Addressing Health Equity and Social Justice within Prevention Registries: 
**Blueprints for Healthy Youth Development**

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Thank you (!!!) Hendricks Brown, Velma McBride Murray, George Howe and Gracelyn Cruden & Nanette D. Hannah!

PSMG: Prevention scientists conducting cutting edge randomized trials and expert methodologists who are committed to addressing the key design and analysis problems of prevention research.
This series is designed to prompt thoughtful, critical, action-oriented conversations about ways to re-tool, re-build, and re-envision the role of prevention science to address racism and discrimination, using social justice and health equity lenses.

We hope that this series will not only question the status quo, but offer new insights on scientific questions, conceptual and theoretical frameworks, methodological approaches, measurement strategies, interventions, and conclusions about how to promote social justice and health equity.
For whom do the interventions developed in our field work or not work?
The Prevention Research Cycle

Basic Research ➔ Theory ➔ Intervention Development ➔ Intervention External Testing ➔ Scaling Up the Intervention in the Real World ➔ Translation to Global Communities

Observations about the world - an asset to be strengthened, or problem to be addressed.

Understand the extent of the problem, structure of the phenomena involved, etc.

Model Building: developing and testing theories of relationships and change.

Intervention Building and Testing

Intervention Evaluation & Adaptation

Intervention Expansion & Distribution: "going to scale"

Field-Generated Interventions

Synthetic Theories

Prior Research/ Theory

Social Justice Framework

Prevention/Health Promotion: A Researchers’ Perspective
• Recognizing in our theories and work that **opportunities, rewards and sanctions** are not equitably or fairly distributed in our society.
African-American youth are 9 TIMES and Latino youth are 4 TIMES more likely than white youth to receive an adult prison sentence for the SAME CRIME.
We are in the same storm, but not in the same boat.

Different populations experience different challenges in prevention.
• Recognizing in our theories and work that **opportunities, rewards and sanctions** are not equitably or fairly distributed in our society.

• Engaging in **equal partnerships** with participants and community members in our research.
Prevention/Health Promotion: A Researchers’ Perspective

How can we ensure that our intervention is producing the most positive impact for each community who elects to adopt it?

Prior Research/ Theory

Observations about the world - an asset to be strengthened, or problem to be addressed.

Synthetic Theories

Understand the extent of the problem, structure of the phenomena involved, etc.

Model Building: developing and testing theories of relationships and change.

Intervention Building and Testing

Intervention Evaluation & Adaptation

Intervention Expansion & Distribution: "going to scale"

Field-Generated Interventions

Social Justice Framework
Community Members’ Perspective

How can we effectively address youth drug use, violence and related outcomes?

How do we help our children thrive?
A Policymaker/Agency Perspective

How can we know that we are funding and implementing the most effective programs for our communities?

How do we not waste taxpayer dollars?
• Researchers: How can we ensure that our intervention is producing the most positive impact for each community who elects to adopt it?

• Community Members: How can we effectively address youth drug use and violence?

• Policymakers/Agency Staff: How can we know that we are funding and implementing the most effective programs for our communities?
Blueprints!

A web-based registry of experimentally proven programs (EPPs) promoting the most rigorous scientific standard and review process for certification.

www.blueprintsprograms.org
What is Blueprints for Healthy Youth Development?

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www.BlueprintsPrograms.org
What is Blueprints for Healthy Youth Development?

Goal:

To provide researchers, communities and policymakers/agencies with a trusted guide to interventions that work.

www.BlueprintsPrograms.org
Each Certified Intervention has a Fact Sheet including:

- Program Name and Description
- Developmental/Behavioral Outcomes
- Risk/Protective Factors Targeted
- Risk/Protective Factors Impacted
- Contact Information/Program Support
- Target Population
- Program Rating and Effect Size
- Operating Domain: Individual, Family, School, Community
- Logic/Theory Model
- Program Costs: Unit Costs, Start-Up, Implementation, Fidelity Monitoring, Budget Tool
- Cost Benefit/Return On Investment (When Available): Net Unit Cost-Benefit, Benefits
- Funding Overview, Financing Strategies
- Program Materials
- References
Role of Blueprints in this process

