

**MATRIX OF EVIDENCE-BASED PROGRAMS AND PRACTICES (EBP) RATING CRITERIA (revised 10/3/06)**

This matrix is an attempt to cross-walk the various evidence-based practices definitions from several national efforts to define these types of programs and practices. Each definition may not be completely comparable across the various rating criteria for each item. Please review each of the definitions carefully for each source.

CBCAP Efficiency Measure	CA Clearinghouse on EBP in Child Welfare	APHSA Guidelines for EBP	SAMHSA Model Programs NREPP	OJJDP Model Programs Guide	Dept. Ed/ What Works	Promising Practices Network	Emerging Practices in the Prevention of Child Abuse and Neglect
<p><b><u>Well-Supported-Programs and Practices</u></b></p> <p>The program articulates a <u>theory of change</u> which specifies clearly identified <u>outcomes</u> and describes the activities that are related to those <u>outcomes</u>. This is represented through the presence of a detailed <u>logic model</u> or <u>conceptual framework</u> that depicts the assumptions for the <u>inputs and outputs</u> that lead to the <u>short, intermediate and long-term outcomes</u>.</p> <p>The practice has a book, manual, training or other available writings that specify components of the service and describes how to administer it.</p> <p>The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving child</p>	<p><b><u>Well Supported – Effective practice</u></b></p> <p>There is no clinical or <u>empirical</u> evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</p> <p>The practice has a book, manual, and/or other available writings that specify components of the service and describes how to administer it.</p> <p>Multiple Site Replication: At least two rigorous <u>randomized controlled trials</u> (RCT's) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, <u>peer-reviewed</u> literature.</p> <p>The practice has been shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that</p>	<p><b><u>Well-supported – efficacious practice</u></b></p> <p>The practice has a sound theoretical basis in generally accepted child welfare or related professional principles.</p> <p>A substantial clinical-anecdotal literature exists indicating the practice has value with children receiving services from the child welfare or related system and their parents/ caregivers.</p> <p>The practice is generally accepted clinical practice as appropriate for use with children receiving services from the child welfare or related system and their parents/ caregivers.</p> <p>There is no clinical or empirical evidence indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</p> <p>The practice has a book, manual or other available writings that specifies the components of the</p>	<p><b><u>Model Programs</u></b></p> <p>are well-implemented, well-evaluated programs, meaning they have been reviewed by the National Registry of Evidence-based Programs and Practices (NREPP) according to rigorous standards of research. Developers, whose programs have the capacity to become Model Programs, have coordinated and agreed with SAMHSA to provide quality materials, training, and technical assistance for nationwide implementation. Model Programs score at least 4.0 on a 5-point scale on Integrity and Utility, based on the <u>NREPP review process</u>.</p>	<p><b><u>Exemplary</u></b></p> <p>In general, when implemented with a high degree of fidelity these programs demonstrate robust empirical findings using a reputable conceptual framework and an evaluation design of the highest quality (experimental).</p>	<p><b><u>"Meets Evidence Standards"</u></b>--randomized controlled trials (RCTs) that do not have problems with randomization, attrition, or disruption, and regression discontinuity designs that do not have problems with attrition or disruption.</p>		<p><b><u>Demonstrated Effective</u></b></p> <p>Programs for which positive outcomes have been shown through experimental research designs using random assignment to experimental and control groups. RCT</p> <p>This is restricted to programs that have undergone rigorous evaluation using an experimental research design (i.e., random assignment to experimental and control groups).</p>

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<p>abuse prevention or family support services.</p> <p><u>Multiple Site Replication</u> in Usual Practice Settings: At least two rigorous <u>randomized controlled trials</u> (RCT's) or comparable <u>methodology in different usual care or practice settings</u> have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, <u>peer-reviewed</u> literature.</p> <p>There is no clinical or <u>empirical</u> evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</p> <p>The practice has been shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time.</p>	<p>the effect is lost after this time.</p> <p>Outcome measures must be <u>reliable</u> and <u>valid</u>, and administered consistently and accurately across all subjects.</p> <p>If multiple outcome studies have been conducted, the overall weight of the evidence supports the <u>effectiveness</u> of the practice.</p>	<p>service and describes how to administer it.</p> <p>At least two randomized, controlled outcome studies (RCT) have found the practice to be superior to an appropriate comparison practice, or different or better than an already established practice when used with children receiving services from the child welfare or related system and their parents/ caregivers.</p> <p>If multiple outcome studies have been conducted, the overall weight of the evidence supports the efficacy of the practice.</p>					

