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Professionalizing the Practice of Public Policy in the Prevention of Violence

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Abstract

The State of the Science Conference Statement on “Preventing Violence and Related Health-Risking Social Behaviors in Adolescents” accurately summarizes the state of knowledge regarding risk factors for violence and intervention efficacy. The Statement missed an opportunity, however, to move the field of prevention practice and policy forward by advocating for more systematic, central review of preventive interventions through a new federal regulatory body, such as an “FDA for Preventive Interventions.” This body would provide review of evidence-based *programs* and aid decision-making in funding. As a complement to this body, decision-makers also need guidelines in evidence-based *practice* in ambiguous circumstances, which characterize much of the reality of public policy. Therefore, this new regulatory body should be accompanied by guidelines for evidence-based practice in intervention and policy. Finally, in order to move forward both of these concepts, a National Academy of Sciences Panel should convene to deliberate how these concepts can be implemented.

Keywords

Prevention; Violence; Public policy

It was a golden opportunity missed

The State of the Science Conference Statement on “Preventing Violence and Related Health-Risking Social Behaviors in Adolescents” is a document that concisely and accurately summarizes the developmental literature on risk and protective factors in violent behavior by youth and the intervention literature on programs that aim to prevent youth violence. It aptly characterizes the state of knowledge of “what works” in youth violence prevention as needing an infusion of rigor and funding. It calls for all the right kinds of research with rigorous methods that are needed to elevate this fledgling field into the realm that is necessary to have an impact on policy and practice. As a scholarly document for the field, it is right on target. But it stopped there. The Panel failed to seize the moment of the public's attention by articulating the measures that are needed to support the translation of science to policy and to elevate the practice of public policy into a professional field that could stand side by side with other health care domains.

The practice of public policy in youth violence prevention includes decisions about resource allocation, evaluation of the impact of those decisions, administration of a variety of programs and policies, and leadership of a broader community of professionals and paraprofessionals who are implementing prevention efforts. Currently, the state of this practice is crude: it leads to inefficient spending, failure to bring effective programs to youth, and, sometimes, even to adverse effects on children by supporting harmful programs.

Most of the American public believes that the process of decision-making for violence prevention funding, indeed for all of social programs, is an ad hoc exercise that requires no

greater expertise than casual observations about the American culture. The citizenry is split between those who cynically believe that nothing works and those who believe that their own pet idea would solve all woes; what they have in common is a lack of belief in the science of violence prevention and the professionalism of prevention policy-making. It is time to support both prevention science and evidence-based public policy.

Youth violence prevention programs as practiced in american communities

In many communities across the country, local teams of citizens assemble to debate the merits of various prevention approaches, and they come away with diverse new policies. In South Carolina, debate is underway to make it a felony for a parent to miss three consecutive parent-teacher conferences. In Illinois, the Governor recently signed legislation requiring Chicago schools to implement a program with all high-risk youth, called Scared Straight, which is known to have harmful effects (Sherman & Strang, 2004). In North Carolina, every public school district must now have an alternative school for deviant youth, in spite of evidence that aggregating deviant youth compounds their problem behavior. It is estimated that over 15 billion dollars a year is now spent on alternative schools across the country (Dodge, Dishion, & Lansford, 2006). The D.A.R.E. Program to prevent substance use is implemented in about 75 percent of all school districts in the country, in spite of repeated evaluations that it has no effect on the prevention of substance use (Ennett, Tobler, Ringwalt, & Flewelling, 1994). Zero-tolerance policies have proliferated in every state following the Gun Free Schools Act of 1995 (Skiba & Peterson, 1999), leading to unprecedented suspension and expulsion of students (Kingery, 2000), in spite of evidence that suspended students are 2.2 times more likely to be incarcerated as adults than students without such a history (Arum & Beattie, 1999).

The need for rigorous evaluation and public review of youth violence prevention programs before they are disseminated broadly is highlighted by several evaluations, using randomized controlled trials, which have revealed that some seemingly “good” ideas lead to harmful outcomes. About 3.6 million high-risk youth attend after-school centers, including the 21st Century Community Learning Center Program, and the trend is growing. These centers bring together youth in community or school facilities, to complete homework and to enjoy each other's company with adults nearby. This innocuous idea actually *increases* antisocial behavior among these youth. A recent randomized control trial with large numbers of centers and youth revealed that youth who are assigned to attend these centers display higher rates of antisocial behavior and school discipline incidents than control youth (James-Burdumy et al., 2005). One explanation might be that the youth who populate these centers are high-risk youth (somewhat deviant youth coming from low-income families lacking in support systems), and aggregating these youth instigates deviancy training which exacerbates antisocial behavior (Dishion, McCord, & Poulin, 1999).

