- and low-risk children, and in high- and low-risk environments; and 3) how to address cultural and social differences in diverse populations to improve program implementation effectiveness.

Use of the Recommendation in States and Communities

U.S. schools provide a critical opportunity for changing societal behavior because almost the entire population is engaged in this institution for many years, starting at an early and formative period. With approximately 71 million children in primary and secondary schools in 2003 and an overall high school graduation rate of 85% (*86*), this opportunity is difficult to overestimate. The potential benefits of improved school function alone are notable. The broader and longer term benefits in terms of reduced delinquency and antisocial behavior are yet more substantial. Universal school-based violence prevention programs represent an important means of reducing violent and aggressive behavior in the United States. The findings of this review suggest that universal school-based violence prevention programs can be effective in communities with diverse ethnic compositions and in communities whose residents are predominantly of lower SES or that have relatively high rates of crime.

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Task Force on Community Preventive Services*

June 1, 2007

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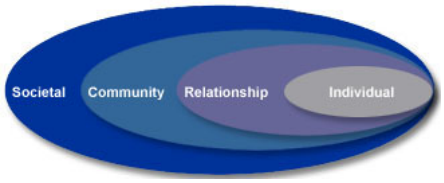
The Social-Ecological Model: A Framework for Prevention



The ultimate goal is to stop violence before it begins. Prevention requires understanding the factors that influence violence. CDC uses a four-level social-ecological model to better understand violence and the effect of potential prevention strategies.[1] This model considers the complex interplay between individual, relationship, community, and societal factors. It allows us to understand the range of factors that put people at risk for violence or protect them from experiencing or perpetrating violence. The overlapping rings in the model illustrate how factors at one level influence factors at another level.

Besides helping to clarifying these factors, the model also suggests that in order to prevent violence, it is necessary to act across multiple levels of the model at the same time. This approach is more likely to sustain prevention efforts over time than any single intervention.

Individual

The first level identifies biological and personal history factors that increase the likelihood of becoming a victim or perpetrator of violence. Some of these factors are age, education, income, substance use, or history of abuse. Prevention strategies at this level are often designed to promote attitudes, beliefs, and behaviors that ultimately prevent violence. Specific approaches may include education and life skills training.

Relationship

The second level examines close relationships that may increase the risk of experiencing violence as a victim or perpetrator. A person's closest social circle-peers, partners and family members-influences their behavior and contributes to their range of experience. Prevention strategies at this level may include parenting or family-focused prevention programs, and mentoring and peer programs designed to reduce conflict, foster problem solving skills, and promote healthy relationships.

Community

The third level explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of violence. Prevention strategies at this level are typically designed to impact the social and physical environment – for example, by reducing social isolation, improving economic and housing opportunities in neighborhoods, as well as the climate, processes, and policies within school and workplace settings.

Societal

The fourth level looks at the broad societal factors that help create a climate in which violence is encouraged or inhibited. These factors include social and cultural norms that support violence as an acceptable way to resolve conflicts. Other large societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society.

Reference

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Top Tier Evidence Initiative:

A Validated Resource, Used by Congress & Executive Branch, To Identify Social Program Models Supported by Definitive Evidence of Effectiveness

Abstract: *The Coalition for Evidence-Based Policy established the Top Tier Evidence initiative in 2008, to assist Congress and the Executive Branch in identifying social program models ("interventions") meeting the top tier evidence standard set out in recent legislative provisions: "well-designed randomized controlled trials [showing] sizeable, sustained effects on important… outcomes" [e.g., Public Laws 110-161 and 111-8]. This standard is consistent with criteria recommended by the National Academies for establishing definitive evidence of effectiveness, and (ii) the standard long used in medicine by the Food and Drug Administration as a condition for licensing a new pharmaceutical drug or medical device. Since the initiative's 2008 launch, its findings have had an important influence on legislation and policy, including new federal initiatives to scale up evidence-based home visitation and teen pregnancy prevention programs. Furthermore, a new Government Accountability Office (GAO) assessment confirms the initiative's adherence to rigorous standards and overall transparency. (Appendix A summarizes these policy developments.)*

The Coalition is a nonprofit, nonpartisan organization, and has no affiliation with any programs or program models. Funding for this project is provided by the MacArthur Foundation and the Edna McConnell Clark Foundation.

Policy question this effort addresses: Across social policy, which interventions are supported by definitive evidence of sizeable, sustained effects? This question might be asked by program officials or grantees seeking to implement the legislative provisions described above. It might also be asked by public officials with responsibility for a broad policy area, who wish to focus their efforts on replicating or scaling up the few interventions in their area for which research provides strong confidence of a sizeable effect on people's lives. Such officials might include, for example, senior federal agency officials/staff, Congressional committee members/staff, senior state-level officials, and local officials such as mayors or school district superintendents.

