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## Standards of evidence for the Greater London Authority

An Evaluation Standard produced as part of  
the Project Oracle Evaluation Toolkit



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## Introduction

This outline of potential standards of evidence has been prepared by the Social Research Unit with the support of international experts. The draft is being circulated at an early stage in its development to benefit from as wide a range of opinion as possible.

In particular, it will be helpful if readers can comment on:

- the benefit of proposed evaluation levels
- the criteria being considered, i.e. intervention specificity, evaluation quality and amount of impact
- the desirability of incorporating cost-benefit analysis
- other ways of achieving a common evaluation standard across the capital.

A degree of technical language is necessary to explain the standards. It is proposed to include a glossary of technical terms in future revisions.

It is proposed to illustrate the final product with case studies to amplify how it will be used in practice. Please let us know if you would like your organisation to be included.

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## Background

### The Mayor of London and 'Time for Action'

Time for Action is the Mayor of London's first step in preventing youth violence over the long term. It features six key strands of work, including supporting young people in custody (Project Daedalus); keeping young people in education (Project Brodie); Mayor's Scholars, London Academies and Apprentices; developing character and responsibility (Project Titan); expanding sport and music opportunities; and establishing and disseminating what really works (Project Oracle). The Mayor's role is in regional leadership: setting the strategic direction of travel for London, leading an effective coalition of agencies around youth violence and youth crime, promoting efficiency of effort, and addressing gaps in provision. Accordingly, Project Oracle is led by the Greater London Authority and is steered by a multi-agency Board.

### Project Oracle

Project Oracle aims to improve the lives of all children living in the capital. It seeks to improve commissioning and service delivery across London by helping to identify and share good practice, and will make high quality information about effective interventions widely available as a guide to funding decisions. Project Oracle will ultimately help to strengthen the case for investment in proven crime reduction and prevention initiatives. Whilst Project Oracle will initially focus on upstream projects designed to tackle youth violence, particularly serious youth violence, over time it is planned to also look at a wide range of approaches and interventions to support how young people develop in London. Two clear, early deliverables for the Project are the development of an evaluation toolkit – incorporating evaluation standard, project assessment framework and self-assessment toolkit – and the establishment of an initial Oracle website in March 2010.

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## The Oracle Evaluation Toolkit

The Evaluation Standard proposed in this document is one of the three elements that make up an Evaluation Toolkit designed for London. The others are an Assessment Framework that will provide a method for “scoring” interventions against these standards, and a self-assessment tool to enable service providers to measure their own intervention against the standards. Accompanying guidance will suggest how the rating/score might be improved, for example through adjusting a service design or evaluation research design. In developing the standard we aim to build consensus around what it is important to discern between. This will be guided by what good evidence and evaluation look like, and workshops will be held to engage key stakeholders in this debate.

## The Social Research Unit, Dartington

The Social Research Unit is an independent registered charity and dedicated to improving the health and development of children through research, development and dissemination activities. Our development projects, in Ireland, across the UK and in the US have all relied on a combination of community engagement and solid evidence to improve children’s outcomes.

## Why is there a need for Standards of Evidence?

Standards provide a benchmark for scientific evidence of effectiveness. In the absence of any standards of evidence, too many interventions for children and families are being used in ignorance; worse, some are being implemented in spite of strong indications that they can be harmful. Better information will mean that resources are more confidently directed toward more effective projects. Widespread use across the London region of a single set of criteria will bring greater consistency to judgements about how to reduce youth violence and promote health and development.

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## Shaping the Standards for London

The majority of the source material used in this document has been applied and tested in the policy and social context prevailing in the US where much of it originated. London's standards will need to be adjusted to suit different conditions.

It is also vital to make the standards work right across the range of interventions available in the city, bearing in mind we intend to improve the evidence base and there may be organisations or interventions for which no formal evaluation is yet complete. Intervention is used here to refer to any technology, treatment, procedure, service or program. So there is an opportunity to build capacity and to help clearly specified and well-implemented interventions to demonstrate their worth.

