



POLICY BRIEF

# The Trump Administration Deals a Blow to Evidence-Based Policy

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*October 2018*



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We intend to tell an unfortunate Washington tale of how the best-laid plans to inject science into policymaking can be abruptly disrupted by a new administration, even when the actions of the new administration have been found to be illegal. Our story has four parts. The first is the creation of the evidence-based movement, which aimed to ensure that social programs were based on evidence of success and that the interventions (box 1) were rigorously evaluated to determine whether they were continually succeeding and improving. We focus attention on one of those programs, the Teen Pregnancy Prevention (TPP) program, which was established during the Obama administration and which the Trump administration has tried to dismantle. The TPP program aims to test and expand teen pregnancy prevention models that are designed to address the ongoing challenge of teen pregnancy. Despite substantial progress, the United States still has higher teen birth rates than most other developed countries (roughly one in four US women still becomes pregnant before age 20),<sup>1</sup> and there are still significant disparities in teen birth rates by race and ethnicity and geography. With a modest investment of approximately \$100 million annually and a strong commitment to high-quality, evidence-based approaches, the TPP program served nearly 500,000 teens in 39 states and Washington, DC, in its first round of five-year projects and contributed significantly to building evidence. The second round of projects built on this experience is on track to serve 1.2 million youth and to generate even more knowledge.

#### BOX 1

##### Key Terms

While terms like program, intervention, and model are often used interchangeably, for the purposes of this paper, we are using terms in the following ways:

- A **program** is an overarching funding stream or initiative, such as the Teen Pregnancy Prevention Program.
- An **intervention** is a specific strategy or model that can be evaluated to assess impacts.
- A **model** is a specific curricula or educational program that can be evaluated to assess impacts, such as one of the 48 evidence-based models on the HHS Teen Pregnancy Prevention Evidence Review.
- A **project** is an individual grant funded by a funding stream that is implementing a specific model.

The first part in our story includes the results of a five-year experiment with 41 of these projects that were published in one of the most thorough and extensive releases of program evaluation studies in the history of government programs, and the initiation of a second round of TPP projects informed by those results. The second part provides detail on how the Trump administration tried, on what we regard as ideological grounds, to kill the second round of projects and divert the money to pay for different projects the administration favored. The third part presents the response of the TPP program's supporters to the incursions by the Trump administration. This part includes encouraging tales of

responses from the projects in the network that the Trump administration attempted to decimate, from Congress (including Republicans and Democrats), and from the courts.

In the final part, we draw conclusions about what we have learned from this episode concerning the commitment of the Trump administration to evidence as well as the possible impacts of the administration's actions on the future of evidence-based policy. One major lesson is that the enterprise of developing evidence and applying it to policy choice is undermined when the evidence is used as a weapon to win a political argument rather than as a tool to improve policy and programs.

## ≡ Origins of the Teen Pregnancy Prevention Program

Although the evidence-based movement of applying scientific evidence to policy choice was gathering steam when Obama became president in 2009, his administration solidified and elevated the movement to an entirely new status. The most important achievement of the Obama administration in stimulating the movement was to create six new programs based on a general conception of how scientific evidence of program success could be used to initiate and improve social programs.<sup>1</sup> Based in large part on the gathering wisdom of the field before 2008, the Obama administration conceived, fought for, and worked with Congress to enact all six programs, mostly on a bipartisan basis.

Now, nearly a decade later, these six programs have experienced somewhat different trajectories. One was gone within four years (the Trade Adjustment Assistance Community College and Career Training Initiative)<sup>2</sup> and one (the Workforce Innovation Fund) was subsumed into the Workforce Innovation and Opportunity Act of 2014. Another program failed to receive new funding after fiscal year 2016 (the Social Innovation Fund). The other three of the original six are still in existence and being funded, although one went through an evolution (the Innovations in Education Fund, or i3, was replaced by the Education Innovation and Research program).<sup>3</sup> Most important, two of the original programs have achieved a high degree of prominence in the nation's capital and around the nation. One of these is the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), which is supported by a \$400 million yearly appropriation, operates in all 50 states, and serves about 80,000 families annually, most of which are in poverty.<sup>4</sup> Rigorous evaluations of many of the MIECHV models have been conducted and analyzed and will soon be released to the public.

The second is the TPP program, which has four features—all of which are shared with the MIECHV program—that are now widely accepted in the evidence-based world as the expected features of evidence-based programs.<sup>5</sup> These four features are (1) use of model interventions that are already supported by strong evidence; (2) evaluation of outcomes by use of rigorous evaluation designs to ensure the interventions continue to produce impacts; (3) investment in rigorously evaluating promising approaches to continue expanding the number of evidence-based interventions; and (4) close cooperation among the projects and with the federal agency overseeing the programs.