A. **Consistent with a National Academies recommendation, this initiative recognizes well-conducted randomized controlled trials as needed to answer this question.** The recent National Academies recommendation states that evidence of effectiveness generally "cannot be considered definitive" without ultimate confirmation in well-conducted randomized controlled trials, "even if based on the next strongest designs."[1] This concept, and the evidence supporting it, are discussed more fully below.

B. **This initiative does not seek to identify *all* evidence-based social interventions – just those meeting the Congressionally-based Top Tier standard.** We recognize that, for many social problems, no interventions yet meet the Top Tier because of gaps in research or other reasons; thus, public officials seeking to address these problems may need to rely on evidence that falls below the Top Tier, including nonrandomized studies. We do not review such evidence, but appreciate its value and refer users to other high-quality resources that do.

Why this initiative is needed:

A. **U.S. social programs, set up to address important American problems, often fall short by funding specific interventions that are not effective.** When evaluated in scientifically rigorous studies, government-funded social interventions – such as K-12 educational curricula, job training projects, crime prevention efforts, and case-management assistance for low-income

families – are frequently found to be ineffective or marginally effective. Those interventions found to produce sizeable, sustained effects on important life outcomes – such as educational achievement, teen pregnancy, criminal arrests, and employment – tend to be the exception. This pattern occurs in many diverse areas of social policy, as well as other fields where rigorous studies have been conducted (e.g., medicine and psychology).

B. Improving social programs is critically needed. The United States has failed to make significant progress in key areas such as –

- **Poverty reduction:** The official U.S. poverty rate in 2007 – even before the current recession – was 12.5%, slightly *higher* than in 1973. (Alternative measures of poverty based on a National Academies recommendation show a different rate but a similar trend over time.)

- **K-12 education:** The U.S. has made very limited progress in raising K-12 achievement since the 1970s, or in closing the achievement gap between minority and white students since the 1980s, according to the respected National Assessment of Educational Progress long-term trend.

- **Substance-abuse prevention:** Government data show that adolescent use of drugs and alcohol, despite a recent decrease, now stands at approximately the same level as in 1990.

C. A few interventions meeting the Top Tier do exist and, if implemented more broadly, could help spark rapid progress against major national problems. The following are examples of interventions that the initiative has already identified as meeting the Top Tier:

- **Nurse-Family Partnership** – a nurse visitation program for low-income, first-time mothers during pregnancy and children's infancy (reduced child abuse/neglect and injuries by 20-50% over 2-15 years, compared to the control groups).

- **Carrera Adolescent Pregnancy Prevention Program** – a youth development program for low-income teens (at age 17, reduced girls' pregnancies and births by 40-50%, compared to the control group).

- **Career Academies** – Small learning communities in low-income high schools, offering academic and technical/career courses as well as workplace opportunities (8 years after high school, increased average earnings by $2200 per year, compared to the control group).

- **Success for All in grades K-2 –** School-wide reform, primarily for high-poverty schools, with a strong focus on reading instruction (3 years after program start, increased school-wide reading achievement in 2nd grade by 25-30% of a grade level, compared to the control group).

D. Currently, there is no efficient way for public officials to distinguish the few interventions backed by Top Tier evidence from the many that *claim* to be. What currently exists are about 15 widely-cited federal, state, and private websites and related resources profiling evidence-based interventions in various areas of social policy. The Coalition carefully examined these sites as part of a collaboration with the Justice Department, and found the following:

- **Most sites are highly inclusive, listing interventions evaluated in studies that provide *suggestive* evidence of effectiveness, but that sometimes yield erroneous conclusions** – such as comparison-group studies ("quasi-experiments") in which the two groups differ in key characteristics, or randomized controlled trials with only short-term follow-up or other key limitations in study design or implementation. As noted above, these studies can be valuable for decisionmaking, and these websites can therefore be useful, in the absence of stronger evidence.

  Too often, however, findings from quasi-experiments and preliminary trials are overturned in large, definitive randomized controlled trials. Reviews in medicine, for example, have found that

50-80% of promising results from phase II studies (mostly quasi-experiments) are overturned in subsequent phase III randomized controlled trials.[2] Similarly, in education, eight of the nine major randomized controlled trials sponsored by the Institute of Education Sciences since its creation in 2002 have found weak or no positive effects for the interventions being evaluated – interventions which, in many cases, were based on promising quasi-experiments or small preliminary trials (e.g., the LETRS teacher professional development program for reading instruction). [3] Systematic "design replication" studies comparing large, well-conducted randomized controlled trials with quasi-experiments in welfare, employment, and education policy also have found that many widely-used and accepted quasi-experimental methods produce unreliable estimates of program impact.[4]

- **Public officials seeking the few Top Tier interventions – backed by definitive evidence of sizeable effects – often cannot distinguish them from the dozens of others on these sites** – others that are backed by widely divergent levels of evidence, and that are often rated differently on the different sites. The intervention providers, of course, frequently cite a listing of their intervention on one of these sites as proof that it is supported by strong evidence. Public officials, most of whom are not researchers, often have no efficient way to assess such claims.