Another idea that is being implemented in public schools is to bring together high-risk youth in classes that provide academic credit and that focus on drug use, antisocial behavior, and good work habits. One version, called Reconnecting Youth, received positive reviews initially, but when it was implemented in a large randomized control effectiveness trial with over 1,000 youth, high-risk youth assigned to intervention classrooms were found to display *higher* rates of anger and association with deviant peer groups after the intervention than were control youth (Cho, Hallfors, & Sanchez, 2005).

The most famous seemingly good idea was implemented in the Cambridge-Somerville Youth Study in 1939, when Judge Richard Clarke Cabot delivered a variety of “helpful” services to high-risk 10-year-olds from urban areas, including mentoring, counseling, and placement in summer camps. Fortunately, Cabot subjected the intervention to a randomized control trial. Long-term outcome analyses revealed that boys assigned to intervention had *worse* outcomes

than control boys. They were more likely to commit crimes and to have a psychiatric disorder as adults (McCord, 2003).

Yet another seemingly good idea has been to administer nondirective counseling groups with high-risk youth, led by well-intentioned adult professionals. Feldman, Caplinger, and Wodarski (1983) randomly assigned high-risk youth to groups populated by all deviant youth or mixed deviant and non-deviant youth. Groups were randomly assigned to engage in open discussion in a nondirective way or adhere to behavioral principles. Direct observations and adult and self reports before and after the intervention revealed that assignment to the nondirective groups of all-deviant youth actually *increased* antisocial behavior rates both in and out of the group sessions and led to harmful outcomes, relative to the other groups.

Many of the programs that are supported at the local level by state and federal funds are surely beneficial to youth, but no evaluation has been conducted yet to enable the world to be confident about their impact. Other programs may have no positive impact and are simply a waste of tax dollars. Still other programs may harm children and we do not know it. Finally, some programs are known to harm children, but government still supports them. In the current policy and funding climate, we have no way to know which programs have which effects.

The use of scientific evidence in publicly-funded violence prevention efforts is clearly at an infancy stage. Most dollars are awarded to programs that have no empirical support, with no support to evaluate their impact on youth through rigorous methods. Lists of empirically-supported programs exist and are growing, but few efforts are underway to support policy decision-makers and funding agencies in how to use these lists and how to engage in evidence-based practice. Finally, no plans are proposed to move the field toward regulated public policy. Thus, the NIH Panel missed an opportunity to professionalize this field, that is, to: (1) promote a government mechanism for evaluating the evaluations of violence prevention programs and policies and regulating their implementation; (2) support the required use of evidence in the practice of policy decision-making; and (3) propose a means to push forward the goals of the first two proposals, through a National Academy of Sciences Panel. These three action steps will be discussed next.

Promoting the evaluation and regulation of youth violence prevention programs and policies

Just 75 years ago, the practice of medicine was more an art than a science, but the profession has changed dramatically. Today, the practice of evidence-based medicine is based on the principle that the quality of patient care is enhanced by the degree to which physicians use treatments that have empirical support for the diagnosed illness with the type of patient at hand (Straus, Richardson, Glasziou, & Haynes, 2005). The very first known randomized control trial (RCT) in medicine was conducted fewer than 60 years ago, in 1948. One of the first crises in preventive medicine occurred with the introduction of polio vaccines in the early 1950s, when the initial distribution of the vaccine was associated with anecdotes of new polio cases. Jonas Salk's discovery and reputation were called into question, but the problem was resolved through systematic empirical analysis that localized the problem to just one manufacturer that had used a flawed vaccine (Offit, 2005). By 1955, the crisis was resolved and the Salk vaccine "saved tens of thousands of children in the United States, Canada, and Europe from lifelong paralysis and demonstrated the feasibility of widespread immunization to control polio" (Kew, 2005, p. 975). The utility of RCTs and empirical evaluation became recognized through this crisis.

In the 1960s, the number of RCTs grew from the hundreds to over 1,000, and today, tens of thousands of RCTs in medicine are ongoing every day. RCTs are responsible for most of the major advances in preventive medicine, including vaccines for measles and hepatitis B, and

preventive interventions for hypertension and high cholesterol (Coalition for Evidence-Based Policy, 2003). The medical field has become dominated by the use of evidence in practitioner decision-making.