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<p>Outcome measures must be <u>reliable</u> and <u>valid</u>, and administered consistently and accurately across all subjects.</p> <p>If multiple outcome studies have been conducted, the overall weight of the evidence supports the <u>effectiveness</u> of the practice.</p> <p>The program is committed and is actively working on building stronger evidence through ongoing <u>evaluation</u> and continuous quality improvement activities.</p> <p>The local program can demonstrate adherence to model <u>fidelity</u> in program implementation.</p>							
<p><b><u>Supported – Programs and Practices</u></b></p> <p>The program articulates a <u>theory of change</u> which specifies clearly identified <u>outcomes</u> and describes the activities that are related to those</p>	<p><b><u>Supported Efficacious</u></b></p> <p>There is no clinical or <u>empirical</u> evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared</p>	<p><b><u>Supported and Probably Efficacious</u></b></p> <p>The practice has a sound theoretical basis in generally accepted child welfare or related professional principles.</p> <p>A substantial clinical-anecdotal literature</p>	<p><b><u>Effective Programs</u></b> are well-implemented, well-evaluated programs that produce a consistent positive pattern of results (across domains and/or replications).</p>			<p><b><u>Proven Program</u></b></p> <p>Study design uses a convincing comparison group to identify program impacts, including randomized-control trial (experimental design) or some quasi-experimental designs.</p>	

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<p><u>outcomes</u>. This is represented through the presence of a detailed <u>logic model</u> or <u>conceptual framework</u> that depicts the assumptions for the <u>inputs</u> and <u>outputs</u> that lead to the <u>short, intermediate and long-term outcomes</u>.</p> <p>The practice has a book, manual, training, or other available writings that specifies the components of the practice protocol and describes how to administer it.</p> <p>The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving child abuse prevention or family support services.</p> <p>There is no clinical or <u>empirical</u> evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its</p>	<p>to its likely benefits.</p> <p>The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describes how to administer it.</p> <p>At least two rigorous <u>randomized controlled trials</u> (RCTs) in highly <u>controlled settings</u> (e.g., university laboratory) have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, <u>peer-reviewed</u> literature.</p> <p>The practice has been shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time.</p> <p>Outcome measures must be <u>reliable</u> and <u>valid</u>, and administered consistently and accurately across all subjects.</p> <p>If multiple outcome studies have been conducted, the overall</p>	<p>exists indicating the practice has value with children receiving services from the child welfare or related system and their parents/ caregivers.</p> <p>The practice is generally accepted clinical practice as appropriate for use with children receiving services from the child welfare or related system and their parents/ caregivers.</p> <p>There is no clinical or empirical evidence indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</p> <p>The practice has a book, manual or other available writings that specifies the components of the service and describes how to administer it.</p> <p>At least two studies using some form of control without randomization (e.g. matched waitlist, untreated group, placebo group) have established the practice's efficacy over time, efficacy over placebo or found</p>	<p>These programs must score at least 4.0 on a 5-point scale on Integrity and Utility, based on the National Registry of Evidence-based Programs and Practices (NREPP) review. (See an explanation of the <u>NREPP Review Process</u>.) The programs listed below are Effective Programs with all the criteria as the Model Programs on this Web site with one exception. The exception is that their developers have yet to agree to work with SAMHSA/CSAP to support broad-based dissemination of their programs but may disseminate their programs themselves. If and when they agree to work with SAMHSA/CSAP, their status will be adjusted and they will become Model Programs.</p>				