Proposed solution: This initiative is a clear, validated resource used by policy officials to identify social interventions meeting Top Tier evidence of effectiveness.

A. **The initiative's expert Advisory Panel includes nationally-recognized, evidence-based researchers and former public officials.** They are: Jonathan Crane, Laurie Ekstrand, Deborah Gorman-Smith, Denise Gottfredson, Ron Haskins, Dan Levy, Larry Orr, and Howard Rolston (see Appendix B for their titles/affiliations).

B. **Under the Panel's guidance, the initiative solicits nominations of candidate interventions for the Top Tier, and administers a streamlined review and selection process.**

   - **The "Top Tier" includes:** *Interventions shown in well-designed and implemented randomized controlled trials, preferably conducted in typical community settings, to produce sizeable, sustained benefits to participants and/or society.*

   - **The solicitation process, review criteria, and procedure for reporting results, are described in Appendix C.**

   - **Brief instructions for nominating a candidate intervention are** posted here. As described in the instructions, our solicitation process began with a demonstration phase focused on interventions for children age 0-6 but has gradually expanded to other policy areas.

C. **Timeline: We report the results of our review process on a quarterly basis, summarizing the Panel's decisions on which interventions meet the Top Tier (see results here).**

D. **Policy impact: Initiative findings are influencing legislation/policy; GAO report confirms its adherence to rigorous standards.** The initiative's findings have had an important influence on recent legislation and policy, including new federal initiatives to scale up evidence-based home visitation and teen pregnancy prevention programs. Furthermore, a new GAO assessment confirms the initiative's adherence to rigorous standards and overall transparency. Appendix A contains a short summary of these developments.

Conclusion: Rigorous research has identified a few interventions that are highly effective in addressing long-term unemployment, educational failure, child abuse, crime, substance abuse, and other problems that damage millions of American lives each year. The Top Tier Evidence initiative enables public officials – for the first time – to readily distinguish these Top Tier interventions from the rest, and put them into widespread use.

References

[1] National Research Council and Institute of Medicine. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press. Recommendation 12-4, page 371.

[2] John P. A. Ioannidis, "Contradicted and Initially Stronger Effects in Highly Cited Clinical Research," *Journal of the American Medical Association*, vol. 294, no. 2, July 13, 2005, pp. 218-228. Mohammad I. Zia, Lillian L. Siu, Greg R. Pond, and Eric X. Chen, "Comparison of Outcomes of Phase II Studies and Subsequent Randomized Control Studies Using Identical Chemotherapeutic Regimens," *Journal of Clinical Oncology*, vol. 23, no. 28, October 1, 2005, pp. 6982-6991. John K. Chan et. al., "Analysis of Phase II Studies on Targeted Agents and Subsequent Phase III Trials: What Are the Predictors for Success," *Journal of Clinical Oncology*, vol. 26, no. 9, March 20, 2008.

[3] *The Impact of Two Professional Development Interventions on Early Reading Instruction and Achievement*, Institute of Education Sciences, NCEE 2008-4031, September 2008, http://ies.ed.gov/ncee/pubs/20084030/.

[4] Howard S. Bloom, Charles Michalopoulos, and Carolyn J. Hill, "Using Experiments to Assess Nonexperimental Comparison-Groups Methods for Measuring Program Effects," in *Learning More From Social Experiments: Evolving Analytic Approaches*, Russell Sage Foundation, 2005, pp. 173-235. Thomas D. Cook, William R. Shadish, and Vivian C. Wong, "Three Conditions Under Which Experiments and Observational Studies Often Produce Comparable Causal Estimates: New Findings from Within-Study Comparisons," *Journal of Policy Analysis and Management*, vol. 27, no. 4, 2008, pp. 724-50. Steve Glazerman, Dan M. Levy, and David Myers, "Nonexperimental versus Experimental Estimates of Earnings Impact," *The American Annals of Political and Social Science*, vol. 589, September 2003, pp. 63-93.

