TESTIMONY TO THE LITTLE HOOVER COMMISSION
May 22, 2003

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Thank you for the invitation to participate in this public hearing. There has been increasing interest in our developing Accountability System and I'm happy to provide a brief summary of it and answer any questions you might have.

A number of years ago we recognized that Arizona had many programs to combat substance abuse, violence and gangs, but didn't know whether they were accomplishing anything. The Arizona Legislature enacted legislation* creating both a Drug and Gang Policy Council* and an Arizona Prevention Resource Center** to, among other things, determine if funding was making an impact.

The first step was to determine total dollar amount spent, on what kinds of programs and in which locations. This past year we tracked over $150 million in expenditures. A copy of the Inventory is available for your perusal.

It became increasingly clear that if we were to determine the impact of the funds – and if we were to assist the state to maximize the potential of those funds – we needed a comprehensive system in place to provide legislators and state agencies information on which to make informed decisions.

So began the development of Arizona's Statewide Accountability and Capacity Building System – largely funded by federal grants from the U.S. Department of Education and the U.S. Department of Health and Human Services for over $2 million.

The Accountability System consists of a number of important tools developed within the past three years by the Arizona Prevention Resource Center to assist the State's policymakers with informed decision-making. Developing these elements has demanded commitment, creative energy and well tested expertise.

Under-girding the Accountability System are three basic themes: (1) investment in prevention and early intervention returns human and financial benefits that the alternatives, especially incarceration, do not; (2) a genuine rather than rhetorical government-wide pledge of collaboration in planning and funding programs will lead to greater community impact; (3) better programming and more effective policy will result from data-based decision making.

By most objective reckonings, the system and its elements seem to belabor the obvious, namely that a comprehensive approach is a prerequisite for making a positive difference. Yet no such model characterizes state efforts around the country. Sophisticated indicators of progress (or lack of it) in reducing specific social ills are rarely and then only unevenly available (hence the Statewide and Community Scorecards). Few states do a credible job inventorying exactly what their programs and agencies are doing in prevention, early intervention and treatment within their cities, communities and neighborhoods (Program Inventory). Replication and adaptation of the best quality programs that are research-based and are succeeding elsewhere is

* Descriptions of these are available upon request.

still rare or wildly irregular (Promoting Effective Practices, Symposium on the Disconnect between Research and Practice, Conducting Statewide Evaluation). Few states can demonstrate that they have done a thorough job of ascertaining accurately just what needs of their communities remain to be met (Systematic Appraisal of Needs, Statewide Parents Survey). Few states have state level Policy Council that controls and oversees over $150 million annually devoted to reducing substance abuse and related issues (Policy Agenda). And only now are some states attempting to utilize the sophisticated mapping techniques of a state-of –the-art Geographic Information System (GIS) to track and analyze precisely where its resources and those provided by the federal government are needed and deployed.

These are the components of Arizona's unique and comprehensive Accountability System. This system assays nothing less than a far reaching analysis of the state's progress in reducing and/or even eliminating a seemingly endless range of destructive pathologies and behaviors, an effort costing Arizona over $150 million annually in programming and an estimated $2-3 billion in consequences. It will allow Arizona to develop a more sensible distribution of resources and redirect dollars from ineffective to effective programs and to neighborhoods and communities where the greatest needs exist. It will track how successful we've been over the years in which communities and by what standards. By potentiating the $150 million it should reduce the social, behavioral and economic costs of this serious problem.

Finally such a system can and should serve as a prototype for the nation not replicated exactly as it operates in Arizona but providing a model in coherence and effectiveness.

The system is actually designed to address the following questions:

- What programs are being funded? In what amounts?
- Are effective programs reaching the people who need them?
- How effective are the programs in Arizona that are not nationally evaluated?
- What kind of needs exist?
- Where are the needs the greatest?
- Should the state develop funding priorities based on geographical area., age. etc.?
- What has been learned about program effectiveness from the research?
- What is the impact of that knowledge on accountability?
- What needs to be done to assure that the most effective programs are implemented?
- How can we be certain that funds are in the hands of skilled providers?
- What are the implications for policy decisions based on the above?

Ongoing refinement has led to four basic goals in order to realize our larger goal of achieving greater impact in Arizona's communities in reducing substance abuse and violence and building community capacity:

- Secure accurate and useful data on program and practice effectiveness.
- Develop a measurement system that serves as a basis for accountability and policy decisions.
- Fund effective programs at a level that will make a difference.
- Assure the capacity of service delivery to implement effective programs and practices with fidelity.

Let me elaborate briefly on two critical issues that may need further explanation: that of selecting evidence based programs and implementing them with fidelity.