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<p>likely benefits.</p> <p>The research supporting the <u>efficacy</u> of the program or practice in producing positive <u>outcomes</u> associated with reducing <u>risk</u> and increasing <u>protective factors</u> associated with the prevention of abuse or neglect meets at least one or more of the following criterion:</p> <p>At least two rigorous <u>randomized controlled trials</u> (RCTs) in highly <u>controlled settings</u> (e.g., university laboratory) have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, <u>peer-reviewed</u> literature.</p> <p>OR</p> <p>At least two between-group design studies using either a <u>matched comparison</u> or <u>regression discontinuity</u> have found the practice to be equivalent to another practice that</p>	<p>weight of evidence supports the <u>efficacy</u> of the practice.</p>	<p>it to be comparable to or better than an already established practice.</p>					

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<p>would qualify as supported or well-supported; or superior to an appropriate comparison practice.</p> <p>The practice has been shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time.</p> <p>Outcome measures must be <u>reliable</u> and <u>valid</u>, and administered consistently and accurately across all subjects.</p> <p>If multiple outcome studies have been conducted, the overall weight of evidence supports the <u>efficacy</u> of the practice.</p> <p>The program is committed and is actively working on building stronger evidence through ongoing <u>evaluation</u> and continuous quality improvement activities.</p> <p>The local program can demonstrate adherence to model <u>fidelity</u> in program implementation.</p>							

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		<p><b><u>Supported and Acceptable Practice</u></b>  The practice has a sound theoretical basis in generally accepted child welfare or related professional principles.</p> <p>A substantial clinical-anecdotal literature exists indicating the practice has value with children receiving services from the child welfare or related system and their parents/ caregivers.</p> <p>The practice is generally accepted clinical practice as appropriate for use with children receiving services from the child welfare or related system and their parents/ caregivers.</p> <p>There is no clinical or empirical evidence indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</p> <p>The practice has a book, manual or other available writings that specifies the components of the service and describes how to administer it.</p>					

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		<p>At least one group study (controlled or uncontrolled) or a series of single-subject studies suggest the efficacy of the practice with children receiving services from the child welfare or related system and their parents/ caregivers</p> <p>OR</p> <p>A practice has demonstrated efficacy with other populations, has a sound theoretical basis for its use with children receiving services from the child welfare or related system and their parents/ caregivers, but has not been tested or used extensively within the child welfare population.</p> <p>If multiple outcome studies have been conducted, the overall weight of the evidence supports the efficacy of the practice.</p>					
<p><b><u>Promising Programs and Practices</u></b></p> <p>The program can articulate a <u>theory of change</u> which specifies clearly identified <u>outcomes</u> and describes the activities that are</p>	<p><b><u>Promising Practice</u></b></p> <p>There is no clinical or <u>empirical</u> evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared</p>	<p><b><u>Promising and Acceptable Practice</u></b></p> <p>The practice has a sound theoretical basis in generally accepted child welfare or related professional principles.</p> <p>A substantial clinical-</p>	<p><b><u>Promising Programs</u></b></p> <p>have been implemented and evaluated sufficiently and are considered to be scientifically defensible. They have demonstrated</p>	<p><b><u>Effective</u></b></p> <p>In general, when implemented with sufficient fidelity these programs demonstrate adequate empirical findings using a sound conceptual framework and an evaluation design of the high</p>	<p><b><u>"Meets Evidence Standards with Reservations"</u></b>--strong quasi-experimental studies that have comparison groups and meet other WWC Evidence Standards, as well as randomized trials with randomization,</p>	<p><b><u>Promising Program</u></b></p> <p>Study has a comparison group, but it may exhibit some weaknesses, e.g., the groups lack comparability on pre-existing variables or the analysis does not employ appropriate</p>	<p><b><u>Reported Effective</u></b></p> <ul style="list-style-type: none"> <li>• Quasi-experimental design</li> </ul>