Around the time the TPP program was enacted, Congress also established a complementary evidence-based adolescent pregnancy prevention program called the Personal Responsibility Education Program that shares the two-tiered structure of the TPP program and MIECHV, with most of the funding allocated through formula grants to states and a smaller amount dedicated to evaluating innovative approaches.<sup>6</sup> A word is in order about each of these features, which together support a fundamental goal of the evidence-based movement: to develop, evaluate, and continuously improve model interventions. The vision here is to find or create interventions that address each of the nation's social problems and that have been thoroughly tested and shown to produce impacts on the problem. This approach is important because most social programs have not been rigorously evaluated and, when they are, they usually do not produce impacts.<sup>7</sup>

Thus, the first feature of the evidence-based approach must be to locate, by reviewing past evaluations or developing new programs, models that are capable of producing impacts. The Department of Health and Human Services (HHS), in the cases of both the MIECHV and TPP programs, initiated work with Mathematica Policy Research to identify the respective home visiting and teen pregnancy prevention models that had been shown to produce significant impacts. In the case of the TPP program, this independent, systematic Teen Pregnancy Prevention Evidence Review,<sup>8</sup> managed by HHS's evaluation experts in the Office of the Assistant Secretary of Planning and Evaluation, focused on interventions evaluated by rigorous designs that demonstrated impacts in changing behavior, specifically some aspect of teen sexual activity or pregnancy itself. The initial Evidence Review of hundreds of teen pregnancy prevention evaluations, released in 2010 before the first TPP projects were awarded, found 28 models with rigorous evidence of impacts (these were the models eligible for replication by the first cohort of TPP Tier 1 projects). The review has been regularly updated as more evidence has emerged. The most recent version of the review, released in 2018, found 48 models that had rigorous evidence of producing at least one impact on a sexual risk behavior or reproductive health outcome.<sup>9</sup>

The Evidence Review examines a variety of models, including those that focus on abstinence, those that address both abstinence and contraception, and those that focus on healthy relationships and youth development. What these have in common is a high standard of evidence. To qualify, each study had to meet high criteria for quality, execution of research design, and demonstrated impact. The resulting menu of effective model programs allows communities to choose interventions that best meet the needs of young people in their communities at different points in their lives. For example, the Mary Black Foundation, a TPP grantee in Spartanburg County, South Carolina, worked with community partners to select and implement several different models, with an abstinence-focused model for younger teens, a school-based model for middle- and high school-age youth, a model that focuses more on contraception for older teens and those in the foster care and juvenile justice systems, and one that focuses on healthy relationships for parenting teens.<sup>10</sup> This Evidence Review is one of the federal, state-level, and privately managed clearinghouses of evidence-based programs included in the Pew-MacArthur Results First Clearinghouse Database. Such clearinghouses are recognized as a key component of the evidence-based movement.<sup>11</sup>

As required by Congress, 75 percent of TPP funding is for competitive grants that replicate the model programs shown to be effective in changing behavior through rigorous evaluation (called Tier 1 projects). In addition to demonstrating behavior change, HHS required that to qualify as evidence based, models must feature a written curriculum and a guidebook that outlines how program operators should implement that curriculum. Although much more than a curriculum guide is required to ensure that new sites know the major elements of a model program and how they should be implemented, part of the process of building evidence is building a strong set of guidelines that will help new operators replicate the model. The ability to replicate model interventions is one of the most important challenges of the evidence-based movement. It is especially helpful if the model originators and subsequent operators who use the programs can identify the one or two most important features of the program—the “active ingredients,” so to speak. Another challenge is to strike a balance between retaining fidelity to the original model and allowing enough flexibility to adapt the model to meet the needs of different populations and places.

The second fundamental feature of the teen pregnancy prevention programs is a focus on continuing to evaluate the interventions by using rigorous evaluation designs. Over the years, the field of program evaluation has developed strong methods that allow evaluation of almost any intervention to find out if it actually produces the impacts it seeks to.<sup>12</sup> Many interventions have been evaluated using designs that make showing impacts easier than it should be, often because they begin with experimental and control groups that are not equivalent. These evaluations often turn out to be unreliable. In fact, one reason that continued evaluation of models identified as evidence based is important is that attempts to replicate models in new sites often fail. The evidence-based movement is attempting to identify models that can be replicated in scores or even hundreds of locations throughout the country. Rigorous evaluation and replication is hard, and the field of program evaluation is littered with interventions that produce impacts according to initial evaluations (including ones that were rigorous and high-quality) but fail to replicate those impacts in subsequent ones. Experts find that only 10 to 20 percent of randomized evaluations of intervention programs demonstrate positive results.<sup>13</sup> This component of the movement is important because without a way to know if even successful programs can be replicated, the enterprise falls apart. Although the exact interpretation of the outcomes of rigorous evaluations is often disputed (especially how important the results of a single evaluation might be), few issues in social science are easier for scientists to agree on than that multiple evaluations showing impacts by a given program model signal that the model is evidence based and worthy of being expanded.

