Wisconsin Family Impact Seminars
Briefing Report

Programs and Policies to Prevent Youth Crime, Smoking, and Substance Use: What Works?

University of Wisconsin-Extension
Center for Excellence in Family Studies
School of Human Ecology
University of Wisconsin-Madison

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First Edition

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Briefing Report

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Purpose, Presenters, and Publications

Family Impact Seminars have been well received in Washington, D.C., by federal policymakers, and Wisconsin is one of the first states to sponsor the seminars for state policymakers. Family Impact Seminars provide state-of-the-art research on current family issues for state legislators and their aides, Governor's Office staff, state agency representatives, educators, and service providers. Based on a growing realization that one of the best ways to help individuals is by strengthening their families, Family Impact Seminars analyze the consequences an issue, policy, or program may have for families.

The seminars provide objective nonpartisan information on current issues and do not lobby for particular policies. Seminar participants discuss policy options and identify common ground where it exists.

"Programs and Policies to Prevent Youth Crime, Smoking, and Substance Use: What Works?" is the 8th seminar in a series designed to bring a family focus to policymaking. This seminar featured the following speakers:

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Each seminar is accompanied by an in-depth briefing report that summarizes the latest research on a topic and identifies policy options from across the political spectrum. Copies are available at Extension Publications, Room 245, 30 North Murray Street, Madison, WI 53715, (608) 262-3346.

Building Policies That Put Families First: A Wisconsin Perspective	Mar. 1993
Single Parenthood and Children's Well-Being	Oct. 1993
Can Government Promote Competent Parenting?	Jan. 1994
Promising Approaches for Addressing Juvenile Crime	May 1994
Welfare Reform: Can Government Promote Parental Self-Sufficiency While Ensuring the Well-Being of Children?	Jan. 1995
Child Support: The Effects of the Current System on Families	Nov. 1995
Teenage Pregnancy Prevention: Programs That Work	Mar. 1996

Or, visit the Policy Institute for Family Impact Seminars website at:
http://www.familyimpactseminars.org (enter a portal and click on State Seminars).

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Executive Summary

According to national estimates, almost half of young people, aged 10 to 17, abuse alcohol and drugs, commit crimes, fail in school, or engage in unprotected sex. Do we know enough to prevent youth from engaging in risky behaviors? What programs and policies work? How cost effective are they? What role can the state play in setting a vision for children and families, implementing prevention programs, and identifying measurable outcomes?

Peter Greenwood, Director of RAND Corporation's Criminal Justice Program, compares the cost effectiveness of prison with four approaches to intervening early in the lives of children at some risk of eventually getting into trouble with the law: two years of home visits followed by four years of day care; parent training and family therapy for families with young children who behave aggressively in school; four years of cash and other incentives to encourage disadvantaged high school students to graduate; and monitoring and supervising high school-aged youths who have already shown delinquent behavior.

For each strategy, Greenwood estimates the number of serious crimes that might be prevented for each million dollars spent. A similar estimate is provided for the California "three strikes" law, which gives longer sentences to repeat offenders. The three strikes law is estimated to reduce serious crime by 21 percent. Graduation incentives might bring about a reduction of 15 percent and are estimated to save enough money to pay most of the program's costs. A combination of parent training, graduation incentives, and supervision of delinquents would prevent additional crimes.

California voters supported the three strikes law, so it appears the public believes that a 21 percent reduction in crime is worth the program's cost of $5.5 billion a year. Adding graduation incentives and parent training—at a cost of less than 1 billion dollars a year—could double that crime reduction.

Phyllis L. Ellickson, Senior Scientist at the RAND Corporation, addresses what we know about keeping kids from going off track. Two approaches that were popular in the past have had little success: the information approach, which stresses the negative consequences of risky behaviors, and the general skills approach, which helps children acquire a more positive self-image by improving their skills in decision-making, communication, and problem-solving.

The next generation of programs, social influence models, zeroed in on the central reason why kids begin problem behaviors—because they believe that "everyone's doing it." For example, drug prevention programs based on this model try to help adolescents recognize these pressures, develop arguments against them, and learn techniques for saying "no." Social influence models also try to instill the motivation to resist. Adolescents tend to be unconcerned about consequences that lie in the future, so these programs emphasize how drugs can affect them now.

RAND's Project ALERT, a school-based program based on the social influence model, reduced both marijuana and cigarette use after three, twelve, and fifteen months. Project ALERT was successful in urban, suburban, and rural environments; middle and low-income communities; and high- and low-minority schools. In general, the social influence approach has been most effective with kids who are not using substances. However, Project ALERT has also worked with teens who have experimented with cigarettes and marijuana.

Even the best programs will have only limited success if they aim at the child alone. Making more substantial inroads requires dealing with the many influences on children's behavior—families, schools, neighborhoods, and society. At the family level, parental support and discipline, and the connection between parent and child are particularly important.

Patrick Remington, Chief Medical Officer at the Wisconsin Division of Health, addresses teen tobacco use. In Wisconsin, 83 percent of young adults (25 to 34 years) tried their first cigarette and 62 percent became regular smokers before they were 18 years old. Why do two-thirds of children try cigarettes and about one-third become regular smokers, eventually addicted to nicotine? The answer is simple. Cigarettes are cheap, accessible, and one of the most heavily advertised products in America.

Dr. Remington reviews policies that may prevent children from smoking—mass media, community programs, increased price, and restricted sales to minors. Research suggests that mass media campaigns will be effective in reducing the demand for cigarettes if they are targeted to youth. Community programs such as clean indoor air ordinances change the social norm to one where smoking is seldom viewed by young children.

Raising the excise tax on cigarettes reduces smoking. For every 10-percent increase in the price, there is a 5-percent decrease in use among adults and a 10- to 15-percent decline among youth. Enforcing existing laws prohibiting cigarette sales to minors makes cigarettes even harder to get.

Clara C. Pratt and Aphra Katzev from Oregon State University describe Oregon's effort to identify a common vision for Oregon's children and families, develop strategies to achieve this vision, and track the state's progress. Oregon is working toward these goals through hundreds of small and large community programs and collaborations. Their efforts are carefully planned, built on a solid research base, and consistently evaluated. Progress is assessed through both (a) benchmarks, aggregate social indicators such as state or county rates of child abuse, juvenile crime, teenage pregnancy, and family poverty, and (b) program performance indicators, data on individual program efforts, and outcomes.

Oregon's Healthy Start offers support to all families with newly born children, targeting first-birth families. Healthy Start reached almost 80 percent of first-birth families in 12 participating counties during fiscal year 1995–96. As a result, almost all of Healthy Start's children from higher risk families have a primary health care provider, 89 percent are receiving regular well-child checkups, and 85 percent never use costly emergency room services for routine care. Of Healthy Start's babies from higher risk families, 90 percent are up-to-date with immunizations compared to 71 percent of Oregon's two-year-olds. Among high risk families, Healthy Start has reduced the risk of child maltreatment and improved the quality of family life.