- 1521 Reviewed
- 98 Certified
- 6 Model Plus Programs
- 12 Model Programs
- 80 Promising Programs

1996

- **Very Strong** Research Evidence
  - Sustained effect
  - Ready to go to scale

- **Strong** Research Evidence
  - Sustained effect
  - Ready to go to scale

- **Moderate** Research Evidence
  - Suggested for further testing

10 Programs

Recommended to communities to go to scale
Role of Blueprints in this process

- **Intervention Specificity**: participants/outcomes/logic model/intervention implementation
- **Evaluation Quality**: Is the evidence strong?
- Did the intervention have a meaningful impact?
- **Dissemination Readiness**: Is the intervention ready for distribution?

1521 Reviewed
98 Certified
- 6 Model Plus Programs
- 12 Model Programs
- 80 Promising Programs

1996 Present
Blueprints Certification Process

A report says a program works

Report undergoes internal review by Blueprints experts

Report sent for external review by Blueprints Advisory Board Members
Blueprints Advisory Board
Distinguished board with expertise in research design and methodology from a variety of disciplines

Thomas Cook  Delbert Elliott  Abby Fagan  Frances Gardner  Denise Gottfredson

J. David Hawkins  Larry V. Hedges  Karl G. Hill  Velma Murray  Patrick Tolan
Blueprints Certification Process

A report says a program works

Report undergoes internal review by Blueprints experts

Report sent for external review by Blueprints Advisory Board Members

Program Certified (6.9% of those reviewed)

Program Excluded (non-certified)
### Blueprints Classification Framework Criteria

The chart below shows the minimum criteria for each effectiveness category in the Blueprints classification framework. It reflects the predominant effect of quality evaluations when multiple trials are available. A more detailed explanation of the criteria for the categories follows the chart.

<table>
<thead>
<tr>
<th>Evaluation Design</th>
<th>Significant Effect</th>
<th>Sustained Effect</th>
<th>Successful Replication</th>
<th>Research Design Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model Plus</strong></td>
<td>2 Randomized Controlled Trials (RCT), or 1 RCT and 1 Quasi-Experimental Design (QED)</td>
<td>Blueprint behavioral outcome ( p &lt; .05 )</td>
<td>Yes</td>
<td>Independent replication in 1 study</td>
</tr>
<tr>
<td><strong>Model</strong></td>
<td>1 RCT and 1 Replication (RCT or QED)</td>
<td>Blueprint behavioral outcome ( p &lt; .05 )</td>
<td>Yes</td>
<td>1 RCT or 1 QED</td>
</tr>
<tr>
<td><strong>Promising</strong></td>
<td>1 RCT, or 2 QEDs</td>
<td>Blueprint behavioral outcome ( p &lt; .05 )</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Ineffective</strong></td>
<td>1 RCT or 2 QEDs</td>
<td>Blueprint behavioral outcome with Null effects</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Harmful</strong></td>
<td>1 RCT or 2 QEDs</td>
<td>Blueprint behavioral outcome with significant harmful effects</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Inconclusive Evidence</strong></td>
<td>RCTs or QEDs</td>
<td>contradictory or weak findings; evidence can’t be fully supported by design; only 1 quality QED</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Insufficient Evidence</strong></td>
<td>Major design flaw No control group No Evaluation</td>
<td>Design too weak to support findings; or no evaluation or control group</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
N=1521
Interventions Reviewed to date

80.1%

49.5%

30.6%

4.5%

0.9%

0.3%

1.7%

11.5%
The two most common problems

• Failure to establish **baseline equivalence** or deal with baseline non-equivalence
• Failure to test for or deal with **differential attrition by intervention condition**

Common Methodological Problems in Randomized Controlled Trials of Preventive Interventions

Christine M. Steeger, Pamela R. Buckley, Fred C. Pampel, Charleen J. Gust, Karl G. Hill

(under review)
And now, for an even BIGGER problem Blueprints is struggling with...
For whom do the interventions developed in our field work or not work?
Many interventions on these registries were developed and tested in one population...