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<p>related to those <u>outcomes</u>. This is represented through presence of a program <u>logic model</u> or <u>conceptual framework</u> that depicts the assumptions for the activities that will lead to the desired <u>outcomes</u>.</p> <p>The program may have a book, manual, other available writings, and training materials that specifies the components of the practice protocol and describes how to administer it. The program is able to provide formal or informal support and guidance regarding program model.</p> <p>The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving services child abuse prevention or family support services.</p> <p>There is no clinical or <u>empirical</u> evidence or theoretical basis indicating that the</p>	<p>to its likely benefits.</p> <p>The practice has a book, manual, and/or other available writings that specify the components of the practice protocol and describe how to administer it.</p> <p>At least one study utilizing some form of control (e.g., <u>untreated group</u>, <u>placebo group</u>, <u>matched wait list</u>) has established the practice's <u>efficacy</u> over the placebo, or found it to be comparable to or better than an appropriate comparison practice. The study has been reported in published, <u>peer-reviewed</u> literature.</p> <p>If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the practice.</p>	<p>anecdotal literature exists indicating the practice has value with children receiving services from the child welfare or related system and their parents/ caregivers.</p> <p>The practice is generally accepted clinical practice as appropriate for use with children receiving services from the child welfare or related system and their parents/ caregivers.</p> <p>There is no clinical or empirical evidence indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</p> <p>The practice has a book, manual or other available writings that specifies the components of the service and describes how to administer it.</p>	<p>positive outcomes in preventing substance abuse and related behaviors. However, they have not yet been shown to have sufficient rigor and/or consistently positive outcomes required for Effective Program status. Nonetheless, Promising Programs are eligible to be elevated to Effective status subsequent to review of additional documentation regarding program effectiveness. Promising Programs must score at least 3.33 on the 5-point scale on parameters of Integrity and Utility.</p>	<p>quality (quasi-experimental).</p>	<p>attrition, or disruption problems and regression discontinuity designs with attrition or disruption problems.</p> <ul style="list-style-type: none"> <li>•</li> </ul>	<p>statistical controls.</p>	

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<p>practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</p> <p>At least one study utilizing some form of <u>control or comparison group</u> (e.g., <u>untreated group, placebo group, matched wait list</u>) has established the practice's <u>efficacy</u> over the <u>placebo</u>, or found it to be comparable to or better than an appropriate comparison practice, in reducing <u>risk</u> and increasing <u>protective factors</u> associated with the prevention of abuse or neglect.. The <u>evaluation</u> utilized a <u>quasi-experimental</u> study design, involving the comparison of two or more groups that differ based on their receipt of the program or practice. A formal, independent report has been produced which documents the program's positive <u>outcomes</u>.</p> <p>The local program is committed to and is actively working on building stronger</p>							

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<p>evidence through ongoing <u>evaluation</u> and continuous quality improvement activities. Programs continually examine long-term <u>outcomes</u> and participate in research that would help solidify the outcome findings.</p> <p>The local program can demonstrate adherence to model <u>fidelity</u> in program or practice implementation.</p>							
<p><b><u>Emerging and Evidence-Informed Programs and Practices</u></b></p> <p>The program can articulate a <u>theory of change</u> which specifies clearly identified <u>outcomes</u> and describes the activities that are related to those <u>outcomes</u>. This may be represented through a program <u>logic model</u> or <u>conceptual framework</u> that depicts the assumptions for the activities that will lead to the desired <u>outcomes</u>.</p> <p>The program may have a book, manual, other</p>	<p><b><u>Acceptable/Emerging Practice – Effectiveness is unknown</u></b></p> <p>There is no clinical or <u>empirical</u> evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</p> <p>The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describes how to administer it.</p> <p>The practice is generally accepted in clinical practice as appropriate for use</p>	<p><b><u>Innovative or Novel Practice</u></b></p> <p>The practice may have a theoretical basis that is innovative or novel, but is a reasonable application of generally accepted child welfare or related professional principles.</p> <p>A relatively small clinical literature exists to suggest the value of the practice.</p> <p>The practice is not widely used or generally accepted by practitioners working with children receiving services from the child welfare or related system and their parents caregivers.</p>		<p><b><u>Promising</u></b></p> <p>In general, when implemented with minimal fidelity these programs demonstrate promising (perhaps inconsistent) empirical findings using a reasonable conceptual framework and a limited evaluation design (single group pre- post-test) that requires causal confirmation using more appropriate experimental techniques.</p>	<p><b><u>Does Not Meet Evidence Screens</u></b>--studies that provide insufficient evidence of causal validity or are not relevant to the topic being reviewed.</p> <p>Does not meet evidence</p> <ul style="list-style-type: none"> <li>• Insufficient evidence</li> </ul>		<p><b><u>Innovative</u></b></p> <p>No known research on effectiveness. This highlights programs that have been particularly creative in overcoming obstacles to program success or that have taken an innovative approach to prevention programming.</p>