A Checklist for Assessing the Impact of Policies on Families

The first step in developing family-friendly policies is to ask the right questions:

- What can government and community institutions do to enhance the family's capacity to help itself and others?
- What effect does (or will) this program (or proposed policy) have for families? Will it help or hurt, strengthen or weaken family life?

These questions sound simple, but they can be difficult to answer.

The Family Criteria (Ad Hoc) Task Force[1] developed a checklist to assess the intended and unintended consequences of policies and programs on family stability, family relationships, and family responsibilities. The checklist includes six basic principles about families that serve as the measure of how sensitive to and supportive of families policies and programs are. Each principle is accompanied by a series of family impact questions.

The criteria and questions are not rank ordered (Ooms & Preister, 1988). Sometimes these criteria conflict with each other, requiring trade-offs. Cost effectiveness also must be considered. Some questions are value-neutral. Others incorporate specific values. People may not always agree on these values, so sometimes the questions will require rephrasing. However, this tool reflects a broad, nonpartisan consensus, and it can be useful to people across the political spectrum.

Checklist: A Tool for Analysis

Check all that apply. Record the impact on family well-being.

1. **Family support and responsibilities.** Policies and programs should aim to support and supplement family functioning and provide substitute services only as a last resort.
   - How does the proposal (or existing program) support and supplement parents' and other family members' ability to carry out their responsibilities?
   - Does it provide incentives for other persons to take over family functioning when doing so may not be necessary?
   - What effects does it have on adult children's ties to their elderly parents?

[1] Adapted from T. Ooms & S. Preister (Eds.) (1988). In *A strategy for strengthening families: Using family criteria in policymaking and program evaluation.* Washington, DC: Family Impact Seminar.

- To what extent does the policy or program enforce absent parents' obligations to provide financial support for their children?
- Does the policy or program build on informal social support networks (such as community/neighborhood organizations, churches) that are so essential to families' daily lives?

2. **Family membership and stability.** Whenever possible, policies and programs should encourage and reinforce marital, parental, and family commitment and stability, especially when children are involved. Intervention in family membership and living arrangements is usually justified only to protect family members from serious harm or at the request of the family itself.
   - What incentives or disincentives does the policy or program provide to marry, separate, or divorce?
   - What incentives or disincentives are provided to give birth to, foster, or adopt children?
   - What effects does it have on marital commitment or parental obligations?
   - How does the policy or program enhance or diminish parental competence?
   - What criteria are used to justify removal of a child or adult from the family?
   - What resources are allocated to help keep the family together when this is the appropriate goal?
   - How does the policy or program recognize that major changes in family relations such as divorce or adoption are processes that extend over time and require continuing support and attention?
3. **Family involvement and interdependence.** Policies and programs must recognize the interdependence of family relationships, the strength and persistence of family ties and obligations, and the wealth of resources that families can mobilize to help their members.
   - To what extent does the policy or program recognize the influence of the family and family members upon individual needs or problems?
   - To what extent does it involve immediate and extended family members in working toward a solution?
   - To what extent does it acknowledge the power and persistence of family ties, especially when they are problematic or destructive?
   - How does it assess and balance the competing needs, rights, and interests of various members of a family? In these situations, what principles guide decisions (i.e., the best interests of the child)?

4. **Family partnership and empowerment.** Policies and programs must encourage individuals and their close family members to collaborate as partners with program professionals in delivery of services to an individual. In addition, parent and family representatives are an essential resource in policy development, program planning, and evaluation.

   - In what specific ways does the proposed or existing program provide full information and a range of choices to families?
   - In what ways do program professionals work in collaboration with the families of their clients, patients, or students?
   - In what ways does the policy or program involve parents and family representatives in policy and program development, implementation, and evaluation?
   - In what ways is the policy or program sensitive to the family's need to coordinate the multiple services they may require?

5. **Family diversity.** Families come in many forms and configurations, and policies and programs must take into account their different effects on different types of families. Policies and programs must acknowledge and value the diversity of family life and not discriminate against or penalize families solely for reasons of structure, roles, cultural values, or life stage.

   - How does the proposal or program affect various types of families?
   - If the proposed or existing program targets only certain families, for example, only employed parents or single parents, what is the justification? Does it discriminate against or penalize other types of families for insufficient reason?
   - How does it identify and respect the different values, attitudes, and behavior of families from various racial, ethnic, religious, cultural, and geographic backgrounds that are relevant to program effectiveness?

6. **Targeting vulnerable families.** Families in greatest economic and social need, as well as those determined to be most vulnerable to breakdown, should have first priority in government policies and programs.

   - Does the proposed or existing program identify and target publicly supported services for families in the most extreme economic or social need?
   - Does it give priority to families who are most vulnerable to breakdown and have the fewest supports?
   - Are efforts and resources targeted on preventing family problems before they become serious crises or chronic situations?

Diverting Children From a Life of Crime: What Are the Costs and Benefits?

Peter Greenwood

The rate of violent crime in the United States is several times higher than in other industrialized democracies. One violent crime is committed in the U.S. for every 130 citizens.

We devote most of the money and energy intended to solve our crime problem to just one approach—putting people who commit crimes in prison and keeping them there. We pay much less attention to preventing crime in the first place.

We devote most of the money and energy intended to solve our crime problem to putting people who commit crimes in prison.

This lopsided allocation of resources makes some sense—a criminal who is in prison cannot commit more crimes. It is not as easy to measure the effectiveness of programs that aim to prevent young people from becoming criminals. We can't predict with certainty which children will wind up in trouble with the law. We can't guarantee that participating in a program will prevent someone from eventually committing a crime. And we know that early positive effects of prevention programs can wear off over time. Yet, we think there should be some benefits from prevention programs. How much? And at what cost?

Measuring costs and benefits

Analysts at RAND considered four approaches to intervening early in the lives of children at some risk of eventually getting into trouble with the law. We can't predict this kind of risk with certainty, but the research shows that the children of young, single, poor mothers are more likely than others to become criminals. Some intervention programs could target these families. Others could focus on the child's behavior. The analysts examined the following approaches:

- Home visits by child-care professionals, beginning before birth and continuing through the first two years of childhood. These visits were followed by four years of day care.
- Parent training and family therapy for families with young children who behave aggressively in school.
- Four years of cash and other incentives to encourage disadvantaged high school students to graduate.
- Monitoring and supervising high school-aged youths who have already shown delinquent behavior.

Each of these approaches has been attempted and the results are summarized in Table 1.