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## Method

We have consulted four experts (brief biographies are given in Appendix A). Brian Flay chaired the Society for Prevention Research's Standards of Evidence committee, which in 2004 set out the criteria that preventive interventions should meet to be considered effective. Delbert Elliott is head of the Centre for the Study and Prevention of Violence, and leads the Blueprints for Violence Prevention project, which aims to identify drug and violence prevention programmes that meet high standards of scientific evidence for effectiveness. Steve Aos is associate director at the Washington State Institute for Public Policy, a non-partisan centre, that conducts policy-relevant research at the bidding of the state's legislators. We have also been in touch with Jon Baron, who heads the Coalition for Evidence-based Policy based in Washington, DC.

With the help of all four, we have identified six robust and widely adopted standards of evidence as the basis for our London proposals (identified in the bibliography). The US sources differ in the number of divisions they make: the Society for Prevention Research (SPR) (2004) uses three; the Working Group of the Federal Collaboration (2005) suggests seven – although there is much common ground in the criteria they advocate for establishing *definitive* evidence of effectiveness.

Our consultation suggests that an extra level might be appropriate for the London context to accommodate an undoubtedly wide range of delivery organisations that have yet to complete any formal evaluation, or else have yet to undergo any evaluation that would meet the high standards of a randomised controlled trial. Levels 1 (Early Evidence of Effectiveness) and 2 (Promising Interventions) are a reflection of the wish to acknowledge promising practices.

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## Standards of evidence for London

### Standard levels

The proposed standards contain five levels, with an increasing degree of intervention specificity and evaluation quality required at each level:

Level 1: Early Evidence of Effectiveness

Level 2: Promising Interventions

Level 3: Effective Interventions

Level 4: Model Interventions

Level 5: System Ready Interventions

Levels 1 and 2 denote interventions that cannot yet provide definitive evidence of effect. They may be new interventions or programmes in the early stages of demonstrating their effectiveness. Levels 3 through 5 indicate differences in the quality of the evaluation and implementation of the programme.

Two further outcomes may be possible. 'Ineffective Interventions' might usefully denote interventions that meet all of the criteria for an effective or model intervention but have been found by robust evaluation to have no significant effect. 'Harmful Interventions' might refer to interventions that meet all of the criteria for an effective or model intervention but with negative main effects or serious side effects. There is a question about where to locate these additions: in terms of evaluation quality, they should sit alongside effective interventions; however, in terms of their intervention impact they should sit lower than Level 1. It is, therefore, suggested that are kept separate from the five levels proposed.

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## Areas of effectiveness

Within each of the five levels are certain key aspects that call for judgements about an intervention's effectiveness:

### **(1) Intervention specificity**

This area assesses whether the intervention does what effective interventions do, even if it has not been evaluated? So, is sufficient attention being paid to the intervention components, to the theory or rationale underpinning the intervention and to the target group population for whom the intervention is suitable? What outcomes are expected? What processes govern recruitment, retention and participation, programme content, technical assistance and training materials and checklists for ensuring there is "fidelity" to the programme model.

### **(2) Evaluation quality**

Has the intervention been evaluated and, if so, to what standard? Was the evaluation interested in the impact on child outcomes, or with how the intervention has been implemented or with consumer satisfaction? Did the evaluation consider how the intervention works and whether it will work in practice? This area also takes into account the type of evaluation that has been undertaken, including the design of the study. For example, is the study an implementation study, comparison group design or a controlled experimental study? Has there been any cost-benefit analysis? Assessment in this area requires attention to sample size, outcome measurement, data collection procedures and statistical analyses.

### **(3) Intervention impact**

This area is concerned with how much of an impact an intervention has on the outcomes specified, as well as with potential side effects. Impact is typically measured in terms of research effect size or practical value, such as the cost-benefit relationship between what is spent on delivering the programme with what is reaped in terms of reduced expenditure on services in the longer term. Effect sizes measure how far a programme has been shown to change an outcome for the participants of the intervention, relative to a comparison group.

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## Criteria

Table 1, over the page, indicates the minimum criteria required for an intervention to match successive levels on the scale. They were found to be common to all of the standards we consulted. Interventions may demonstrate other criteria from areas higher up on the scale, but unless the minimum criteria are fulfilled in all areas at a particular level, the rating will not apply.

The sections that follow give more detail on the core criteria within each the five levels. The aim will be to link these criteria to the second tool in the Oracle Evaluation Toolkit – the Assessment Framework – where interventions will be rated against each of the three areas of effectiveness: intervention specificity, evaluation quality and intervention impact.