...but now we would like to implement them in other populations.

- Should we assume that the intervention will not work without adaptation?
- Or should it be implemented exactly as designed in the new community with high fidelity?
Many interventions on these registries were developed and tested in one population...

...but now we would like to implement them in other populations.

Can interventions be transported cross-culturally?
Transportability of interventions across cultures

• One view is that preventive interventions are effective in new cultural contexts
  – only if there is an extensive multi-stage adaptation process (Castro, et al.)
  – if there is limited “cultural distance” between the populations (Sussman, et al.)

• However, meta-analyses of cross-country transportability do not necessarily support this.
Transportability of interventions across cultures

Examined 17 studies that transported four parenting interventions.

Three were originally designed and tested in the United States
- Incredible Years
- Parent–Child Interaction Therapy [PCIT]
- Parent Management Training Oregon [PMTO]

and one in Australia
- Triple P

Gardner, et al. (2016)

Frances Gardner
Transportability of interventions across cultures

Canada, Iceland, Iran, Ireland, Sweden, Holland, Puerto Rico, Norway, Hong Kong, the United Kingdom
Transportability of interventions across cultures

values than those ranked more individualistic. There were no differences in effects by country-level policy or resource factors. Contrary to common belief, parenting interventions appear to be at least as effective when transported to countries that are more different culturally, and in service provision, than those in which they were developed. Extensive adaptation did not appear necessary for successful transportation.

*Intervention, University of Oxford*

Gardner, et al. (2016)
Transportability of interventions across cultures

What about indigenous communities in the US & Canada?

Compared CTC risk and protective factors for 5,095 self-identified Native American youth to those of 284,000 youths in a nationally representative CTC database.
## Transportability of Interventions Across Cultures

Scale reliabilities were similar across the two groups.

### Community Domain

<table>
<thead>
<tr>
<th>Scale Description</th>
<th>Full Sample</th>
<th>Native American Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1: Positive Community Opportunities</td>
<td>0.77</td>
<td>0.76</td>
</tr>
<tr>
<td>C2: Positive Comm. Rewards</td>
<td>0.82</td>
<td>0.80</td>
</tr>
<tr>
<td>C3: Low Neighborhood Attachment</td>
<td>0.80</td>
<td>0.78</td>
</tr>
<tr>
<td>C4: Comm. Disorganization</td>
<td>0.82</td>
<td>0.82</td>
</tr>
<tr>
<td>C5: Personal Transitions and Mobility</td>
<td>0.71</td>
<td>0.73</td>
</tr>
<tr>
<td>C6: Laws and Norms Favorable to Drug Use and Firearms</td>
<td>0.81</td>
<td>0.80</td>
</tr>
<tr>
<td>C7: Perceived Availability of Drugs and Firearms</td>
<td>0.88</td>
<td>0.88</td>
</tr>
</tbody>
</table>

### Family Domain

<table>
<thead>
<tr>
<th>Scale Description</th>
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<th>Native American Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1: Family Attachment</td>
<td>0.81</td>
<td>0.77</td>
</tr>
<tr>
<td>F2: Family Opportunities for Positive Involvement</td>
<td>0.82</td>
<td>0.80</td>
</tr>
<tr>
<td>F3: Family Rewards for Positive Involvement</td>
<td>0.80</td>
<td>0.78</td>
</tr>
<tr>
<td>F4: Poor Family Supervision</td>
<td>0.80</td>
<td>0.80</td>
</tr>
<tr>
<td>F5: Poor Family Discipline</td>
<td>0.83</td>
<td>0.80</td>
</tr>
<tr>
<td>F6: Family Conflict</td>
<td>0.73</td>
<td>0.72</td>
</tr>
<tr>
<td>F7: Family History of Antisocial Behavior</td>
<td>0.85</td>
<td>0.86</td>
</tr>
<tr>
<td>F8: Parental Attitudes favorable to ATOD Use</td>
<td>0.86</td>
<td>0.88</td>
</tr>
<tr>
<td>F9: Parental Attitudes favorable toward Antisocial Behavior</td>
<td>0.83</td>
<td>0.84</td>
</tr>
</tbody>
</table>