Table 1: Program Effectiveness and Cost Parameters

Parameter	Visits and day care	Parent training	Graduation incentives	Delinquent supervision
Pilot prevention rate (%)	50	60	70	10
Effective prevention rate for juvenile crime (%)	24	29	56	8
Effective prevention rate for adult crime (%)	9	11	50	8
Targeting ratio	2:1	2:1	3:1	4.5:1
Cost per participant (thousands of dollars)	29.4	3.0	12.5	10.0

The top line of the table shows how effective each program has been in reducing rates of arrest or re-arrest. There are two cautions about these results. The reductions shown in the pilot programs are likely to be greater than we could expect after the programs are scaled up. And the effects of the programs are likely to decay over time.

The analysts have taken these "scale up" and "decay" factors into account, and lines two and three of the table show hypothesized *effective* prevention rates. They predicted larger "decay" for the home visits and parent training programs because they occur earlier and are more likely to decay before children reach an age when they might get into trouble with the law.

The targeting ratio, line four, shows how the expected lifetime crime rate for program participants compares with the population as a whole. The timing of the programs affects these ratios because programs for older youth focus on those who are greatest risk of criminal activity.

Three of the four early-intervention approaches compare favorably with incarceration in their cost-effectiveness.

Finally, the table gives an estimate of the cost of each program.

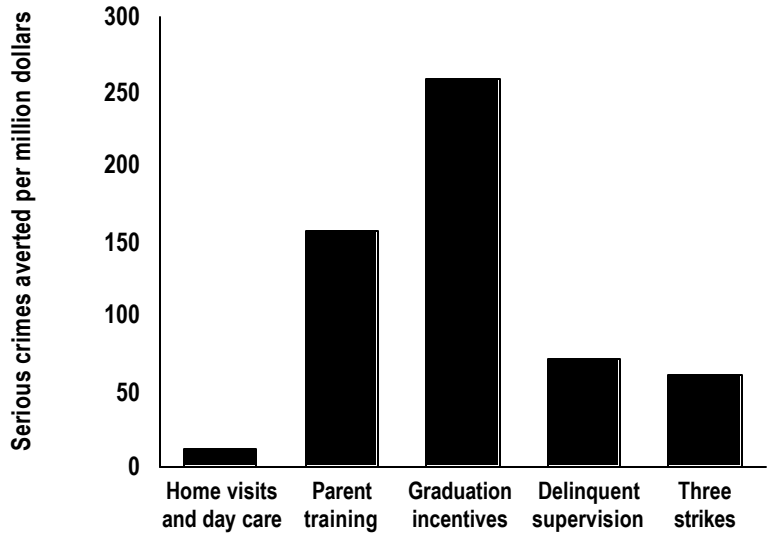
We can use the data in Table 1, combined with other information, to estimate how many serious crimes might be prevented over the lifetimes of the participants. We can express this in terms of the number of serious crimes prevented for each million dollars spent. In Figure 1, we present these estimates and a similar estimate for California's "three strikes" law. This well-publicized California law gives longer sentences to repeat offenders. Three of the four early-intervention approaches compare favorably with incarceration in their cost-effectiveness. But we should be careful about taking these results at face value for two reasons:

- First, the costs shown for the four early intervention programs are only the costs of the programs themselves. They do not take into account the money saved by not imprisoning youths who were diverted from criminal

behavior. It is estimated that graduation incentives, for example, would save enough money to pay most of the costs of the program.

- Second, the estimates come from limited demonstrations and educated guesses. Actual values could be quite different from those shown. However, researchers found that even big variations in these estimated values do not reverse the cost-effectiveness outcomes as compared with the three-strikes law.

Figure 1: Estimates of the Number of Serious Crimes Prevented for Each Million Dollars Spent



These findings do not mean that incarceration is the "wrong" approach. Even if they were implemented at full scale, the total effect of all four early interventions would still be smaller than that of the three-strikes law. It has been estimated that the three-strikes law might reduce serious crime by 21 percent. Graduation incentives might bring about a reduction of 15 percent. The other interventions probably would have less effect.

A 21-percent reduction in crime is substantial. But Americans will want to know what else can be done about the other 79 percent. This study indicates that parent training, graduation incentives, and supervision of delinquents would prevent additional crimes. California voters supported the three-strikes law, so it appears the public believes that a 21-percent reduction in crime is worth the program's cost of $5.5 billion a year. Adding graduation incentives and parent training—at a cost of less than 1 billion dollars a year—could double that crime reduction. Testing this prediction will require broader demonstrations, costing millions of dollars. The RAND researchers conclude that such demonstrations would be an investment worth the cost.

RAND research briefs summarize research that has been more fully documented elsewhere. This research brief describes work done in RAND's Criminal Justice Program with funding from the University of California, the James Irvine Foundation, and RAND's own funds. The work is documented in *Diverting children from a life of crime: Measuring costs and benefits,* by Peter W. Greenwood, Karyn E. Model, C. Peter Rydell, and James Chiesa, MR-699-UCB/RC/IF, 1996, 88 pp., $15.00, ISBN: 0-8330-2383-7, available from National Book Network (Telephone: 800-462-6420; FAX: 301-459-2118) or from RAND on the Internet (order@rand.org). Abstracts of all RAND documents may be viewed on the World Wide Web (http://www.rand.org). RAND is a nonprofit institution that helps improve public policy through research and analysis; its publications do not necessarily reflect the opinions or policies of its research sponsors.

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Helping Urban Teenagers Avoid High-Risk Behavior: What We've Learned From Prevention Research

Phyllis L. Ellickson

Compared with the children of the 1950s, today's' youth are much more likely to suffer poverty and economic hardship and to live in households where only one parent is available to meet their emotional and physical needs. As teenagers, they are more likely to engage in high-risk activities like these:

- **Drug use.** Cigarettes and alcohol are the most popular drugs among teenagers. They also cause more deaths than all other drugs combined (Office on Smoking and Health, 1990). One high school senior in five smokes daily. About 30 percent engage in binge drinking, contributing to the high rate of alcohol-related traffic accidents. Sixteen percent have used illegal drugs (National Center for Statistics and Analysis, 1989; NIDA, 1992).
- **Violence.** Drug use often contributes to violent behavior. Increasing numbers of teenagers are either perpetrators or victims of violence. (Centers for Disease Control, 1991). Violence can happen anywhere, but it is particularly serious in the urban core, where homicide is the second leading cause of death among young African-American males and the third leading cause among all adolescents (Fingerhut, Ingram, & Feldman, 1992; Office of Technology Assessment, 1991).
- **Sexual activity.** More than half of American high school students have had sexual intercourse. They are beginning to have sex at a younger age (Centers for Disease Control, 1992; Office of Technology Assessment, 1991). Most do not use condoms consistently, putting them at risk for AIDS, other diseases, and pregnancy. A million teenagers become pregnant every year. More of those who give birth are not married (U.S. Congress, 1989). About 20 percent of all AIDS cases were probably contracted during or just after high school (Hingson, Strunin, Berline et al., 1990).