A third vital feature of the TPP program is that it invests in innovation and expanding the menu of evidence-based interventions. Congressional language calls for using 25 percent of the funds to support grants to develop, replicate, refine, and test additional models and innovative strategies for preventing teen pregnancy (called Tier 2 projects). This use of funds has served as an important way to fill gaps in models for underserved populations, to evaluate newer approaches, and to generate more evidence about what works.

A fourth feature of the TPP program is that it created a network of individual projects that received considerable guidance from the Office of Adolescent Health (OAH), the agency administering the

program. This includes ensuring high-quality program implementation and replication, promoting and overseeing program evaluation, providing evaluation technical assistance to grantees, sharing experience and knowledge gained across the network of projects, and continually learning from results. Especially at the beginning of the network, and as new projects are added, projects will inevitably have a steep learning curve, which the lead agency can address efficiently. Through the process of managing the TPP program, OAH staff developed strong internal skills and evidence-based capacity that has served as a model for other federal initiatives.

We are now in a transition period during which rigorous program evaluation is becoming more widespread as we build the evidence base about interventions addressed to several of the nation's most important social issues. Preventing teen pregnancy is the issue furthest along in this pursuit, so many of its methods are being employed for the first time and offer important lessons, as we will explain in the next section.

## Teen Pregnancy Program Implementation

In this brief, we consider two rounds of grant making by OAH (table 1). In the first round, briefly reviewed in this section, OAH awarded 102 competitive grant projects (75 in Tier 1 and 27 in Tier 2). In addition, 13 innovative projects were awarded through Personal Responsibility Education Program funds and included as part of the Tier 2 evaluation process.<sup>14</sup> Projects selected a wide variety of models to meet the needs of the young people and communities they were serving. This includes some models that focus on abstinence, some that address both abstinence and contraception, and others that focus on healthy relationships and youth development. They were delivered in various settings (including schools, community programs, and clinics) and communities (urban, rural, and suburban) and served diverse populations. They focused on replicating outcomes and rigorous evaluation rather than on a particular ideological approach or content. Together, these five-year projects produced 41 rigorous evaluations.

The OAH summary of the network results, along with a remarkable set of reports that occupy an entire issue of the *American Journal of Public Health* (AJPH), were released in the summer of 2016. The AJPH issue contained an overview of the TPP program and results by Evelyn Kappler, the head of OAH; an editorial about the studies by evaluation experts at HHS's Office of the Assistant Secretary for Planning and Evaluation; and a helpful summary of the impact findings by OAH staff. In addition, the AJPH issue contained numerous articles about the individual models and about important issues of implementing and evaluating the programs, including replication, impacts, technical assistance, theory, and other related topics. All in all, it was a remarkable exclamation point after the first round of evaluations had been completed. At the very least, the publication gave a new meaning to the concept of transparency for the effectiveness (or ineffectiveness) of federal programs.

TABLE 1

## Number of Teen Pregnancy Prevention Program Grant Projects

	Cohort 1 (2010–14)	Cohort 2 (2015–19)
Tier 1	75	58
Tier 2	27	26
<b>Total</b>	<b>102</b>	<b>84</b>

Source: Author analysis

The 41 studies featured in the July 2016 publication showed that 4 of the 10 (40 percent) Tier 1 models produced at least one significant impact and 8 of the 19 (42 percent) Tier-2 models produced at least one significant impact.<sup>15</sup> Since some models were evaluated in multiple settings, it is also instructive to look at the results by the number of evaluation studies. In this case, 4 of 19 (21 percent) Tier 1 evaluations and 8 of 22 (36 percent) Tier 2 evaluations produced at least one significant positive impact. However, if we eliminate 13 studies that OAH considered to be inconclusive because they experienced implementation or evaluation challenges, such as too small a sample size, then 4 of 12 (33 percent) Tier 1 evaluations and 8 of 16 (50 percent) Tier 2 studies showed positive impacts.<sup>16</sup> Almost all the results that were not positive were null, meaning the evaluation didn't detect an impact on behavior, not that they detected a negative impact. By any measure, the success rate of these rigorous evaluations exceeded the 10 to 20 percent success rate for similar evaluations across other fields.<sup>17</sup> And, as noted in the report of the bipartisan Commission on Evidence-Based Policymaking, the TPP program is an example of a federal program developing increasingly rigorous portfolios of evidence.<sup>18</sup>