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**Table 1: Minimum criteria for standard levels**

Level	Intervention specificity	Evaluation quality	Intervention impact
Early Evidence of Effectiveness	There are specified outcomes and target group criteria.	A coherent strategy for an evaluation of the intervention is in place.	There is evidence that the intervention is being implemented as intended.
Promising Interventions	There is a clear logic or strong theoretical basis underpinning both the processes and content of the intervention.	A matched controls comparison group study has been completed.	There is evidence of a deterrent effect or positive effect.
Effective Interventions	Training and implementation manuals are available.	A randomised comparison group study is required. A replication study is required but it may be internal.	A consistent pattern of statistically significant (positive) effects is demonstrated.
Model Interventions	The intervention is delivered under real-world conditions.	An external replication study is required.	The effects are sustained beyond treatment for at least 1 year. There are no known negative/harmful effects.
System Ready Interventions	The intervention is delivered at scale; in real-world conditions by appropriate professionals. Manuals and technical support are readily available.	Cost-benefit analysis is undertaken Monitoring and evaluation tools are available to providers.	Cost-benefit information suggests that the intervention at least breaks even. Impact is established for subgroups.

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## Level 1 Early Evidence of Effectiveness

### Relevance to other standards

Few standards recognise a level of effectiveness that lacks any evaluation information. One standard (Sherman et al. 1998) acknowledges non-rigorous evaluation techniques; another (NAPP, 2008) allows the elements of intervention to be assessed separately, among them descriptions of evaluation and intervention and it is possible that some interventions match few of the listed criteria in those respects. Early Evidence of Effectiveness recognises that interventions may not have been formally evaluated but may still have succeeded in bringing clarity to the outcomes they seek for a certain target group.

### Intervention specificity

- The characteristics of the target group are clearly defined by inclusion and exclusion criteria.
- Desired outcomes are clearly specified.
- Explicit processes for recruiting participants include referral pathways and checks or interviews to ensure that participants meet the target group criteria.
- Where multiple sites are offering an intervention, checks should be kept on variations in intervention content and participant groups.

### Evaluation quality

- There is a coherent strategy for a rigorous (controlled) evaluation of the intervention.

If there is no strategy for rigorous evaluation, at least one of the following forms of non-rigorous evaluation should have been undertaken:

- an implementation study, documenting what the intervention comprises and what participants received.
- a non-comparison (single) group study where the relationship between the intervention and the outcome(s) is analysed before and after the intervention is delivered

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- an unmatched comparison group study, where there may be no control for pre-existing differences at baseline between the treatment and comparison groups.

## **Intervention impact**

- There is evidence that the intervention is being implemented as intended. Monitoring and documentation are adequate; participants received all appropriate elements of the intervention, in the intended format
- There is no evidence or indication that the intervention is harmful to participants.

## **Factors distinguishing Level 1 from Level 2**

- No formal evaluation of the intervention may have been completed at Level 1.
- There may be no objective evidence that the intervention is effective.
- Where an evaluation study has been completed at Level 1, there may be no comparison group against which to compare intervention group outcomes.

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## Level 2 Promising Interventions

### Relevance to other standards

This level approximates to the University of Maryland (Sherman et al. 1998) ranking of a level 3 study; that is a non-experimental study but one where intervention and comparison groups are matched on pre-existing differences or where statistical techniques are used to control for these differences. It also has a number of features in common with the Blueprints Promising programmes standard criteria, including a requirement for a strong research design and evidence of a deterrent effect or significant positive impact.

### Intervention specificity

- All of the criteria from Level 1 apply.
- A clear logic or strong theoretical basis underpins the processes and content of the intervention.
- Training materials and implementation procedures are available.

### Evaluation quality

- All of the criteria from Level 1 apply.
- A comparison group evaluation has been undertaken. Comparison group studies should use at least quasi-experimental designs with matched controls to ensure that pre-existing differences are minimal and, where present, controlled.
- Where comparison groups are not possible (e.g. if the intervention is being delivered universally), repeated time-series (multiple-baseline) designs may be appropriate. This involves collecting data repeatedly about the intervention participants over an extended period to monitor changes.