These high-risk behaviors—not disease in the traditional sense—are the greatest threats to adolescent health and well-being (Vanderpool & Richmond, 1990). These behaviors afflict all kids, but they pose the most severe threats to poor children. Poor children have fewer educational and employment opportunities. This makes them particularly vulnerable to the attractions of sex, drugs, and violence and to their consequences—teenage parenthood, job and marital instability, emotional distress, accidental injury, disease, and death.

What do we know about how to keep kids from going off track? Researchers at RAND and elsewhere have assessed the effects of programs designed to prevent high-risk behavior among young teens. Most of these programs have been

based in schools, targeting adolescents in middle or junior high school. Most try to delay or prevent kids from beginning a specific problem behavior or to keep them from progressing to frequent involvement. The programs typically focus on changing the child by helping him or her develop the motivation to avoid high risk behavior and learn skills for resisting.

From these studies, we have learned a lot about what works. We also have learned about the limits of programs that focus solely on changing children's behavior without altering their social and economic circumstances. This paper summarizes the results of recent prevention research, discusses policy implications, and suggests strategies for improving our success rate.

What we've learned from prevention research

Two approaches that were popular in the past have had little success. They are:

- The information approach, which stresses the negative consequences of high risk behaviors, and
- The general skills approach, which helps children acquire a more positive self-image by improving their skills in decision-making, communication, and problem-solving (Ellickson & Robyn, 1987).

These programs failed because they were based on faulty assumptions. The first assumed that knowledge alone is enough to change behavior. The second assumed that a general sense of competence and self-esteem can help kids reject specific risky behaviors (Goodstadt, 1986). They also failed because they did not work on the central reason why kids begin problem behaviors—because their friends or other important people are doing it and because they think it will get them something they want.

The social influence model is the core of the most promising programs.

The next generation of programs grew out of a better understanding of why and how kids choose to engage in dangerous or deviant behavior. These programs zeroed in on teens' belief that "everyone's doing it" and helped them develop strategies for resisting social pressure. The social influence model is the core of the most promising programs. A few researchers have used it to postpone sexual activity, but most of our information about the model's effectiveness comes from evaluating its effect on drug use.

How the social influence model works

Adolescents are especially vulnerable to social pressures. They tend to copy adult behavior, including drinking, smoking, and using other drugs. Drug prevention programs based on the social influence model try to help adolescents recognize these pressures, develop arguments against them, and learn techniques for saying "no."

The model also recognizes that children must be motivated to resist (Ellickson & Robyn, 1987; Evans, Rozelle, Mittelmark, Hansen, Bane, & Havis, 1978). Social influence programs try to instill motivation to resist by helping kids understand the consequences of drug use, by undermining the belief that "everyone uses," and

by developing and reinforcing group norms against use. Adolescents tend to be unconcerned about consequences that lie in the future, so these programs emphasize how drugs can affect them now.

The original versions of the model were applied to smoking prevention and focused on external influences such as family, peers, and the media (Evans et al., 1978). Newer versions also stress internal pressures such as the desire to be accepted or to look cool (Ellickson, 1984).

Results from programs based on the social influence model

Smoking prevention programs report modest success. The reductions in smoking, usually measured at between 20 and 50 percent, typically last one to two years after the program. Follow-up lessons extend the effects (Best, Thomson, Santi, Smith, & Brown, 1988), but many early programs did not have boosters. Follow-up lessons are rare in high school, and, not surprisingly, program effects usually disappear during high school (Flay, Koepke, Thomson, Santi, Best, & Brown, 1989; Murray, Pirie, Luepker, & Pallonen, 1989). About 5 to 10 percent of students who participate in anti-smoking programs are helped—they are less likely to start smoking or to be current or frequent smokers (Cleary, Hitchcock, Semmer, Flinchbaugh, & Pinney, 1988).

Project ALERT reduced cigarette smoking by a third and curbed frequent heavy smoking among experimenters by 50 to 60 percent.

Smoking prevention programs have been most effective in delaying the onset of tobacco use and less successful in targeting high-risk and minority youth (Glynn, 1989). Most of these programs have been tested in communities that are white and middle class. However, two recent studies reported significant reductions in smoking among urban African-American and Hispanic students (Botvin, Batson, Witts-Vitale, Bess, Baker, & Dusenbury, 1989; Botvin, Dusenbury, Baker, James-Ortiz, & Kerner, 1989). Several reported "boomerang" or negative effects for previous smokers.

Programs focused on other substances have mixed results.

RAND's Project ALERT was designed to equip students with motivation and skills to resist pressures to use alcohol, cigarettes, and marijuana. It included eight lessons for seventh graders and three "booster" lessons for eighth graders. After three, twelve, and fifteen months, Project ALERT reduced both marijuana and cigarette use. It was effective for both low- and high-risk students and with minorities as well as whites. It delayed first use of marijuana and held down regular (weekly) use among prior users. It reduced cigarette smoking by a third and curbed frequent heavy smoking by students who had experimented with cigarettes by 50 to 60 percent. It was less successful against alcohol—the early effects disappeared by eighth grade (Ellickson & Bell, 1990).

Another program, Project STAR (University of Southern California's Midwestern Prevention Project) added several community components to a school-based program. Data from this program have been analyzed several times with different

results. The most recent analysis reported modest reduction in cigarette and marijuana use, but not in alcohol use (Johnson, Pentz, Weber, Dwyer, Baer, MacKinnon, & Hansen, 1990).

Similar programs, including Michigan's Alcohol Misuse Prevention Study and Cornell's Life Skills Training, also showed mixed results.

Project DARE, the police-led program that originated in Los Angeles, has shown little effect on behavior (Ringwalt, Ennett, & Holt, 1990).

Assessment of the research

The research shows that school-based programs can work. They are more likely to be effective against use of cigarettes and marijuana than alcohol. In addition, they are more likely to be effective with people who have never used or who have only experimented than with committed users. When the model is applied to sexual involvement, it is likely to have a higher success rate among those who are not yet sexually active (Howard & McCabe, 1990).

Although critics have suggested that the social influence model works only for middle class white kids, Project ALERT was successful in urban, suburban, and rural environments and in middle- and low-income communities with homogeneous or diverse populations. It worked in high-minority and low-minority schools. Similarly, the Life Skills Training approach has shown promise with both Hispanic and African-American kids, and the Atlanta program for postponing sexual involvement was tested in low-income schools with predominantly African-American students.

The social influence approach is most effective with kids who have not already committed themselves to a risky or deviant lifestyle. However, it has been shown to help both high- and low-risk kids. In fact, Project ALERT was more effective with cigarette experimenters than with nonsmokers. It also curbed regular marijuana use among the high-risk kids who had already tried it.