Appendix A

November 9, 2009

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The Coalition for Evidence-Based Policy is pleased with GAO's confirmation of the Top Tier initiative's adherence to rigorous standards and overall transparency

The Coalition is pleased with the GAO report's key findings that the Top Tier initiative's criteria conform to general social science research standards (pp. 15-23), and that its process is mostly transparent (pp. 9-15). We also agree with its observation that the Top Tier initiative differs from common practice in its strong focus on randomized experiments, and would add that this was the initiative's goal from the start. Indeed, its stated purpose is to identify interventions meeting the top tier standard set out in recent Congressional legislation: "*well-designed randomized controlled trials [showing] sizeable, sustained effects on important … outcomes*" (e.g., Public Laws 110-161 and 111-8).

Consistent with our initiative's unique focus on helping policymakers distinguish the relatively few interventions meeting this top evidentiary standard from the many that *claim* to, we have – as noted in the GAO report – identified 6 interventions as Top Tier out of the 63 reviewed thus far. The value of this process to policymakers is evidenced by the important impact these findings have already had on federal officials and legislation. For example, the initiative's findings for the Nurse-Family Partnership (NFP) have helped to spur the Administration and Congress' proposed national expansion of evidence-based home visitation. (The NFP study results are cited in the President's FY 2010 budget.) Similarly, the initiative's findings for the Carrera Adolescent Pregnancy Prevention program and Multidimensional Treatment Foster Care (MTFC) have helped inform the Administration and Congress' proposed evidence-based teen pregnancy prevention program. (The MTFC study results are cited in the Senate's FY10 Labor-HHS-Education Appropriations Committee report.[1])

In fact, OMB Director Peter Orszag recently posted on the OMB website a summary of the Administration's "two-tiered approach" to home visitation and teen pregnancy, which links to the Coalition's website.[2] The approach includes (i) funding for programs backed by strong evidence, which he identifies as "the top tier;" and (ii) additional funding for programs backed by "supportive evidence," with a requirement for rigorous evaluation that, if positive, could move them into the top tier.

Consistent with this Administration approach, we recognize (and agree with GAO) that nonrandomized studies provide important value – for example, in (i) informing policy decisions in areas where well-conducted randomized experiments are not feasible or not yet conducted; and (ii) identifying interventions that are particularly promising, and therefore ready to be evaluated in more definitive randomized experiments. We think the GAO report somewhat overstates the confidence one can place in nonrandomized findings alone, per (i) a recent National Academies recommendation[3] that evidence of effectiveness generally "cannot be considered definitive" without ultimate confirmation in well-conducted randomized experiments, "even if based on the next strongest designs;" and (ii) evidence that findings from nonrandomized studies are often overturned in definitive randomized experiments (see attachment). But the important and complementary value of well-conducted nonrandomized studies as part of an overall research agenda is a central theme of the Coalition's approach to evidence-based policy reform.

In conclusion, we appreciate GAO's thoughtful analysis, and will use its valuable observations to strengthen our initiative as it goes forward. Although the Congressionally-established top tier standard itself was not a main focus of the GAO report (as opposed to our process), we have attached some brief background on the standard and the reasons we support its use as an important element of appropriate policy initiatives.

Jon Baron, President

The Congressionally-established Top Tier evidence standard is based on a well-established concept in the scientific community, and strong evidence regarding the importance of random assignment.

Congress' Top Tier standard is based on a concept well-established in the scientific community – that when results of multiple (or multisite) well-conducted randomized experiments, carried out in real-world community settings, are available for a particular intervention, they generally comprise the most definitive evidence regarding that intervention's effectiveness. The standard further recognizes a key concept articulated in a recent National Academies recommendation: although many research methods can help identify effective interventions, evidence of effectiveness generally "cannot be considered definitive" without ultimate confirmation in well-conducted randomized experiments, "even if based on the next strongest designs."[3]

Although promising findings in nonrandomized quasi-experimental studies are valuable for decisionmaking in the absence of stronger evidence, too often such findings are overturned in subsequent, more definitive randomized experiments. Reviews in medicine, for example, have found that 50-80% of promising results from phase II (mostly quasi-experimental) studies are overturned in subsequent phase III randomized trials.[4] Similarly, in education, eight of the nine major randomized experiments sponsored by the Institute of Education Sciences since its creation in 2002 have found weak or no positive effects for the interventions being evaluated – interventions which, in many cases, were based on promising, mostly quasi-experimental evidence (e.g., the LETRS teacher professional development program for reading instruction).[5] Systematic "design replication" studies comparing well-conducted randomized experiments with quasi-experiments in welfare, employment, and education policy have also found that many widely-used and accepted quasi-experimental methods produce unreliable estimates of program impact.[6]

Thus, we support use of the Top Tier standard as a key element of policy initiatives seeking to scale up interventions backed by the most definitive evidence of sizeable, sustained effects, in areas where such proven interventions already exist. The standard has a strong basis in scientific authority and evidence, as reflected, for example, in the recent National Academies recommendation.