Developments in the fields of clinical psychology, education, and social policy have taken slightly different turns. In psychology, Division 12 of the American Psychological Association (APA) established a Task Force in 1993 for the purpose of promoting the use of empirically supported treatments (ESTs). Over the past decade, however, training in the use of these treatments has not significantly increased among doctoral programs or internships, and, in fact, training in the major empirically supported child antisocial behavior treatment (behaviorally based parent training) has actually decreased (Woody, Weis, & McLean, 2005). Some clinical psychology program training directors oppose the concept altogether because it infringes on their autonomy and dehumanizes clients (Woody et al., 2005).

In education, a dramatic shift occurred with the January, 2002, passage of the No Child Left Behind Act. This Act mandates accountability through end-of-grade tests scores but only suggests (and does not require) the use of evidence-based educational interventions. Schools are required to improve scores, but the methods that they use are still left to local decision-makers.

In social policy, a great divide exists between the evaluation of programs by non-profit organizations (such as RAND and MDRC, with universities contributing a little) and the practice of public policy in the real world. A recent survey of major public policy schools by the Coalition for Evidence-Based Policy (2005) revealed that only 18 percent of schools require a course in program evaluation, and most schools spend less than five hours of student time on the topic of randomized controlled trials. It is not surprising that, in practice, most social programs are funded by government without any evidence supporting their own stated goals, nor any attempt to provide an evaluation through scientific means. The practice of social policy in general, and publicly-supported youth violence prevention in particular, is at a crossroads. The time is right to push forward the evaluation and regulation of violence prevention programs that are funded by government.

Numerous lists of evidence-based programs in youth violence prevention already exist, the best known being the Blueprints for Violence Prevention published by the Center for the Study and Prevention of Violence at the University of Colorado (available at: <http://www.colorado.edu/cspv/blueprints/>). Other lists have been assembled by the Office of Juvenile Justice and Delinquency Prevention, SAMHSA, the Washington State Institute for Public Policy, and the Coalition for Evidence-Based Policy, among others. In late 2005, the federal government produced yet another list, with descriptions of evaluations, called Helping America's Youth (available at <http://www.helpingamericasyouth.gov>). The large number of such lists, the inconsistency in the programs included or not included in each list, and the diverse criteria used to determine membership in a list point to the need for systematic documentation of interventions and their impacts. In medicine, inclusion on a private list is not sufficient to endorse the use of a drug. Instead, in order for a pharmacotherapeutic intervention to be allowed, it must be endorsed by the Federal Drug Administration, the FDA. The FDA requires at least minimal evaluation, almost always through randomized control trials, that assess both the therapeutic impact and potential adverse effects. Although controversy continues regarding the adequacy of this system, this form of regulation is well beyond the system in social programming, which has no regulation at all.

An "FDA for Social Programs" would require that any psychosocial intervention undergo a set of randomized controlled trials prior to government-supported dissemination. Inclusion in the Colorado Blueprints program requires evaluation both by the creator of a program and at

least one replication by an independent investigator. In order to be included on the Blueprints list, a program must be described in sufficient detail so as to be implemented with fidelity. Usually, this detail involves training manuals. The program must also describe the population for which it is intended. Although the Blueprints program is a splendid model, it is a private entity that lacks the regulatory power of a federal program. The FDA regulates the implementation of drug therapies, with power to stop use if and when a drug is deemed to be harmful. No such regulatory body exists today for social programs, and the consequence is that ineffective and harmful programs continue to be used, and funded by the federal government, every day.

Promoting evidence-based practice in public policy

The existence of a list of approved programs is not sufficient for effective practice in social policy, just as the existence of an FDA does not guarantee effective medical practice. Several obstacles must be overcome. First, practitioners of public policy, agency directors, and funders must learn how to practice “evidence-based decision-making” in social policy. Given the mandate to lower the rate of youth violence in a local community but limited funds to disburse, it is not clear how a decision-maker should act. Merely funneling dollars to support one of the programs on the Blueprints list may not be sufficient, or even appropriate. Effectiveness of the selected program might not generalize to the local population. Cultural and other differences between the population on which the program was tested and the new population might diminish program effectiveness or require new evaluation. The local context might not support the level of training, supervision, or funding necessary to guarantee effectiveness. Even prior to selecting a program is analysis of the local problem. In the new local context, is the problem one of inadequate treatment options for first-time offenders or one of a “polluted” neighborhood and peer culture that breeds rampant violence? Could long-term preventive intervention with infants lower the rate of violence in this community, or is the residential mobility rate too high to make such an investment worthwhile for the local community? Given these questions, what level of evaluation is necessary when implementing an evidence-based program in a new local context? Is another RCT necessary? These issues are analogous to the issues faced by an individual practitioner, who must figure out how to engage in “evidence-based clinical practice.”