Project DARE has shown little effect on behavior.

Some authors think these programs are most effective when taught by older teens or same-age peers rather than adults. We think this verdict is premature. Project ALERT did not yield conclusive evidence favoring one mode of delivery over another.

Essential ingredients of school-based programs

We can use the outcomes of these program tests to determine which features of the programs are likely to work.

1. **The prevention process should start before or shortly after the onset of high-risk behavior.**

   The age at which kids begin a risky behavior varies, so the appropriate age for prevention will vary, too. In communities where children have already started smoking or drinking by the end of elementary school, it is more effective to target sixth graders rather than junior high school students. In other communities where the age of first experimentation is later, it is better to start social influ-

ence programs in junior high, when teens are particularly vulnerable to peer pressure. If the goal is to delay sexual activity, similar considerations apply. Usually these programs are most appropriate for eighth or ninth graders.

2. **Prevention programs should plan for the possibility that some adolescents may rebel against the message.**

   Social influence programs typically stress that high-risk behaviors can have negative effects on social relationships—they can get you in trouble, make you act silly, or give you ashtray breath. Messages like this may bolster the resolve of the uncommitted, but they may have a boomerang effect on those who are already committed to risky behavior.

   Project ALERT, for example, had a negative effect on committed cigarette smokers. Cigarette smoking tends to be public, while early marijuana use is not. The public setting for cigarette smoking makes this behavior harder to back away from. Public use seems to lock behaviors in place. It is not surprising that the more visible early smokers reacted negatively to the Project ALERT curriculum, while the less public marijuana users did not.

   Social influence programs typically stress that high-risk behaviors can get you in trouble, make you act silly, or give you ashtray breath.

   To minimize rebellious reactions, program developers should acknowledge that some teens may already be involved with drugs, sex, or other high-risk activities. They should explain that the program can help those teens change if they choose to do so. The goal should be to keep these kids in the program and ward off boomerang effects.

3. **Prevention programs should stress both motivation and skill building.**

   If children want to use drugs or be sexually active, it is not likely that simply learning a set of resistance skills will stop them. On the other hand, kids who don't want to engage in risky behaviors but who are not able to identify and resist them, are not likely to avoid temptation.

   With alcohol, the principal stumbling block often is weak motivation. Several studies showed that social influence programs have little or no effect on drinking, although they have produced significant effects on cigarette smoking and marijuana use. We think the difference lies in how society views these three substances. Most adults do not smoke or use pot, but they do drink. In light of that powerful message, convincing teenagers not to drink becomes a daunting task.

4. **The most successful programs build on social norms that foster the objectives of the program.**

   Evidence of the success of anti-smoking programs came on the heels of a radical decline in the popularity of cigarette smoking. After the 1964 Surgeon General's report and the anti-smoking campaigns of the late 1960s, cigarette consumption dropped dramatically (Warner, 1977). Big declines in marijuana use also came before the evidence that prevention programs could work. These changes in social norms created a climate in which cigarettes and marijuana became less desirable.

This kind of social climate does not exist for alcohol use. For that reason, it is less likely that prevention programs targeting alcohol use will succeed. The social norm against driving after drinking is stronger, and programs that target such alcohol-related problems and misuse of alcohol have been more successful.

5. **One intervention experience is not enough. Sustaining early gains requires multiple experiences over time.**

   Programs that included booster lessons had effects that lasted longer than one-time lessons. Most programs failed to continue this kind of reinforcement through high school, and the programs' effects wore off during the high school years. Programs that continue to offer booster lessons though high school would have a better chance of lasting effects.

Limitations of child-focused programs

Even the best programs will have only limited success if they aim at the child alone. Trying to "fix the kid" without changing the environmental factors that shape adolescent behavior appears to work for only 5 to 10 percent of teenagers. To make more substantial inroads, we need to deal with the many influences on children's behavior—families, schools, neighborhoods, and the broader society.

Peers play an important role in introducing kids to drugs, sex, and delinquency. But family and school experiences can increase or decrease a child's vulnerability to these influences. When their family situation is stressful and there is trouble at school, children are more likely to know and emulate peers and adults who engage in deviant behaviors (Ellickson & Hays, in press). But, a caring adult and success at school can protect kids from trouble (Rutter, 1985; Werner & Smith, 1982). Similarly, community and social norms can either promote or discourage problem behaviors.

Trying to "fix the kid" without changing the environment appears to work for only 5 to 10 percent of teenagers.

At the family level, parental support and discipline, and the connection between parent and child are particularly important (Baumrind, 1965). Disrupted families are not the problem. The problems arise from the consequences of disruption—loss of income, lack of time for the child, limited access to child care and health services, and hostility between the parents. These stresses strain the relationship between parent and child and make it hard to maintain consistent discipline. These stresses have risen dramatically for three reasons. One, there are more single-parent families. Two, the bottom fifth of American households are worse off economically. The third cause is a consequence of the other two—there are more children who are poor.

At the school level, children are affected by both their actual performance and by the expectations for their future academic achievement. Children who are doing well in school and who have plans for college or a career are less likely to get involved with drugs, to become teenage parents, or to be serious delinquents (Ellickson, & Hays, 1991; Ellickson & Hays, in press; Elliot, Huizinga, & Ageton, 1985).

Efforts to help families cope with stress and to make schools more positive environments for success should start in elementary school or before. They should provide extra assistance to kids who already show signs of trouble—disorderly conduct, poor attendance, or failing grades.

Policy implications

No single program or policy will fix the problems urban kids face. Efforts aimed solely at the child will delay or deter problem behavior for only 5 to 10 percent of teenagers. If that group includes the 20 percent at highest risk, these prevention programs may reach between one-quarter and one-half of high risk kids.

Social influence model programs have a low per-child cost.

Most experts agree that protecting kids from high risk behavior during adolescence has big payoffs. The earlier kids start high-risk activities, the more likely they are to continue them and the more likely they are to experience serious consequences (National Academy of Sciences, 1985; Robins & Pryzbeck, 1985). For this reason, delaying the onset of high-risk behaviors may result in less harm.

Are the benefits of programs that help only a small proportion of the total adolescent population worth the cost? We do not have the careful analysis that would answer this question with certainty. The greatest benefits come when the cost of failure is extremely high—programs that prevent AIDS and teen pregnancy, for example. There is also a relative benefit-to-cost advantage when the cost per child is low, and social influence model programs have a low per-child cost.

In principle, targeting programs at the most vulnerable kids appears to be the most cost-effective. But we know very little about how to identify the high-risk child before serious problems occur. And we know that programs designed for kids who are already in trouble, or who we think might get into trouble, can increase their risk by lumping them together with other kids in trouble and labeling them as "problems." We need careful evaluation of programs targeted at high-risk kids.