References

[1] Sen. Rept. 111-66.

[2] Peter Orszag's summary of the Administration's two-tiered approach is posted at http://www.whitehouse.gov/omb/blog/09/06/08/BuildingRigorousEvidencetoDrivePolicy/.

[3] National Research Council and Institute of Medicine. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press. Recommendation 12-4, page 371.

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[6] Howard S. Bloom, Charles Michalopoulos, and Carolyn J. Hill, "Using Experiments to Assess Nonexperimental Comparison-Groups Methods for Measuring Program Effects," in *Learning More From Social Experiments: Evolving Analytic Approaches*, Russell Sage Foundation, 2005, pp. 173-235. Thomas D. Cook, William R. Shadish, and Vivian C. Wong, "Three Conditions Under Which Experiments and Observational Studies Often Produce Comparable Causal Estimates: New Findings from Within-Study Comparisons," *Journal of Policy Analysis and Management*, vol. 27, no. 4, pp. 724-50. Steve Glazerman, Dan M. Levy, and David Myers, "Nonexperimental versus Experimental Estimates of Earnings Impact," *The American Annals of Political and Social Science*, vol. 589, September 2003, pp. 63-93.

Appendix B:

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Appendix C

Overview of the Top Tier Solicitation Process, Review Criteria, and Procedure for Reporting Results

The Top Tier Evidence initiative uses the following solicitation, review, and reporting processes to identify and validate interventions meeting the Top Tier standard.

1. **In July 2008, we began soliciting nominations of interventions for review as candidates for the Top Tier.** The solicitation initially focused on interventions for children age 0-6, but is gradually expanding to other policy areas (see current nomination instructions here). In addition to soliciting nominations, we proactively seek out promising candidate interventions from other sources, such as those listed as "model" or "proven" on various websites of evidence-based programs.

2. **The standard we use to evaluate candidates for the Top Tier, based on the Congressional legislative language, is: "*Interventions shown in well-designed and implemented randomized controlled trials, preferably conducted in typical community settings, to produce sizeable, sustained benefits to participants and/or society*."**

   - **In applying this standard, we use the attached *Checklist For Reviewing a Randomized Controlled Trial***, which closely tracks guidance from the U.S. Office of Management and Budget (OMB), National Academies, and other respected research organizations, and reflects well-established principles on what constitutes a high-quality trial (e.g., adequate sample size, low sample attrition, valid outcome measures, intention to treat analysis, and so on). It also addresses the importance of replication in establishing strong evidence – namely, demonstration of effectiveness in at least two well-conducted trials or, alternatively, one large multi-site trial.

   - **Our main focus, for each candidate intervention, is on assessing whether there is strong evidence that the intervention's effects are *sizeable* and *sustained*.** However, in some cases, we might also take into account such factors as the intervention's cost and ease of implementation (e.g., cases where the cost is exceptionally low).

   - **Over time, we develop short case summaries illustrating the reasoning we use in applying the above standard and guidance to particular studies**, thus building a body of additional guidance for reviewers and applicants that is grounded in case-by-case decisions. (This approach – using actual case decisions to grow the body of guidance over time – has been long used by the Food and Drug Administration in its well-established procedures for reviewing randomized controlled trials of pharmaceutical drugs.) These summaries are shown here.

3. **For each viable candidate, we search the literature and contact experts to identify all other high-quality randomized trials of the intervention (in addition to those initially brought to our attention).** Also, for interventions being considered for the Top Tier on the basis of a limited number of well-designed and implemented randomized trials, we check the literature of high-quality non-randomized studies of the intervention, to look for any patterns of effects that differ from those in the trials (possibly suggesting problems in generalizability) or for any adverse intervention effects.

4. **The initiative's Advisory Panel, comprised of nationally-recognized, evidence-based researchers and former public officials, makes the final decisions on which interventions to identify as Top Tier.** A list of Panel members and their titles/affiliations, is shown in Appendix B. The Panel meets quarterly.

5. **Interventions that the Panel has identified as Top Tier are posted here.** Each posting concisely summarizes in plain, jargon-free language: (a) the intervention, and how it differed from what the control group(s) received; (b) the populations and settings in which the intervention was evaluated, (c) the design and implementation of each well-designed and implemented randomized controlled trial of the intervention

(tracking the items in the attached *Checklist*), and (d) the effects found in each trial on the main outcomes of interest (including any findings of no effect). The posting also notes any relevant limitations of each trial summarized (e.g., small sample size). Prior to posting, we ask the intervention provider and/or researchers who conducted the trials to review each draft write-up for any inaccuracies or items we may have missed.