### School Domain

<table>
<thead>
<tr>
<th>Scale Description</th>
<th>Full Sample</th>
<th>Native American Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1: School Opportunities for Prosocial Involvement</td>
<td>0.65</td>
<td>0.70</td>
</tr>
<tr>
<td>S2: School Rewards for Prosocial Involvement</td>
<td>0.72</td>
<td>0.73</td>
</tr>
<tr>
<td>S3: Poor Academic Performance</td>
<td>0.63</td>
<td>0.60</td>
</tr>
<tr>
<td>S4: Low School Commitment</td>
<td>0.69</td>
<td>0.69</td>
</tr>
</tbody>
</table>

### Peer/Individual Domain

<table>
<thead>
<tr>
<th>Scale Description</th>
<th>Full Sample</th>
<th>Native American Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>I1: Low Perceived Risks for Drug Use</td>
<td>0.87</td>
<td>0.86</td>
</tr>
<tr>
<td>I2: Early Initiation of Drug Use and Antisocial Behavior</td>
<td>0.80</td>
<td>0.78</td>
</tr>
<tr>
<td>I3: Sensation Seeking</td>
<td>0.79</td>
<td>0.81</td>
</tr>
<tr>
<td>I4: Gang Involvement</td>
<td>0.90</td>
<td>0.90</td>
</tr>
<tr>
<td>P1: Social Skills</td>
<td>0.65</td>
<td>0.69</td>
</tr>
<tr>
<td>I5: Belief in the Moral Order</td>
<td>0.70</td>
<td>0.71</td>
</tr>
<tr>
<td>I6: Rebelliousness</td>
<td>0.74</td>
<td>0.76</td>
</tr>
<tr>
<td>P2: Friends’ Delinquent Behavior</td>
<td>0.89</td>
<td>0.89</td>
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<td>P3: Friends’ Use of Drugs</td>
<td>0.87</td>
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<td>0.84</td>
<td>0.87</td>
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<td>0.88</td>
<td>0.89</td>
</tr>
<tr>
<td>I9: Religiosity</td>
<td>N/A (only one item)</td>
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(table continued in next column)
Scale reliabilities were similarly reliable across groups.

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Transportability of interventions across cultures

Prediction of outcomes was similar across the two groups

Predicting Regular Alcohol Use in Adolescence

- Full Sample
- Native American

Odds of Regular Drinking
Transportability of interventions across cultures

CTC survey measures of risks, protection and outcomes are reliable and valid within this Native American youth sample.
Transportability of interventions across cultures

Potential other factors influencing health and health-related behaviors beyond the RPFs measured here that are specific to the circumstances in which Native American youth grow up.

- institutional racism
- disparities in access to and delivery of health services
- exposure to trauma
- stressors related to discrimination
- historical trauma
- colonization
- loss of culture specific to their sociohistorical context
- dissonance between cultural ideals and behavioral realities

- involvement in traditional and spiritual practices
- cultural identity
- presence of strong extended families and social networks that can provide culturally competent care
Transportability of interventions across cultures

"Your interventions from America aren’t replicating here in Europe."
emic & etic approaches in research

Kenneth Pike (1967) – Linguistics $\rightarrow$ cultural anthropology
   x-cultural social sciences

- **emic** - behavior has to be understood in the context of the culture in which it occurs

- **etic** - cultural differences in a behavior can be considered as variations on a common theme
emic examples

A Blueprints certified promising program for African American parents and their early adolescent children, designed to reduce adolescent substance use, conduct problems, and sexual involvement.

A Blueprints certified promising multilevel family-based intervention designed to prevent substance use and sexual risk behavior in Hispanic adolescents.
Promoting First Relationships was validated on a sample of families with an open child welfare case (Oxford et al., 2016); 77% of parents were white.
This intervention was THEN tested with American Indian families living on a rural reservation.