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The research design should also show evidence of:

- sound outcome measurement; measurement instruments should have previously demonstrated validity and reliability, or the study must demonstrate their quality
- appropriate sample size and sufficient statistical power to give confidence in the findings
- efforts to reduce selection bias and attrition. Evaluations should operate on an intent-to-treat basis and seek to follow up participants' progress whether or not they drop-out of the intervention
- appropriate statistical analyses.

## **Intervention impact**

- All of the criteria from Level 1 apply.
- There is evidence that the intervention has a deterrent effect or significant positive effect on specified outcomes.
- If there is more than one study available, the preponderance of evidence favours the intervention.

## **Factors distinguishing Level 2 from Level 3**

- Although desirable, there is not a requirement at Level 2 to demonstrate long-term effects of the intervention.
- Level 2 interventions do not require a replication evaluation study.

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## Level 3 Effective Interventions

### Relevance to other Standards

This level is equivalent to The Working Group of the Federal Collaboration's (2005) Effective with Reservation classification and has many of the features of the Society for Prevention Research's (2004) Efficacy level and of The University of Maryland's (Sherman et al. 1998) description of their Level 4 study.

### Intervention specificity

- All of the criteria from Level 2 apply.
- A manual detailing training and implementation materials permits faithful replication of the programme by someone other than the developer.
- The intervention must include a statement of 'for whom and under what conditions' it is expected to be effective.

### Evaluation quality

- All of the criteria from Level 2 apply.
- The evaluation design must include at least one comparison group that does not receive the intervention. Assignment to the groups should be random at a level appropriate to the intervention, i.e. individual, school, etc. and there should be a clear description of the method of recruitment into intervention and comparison groups.
- There should be a replication evaluation study. It is sufficient for this to be an internal replication; that is, one conducted by the same researcher/developer.
- There is at least one long-term follow-up of a core/specified outcome measure.

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## **Intervention impact**

- All of the criteria from Level 2 apply.
- There are consistent statistically significant effects, from at least two high-quality studies that carry appropriate statistical power.
- Effects are sustained for at least six months and preferably for a year after the intervention.
- There are no negative effects on key outcome measures nor any health-compromising side effects.
- All outcomes are reported – positive, negative or non-significant.

## **Factors distinguishing Level 3 from Level 4**

- A Level 3 intervention may be delivered under optimal research conditions; that is, with close researcher involvement.
- The replication evaluation study required for Level 3 need not be external or independent; this is required at Level 4.

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## Level 4 Model interventions

### Relevance to other standards

This level is largely equivalent to Blueprints Model programme certification and the Society for Prevention Research's Effectiveness level. Only such model programmes should be taken to scale and ample time and resources must be invested in local capacity building prior to implementation.

### Intervention specificity

- All of the criteria from Level 3 apply.
- Manuals and appropriate training and technical support must be available.
- The intervention must be delivered and evaluated under the same conditions as one would expect in the real world.
- The intervention must include a theory of the causal mechanisms that underlie the change being sought.
- There should be clear cost information, extending to detail about the resources (economic and human) required to deliver the intervention.

### Evaluation quality

- All of the criteria from Level 3 apply.
- At least two studies of the intervention should have been completed, including one external or independent replication study.
- The level of exposure should be measured in both treatment and control groups, through attention to the level of implementation and adherence of the target group to the intervention activities.
- The degree to which findings are generalisable should be assessed, through "dosage" analyses (quantity of the intervention received) or replication with different populations and subgroup analyses (differences in impact depending on age, gender, risk levels, etc), where possible.

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## **Intervention impact**

- All of the criteria from Level 3 apply.
- The studies should demonstrate sustained effects, beyond the intervention for at least a year and/or across developmental stages.
- A minimum effect size should be applied: one-tenth of one standard deviation (0.1) is recommended.

## **Factors distinguishing Level 4 from Level 5**

- Level 4 interventions may not have been delivered independently of the developer or by real-world professionals. That is, these interventions have yet to be delivered to scale within a system.

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## Level 5 System ready interventions

### Relevance to other Standards

Level 5 denotes interventions that are suitable to be disseminated and widely used (taken to scale). This level is equivalent to the Society for Prevention Research's (2004) standard of 'Broad Dissemination'.

#### Intervention specificity

- All of the criteria from Level 4 apply.
- All technical support should be readily available.
- The intervention can and should be delivered in 'real-world' conditions by appropriate professionals, i.e. teachers, social workers, health visitors, etc. and not researchers.
- Thought should be given to factors that will ensure that the intervention is sustainable in the longer-term, for example through integration within existing systems or service pathways.