6. **For each nominated intervention not approved as Top Tier, we contact the nominator informally to convey the result and briefly explain the reason** (e.g., studies did not use random assignment, or Panel awaits longer-term follow-up to see if effects are sustained).

7. **We also post on the initiative's website a complete list of all interventions and studies that we have reviewed**, to enable readers to identify and alert us to any interventions or studies that we may have missed. This is a simple list (posted here), and does not include explanations of why each listed intervention was or was not approved as Top Tier.

Note: This checklist addresses whether an intervention is supported by strong evidence, but not whether its effects are sizeable or sustained, which would also be key factors in determining the "top tier."

Checklist For Reviewing a Randomized Controlled Trial of a Social Program or Project, To Assess Whether It Produced Valid Evidence

Coalition for Evidence-Based Policy
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We welcome comments and suggestions on this document (jbaron@coalition4evidence.org).

Checklist For Reviewing a Randomized Controlled Trial of a Social Program or Project, To Assess Whether It Produced Valid Evidence

This is a checklist of key items to look for in reading the results of a randomized controlled trial of a social program, project, or strategy ("intervention"), to assess whether it produced valid evidence on the intervention's effectiveness. This checklist closely tracks guidance from both the U.S. Office of Management and Budget (OMB) and the U.S. Education Department's Institute of Education Sciences (IES)[1]; however, the views expressed herein do not necessarily reflect the views of OMB or IES.

This checklist limits itself to key items, and does not try to address all contingencies that may affect the validity of a study's results. It is meant to aid – not substitute for – good judgment, which may be needed for example to gauge whether a deviation from one or more checklist items is serious enough to undermine the study's findings.

A brief appendix addresses *how many* well-conducted randomized controlled trials are needed to produce strong evidence that an intervention is effective.

Checklist for overall study design

☐ **Random assignment was conducted at the appropriate level – either groups (e.g., classrooms, housing projects), or individuals (e.g., students, housing tenants), or both.**

Random assignment of individuals is usually the most efficient and least expensive approach. However, it may be necessary to randomly assign groups – instead of, or in addition to, individuals – in order to evaluate (i) interventions that may have sizeable "spillover" effects on nonparticipants, and (ii) interventions that are delivered to whole groups such as classrooms, housing projects, or communities. (See reference 2 for additional detail.[2])

☐ **The study had an adequate sample size – one large enough to detect meaningful effects of the intervention.**

Whether the sample is sufficiently large depends on specific features of the intervention, the sample population, and the study design, as discussed elsewhere.[3] Here are two items that can help you judge whether the study you're reading had an adequate sample size:

- If the study found that the intervention produced *statistically-significant* effects (as discussed later in this checklist), then you can probably assume that the sample was large enough.

- If the study found that the intervention did *not* produce statistically-significant effects, the study report should include an analysis showing that the sample was large enough to detect meaningful effects of the intervention. (Such an analysis is known as a "power" analysis.[4])

Reference 5 contains illustrative examples of sample sizes from well-conducted randomized controlled trials conducted in various areas of social policy.[5]

Checklist to ensure that the intervention and control groups remained equivalent during the study

- ☐ **The study report shows that the intervention and control groups were highly similar in key characteristics prior to the intervention (e.g., demographics, behavior).**

- ☐ **If the study asked sample members to consent to study participation, they provided such consent *before* learning whether they were assigned to the intervention versus control group.**

  If they provided consent afterward, their knowledge of which group they are in could have affected their decision on whether to consent, thus undermining the equivalence of the two groups.

- ☐ **Few or no control group members participated in the intervention, or otherwise benefited from it (i.e., there was minimal "cross-over" or "contamination" of controls).**

- ☐ **The study collected outcome data in the same way, and at the same time, from intervention and control group members.**

- ☐ **The study obtained outcome data for a high proportion of the sample members originally randomized (i.e., the study had low sample "attrition").**

  As a general guideline, the studies should obtain outcome data for at least 80 percent of the sample members originally randomized, including members assigned to the intervention group who did not participate in or complete the intervention. Furthermore, the follow-up rate should be approximately the same for the intervention and the control groups.

  The study report should include an analysis showing that sample attrition (if any) did not undermine the equivalence of the intervention and control groups.