Authors adapted the program to increase cultural relevance based on focus groups with tribal community members and hired members of the tribal community to assist with implementation.

Adaptations included:
1. a unique name for the program
2. a study logo by a Native artist
3. longer home visits to include more time for conversation
4. a small gift for the child at research visits
5. a handout about caregiver-child transitions and separations

An experimental pilot study found improved child-caregiver outcomes for families in the treatment group compared to control families.
For whom do the interventions developed in our field work or not work?

At this point, both emic and etic strategies are needed.
Thoughtful and deliberate alteration to the delivery of an intervention to improve its fit in a given context (i.e., adaption) can lead to improved engagement, acceptability, and outcomes.

https://cancercontrol.cancer.gov/is/tools/practice-tools
What You Can Do: **Balance Fidelity and Adaptations**

Making too many changes to an intervention can reduce its original effectiveness, or worse, introduce unintended and harmful outcomes.

Before making adaptations to the intervention, you should think about how the change to the original intervention can improve the fit to your community, setting, or target population, and at the same time, maintain fidelity to the core components of the original intervention. Think of possible adaptations as you would a green, yellow, or red traffic light: green light changes are usually OK to make; yellow light changes should be approached with caution; and red light changes should be avoided when possible.¹²

**GREEN LIGHT CHANGES**

- Usually minor
- Made to increase the reach, receptivity, and participation of the community
- May include:
  - Program names
  - Updated and relevant statistics or health information
  - Tailored language, pictures, cultural indicators, scenarios, and other content

**YELLOW LIGHT CHANGES**

- Typically add or modify intervention components and contents, rather than deleting them
- May include:
  - Substituting activities
  - Adding activities
  - Changing session sequence
  - Shifting or expanding the primary audience
  - Changing the delivery format
  - Changing who delivers the program

**RED LIGHT CHANGES**

- Changes to core components of the intervention
- May include:
  - Changing a health behavior model or theory
  - Changing a health topic or behavior
  - Deleting core components
  - Cutting the program timeline
  - Cutting the program dosage

https://cancercontrol.cancer.gov/is/tools/practice-tools
Addressing Health Equity and Social Justice within Prevention Registries

• The question is not only how do you implement interventions with fidelity, but with whom have these interventions been tested?

• If there is a need for adaptation, can we (Blueprints) provide some guidance from the developers?

• In order to inform the debate, we need to know for which populations have these interventions already been tested.

• We need basic baseline data.
Karl’s references


Karl’s references


Also lots here: https://www.blueprintsprograms.org/publications/
Addressing Health Equity and Social Justice within Prevention Registries

Pamela R. Buckley, PhD
University of Colorado Boulder
In collaboration with Velma McBride Murry, PhD

Examining the Representation of Ethnic Minority Groups in Preventive Intervention Research

Prevention Science and Methodology Group
Systemic Racism and Prevention Science:
Enhancing Social Justice to Achieve Health Equity
May 18, 2021
Lack of representation of youth of color in health-related research studies is well-documented (Fisher & Kalbaugh, 2011).

A critical evaluation of this omission has not been undertaken to substantiate this claim.

Necessary for prevention or intervention efforts focused on social, behavioral, and educational outcomes to ID for whom do interventions work, under what conditions, and serving which outcomes?

Why?

- If researchers do not specify target populations, practitioners are vulnerable to misinterpreting relative strength of evidence even if it is well-defined.
- Misinterpretation risks over- or under-ascribing an intervention’s utility to be scaled up or implemented across settings.
Literature Review

Gaps in research on racial/ethnic minoritized groups that impede effectiveness of preventive interventions, including:

- Insufficient attention to protective processes that prevent and avert risk (Murry et al., 2018).
- Discounting input and guidance from community stakeholders of diverse communities (Supplee & Meyer 2015)
- Overlooking crucial information about how to effectively transition interventions from white to racial/ethnic minority populations (Rousseau & Gunia 2015).

Interventions validated with largely white samples are often recommended for all populations.