Up to ten years ago, there were few prevention or intervention programs designed to reduce or eliminate health-compromising behavior of children and adolescents that were scientifically demonstrated to be effective. Indeed, with respect to delinquency, violence, and substance abuse programs, the scientific community's judgment was that nothing had been demonstrated to work. During the last decade, however, we have seen a major research breakthrough - a number of prevention and intervention programs have been demonstrated in clinical trials and rigorous evaluations to be effective. The potential for a major initiative to reduce these health-compromising behaviors has moved to the forefront of the national agenda.

The emphasis on research-based practice has led communities to search for efficacious programs that would be most effective and appropriate for their problems and population. To eliminate the need for the public to conduct detailed program searches, various organizations have produced lists of "model" programs that demonstrate some evidence of effectiveness, but the scientific criteria for selecting these programs varies from list to list; unfortunately there is little agreement by researchers on a common standard for model programs. These lists tend to be more confusing than helpful to the public. In fact, one must be diligent when examining the lists to ensure that at least a minimal scientific standard has been applied; for example, that programs demonstrate effectiveness using, at a minimum, a research design that includes a comparison (i.e., control) group. Anything less rigorous than this approach cannot provide even minimal evidence to justify disseminating and implementing programs on a wide scale, but there are greater standards we should adhere to (randomization, replicability, sustainability, cost-effectiveness, etc).

We have many lessons from other fields (medicine, social policy, etc.) about how commonly used practices are based on erroneous conclusions and lead to practices that are ineffective at best – or harmful.

> "A recent, well-publicized example is hormone replacement therapy for postmenopausal women. Over the past 30 years, more than two dozen epidemiological studies (a type of comparison-group study) have found hormone therapy to be effective in reducing the women's risk of heart disease and stroke. But when hormone therapy was finally evaluated in two large-scale randomized trials – medicine's "gold standard" – it was actually found to do the opposite – namely, it *increased* the incidence of heart attacks and stroke, as well as breast cancer.

Many other important examples exist of medical interventions that initially appeared effective in comparison-group studies, but which were subsequently found in large-scale randomized trials to be ineffective or harmful. For instance:

-enriched oxygen environments for premature infants (found to be harmful);
- beta carotene and vitamin A to prevent lung cancer (found harmful);
-idoxuridine to treat herpes encephalitis (found harmful);
-bone-marrow transplants for women with advanced breast cancer (found ineffective);
-angiotensin-converting-enzyme inhibitors to prevent cancer (found ineffective);
-dietary salt restriction to reduce hypertension (found only marginally effective).

Important examples also exist of interventions that initially appeared ineffective or harmful in comparison-group studies, but which were subsequently proven effective in randomized trials. For instance:

-anti- hypertensive therapy to prevent coronary heart disease;
-aspirin to reduce the risk of major coronary events;
-digoxin for patients with heart failure.

If randomized trials of these medical interventions had never been carried out and the comparison-group results had been relied on instead, the result would have been needless death or serious illness for millions of people." [1]

It is clear that a high standard is necessary if model programs are to be widely disseminated, a standard that virtually guarantees that the program will be effective if implemented with fidelity. Most local program agencies have neither the expertise nor the resources to undertake rigorous evaluations to determine program effectiveness. We cannot risk losing the public confidence in the research community that has been achieved to date by putting forth programs that prove in practice to be ineffective. We have to be *very* confident programs will work before recommending them as model programs for widespread adoption.

Although the work in identifying model or exemplary programs with agreed-upon standards must continue, the fact that we do have some highly effective programs requires that we move beyond this initial step and establish effective marketing and dissemination strategies to demonstrate the utility of these programs. We must also help agencies and communities to select appropriate programs and to implement these programs with fidelity. This will involve helping program designers to build training and technical assistance delivery systems, provide formal certification of trainers, develop the information and tools designed to enhance a sites' readiness and ability to adopt and implement a program, and the establishment of an effective monitoring system to oversee implementation fidelity.

[1] Extracted from a draft report "Bringing Evidence-Driven Programs to Crime and Substance Abuse Policy: A Recommended Federal Strategy", Coalition For Evidence-Based Policy, April 30, 2003

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While the last decade has shown great promise in identifying effective programs, the prevention field has lagged behind in effectively disseminating these programs and insuring their implementation with fidelity. To fail to move forward at this critical juncture would risk losing the momentum achieved in recent years and the opportunity for achieving a significant reduction in health compromising behaviors in the next generation of children and youth. We must convince the public to make better utilization of the limited resources available to address youth violence, delinquency, substance use, teen pregnancy, depression, and other health compromising behaviors. This means that we must avoid pouring our limited resources into programs that have been demonstrated to be ineffective at best and in some instances, harmful; and invest in programs that are truly effective in preventing or reducing the magnitude and consequences of these behaviors.

A final note about Arizona – We are most interested in infusing such a system in Arizona – rather than it be a pilot or innovative federally funded effort. Therefore, we have been seeking legislation that would make this system a part of the fabric of the state. We see such a system as completing an infrastructure to facilitate the state in genuinely reducing substance abuse and violence by enabling informed decisions, and building selection and implementation capability in communities.