We also need a long-term commitment to deal with the social and economic forces that make our children vulnerable to harm as adolescents and adults. Specifically, we should examine the following promising ideas.

1. Develop and test sequential programs for curbing high-risk behavior during middle, junior, and high school.
2. Implement and evaluate new policies and programs for younger children. These programs should help families and schools provide environments in which children can flourish.
3. Recognize that some government policies make the problem worse instead of better. Then fix these policies.

America can no longer afford to stand by while millions of teenagers jeopardize their futures. We must invest in our children. We must build the foundation for them to become successful and productive adults. We must help them avoid risky choices that threaten their well-being. This investment should begin in childhood and be sustained through adolescence.

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A Review of Policies to Prevent Children From Smoking

Patrick Remington, MD, MPH

Today, most people try their first cigarette and become regular smokers as children. In Wisconsin, 83 percent of young adults (25 to 34 years) tried their first cigarette and 62 percent became regular smokers before they were 18 years old (Table 1). The percentage who begin smoking as children has increased dramatically over the last 50 years. This explains why smoking is now considered a "pediatric disease."

Table 1. Percent of adults who began smoking as children,* Wisconsin, 1995

	Percent who tried first cigarette as a child			Percent who became a regular smoker as a child		
Current age	Men	Women	Both	Men	Women	Both
25–34	83	84	83	61	63	62
35–44	79	66	72	51	44	47
45–64	67	57	62	45	24	35
65+	68	39	54	26	12	19

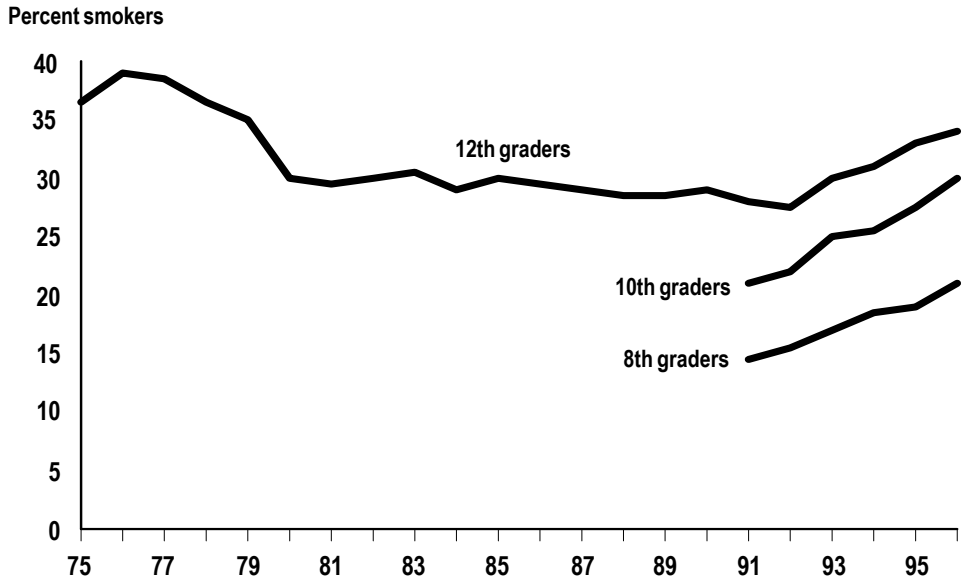
Note. From the 1995 Behavioral Risk Factor Survey, Wisconsin Division of Health.
*Children 17 years of age and younger.

Given all we have learned about the health risks of smoking, why do two-thirds of children try cigarettes—and about one-third become regular smokers, eventually addicted to nicotine? The answer is simple. Cigarettes are cheap, accessible, and one of the most heavily advertised products in America. The fact that cigarettes are dangerous and for "adults only" merely increases the appeal to adolescents.

Over the past 30 years, most efforts to prevent children from smoking have been directed at children in school. These health education classes discourage children from smoking by pointing out that smoking is dangerous—it can cause lung cancer, emphysema, or heart attacks. As a result, smoking rates among youth declined sharply during the late 1970s. But by 1980, smoking rates leveled off, and they began to increase in 1993. The rate among high school seniors in 1996 (34 percent) is the highest since the 1970s (Figure 1). Data from surveys of children in ninth through twelfth grade in Wisconsin show a similar recent increase in the rate of smoking (Table 2).

As a result of the increasing smoking rates among children, considerable public debate has been focused on what can be done to reverse this trend. The purpose of this paper is to review current policies that may prevent children from smoking—mass media, community programs, increased price, and restricted sales to minors.

Figure 1. Trends in smoking among school-aged children



Note. From *Monitoring the Future Study,* University of Michigan, 1997

Table 2. Trends in the percent of high school aged children who smoke,* Wisconsin and the U.S., 1991–95

Year	Wisconsin	U.S.
1991	23%	27%
1993	25%	30%
1995**	37%	35%

*Percent of high school students who smoked cigarettes in the last 30 days, grades 9–12, Youth Behavioral Risk Factor Surveys.
**Data from 1995 for Wisconsin are based on responses from only 19 school districts statewide.

Mass media

Young people are exposed to cigarette messages through print media and promotional activities such as offers for free jackets and lighters in exchange for cigarette carton tops. Cigarette advertising has been shown to affect young people's perceptions of the pervasiveness, image, and function of smoking. Advertising also increases young people's risk for smoking. The expenditure of $6 billion annually for advertising and promotion by the tobacco industry is practical proof of its effectiveness.

Although mass media have been used in the U.S. to convey messages urging youth not to smoke, these efforts have been meager when compared with the highly coordinated and well-funded campaigns of tobacco advertisers. Nevertheless, research suggests that mass media campaigns will be effective in reducing the demand for cigarettes if they are carefully designed and targeted to youth.

Community-based programs

Studies have shown that community-wide programs are effective in reducing smoking among youth. For example, community-based coalitions that promote local clean air ordinances, such as the smoking ban in Madison's restaurants, change the environment in which children live. With smoking banned in almost all places that children frequent, children of non-smoking parents may seldom see an adult smoke. One study suggested that if smoking were banned in all private work sites, smoking rates among youth would decline by 41 percent.

A recent report in the *Cancer Letter* suggests that statewide programs also can be effective in reducing tobacco use. The National Cancer Institute's $20 million American Stop-Smoking Intervention Study (ASSIST) demonstrated that interventions reduced smoking by 10 percent in the 17 intervention states (Wisconsin is included), and that the gap continues to widen. All 17 ASSIST states strengthened clean indoor air regulations, improved enforcement of laws restricting sales of tobacco to youth, and increased tobacco excise taxes. These initiatives have been supported through statewide and local tobacco coalitions. They promote nonsmoking as the social norm.

For every 10-percent increase in cigarette excise taxes, there is a 5-percent decrease in use among adults and a 10- to 15-percent decline among youth.