Heightens external validity concerns about widely disseminated interventions that are tested for one group but exported, perhaps uncritically, to others.
Purpose

• Using data collected by Blueprints, we are launching a systematic review of the representation of ethnic minority groups in preventive intervention research.

• Blueprints is the longest standing clearinghouse, among up to 20 within the United States alone (Burkhardt et al., 2015).
• **Objective:** To examine the prevalence of transparent research practices for studies reviewed by Blueprints between 2018-2019.

• **Examine the rate of:**
  - Public availability of data, code and research materials used to conduct confirmatory research.
  - Prospective registration or registration before data analysis.
  - Discrepancies between confirmatory research reported in the trial registration (i.e., registered primary outcomes) and those included in articles (i.e., published primary outcomes).

• **Conclusion:**
  - Preventive intervention research needs to be more transparent.
  - Clearinghouses rely on robust findings to make well-informed decisions and researchers are incentivized to meet clearinghouse standards.
  - Clearinghouses should consider policies that encourage transparency to improve the credibility of evidence-based interventions.
Aims

To develop codes that identify groups by race, ethnicity, gender, and economic status.

To apply these codes to samples recorded in the Blueprints database and conduct a descriptive analysis of these codes.

To identify additional considerations of importance to inform and guide preventive intervention research, such as cultural adaptation, competence, modification, and responsiveness.

To submit a manuscript (*Prevention Science*) that examines the representation of ethnic minority groups in preventive intervention research overall, and by subgroup (e.g., geographic location of the study, outcomes reported, target age, etc.).
Steps for Synthesizing Research

Cooper’s (1998) classic text

1. Formulating the problem (background/literature review)
2. Searching the literature
3. Gathering information from studies (coding)
4. Analyzing outcomes of the studies (descriptive analysis)
5. Interpreting the findings
6. Presenting the results
Inclusion Criteria

**Impact studies** (research conducted to determine the efficacy or effectiveness of a preventive intervention or strategy).

**Interventions for youth designed to:**

- Prevent or reduce negative behavioral health outcomes (e.g., mental health problems, substance use, delinquency/crime, and other health-related behaviors)
- Promote positive development (e.g., academic achievement or prosocial behavioral outcomes).

**Target ages under 25 years** (includes post-secondary education and early employment experiences).

**Published between 2010 and 2020** (to examine trends).
<table>
<thead>
<tr>
<th>Evaluation Design Studies</th>
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<tr>
<td><strong>Randomized Control Trials (RCTs)</strong></td>
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<tr>
<td><strong>Cluster Randomized Control Trials (c-RCTs)</strong></td>
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<td><strong>Quasi-Experimental Design studies (QEDs)</strong></td>
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</table>
Exclusion Criteria

- Interventions with a sole focus on evaluating treatment programs for diagnosed or clinical-level mental health problems (e.g., medical or pharmacological interventions).
- Pre/post design studies (without a control group).
- Process evaluation studies (with no impact analysis).
Target studies in the grey literature and journal articles.

Use Boolean operators to create multiple search terms:

• Several clauses are used to select academic journals.
• Search terms are applied to locate outcomes for youth relating to physical and mental health, delinquency, education, prosocial behavior, and problem behavior.
• Boolean operators are entered into the Web of Science search engine (multiple academic disciplines).

Search blogs, other registries, and research sites.

Accept self-nominations from developers and researchers.
Sample

• Each program can have 1+ evaluation studies.
• Blueprints database:
  ✓ 3,925 studies (1,569 interventions) entered since 1996 when Blueprints started.
  ✓ 1,649 studies (922 interventions) published from 2010 on.
Coding Instrument

Program-level codes (name, BPs rating, target age, primary outcomes)

Specific group(s) explicitly targeted by the intervention:

• Asian or Asian American
• Black or African American
• Native American or American Indian or Alaska Native
• Native Hawaiian or Pacific Islander
• White
• Hispanic or Latino
• Gender
• Youth in rural communities
• Youth in urban communities
• Low-income youth and families
• No group explicitly targeted
Study-Level Codes (Setting)