In the summer of 2015, even before final publication of findings from the first cohort of evaluation studies in 2016, OAH funded a second cohort of 84 projects.<sup>19</sup> As in the first cohort, funding was divided into two tiers, this time with 58 Tier 1 projects and 26 Tier 2 projects. The new projects went through a careful competitive selection process informed by the results from the first cohort. Once the final evaluation results came out from the first cohort, OAH provided guidance to help shift the second cohort of Tier 1 projects toward replicating the more effective models based on what had been learned about what worked best and for which populations and settings. As a result, the mix of models replicated by the second cohort of Tier 1 projects was quite different in three ways. First, one model (the Teen Outreach Program), that had been widely replicated in the first cohort but didn't successfully replicate results in most new settings, was used only on a very limited basis in the second cohort. Second, a number of new models were added to the Evidence Review based on the emerging evidence from Tier 2 evaluations in the first cohort, and were then selected for replication as Tier 1 projects in the second cohort (for example, a new Tier 1 healthy relationship model called Love Notes is now being replicated in at least nine TPP sites). Third, OAH disallowed replication in the second cohort of one model (Cuidate) that had produced negative results in the first cohort<sup>20</sup> and allowed one other (It's Your

Game: Keep It Real) to be replicated only under narrow circumstances that were different than the first cohort evaluation. More detail on these differences is provided in the appendix.

These projects were on track to serve 1.2 million youth in 39 states and the Marshall Islands and to contribute significantly to the evidence base. In addition to scaling up and further evaluating some Tier 1 models, more than 20 rigorous evaluations were underway for the new Tier 2 projects. These included research to fill gaps in the existing evidence base. For example, a Tier 1 project operated by Centerstone, a large behavioral health organization, planned to serve more than 60,000 youth across 80 mainly rural counties in Indiana, Kentucky, and Tennessee. They use three different evidence-based models selected to be appropriate to different youth in different settings, including after-school programs, community centers, juvenile detention centers, middle and high schools, and residential facilities.<sup>21</sup> Johns Hopkins University is testing a model developed specifically for Native American youth.<sup>22</sup> Healthy Futures of Texas is evaluating the effectiveness of Big Decisions, an abstinence-plus approach to preventing teen pregnancy that has been found promising for low-income Hispanic urban youth to test the curriculum's efficacy for low-income Hispanic youth in rural communities.<sup>23</sup> These evaluations, all but one of which were randomized controlled trials, were funded by a combination of individual project funds and some national evaluation activities funded directly by OAH.

## The Trump Administration's Surprise Attack

Just as the second-cohort projects were beginning their third year of operation, HHS sent notices dated July 1, 2017, to all the projects informing them that their funding would be terminated on June 30, 2018, two years before the expected end of their five years of funding.<sup>24</sup> Amazingly, Congress, which had established the TPP program after extensive negotiations in 2009 and continued to fund it every subsequent year, was not even consulted (see more on this issue in the next section). Terminating the program's funding meant disrupting projects that were well under way and upending carefully designed evaluations that had already collected several years of data before HHS ever learned the results.

The administration took two other specific actions that are important parts of this story and reflect a serious movement away from high-quality evidence. First, in November 2017, HHS announced "a new research and evaluation collaboration to support and improve teen pregnancy prevention and sexual risk avoidance programs."<sup>25</sup> This included approximately \$18 million in contracts to support research related to sexual risk avoidance, which were supported by shifting funds away from existing evaluation and technical assistance activities within OAH. Second, in April 2018, HHS issued two new funding opportunity announcements (FOAs).<sup>26</sup> The new Tier 1 announcement moved away from the strong focus on replicating rigorously evaluated models that had been found to change behavior and, in a notable departure from the past, failed to reference the Evidence Review as a source of effective models (interestingly, the 2018 update of the Evidence Review was publicly released one business day after the FOA). Instead, the announcement requires applicants to replicate a sexual risk avoidance strategy or a sexual risk reduction strategy that incorporates the common characteristics outlined in one of two "program tools." Regardless of which strategy they pick, all projects must emphasize that



teen sex is a risk and focus on helping youth delay sex or return to not having sex. The new Tier 2 announcement also had a less rigorous standard for evaluating promising models than in the past. In the words of Jon Baron, vice president of evidence-based policy at the Laura and John Arnold Foundation, a nonpartisan foundation, the new approach is like “starting from ground zero as if nothing has been learned.”<sup>27</sup> These FOAs were later challenged in court (as described in the next section).

## The Response

The reaction by program operators to the July termination notices might be modestly described as shock and awe. Many operators could not understand what was going on or why. The termination notices came without any explanation, and HHS subsequently struggled to provide a rationale. As internal documents that later became public made clear, the decision was made by political appointees without involvement or concurrence of career staff.<sup>28</sup> As Dr. Jennifer Hattema, an associate professor at the University of New Mexico Health Science Center who was conducting a TPP project, put it: “We’re just reeling. We’re not sure how we’ll adapt.”<sup>29</sup> Finishing their projects two years early meant that project operators would not even have the chance to complete their evaluations and thereby determine if their projects had produced impacts. As the project operators began to wake up and see what they faced, other groups joined the growing cacophony of voices protesting the administration’s actions and proposing and implementing strategies to stop the changes. These groups included the advocates, Congress, and lawyers representing the projects.