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<p>available writings, training materials, OR may be working on documents that specifies the components of the practice protocol and describes how to administer it.</p> <p>The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving child abuse prevention or family support services.</p> <p>There is no clinical or <u>empirical</u> evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</p> <p>Programs and practices may have been evaluated using less rigorous <u>evaluation</u> designs that have with no <u>comparison group</u>, including “<u>pre-post</u>” designs that examine change in individuals from before the program or practice was</p>	<p>with children receiving services from child welfare or related systems and their parents/caregivers.</p> <p>The practice lacks adequate research to empirically determine <a href="#">efficacy</a>.</p>	<p>There is neither clinical or empirical evidence nor theoretical basis suggesting that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</p> <p>The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describes how to administer it.</p>					

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<p>implemented to afterward, without comparing to an <u>“untreated” group</u> – or an <u>evaluation</u> may be in process with the results not yet available.</p> <p>The program is committed to and is actively working on building stronger evidence through ongoing <u>evaluation</u> and continuous quality improvement activities.</p>							
<p><b><u>Programs and Practices Lacking Support or Positive Evidence</u></b></p> <p>The program is not able to articulate a <u>theory of change</u> which specifies clearly identified <u>outcomes</u> and describes the activities that are related to those <u>outcomes</u>.</p> <p>The program does not have a book, manual, other available writings, training materials that describe the components of the program.</p> <p>Two or more <u>randomized</u>,</p>	<p><b><u>Fails to Demonstrate Effect</u></b></p> <p>Two or more <u>randomized controlled trials</u> (RCT's) have found the practice has not resulted in improved outcomes, when compared to usual care.</p> <p>If multiple outcome studies have been conducted, the overall weight of evidence does not support the <u>efficacy</u> of the practice.</p>						

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<p><u>controlled trials (RCTs)</u> have found the practice has not resulted in improved <u>outcomes</u>, when compared to usual care.</p> <p>OR</p> <p>If multiple outcome studies have been conducted, the overall weight of evidence does NOT support the <u>efficacy</u> of the practice.</p> <p>OR</p> <p>No evaluation has been conducted. The program may or may not have plans to implement an evaluation.</p>							
	<p><b><u>Concerning practice</u></b></p> <p>If multiple outcome studies have been conducted, the overall weight of evidence suggests the intervention has a negative effect upon clients served; and/or</p> <p>There is a reasonable theoretical, clinical, <b><u>empirical</u></b>, or legal basis suggesting that the practice constitutes a risk of harm to those</p>	<p><b><u>Concerning practice</u></b></p> <p>The theoretical basis for the practice is unknown, a misapplication of child welfare principles, or a novel, unique, and concerning application of child welfare or related professional principles.</p> <p>Only a small and limited clinical literature exists suggesting the value of the practice.</p>					

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	receiving it, compared to its likely benefits.	<p>There is reasonable, theoretical, clinical, or empirical basis suggesting that compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.</p> <p>The practice has a manual or other writings that specify the components and administration characteristics of the practice that allows for implementation.</p>					
						Not listed on site Study does not use a convincing comparison group. For example, the use of before and after comparisons for the treatment group only.	