- Research design (RCT, c-RCT, QED)
- Country (USA or outside the USA)
- Locale (rural, suburban, urban)
- Region (Northeast, Midwest, South, West, U.S. Territories)
- Sample size (individual, cluster)
- Certified by Blueprints?
  - Indicating well-designed and well-implemented (i.e., high internal validity – see Steeger, Buckley et al., 2021).
Study-Level Codes: Racial Composition

- Census Bureau collects racial data in accordance with guidelines provided by the U.S. Office of Management and Budget (OMB).
- Racial categories reflect a social definition of race recognized in the US and not an attempt to define race biologically, anthropologically, or genetically.
- OMB requires five minimum categories:
  - % Asian or Asian American
  - % Black or African American
  - % Native American or American Indian or Alaska Native
  - % Native Hawaiian or Pacific Islander
  - % White
Definitions of Race (OMB)

- **White** – origins in any of the original peoples of Europe, the Middle East, or North Africa.
- **Black or African American** – Origins in any of the Black racial groups of Africa.
- **American Indian or Alaska Native** – Origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
- **Asian** – Origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- **Native Hawaiian or Other Pacific Islander** – Origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
Additional Race Composition Codes

% Multi-Racial (must clearly be specified this way)

% Not Specified

- Percentages for only some racial groups
- Latino/Hispanic
Ethnicity

- Race and Ethnicity are distinct identities according to the US Census.
  - Ethnicity is a grouping of people who identify with each other based on shared attributes that distinguish them from other groups.
  - E.g., common set of traditions, ancestry, language, history, society, culture, nation, religion or social treatment within their residing area.
- Hispanic or Latino origin asked as a separate question on the US Census.
Study-Level Codes: Ethnic Composition

• **Codes:**
  - % Hispanic or Latino
  - % Not Hispanic or Latino (remainder of sample)

• **Definition:** The US OMB defines "Hispanic or Latino" as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.
Study-Level (Additional) Codes

Gender
- % Male
- % Female
- % Other

Economic Disadvantage (e.g.):
- % Qualifies for the free/reduced lunch (FRL) program
- % Receives Medicaid
- % Pell-Eligible
- % Qualify for the Children's Health Insurance Program (CHIP)
Status of Study

Pilot test

- Round 1: Met with Dr. Murry, Buckley and team (2 additional coders) to code studies not in our sample to develop then pilot the codebook
- Round 2:
  - Dr. Buckley and team (2 additional coders) double-coded 24 studies
  - Rotation so all 3 team members code studies with one another
  - Revised code book instructions

Inter-Rater Reliability (IRR)

- Cohen’s kappa (categorical outcomes) and the ICC (continuous outcomes)
- Standards: < .5 Poor, .5-.75 Moderate, .75-.9 Good, >.9 Excellent
- Pilot data (n = 24) IRR = .82

Training
Establishing the internal validity of interventions is the dominant focus across most clearinghouses.

However, issues of external validity are salient as EBI developers wrestle with barriers to implementation.

Clearinghouses are positioned to play a useful role in identifying gaps in implementation to address external validity concerns.

This study is part of a larger effort to address the issue of cultural representation in preventative intervention research.
Blueprints 4 Standards

- **Intervention Specificity**: Intervention description clearly identifies
  - The intended outcome(s)
  - Whether specific risk &/or protective factors are targeted to produce this change
  - The population for which the intervention is intended
  - How the components of the intervention work to produce this change

- **Evaluation Quality**: The evaluation trials produce valid and reliable findings.
  - See Steeger, Buckley et al. (2021)

- **Intervention Impact**: Preponderance of evidence from high-quality evaluations show significant positive change and no evidence of harmful effects.

- **Dissemination Readiness**: The intervention is currently available for dissemination and has the necessary support required for implementation with fidelity.
  - Description of the sample(s) in which the intervention was validated.
  - Critical examination of transporting the intervention to other samples (one tool – meta-analysis).
References


Thank you!