This widespread concern about cutting short the TPP projects generated, and was further fueled by, media coverage that was extensive for a program as small as TPP (about \$100 million a year), with hundreds of national and local stories.<sup>30</sup> The coverage included, among many others, news and opinion pieces in the *New York Times*, the *Washington Post*, *CBS News*, the *Hill*, the *Wall Street Journal*, *Breitbart Connect*, *Politico*, *Democracy*, and local papers in places such as Maryland, Ohio, South Carolina, Tennessee, Texas, Washington State, and West Virginia, where projects were being disrupted. Much of the media coverage questioned the administration’s decision, called attention to the unusual nature of ending the grants, and highlighted the negative impact on local projects, but there were articles and editors on both sides of the debate (see, for example, the editorial supporting the Trump administration by the editors of the *Wall Street Journal*).<sup>31</sup>

A detailed analysis of the cuts in *Wired*, written by science writer Megan Molteni, focused on the likely consequences of the cut, particularly of cutting short ongoing evaluations, and the way projects were responding.<sup>32</sup> Prominent *NBC News* reporter Heidi Przybyla, among others, also wrote extensive analyses of the internal process behind the Trump administration decision to cut the grants.<sup>33</sup> As a number of reporters noted, appointees at HHS’s Office of the Assistant Secretary for Health, led by the new chief of staff Valerie Huber, came into the administration with a long record of opposing teen pregnancy prevention approaches that included use of birth control, advocating for abstinence programs, and seeking to defund the TPP program. Huber and her colleagues charged that the TPP program “normalized” teen sex. In fact, as noted previously in this brief, the TPP program supports a

wide variety of approaches and focuses on results rather than content. Although many of the models funded by TPP advocate use of birth control for sexually active teens, most also emphasize the wisdom of abstaining from sex. But that is not what Huber and her colleagues favored: they wanted abstinence, pure and simple.<sup>34</sup> Huber and her associates have recently rebranded this approach as “sexual risk avoidance,” which rejects the use of birth control in favor of avoiding nonmarital sexual activity. From the beginning of her appointment as chief of staff, it appears to have been Huber’s goal to dismantle the existing TPP program—and along with it the long record of working out the details of implementing evidence-based policy on a broad scale. As could have been predicted from her previous writing and speeches, she would prefer to redirect some or all of the money saved by terminating the TPP projects and related evaluation activities toward sexual risk avoidance projects and approaches.

The articles in the popular press and other documents issued by advocates for the TPP program highlighted four major arguments against the administration’s actions. The first is that terminating the projects early subverted the role of Congress. Congress had consistently funded the TPP program since 2010, allowing OAH to fund one cohort of five-year projects and to award a second cohort of projects that were now in the third of their five years. In fact, the administration’s abrupt notice that it would end the projects mid-stream took place before Congress had even begun deliberating on the funding that would support the projects’ fourth year. Many members of Congress expressed concern about the administration’s actions, such as through letters signed by 37 senators and 149 representatives and questions raised in confirmation hearings of administration nominees. For the most part, the public concerns have been raised by Democrats, but some Republicans have also raised concerns, such as former congressional representative Charlie Dent, who sent a letter to HHS.<sup>35</sup> It is worth noting that despite the administration’s attack on the existing projects, Congress ended up continuing the TPP program at its current funding level and with its current legislative language for year four and year five (while the Republican-led House has attempted to defund the program even before the Trump administration’s actions, the Senate has repeatedly supported the program on a bipartisan basis and—so far—has prevailed).

In a second argument, critics noted that suddenly cutting off funding to 84 projects serving over a million youth is not only unusual but disruptive of normal program administration. Especially because OAH was pursuing a strategy for evaluating and improving TPP programs over time, the sudden termination of funding for the projects was highly disruptive. As noted, evidence-based programs are dependent on evaluations to determine whether they work. Ending the projects prematurely ends the possibility of learning more about replication of existing evidence-based models under Tier 1 and rigorous evaluation of innovative new approaches under Tier 2. This loss, in turn, would deprive program developers, operators, and researchers of valuable evidence both about specific interventions and about how to improve evidence-based programs more generally.

Another important argument being used by TPP supporters is that the scientific evidence on teen pregnancy prevention is stronger than that supporting most social programs and is getting stronger as a result of the investments under the TPP program. Thus, the administration’s claim that the programs “don’t work” is not justified by the evidence. This administration claim is a coin with two sides. On one

side is the evidence on the abstinence programs favored by the administration, as events soon showed;<sup>36</sup> on the other side is the evidence on the programs that had been awarded funding by OAH. The Obama administration had designed and Congress had funded the TPP programs and the Personal Responsibility Education Program not just to reduce the national problem with teen pregnancy but also to find a way to develop more effective policies that actually have impacts on social problems.