## **References:**

### **California Evidence Based Clearinghouse for Child Welfare**

<http://www.cachildwelfareclearinghouse.org/>

### **APHSAs Guide for Child Welfare Administrators on Evidence Based Practices**

<http://www.aphsa.org/home/doc/Guide-for-Evidence-Based-Practice.pdf>

### **SAMHSA National Registry for Evidence-Based Programs and Practices**

<http://modelprograms.samhsa.gov/>

### **OJJDP Model Programs Guide**

<http://www.dsgonline.com/mpg2.5/ratings.htm>

### **Blueprints for Violence Prevention**

<http://www.colorado.edu/cspv/blueprints/index.html>

### **Evidence of Deterrent Effect with a Strong Research Design**

This is the most important of the selection criteria. Relatively few programs have demonstrated effectiveness in reducing the onset, prevalence, or individual offending rates of violent behavior. The Blueprints [Advisory Board](#) accepts evidence of deterrent effects for three key indicators -- violence (including childhood aggression and conduct disorder), delinquency, and/or drug use -- as evidence of program effectiveness. Providing sufficient quantitative data to document effectiveness in preventing or reducing the above behaviors requires the use of evaluative designs that provide reasonable confidence in the findings (e.g., experimental designs with random assignment or quasi-experimental designs with matched control groups). Most researchers recognize random assignment studies (randomized trials) executed with fidelity as providing the highest standard of program evaluation.

When random assignment cannot be used, the Advisory Board considers studies that use control groups matched as closely as possible to experimental groups on relevant characteristics (e.g., gender, race, age, socioeconomic status, and income) and studies with control groups that use statistical techniques to control for initial differences on key variables. As carefully as experimental and control groups are matched, however, it is impossible to determine if the groups may vary on some characteristics that have not been matched or controlled for and that are related to program outcome. Random assignment, therefore, is believed to be the most rigorous of methodological approaches.

Research designs vary greatly in quality, particularly with respect to several key aspects: sample size, attrition (loss of study participants over time), and measurement issues. At a minimum, the following issues need to be addressed: (1) Sample sizes must be large enough to provide statistical power to detect effects. It is more difficult to detect statistically significant differences between groups when small sample sizes are used. (2) Attrition, or loss of study participants, may be indicative of problems in program implementation or may be a failure to locate subjects during a follow-up period. Attrition is dangerous, particularly because it can compromise the integrity of the original randomization or matching process. It reduces confidence that the original sample and final sample are comparable and that the final experimental and control comparisons reflect only treatment effects. (3) Tests to measure outcomes must be administered fairly, accurately and consistently to all study participants. For example, the use of inconsistent measures over time may produce less reliable test scores. The instruments which are used to measure outcomes should be demonstrated to be reliable and valid.

### **Sustained Effects**

Although one criterion of program effectiveness is that it demonstrates success by the end of the treatment phase, it is also important to demonstrate that these program effects endure beyond treatment and from one developmental period to the next. Designation as a Blueprints program requires a sustained effect at least one year beyond treatment, with no subsequent evidence that this effect is lost. Unfortunately, many programs that demonstrate initial success fail to show long-term maintenance of the effects after the intervention has ended. Depending on whether effects are immediate or delayed, the full impact of an intervention or treatment may not be realized at the end of treatment. Significant improvement may be realized over time, or a decay or decline may result. For example, if a preschool program designed to offset the effects of poverty on school performance (e.g., Head Start) demonstrates its effectiveness when children start school, it is also important to demonstrate that these effects are sustained over a longer period of time. Unless this protective effect is sustained through high school, it is unlikely to have an impact during this critical period when problem behavior is at its peak: the effect must be sustained if it is to help adolescents maintain a successful life course trajectory. Although programs that have specifically failed to produce a sustained effect do not qualify for the Blueprints model or promising categories, programs that have not yet demonstrated long-term effects (because sufficient time has not yet elapsed or follow-up analyses were never planned) may be considered as promising programs.

### **Multiple Site Replication**

Replication is an important element in establishing program effectiveness and understanding what works best, in what situations, and with whom. Some programs are successful because of unique characteristics in the original site that may be difficult to duplicate in another site (e.g., having a charismatic leader or extensive community support and involvement). Replication establishes the strength of a program and its prevention effects and demonstrates that it can be successfully implemented in other sites.

Programs that have demonstrated success in diverse settings (e.g., urban, suburban, and rural areas) and with diverse populations (e.g., different socioeconomic, racial, and cultural groups) create greater confidence that such programs can be transferred to new settings. As communities prepare to tackle the problems of violence, delinquency, and substance abuse, knowledge that a specific program has had success in various settings with similar populations adds to its credibility.