- ☐ **The study, in estimating the effects of the intervention, kept sample members in the original group to which they were randomly assigned.** This even applies to:

  - Intervention group members who failed to participate in or complete the intervention (retaining them in the intervention group is consistent with an "intention-to-treat" approach); and

  - Control group members who may have participated in or benefited from the intervention (i.e., "cross-overs," or "contaminated" members of the control group).[6]

Checklist for the study's outcome measures

- ☐ **The study used "valid" outcome measures – i.e., outcome measures that are highly correlated with the true outcomes that the intervention seeks to affect.** For example:

  - Tests that the study used to measure outcomes (e.g., tests of academic achievement or psychological well-being) are ones whose ability to measure true outcomes is well-established.

- If sample members were asked to self-report outcomes (e.g., criminal behavior), their reports were corroborated with independent and/or objective measures if possible (e.g., police records).

- The outcome measures did not favor the intervention group over the control group, or vice-versa. For instance, a study of a computerized program to teach mathematics to young students should not measure outcomes using a computerized test, since the intervention group will likely have greater facility with the computer than the control group.[7]

☐ **The study measured outcomes that are of policy or practical importance – not just intermediate outcomes that may or may not predict important outcomes.**

As illustrative examples: (i) the study of a pregnancy prevention program should measure outcomes such as actual pregnancies, and not just participants' attitudes toward sex; and (ii) the study of a remedial reading program should measure outcomes such as reading comprehension, and not just the ability to sound out words.

☐ **Where appropriate, the members of the study team who collected outcome data were "blinded" – i.e., kept unaware of who was in the intervention and control groups.**

Blinding is important when the study measures outcomes using interviews, tests, or other instruments that are not fully structured, possibly allowing the person doing the measuring some room for subjective judgment. Blinding protects against the possibility that the measurer's bias (e.g., as a proponent of the intervention) might influence his or her outcome measurements. Blinding would be important, for example, in a study that measures the incidence of hitting on the playground through playground observations, or a study that measures the word identification skills of first graders through individually-administered tests.

☐ **Preferably, the study measured whether the intervention's effects lasted long enough to constitute meaningful improvement in participants' lives (e.g., a year, hopefully longer).**

This is important because initial intervention effects often diminish over time – for example, as changes in intervention group behavior wane, or as the control group "catches up" on their own.

Checklist for the study's reporting of the intervention's effects

☐ **If the study claims that the intervention has an effect on outcomes, it reports (i) the size of the effect, and whether the size is of policy or practical importance; and (ii) tests showing the effect is statistically significant (i.e., unlikely to be due to chance).**

These tests for statistical significance should take into account key features of the study design, including:

- Whether individuals (e.g., students) or groups (e.g., classrooms) were randomly assigned;

- Whether the sample was sorted into groups prior to randomization (i.e., "stratified," "blocked," or "paired"); and

- Whether the study intends its estimates of the intervention's effect to apply only to the sites (e.g., housing projects) in the study, or to be generalizable to a larger population.

- **The study reports the intervention's effects on all the outcomes that the study measured, not just those for which there is a positive effect.**

  This is so you can gauge whether any positive effects are the exception or the pattern. In addition, if the study found only a limited number of statistically-significant effects among many outcomes measured, it should report tests showing that such effects were unlikely to have occurred by chance.

Appendix: How many randomized controlled trials are needed to produce strong evidence of effectiveness?

To have strong confidence that an intervention would be effective if faithfully replicated, one generally would look for evidence including the following:

- **The intervention has been demonstrated effective, through well-conducted randomized controlled trials, in more than one site of implementation.**

  Such a demonstration might consist of two or more trials conducted in different implementation sites, or alternatively one large multi-site trial.

- **The trial(s) evaluated the intervention in the real-world community settings and conditions where it would normally be implemented** (e.g., community drug abuse clinics, public schools, job training program sites).

  This is as opposed to tightly-controlled conditions, such as specialized sites that researchers set up at a university for purposes of the study, or settings where the researchers themselves administer the intervention.

- **There is no strong countervailing evidence, such as well-conducted randomized controlled trials of the intervention showing an absence of effects.**

References

[1] U.S. Office of Management and Budget (OMB), What Constitutes Strong Evidence of Program Effectiveness, http://www.whitehouse.gov/omb/part/2004_program_eval.pdf, 2004; U.S. Department of Education's Institute of Education Sciences, Identifying and Implementing Educational Practices Supported By Rigorous Evidence, http://www.ed.gov/rschstat/research/pubs/rigorousevid/index.html, December 2003; What Works Clearinghouse of the U.S. Education Department's Institute of Education Sciences, Key Items To Get Right When Conducting A Randomized Controlled Trial in Education, prepared by the Coalition for Evidence-Based Policy, http://ies.ed.gov/ncee/wwc/pdf/guide_RCT.pdf.