To compare the evidence on abstinence education and the kind of evidence used as criteria for and generated by the TPP program is to compare a minnow with a whale. Few abstinence-only programs have been well evaluated, and a variety of researchers have found that nearly all the programs failed to produce—let alone replicate—impacts. The few that have met the objective standards of the Evidence Review are included there and are eligible for funding under TPP. A review of abstinence-only programs published in 2017 by a team of medical researchers and published in the *Journal of Adolescent Health* concluded that the programs “are not effective in delaying initiation of sexual intercourse or changing other sexual risk behaviors.”<sup>37</sup> Another summary of research on abstinence programs by Professor Aaron Carroll of the Indiana University School of Medicine also found the preponderance of evidence to be weak.<sup>38</sup> Even a review by the Institute for Research and Evaluation, which critiques the strength of results from many of the school-based programs referred to as “comprehensive sexuality education” while applying different criteria than those used in the Evidence Review, found only two replication studies of abstinence programs, neither of which had conclusive positive results.<sup>39</sup>

The most recent version of the Evidence Review includes 48 models that had rigorous evidence of producing at least one impact on a sexual risk behavior or reproductive health outcome.<sup>40</sup> The list includes a variety of approaches including four abstinence models (ranging from abstinence-only until marriage to abstinence-based).<sup>41</sup> In addition, several of the models on the list that teach about both abstinence and contraception have proven effective in delaying sex, highlighting the key difference between focusing on content versus results. As discussed, the success rate for the first round of evaluations released in 2016 exceeds the success rate that experts typically expect in randomized control trials, adds up to a strong performance, and shows that the evidence-based approach being followed by OAH was bearing fruit before the Trump administration’s assault.

The fourth argument, launched by Washington advocates and public interest lawyers for the TPP projects, was that the administration’s actions were illegal.<sup>42</sup> They took the administration to court in two categories of cases. A first group of lawsuits was filed between February and April 2018 in federal courts in Washington, DC; Baltimore, Maryland; Spokane, Washington; and Seattle, Washington, on behalf of TPP program grantees challenging the termination of their projects.<sup>43</sup> By June, the judges in all these cases decided in favor of the TPP grantees, finding that HHS’s action to terminate the projects was arbitrary and capricious and violated administrative regulations. This included a June decision in a class action suit brought by Healthy Futures of Texas on behalf of all remaining grantees not included in separate decisions.<sup>44</sup> These rulings ordered HHS to process year-four applications submitted by grantees as if the agency had not shortened their projects.

Reading the rulings issued by the judges in these cases shows the language they used in explaining their rulings was very direct. For example, Judge Catherine Blake of the US District Court for Maryland concluded that

“HHS has not shown that it considered any of the congressionally-prescribed criteria for judging the programs; namely, medically accurate and age-appropriate programs aimed at preventing teen pregnancy when making its decision to end the plaintiffs’ program periods early.”<sup>45</sup>

One judge even wrote in his order that the administration’s action was so unjustified that it “easily qualified” as arbitrary and capricious. Similarly, Judge Thomas Rice, chief judge of the US District Court for the Eastern District of Washington, questioned HHS’s basic justification for cutting the TPP funds when he ruled that cutting the TPP programs would cause “irreparable harm to the youth they serve, their staff, the communities, and Plaintiffs’ reputation within those communities.”<sup>46</sup>

By late August, HHS had complied with these orders and funded the projects for year four (which runs from July 1, 2018, to June 30, 2019). Whether the federal government will appeal in any of the grant termination cases remains to be seen (to date, it has dropped appeals in the Baltimore, Spokane, and Seattle cases). While it is likely the projects will proceed for year four, the jury is out on what the administration will do for year five. There are also grounds for concern about how the disruption and uncertainty about these projects will affect program operations and outcomes and how it will affect the quality of ongoing evaluations. For example, some grantees may be scaling back their evaluations and losing sample size, which could have an unfortunate impact on results down the road, especially for Tier 2 projects. They are also having to navigate these challenges without the robust evaluation technical assistance that OAH has provided in past years.

A second category of cases challenged the TPP program FOA that HHS issued in April 2018.<sup>47</sup> These FOAs came out after several judges had already ruled against HHS’s actions to terminate the current projects. In June, Multnomah County, Oregon, filed a suit claiming that the grant criteria in the new FOA violated congressional requirements for rigorously evaluated, proven-effective programs and substituted an ideologically driven approach that privileges abstinence-only content.<sup>48</sup> This was followed by several Planned Parenthood affiliates filing cases in New York City and Spokane, Washington, on similar grounds.