Some projects may be initially implemented as a multisite single design (i.e., several sites are included in the evaluation design). When this occurs, the evaluation should check for overall main effects and sources of variation across sites. Becoming a Blueprints model program requires at least one replication with demonstrated effects. This criterion does not need to be met to qualify as a promising program.

### **Additional Factors**

In the selection of Blueprints model programs, two additional factors are considered: whether a program conducted an analysis of mediating factors and whether a program is cost effective.

**Analysis of Mediating Factors.** The Blueprints Advisory Board looks for evidence that change in the targeted risk or protective factor(s) mediates the change in violent behavior. This evidence clearly strengthens the claim that participation in the program is responsible for the change in violent behavior, and it contributes to our theoretical understanding of the causal processes involved. In its reviews of different programs, the Advisory Board has discovered that many programs reporting significant deterrent "main effects" have not collected the data necessary to complete an analysis of mediating factors.

**Costs versus Benefits.** Program costs should be reasonable and should be less or no greater than the program's expected benefits. High price-tag programs are difficult to sustain when competition is high and funding resources low. Implementing expensive programs that will, at best, have small effects on violence is counter-productive. Although outcome evaluation research established that Blueprints programs were effective in reducing violence, delinquency, and drug use, very few data were available initially regarding the costs associated with replicating these programs.

Two recent cost-benefit studies involving Blueprints programs -- the RAND Corporation Study and a study by the Washington State Institute for Public Policy -- suggest that these programs are cost-effective (Greenwood, Model, Rydell, & Chiesa, 1996; Washington State Institute for Public Policy, 1998, 2001).

The selection criteria identified above establish a high standard, one that has proved difficult for most programs to meet, thus explaining why there are only 11 Blueprints programs. This high standard reflects the level of confidence necessary, however, for recommending that communities replicate these programs with reasonable assurances that they will prevent violence. The Blueprints model programs are not intended to be a comprehensive list of programs that work, but rather reflect a selection of programs with strong research designs for which we have found good evidence of their effectiveness in delinquency, violence, or substance abuse prevention and reduction. There is no implication that programs not on this list are necessarily ineffective. Chances are that there are a number of good programs that have just not yet undergone the rigorous evaluations required to demonstrate effectiveness. But our evaluations have also revealed that many programs are ineffective, and a few are iatrogenic (i.e., harmful). Without evaluations, we just don't know. It is in the best interests of our children to evaluate, so we can have confidence that what we are doing for them actually helps. As time goes on and new research findings are published, CSPV hopes to add to this list other credible, effective programs which communities can use confidently. CSPV will also continue to follow evaluations of Blueprints programs to refine our knowledge of their effectiveness for specific populations and over longer periods of time.

### **Department of Education What Works Clearinghouse**

<http://www.whatworks.ed.gov/>

### **Promising Practices Network**

<http://www.promisingpractices.net/criteria.asp>

### **Social Programs that Work (Coalition for Evidence based Policy)**

<http://www.evidencebasedprograms.org/>

This site summarizes a select group of randomized controlled trials (RCTs) that--

1. Are well-designed and implemented; and
2. Have significant policy implications-- because they show, for example, that (a) a social intervention has an important effect on life outcomes and, preferably, can be readily replicated at modest cost; or (b) a widely-used intervention has little or no effect.

To determine whether an RCT is well-designed and implemented, we use the criteria in the U.S. Office of Management and Budget (OMB) document [What Constitutes Strong Evidence of a Program's Effectiveness](#) (see appendix, pp 14-16), including such items as:

- Adequate sample size;
- Few or no systematic differences between the intervention and control groups prior to the intervention;
- Low attrition, and little or no difference in attrition between the intervention and control groups;
- Few or no cross-overs between the intervention and control groups after randomization;
- Placebo controls, where appropriate;
- Intention-to-treat analysis of study outcomes;
- Valid outcome measures, preferably well-established tests and/or objective, “real-world“ measures (e.g., arrest rates for a crime intervention);
- Blinded evaluators, where appropriate;
- Preferably long-term follow-up;
- Appropriate tests for statistical significance (in group-randomized trials, “hierarchical” tests that are based both on the number of groups and the number of individuals in each group);
- Preferably, corroboration of the study results in more than one study or implementation site -- preferably typical community or school settings.