Guidelines and regulations for evidence-based practice of social policy are needed. It is likely that the guidelines will include components of systems analysis that includes an estimate of impact on the treated as well as the rest of the community population, cost-benefit analysis that weighs the financial return on investment in a program, and political analysis that evaluates a community's receptivity to a program. These guidelines would be designed to help policymakers consider the relevant parameters when making funding decisions.

Most current practitioners and decision-makers lack the expertise that is necessary to practice evidence-based decision-making in social policy. Models for mid-career training must be developed and implemented to move the field forward. Graduate programs in the human services professions (e.g., clinical psychology, counseling, social work) and public policy should integrate this kind of training into their curricula. Standards for certification of expertise should be developed for public decision-makers.

The regulations should address the type of new outcome evaluation that would be necessary when a program is implemented in a local context. For example, a three-tiered system might be contemplated, as follows. The first tier would apply to evidence-based programs that are adopted with a similar population to that on which the evidence is based. In this case, random assignment and a new control group may be unnecessary, but minimal documentation of implementation fidelity and tracking of outcomes may still be mandated. The second tier would

apply to evidence-based programs that are being applied to a “new” context. In this case, local communities might not be able to support a new RCT (although one would be desired), but they might be required to allocate a percent of available funds for objective data collection that includes independent assessment and reporting of outcomes. The third tier would address true innovation. In youth violence prevention, like medicine, a structure needs to be put in place that encourages the creation of new programs while still maintaining the public's safety. Currently, the only safeguards for the public occur if a new program is undergoing trial through a university or other organization that requires an Institutional Review Board for the Protection of Human Subjects. No such body reviews the expenditure of most public funds used for violence prevention because these funds are allocated by government to community agencies and do not constitute research. After-school programs, mentor programs, delinquency diversion efforts, and club activities are routinely funded by governments with no review of the protection of the youth participants. The third tier would put into place a mechanism that encourages innovation by local program developers in a way that ensures the rigorous evaluation of the program's impact. A percent of total funds for a domain such as youth violence could go to innovation. At the pilot stage of most programs, the program is not subject to random assignment but instead to close scrutiny and modification through an iterative process. When a program is sufficiently mature, it becomes ready for evaluation by RCTs. This third tier would monitor both the pilot phase and the RCTs by requiring advance registration of programs with a federal agency.

Promoting evidence-based policy and practice through a National Academy of Sciences panel

The State of the Science Panel on Preventing Violence and Related Health-Risking Social Behaviors in Adolescents stopped short of calling for federal leadership and action in promoting the systematic monitoring and regulation of prevention programs in youth violence. It was here, while it had its 15 min of public attention, that it missed its golden opportunity. What is needed in order to move the policy field forward is a visible and prominent panel that is charged by the federal government with reviewing the state of funding, practice, and policy in youth violence prevention in order to promote the use of scientific evidence in this field. A National Academy of Sciences Panel would carry the credibility that is necessary to change practice. The Panel should be charged with: (1) generating a public regulatory mechanism (a standing agency) to evaluate the effectiveness of any social program designed to prevent youth violence; (2) proposing standards for implementation, evaluation, and funding of evaluation for different kinds of youth violence prevention programs; and (3) providing guidelines for the use of scientific evidence in the practice of funding programs.

A final note

As I reflect on the proposals being made in this commentary, it occurs to me that many child clinical psychologists may conclude that the state of science is not far enough along to warrant the guidelines and regulations proposed, and they may feel uncomfortable with the assumption of expertise by scientists that is implied here. I share that discomfort. I am persuaded, though, by a vision of social policy in the year 2020, when youth violence prevention science and practice might be characterized by the same level of professional rigor that currently applies to medicine, engineering, and, even, the business world. Perhaps then the field of prevention science might finally have a real impact on reducing the overall levels of violence among youth.

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