In the meantime, HHS went forward with the grant review process under the April 2018 FOA and seemed intent on awarding grants in September under the new criteria, with whatever funds are available after it has provided year-four funding for existing TPP projects as required by the courts and from cancelling other activities. However, these plans were upended in late August, when judges in Oregon and the Southern District of New York ruled that the Trump administration’s Tier 1 FOA violates congressional intent (as well as other laws) and ordered HHS not to proceed with awarding TPP funds under this FOA.<sup>49</sup>

Of particular relevance for those interested in evidence, the courts found the administration's actions violated the appropriations law, which required that Tier 1 "shall be for replicating programs that have been proven effective through rigorous evaluation" and that the FOA would direct funds to programs that do not meet that requirement.<sup>50</sup> The judges drew a clear distinction between the "tools" referenced in the FOA and programs that have been rigorously evaluated. While the Oregon case only dealt with Tier 1, the New York case also challenged the Tier 2 FOA. The judge reached a different conclusion on that matter, ruling that the Tier 2 FOA was "not inconsistent with Tier 2's statutory mandate to 'test additional models and innovative strategies.'"<sup>51</sup> The judge in Spokane ruled against the grantee on technical grounds (indicating they didn't have legal standing), so he did not rule on the merits of the case. It is unknown how HHS will respond to these decisions.<sup>52</sup> On September 27<sup>th</sup>, OAH awarded \$5 million for 14 new Tier 2 grants under the April FOA,<sup>53</sup> and in a rather unusual move, also issued a September 26<sup>th</sup> press release about \$19 million for 41 Tier 1 grants that would have been funded but for the litigation.<sup>54</sup>

Meanwhile, in late September, Congress approved and the president signed the fiscal year 2019 appropriations bill, which could fund the fifth year of TPP projects.<sup>55</sup> This bipartisan spending deal continued the TPP program at its current funding level and with the same evidence-based language that has existed for many years. Although the Republican-led House has historically not supported TPP, it has always been preserved in the final spending negotiations because of strong support from the Senate, and this year was no exception.

## Summary

At this point, it is unclear what the outcome of the Trump administration's attack on the TPP program specifically, and perhaps on evidence-based policy more generally, might be. Even so, several conclusions seem undeniable. The first is that the administration either does not understand the goals and dimensions of the evidence-based movement or chooses to apply its commitment to evidence unevenly depending on their policy goals. In the short run, the goal of the TPP part of the movement is to reduce teen sexual activity, to increase the use of birth control, and above all to reduce teen pregnancy. These goals are of great importance in and of themselves. True enough, the nation has made dramatic progress in reducing teen pregnancy, progress that features a decline of well over 60 percent since 1991 and that has accelerated since the federal investments in evidence-based programs.<sup>56</sup> But we still have higher teen birth rates than most other developed countries, and roughly one in four US women still becomes pregnant before age 20.<sup>57</sup> Further, despite dramatic progress among all states and all ethnic and racial groups, there are still significant disparities, with black and Hispanic females, teens in rural areas, older teens, and teens in foster care more likely to experience teen pregnancy. What's more, nearly 80 percent of all teen births are reported by teens themselves as unplanned.<sup>58</sup> These statistics show both that progress is possible and that the nation needs to keep the momentum going on reducing teen pregnancy, particularly among young people and communities where disparities and challenges persist.

Based on what we know from research, there is no reason to believe that shifting spending away from a variety of evidence-based models that can meet the needs of diverse teens and communities to more spending focused solely on abstinence will reduce either teen sex or pregnancy rates.<sup>59</sup> While communities might select an effective abstinence model for young teens (a few are included as TPP evidence-based programs), many will prefer an effective model that also teaches about contraception for older teens who are sexually active. It follows that the Trump administration's strategy of reducing teen pregnancy by reducing spending on replicating well-tested programs and rigorously evaluating promising approaches that increase knowledge about what works for different communities and settings would be a major step backward for young people and the evidence movement and could reverse the positive outcomes we've seen.

This consideration leads to another conclusion about this episode that should be emphasized. One of the major goals of the evidence-based movement is to give priority to rigorous evidence over ideological commitments. The senior administrators brought into the Trump administration to oversee teen pregnancy prevention efforts who quickly set about trying to kill the evidence-based TPP program (which, as we have explained, supported a wide variety of approaches and focused on outcomes rather than content) and substitute abstinence-only education revealed that they gave priority to policy and practice supported by ideology rather than evidence. This is precisely the type of decisionmaking that the evidence-based movement is designed to minimize. We are not arguing that evidence is the only factor that should be taken into account when making policy decisions, but it should be an important factor. Why would it be ignored? The answer in this case seems to be that it was trumped by ideological considerations.