#### Evaluation quality

- All of the criteria from Level 4 apply.
- Multiple independent replication evaluations studies should be conducted.
- All monitoring and evaluation tools must be available to providers.
- Cost-benefit analysis should have been undertaken.

#### Intervention impact

- All of the criteria from Level 4 apply.
- There should be positive cost-benefit data that indicates that the intervention should at least break even; that is it returns *at least* £1 for every pound invested, or better.

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## Appendix A Expert biographies

### STEVE AOS

Economist Steve Aos is Acting Director of the Washington State Institute for Public Policy. The Institute was created by the Washington State legislature in 1983 to provide non-partisan analysis for state government in Washington State.

He is an expert in cost-benefit analysis, with over 29 years of experience in a range of public policy areas, as well as in the private sector. His current work focuses on identifying and evaluating the costs and benefits of programs and policies for reducing crime, improving educational outcomes, reducing child abuse and neglect, teen pregnancy, and substance abuse in Washington State. He is the lead author of the Washington State Institute for Public Policy's nationally recognized work on the benefits and costs of prevention and early intervention programmes for youth.

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## JON BARON

Jon Baron is founder and current President of the not-for-profit, non-partisan Coalition for Evidence-Based Policy, established in 2001. The Coalition’s mission is to increase government effectiveness through rigorous evidence about “what works”. The Coalition has built a strong track record in working with key Executive Branch and Congressional policymakers to advance evidence-based reforms in major US social programs. The Coalition has been notably instrumental in helping the Obama administration develop a new \$13.5 million evidence-based home visitation program which sets a high evidentiary standard.

He has been nominated twice by the President and confirmed by the Senate to serve on the National Board for Education Sciences (2004-2011) and is the Board’s current Vice-Chair. The Board helps set the research priorities and agenda for the U.S. Department of Education’s Institute of Education Sciences. He has also previously served as the Executive Director of the Presidential Commission on Offsets in International Trade (2000-2001); Program Manager for the Defense Department’s Small Business Innovation Research (SBIR) program (1995-2000); and Counsel to the House of Representatives Committee on Small Business (1989-1994).

## BRIAN FLAY

Brian Flay is Professor of Public Health in the College of Health and Human Sciences at Oregon State University and Director of the Youth Core at Hallie Ford Center for Healthy Children and Families. He was the chair of the Society for Prevention Research committee that worked out a definitive set of standards against which intervention programs could judge their effectiveness.

He is a member of the Editorial Board of Prevention Science (2007-Present), Journal of Health and Mass Communication (2007-Present), American Journal of Health Behaviour (2002-Present) and the Journal of Research on Character Education. In 2008, he received the Service to the Society for Prevention Research (SPR) Award. Research interests include health promotion and disease prevention research; smoking and drug abuse prevention; violence prevention; youth HIV/AIDS prevention; prevention research

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methods and theory; prevention research training.

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## **DELBERT ELLIOTT**

Delbert Elliott is Professor of Sociology and Director of the Center for the Study and Prevention of Violence (CSPV), Institute of Behavioural Science (IBS), University of Colorado. Founded in 1992, the CSPV provides informed assistance to groups committed to understanding and preventing violence. It also facilitates links between the research community, practitioners and policy makers, in an effort to establish more complete and valuable information to impact violence-related policies, programs and practices.

His work is in theory development and testing, primarily in crime, delinquency and violent behaviour. He was Co-principle Investigator on the Omaha Domestic Violence Experiment, the Denver Youth Survey, and OJJDP's National Evaluation of the Diversion Initiative. He is also a Fellow of the American Society of Criminology and has recently completed his term as President of the Society.

The author of several books on juvenile delinquency and behaviour, his most recent work includes *Serious Violent Offenders* (With D. Huizinga and B. J. Morse) and *Beating the Odds: Successful Youth Development in Disadvantaged Neighborhoods*. He has received many national awards including the Public Health Service Medallion for Distinguished Service from U.S. Surgeon General Dr David Satcher in 2001. He attained

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his Masters and Doctorate from the University of Washington, Seattle, and a Bachelor's degree in Sociology from Pomona College.

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