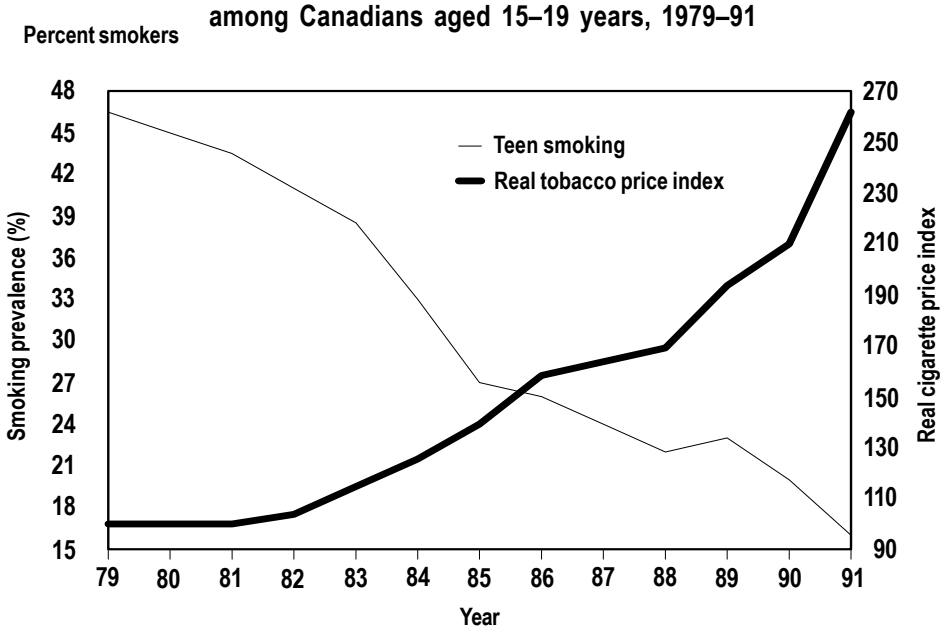
Taxation

One fundamental principle of economics states that when the real price of any commodity rises, consumption of that commodity falls. Many studies have shown that increasing the price of cigarettes— raising the excise tax, for example— leads to a reduction in smoking among young people. For every 10-percent increase in the price, there is a 5-percent decrease in use among adults and a 10- to 15-percent decline among youth.

In Canada increases in the excise tax were associated with sharp declines in youth smoking. In 1991, the average tax on a pack of cigarettes was $3.72, more than eight times what it was in 1980 and seven times the average in the U.S. These large increases in the tax were associated with a 35-percent decline in

smoking among adults and a 62-percent decline among children (Figure 2). This occurred at a time when smoking rates among youth had been rising.

Figure 2. Real* cigarette prices and cigarette smoking prevalence among Canadians aged 15–19 years, 1979–91



Note. From Health and Welfare Canada (1991); Sweanor (1992).
*The price of cigarettes relative to the price of all goods and services in Canada, adjusted for inflation with 1979–80 being the benchmark years.

Youth access

Restricting the availability of tobacco to minors is important for two reasons. First, it may limit the supply of cigarettes, reducing the likelihood that children who experiment will become regular smokers. Second, adding penalties for the purchase or possession of cigarettes by youth may discourage those who are afraid of breaking the law.

Although nearly every state has passed a law making sales to minors illegal, only two studies have demonstrated that these laws are associated with reduced youth smoking rates. Recent policies by the Department of Health and Human Services (Synar Amendment) and the Food and Drug Administration have called for increased compliance by vendors with state laws.

Summary

Many studies, including the recent evaluation of the ASSIST program, have demonstrated the effectiveness of policy interventions to prevent youth from smoking. These policies act in different and complementary ways. Some reduce the de-

mand for cigarettes among youth. For example, counter advertising reduces the appeal of smoking and clean indoor air ordinances change the social norm to one where smoking is seldom, if ever, viewed by young children. Other policies help reduce the supply of cigarettes for youth who have decided to experiment and smoke. Additional taxes increase the price of cigarettes and directly affect the ability of a child to purchase them. Programs that enforce existing laws prohibiting sale of cigarettes to minors make cigarettes even harder to get.

No single policy will be effective in preventing youth from smoking. States must consider a broad strategy that combines school-based health education with all of the policies described above. Several states, including California, Arizona, Massachusetts, and Michigan, have increased the cigarette excise tax and used some of the revenue to fund school health education and aggressive media and community-based programs targeted toward youth. Recent independent evaluations have shown that these statewide programs are effective in reducing smoking in the general population (Table 3). Progress in preventing youth from smoking will be more challenging, given the tobacco industry's determination and resources to do just the opposite.

Table 3. Impact and approximate costs of statewide strategies to prevent children from smoking in Wisconsin

Strategy	Reduces	Average annual cost*	Example
Mass media	Demand	$10–20 million	Counter-advertising
Community-wide programs	Demand	$5–10 million	Clean indoor air laws
Increased cost	Both	Generates $4 million per 1 cent increase	Cigarette excise taxes
Restricting sales to minors	Supply	$300–500,000	Enforcing bans on sales to youth

*Based on per capita budgets and evaluations of statewide programs in Massachusetts and California.

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ASSIST gets extra year of funding while NCI considers role in tobacco control. (1997). *Cancer Letter, 23*(2), 1-5.

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Building Results: From Wellness Goals to Positive Outcomes for Oregon's Children, Youth, and Families

Clara C. Pratt and Aphra Katzev

Oregon will develop the best future for its people if we share a common vision, develop strategies to achieve this vision, and track our progress toward this vision. The Oregon Commission on Children and Families and Oregon's 36 county commissions have identified five critical goals to improve the well-being of children, youth, and families (Figure 1). These goals will help focus government, non-governmental, business, and other community efforts.

Oregon's goals for children, youth, families, and communities are:

- Nurturing Families
- Healthy, Thriving Children
- Positive Youth Development
- Academic Success and Progress for Children and Youth
- Caring Communities and Systems

Oregon will reach these goals by making steady, deliberate steps— through hundreds of small and large community programs, collaborations, and other efforts. Indicators of progress—from statewide benchmarks to individual program performance indicators—are essential to guide each step toward our goals. Carefully planned, built on a solid empirical base, and consistently evaluated, these multiple community efforts will create a more positive environment for all children, youth, and families.