Finally, the Trump assault on the TPP program has implications for the future of evidence-based policymaking. The background provided in some detail throughout this brief shows that the evidence-based movement is designed to create a strategy that will justify investments in social programs that produce impacts. Roughly, the strategy is to develop high-quality programs, to gradually expand the best ones while additional testing is conducted to ensure that the programs maintain their impacts, and to eventually spend most government dollars on programs that show benefits. To date, the TPP branch of the movement is the most advanced. Its results are not ideal, but across the 41 studies in the first round, more models had significant impacts than perhaps any other set of model programs tested so far in other areas. It would be reasonable to expect that the second round of projects, having learned from the first round through the efforts of OAH, would produce an even more impressive set of impacts—if they had not been disrupted.

The administration's rationale for killing the TPP program based on the evidence from the first round of results is a disingenuous case of using evidence as a weapon rather than a tool. The second round of projects was informed by and is learning from those results, and it is in the midst of generating new evidence; this is exactly as expected given the iterative nature of science and evidence building. The administration criticizes the results from the TPP projects to date yet proposes to replace them with an approach that rests on far weaker evidence and uses less rigorous standards of evaluation. What's more, administration attacks could have a chilling effect on future evidence-based ventures. Will

program developers, operators, and researchers want to subject themselves to such disruption and uncertainty?

Let us hope that between the courts and Congress, the TPP program will be able to survive in something close to its present form and that the growth of the evidence-based movement will continue to yield benefits.

## Appendix: Teen Pregnancy Prevention Round 1 and Round 2 Models

TABLE A.1

Change in Models used in Tier 1 Teen Pregnancy Prevention Program Grants

Model	Number of projects using model in cohort one (2010–14)	Number of projects using model in cohort two (2015–19)	Change
Aban Aya	1	0	-1
Adult Identity Mentoring (Project AIM)	2	7	5
AIM 4 Teen Moms	0	0	0
All 4 You!	2	7	5
Assisting in Rehabilitating Kids (ARK)	0	0	0
Be Proud! Be Responsible!	4	14	10
Be Proud! Be Responsible! Be Protective!	1	2	1
Becoming a Responsible Teen (BART)	7	0	-7
Children's Aid Society - Carrera	7	2	-5
Cuidate!	4	0	-4
Draw the Line/Respect the Line	4	12	8
Families Talking Together	1	9	8
FOCUS	1	0	-1
Generations	NA	0	0
Get Real	0	7	7
Health Improvement Project for Teens (HIP) Teens	0	0	0
Healthy Futures	NA	3	3
Heritage Keepers Abstinence Education	0	0	0
HORIZONS	0	0	0
It's Your Game: Keep It Real	4	3	-1

Love Notes	NA	9	9
Making a Difference!	6	16	10
Making Proud Choices!	6	31	25
Positive Potential! Be the Exception (6th grade)	NA	0	0
Positive Prevention PLUS	NA	9	9
Prime Time	NA	0	0
Project IMAGE	0	0	0
Project TALC	0	0	0
Promoting Health Among Teens! Abstinence-Only Intervention	4	5	1
Promoting Health Among Teens! Comprehensive Abstinence and Safer Sex Intervention	1	1	0
Raising Healthy Children	1	2	1
Reducing the Risk	9	15	6
Respecto/Proteger	0	0	0
Rikers Health Advocacy Program	0	0	0
Safer Choices	0	1	1
Safer Sex Intervention	6	5	-1
Seventeen Days	1	11	10
SHARP	1	8	7
SiHILE	1	1	0
Sisters Saving Sisters	0	1	1
STRIVE	0	0	0
Teen Health Project	2	5	3
Teen Options to Prevent Pregnancy (T.O.P.P.)	NA	0	0
Teen Outreach Program (TOP)	17	2	-15
Total number of models used	24	26	2
Number of models used in cohort two that weren't available in cohort one	--	8	8
Number of Tier 1 models from cohort one replicated in cohort two	24	18	-6

**Notes:** NA indicates models that weren't available for replication in cohort 1. Most of these were evaluated through Tier 2 projects in cohort 1 and made available for Tier 1 replication in cohort two. For cohort two, this list represents models used in Tier 1B projects. There are seven Tier 1A projects that help build capacity of communities to replicate evidence-based models. They didn't identify models to be used. Cohort one, Tier 1 projects were comparable to cohort two, Tier 1B projects.



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BROOKINGS



With support from the Laura and John Arnold Foundation, researchers from the Urban Institute, Brookings Institution, American Enterprise Institute, and the Pew-MacArthur Results First Initiative have formed the Evidence-Based Policymaking Collaborative. The Collaborative brings together researchers from organizations across the ideological spectrum to create tools to support evidence-based policymaking at the federal level. The Collaborative's work is assisted by an Advisory Group consisting of stakeholders throughout the evidence-based policymaking field. The opinions expressed in this brief do not necessarily reflect the views of all members of the Evidence-Based Policymaking Collaborative.