[2] Random assignment of groups rather than, or in addition to, individuals may be necessary in situations such as the following:

(a) The intervention may have sizeable "spillover" effects on individuals other than those who receive it.

For example, if there is good reason to believe that a drug-abuse prevention program for youth in a public housing project may produce sizeable reductions in drug use not only among program participants, but also among their peers in the same housing project (through peer-influence), it is probably necessary to randomly assign whole housing projects to intervention and control groups to determine the program's effect. A study that only randomizes individual youth within a housing project to intervention versus control groups will underestimate the program's effect to the extent the program reduces drug use among both intervention and control-group students in the project.

(b) The intervention is delivered to groups such as classrooms or schools (e.g., a classroom curriculum or schoolwide reform program), and the study seeks to distinguish the effect of the intervention from the effect of other group characteristics (e.g., quality of the classroom teacher).

For example, in a study of a new classroom curriculum, classrooms in the sample will usually differ in two ways: (i) whether they use the new curriculum or not, and (ii) who is teaching the class. Therefore, if the study (for example) randomly assigns individual students to two classrooms that use the curriculum versus two classrooms that don't, the study will not be able to distinguish the effect of the curriculum from the effect of other classroom characteristics, such as the quality of the teacher. Such a study therefore probably needs to randomly assign whole classrooms and teachers (a sufficient sample of each) to intervention and control groups, to ensure that the two groups are equivalent not only in student characteristics but also in classroom and teacher characteristics.

For similar reasons, a study of a schoolwide reform program will probably need to randomly assign whole schools to intervention and control groups, to ensure that the two groups are equivalent not only in student characteristics but also school characteristics (e.g., teacher quality, average class size).

[3] What Works Clearinghouse of the U.S. Education Department's Institute of Education Sciences, *Key Items To Get Right When Conducting A Randomized Controlled Trial in Education*, op. cit., no. 1.

[4] Resources that may be helpful in reviewing or conducting power analyses include: the William T. Grant Foundation's free consulting service in the design of group-randomized trials, at http://sitemaker.umich.edu/group-based/consultation_service; Steve Raudenbush et. al., *Optimal Design Software for Group Randomized Trials*, at http://sitemaker.umich.edu/group-based/optimal_design_software; Peter Z. Schochet, *Statistical Power for Random Assignment Evaluations of Education Programs* (http://www.mathematica-mpr.com/publications/PDFs/statisticalpower.pdf), prepared for the U.S. Education Department's Institute of Education Sciences, June 22, 2005; and Howard S. Bloom, "Randomizing Groups to Evaluate Place-Based Programs," in *Learning More from Social Experiments: Evolving Analytical Approaches*, edited by Howard S. Bloom. New York: Russell Sage Foundation Publications, 2005, pp. 115-172.

[5] Here are illustrative examples of sample sizes from well-conducted randomized controlled trials in various areas of social policy: (i) 4,028 welfare applicants and recipients were randomized in a trial of Portland Oregon's Job Opportunities and Basic Skills Training Program (a welfare-to work program), to evaluate the program's effects on employment and earnings – see http://evidencebasedprograms.org/wordpress/?page_id=140; (ii) between 400 and 800 women were randomized in each of three trials of the Nurse-Family Partnership (a nurse home visitation program for low-income, pregnant women), to evaluate the program's effects on a range of maternal and child outcomes, such as child abuse and neglect, criminal arrests, and welfare dependency – see http://evidencebasedprograms.org/wordpress/?page_id=57; 206 9th graders were randomized in a trial of Check and

Connect (a school dropout prevention program for at-risk students), to evaluate the program's effects on dropping out of school – see http://evidencebasedprograms.org/wordpress/?page_id=92; 56 schools containing nearly 6000 students were randomized in a trial of LifeSkills Training (a substance-abuse prevention program), to evaluate the program's effects on students' use of drugs, alcohol, and tobacco – see http://evidencebasedprograms.org/wordpress/?page_id=128.

[6] The study, after obtaining estimates of the intervention's effect with sample members kept in their original groups, can sometimes use a "no-show" adjustment to estimate the effect on intervention group members who actually participated in the intervention (as opposed to no-shows). A variation on this technique can sometimes be used to adjust for "cross-overs." See Larry L. Orr, *Social Experimentation: Evaluating Public Programs With Experimental Methods*, Sage Publications, Inc., 1999, p. 62 and 210; and Howard S. Bloom, "Accounting for No-Shows in Experimental Evaluation Designs," *Evaluation Review*, vol. 8, April 1984, pp. 225-246.

[7] Similarly, a study of a crime prevention program that involves close police supervision of program participants should not use arrest rates as a measure of criminal outcomes, because the supervision itself may lead to more arrests for the intervention group.