



The Evaluation of the Teen Outreach Program (TOP) in Florida

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| Intervention Name | Teen Outreach Program (TOP) |
| Intervention Description | <p>TOP is a youth development and service learning program for youth ages 12 to 17 designed to reduce teenage pregnancy and increase school success by helping youth develop a positive self-image, life management skills, and realistic goals. The TOP model consists of three components implemented in school, after school, or in community settings over nine months: (1) weekly curriculum sessions, (2) community service learning, and (3) positive adult guidance and support. The TOP Changing Scenes Curriculum is separated into four age-/stage-appropriate levels, Level 1 is typically for youth ages 12 or 13 and Level 4 is typically for youth age 17. The curriculum focuses on the presence of a consistent, caring adult; a supportive peer group; skill development; sexual health; and sexual behavior choices. The intended program dosage for each participant is a minimum of 25 weekly sessions (one per week at 40–50 minutes each) and at least 20 hours of community service learning over nine months. One or two facilitators who plan the order of sessions based on the needs and interest of youth implement TOP in a group of 10 to 25 youth.</p> <p>Trained facilitators who work for the Florida Department of Health deliver the Level 2 TOP curriculum in school classrooms. Youth receive TOP in health (or a class that includes health-type curriculum components); in each school, this class is a requirement for graduation and enrolls mostly 9th-grade students. TOP is being implemented as supplemental education in health or health-type classes. That is, TOP is being delivered in addition to business-as-usual programming.</p> |
| Counterfactual | Business as usual |
| Counterfactual Description | Youth in control schools are enrolled in classes that cover health or health-type curriculum components. Classroom teachers deliver the expected content of each course. Depending on the course, this content includes developing and enhancing healthy behaviors that influence lifestyle choices and students' health and fitness; developing skills related to critical thinking, learning, and problem solving; enabling students to enhance their performance in both academic and nonacademic areas; and equipping students with knowledge, skills, and abilities necessary to pursue leadership roles and endeavors within individual fields of interest. |
| Primary Research Question(s) | <p>What is the impact of TOP relative to business as usual on ever having vaginal sexual intercourse at the end of the program?</p> <p>What is the impact of TOP relative to business as usual on reported pregnancies one year after the end of the program?</p> |
| Additional Outcomes | The "5 Cs" of positive youth development (character, competence, caring, connections, and confidence), course failures, and school suspensions |

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| Sample | The evaluation considered 115 traditional public high schools and combination middle/high schools in 26 nonmetropolitan Florida counties. Eligibility for school participation in this evaluation included (1) year-long health classes (or classes that included health components), (2) agreement to be randomly assigned to receive TOP or serve as a control school, and (3) agreement to have youth surveys administered in classrooms at multiple data collection points. In summer 2011, 28 high schools from 12 counties meeting the eligibility requirements were matched into pairs (treatment/control). This study included two cohorts of youth: Cohort 1 youth were enrolled in fall 2012 from the 28 public high schools. In fall 2013, Cohort 2 youth were enrolled from 26 of the original schools remaining in the sample. Eligible youth included all students who were enrolled in the identified health or health-type class, except in the nine high schools in which random subsampling occurred at the class level due to overlapping classes. When two eligible evaluation classes were scheduled to meet at the same time in a school, one of them was randomly selected to be in the evaluation. Youth were deemed ineligible if they (1) were not enrolled in a class randomly selected for the evaluation, (2) joined a participating class after the parental consent process occurred, or (3) had any illness or disability that prevented them from participating in the surveys. Of 9,240 eligible youth, 8,706 had parental permission to be in the study (4,040 treatment and 4,666 control). |
| Setting | The evaluation began in 28 traditional public high schools in 12 nonmetropolitan Florida counties. These counties were selected because they had higher rates and/or rankings overall for four of the following six indicators, compared with nonselected counties: (1) birth rate per female population ages 15 to 19 years, (2) repeat birth rate per female population ages 15 to 19 years, (3) combined chlamydia and gonorrhea rates per female population ages 15 to 19 years, (4) high school dropout rates, (5) graduation rates, and (6) out-of-school suspensions. |
| Research Design | This evaluation is a school-level longitudinal randomized control trial. In summer 2011, matched pairs of high schools were determined based on factors including county (that is, schools within the same county were matched first); school size (that is, small or large schools); type of health class; and class scheduling (that is, presence of block scheduling). Matched pairs were randomized to TOP or control schools. Passive parental permission and youth assent were obtained after school-level randomization. During the parent permission and youth assent process, students and their parents were blind to each school's treatment status; instead, the study activities were described as participation in an evaluation of school health programs in Florida. Randomization was conducted by USF evaluation staff. A baseline paper-and-pencil survey was administered in classrooms, following the parental permission process. The second survey was administered, immediately following the delivery of the TOP in intervention schools and to youth in control schools, at the end of the school year. A third survey was administered 12 months after the end of the intervention. All surveys were group-administered in classrooms, except when youth moved or were absent from school, in which case they completed an abridged survey over the telephone or online. |
| Impact Findings | To be determined when data collection and analysis are complete. |
| Implementation Findings | To be determined when data collection and analysis are complete. |
| Schedule/Timeline | Sample enrollment was completed in fall 2013. The baseline survey ended in fall 2013, the immediate post-test survey ended in spring 2014 and the 12-month post-test survey ends in spring 2015. A final report, which focuses on immediate post-test data for both cohorts and 12-month post-program data for Cohort 1, will be available to the Office of Adolescent Health in 2015-2016. |