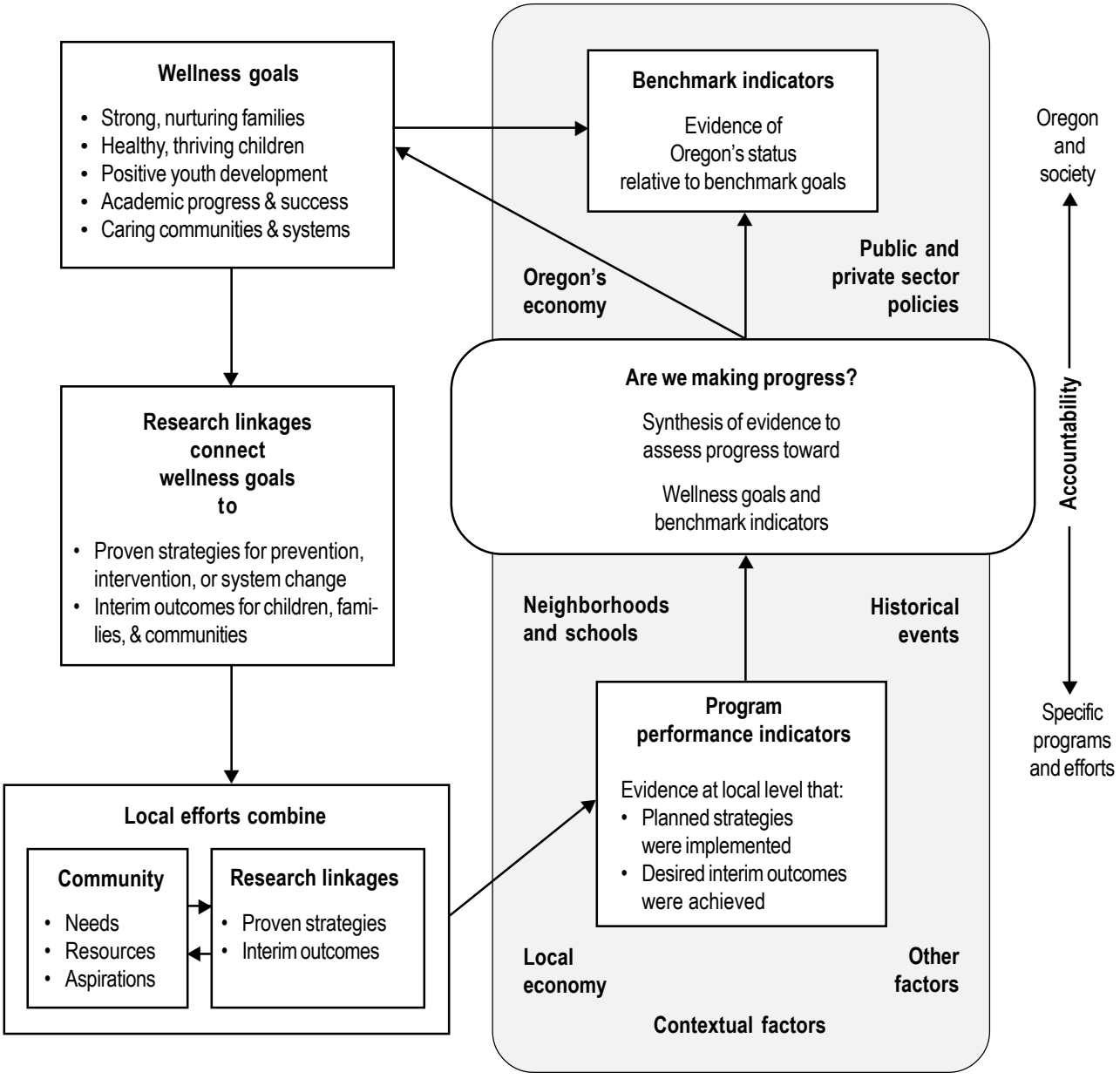
The model described in this paper illustrates the relationships among Oregon's wellness goals for children, youth, families, and communities. It describes:

- Research on interim outcomes and proven strategies to achieve these outcomes.
- Community needs, aspirations, and resources.
- Contextual factors that influence outcomes.
- Indicators of progress and accountability—benchmark indicators and program performance indicators.

Research linkages: Connecting goals to strategies and outcomes

Research can inform our efforts to improve the well-being of Oregon's children, youth, families, and communities. Specifically, research can help to:

Figure 1. Wellness for Oregon's Children, Youth, and Families



- Establish realistic short-term or interim outcomes that can be connected reliably to long-term goals.
- Identify prevention, intervention, and other strategies that are proven to be effective in reaching desired outcomes and goals.
- Define risk and other characteristics of persons who might benefit from support, thus helping communities to target prevention and intervention strategies.

In short, research can guide the development and evaluation of specific prevention and intervention efforts by revealing proven strategies and realistic, interim outcomes that will lead to long-term goals.

Research can reveal proven strategies and identify realistic, interim outcomes that will lead to long-term goals.

Research has limitations, however. Because human development and behavior are so complicated, research is just beginning to unravel the many factors that lead to positive, or negative, outcomes for children, youth, families, and communities. Sometimes studies provide conflicting findings. Other times, the individuals who were included in a study aren't really like those in another community. Perhaps the questions asked aren't exactly what we need to know. Most importantly, we learn more through new research every day.

Because of these limitations, research can inform, but not fully dictate, prevention and intervention efforts. Only research findings that met two criteria were included in this current guide. Specifically, the research had to, repeatedly and reliably, do the following.

- Demonstrate a strong connection between the desired goal and measurable, interim outcomes for children, youth, families, and communities.
- Clarify policies, programs, and other strategies that are proven to lead to the desired goals and interim outcomes.

This research provides critical information about achieving wellness goals through proven strategies and realistic interim outcomes.

Community needs, aspirations, and resources

To create locally appropriate strategies and outcomes, research must mesh with the needs, aspirations, and resources of individual communities. Communities can build on reliable research findings to:

- Guide the local assessment of needs and resources.
- Establish measurable interim outcomes for local prevention and intervention efforts.
- Focus prevention and intervention efforts on strategic activities with the greatest potential payoff.

In addition to building on empirically proven strategies and measurable interim outcomes, effective community planning also must do the following (Bogenschneider, 1996):

- Address important local needs, aspirations, and resources
- Involve the target audience in planning, design, implementation, and evaluation.
- Respond to cultural, ethnic, and gender diversity.
- Create a comprehensive, responsive, and ongoing support system for children, youth, and families.

Such effective community planning will result in successful local strategies that improve the well-being of children, youth, families, and communities.

Contextual factors

In this era of accountability, it is important to acknowledge the social, political, economic, and physical environments that can strongly influence the success of any program. For example, a very powerful and potentially effective youth employment program may fail to achieve its intended outcomes in times of high unemployment. Terrible weather can reduce participation in a planned series of classes. These and other major contextual factors that influence prevention and intervention efforts and outcomes must be acknowledged when planning, conducting, and evaluating program efforts.

Indicators of progress

When empirically sound and locally appropriate prevention and intervention efforts are underway, it is critical to monitor and evaluate these efforts. Two types of data or information can be used to assess progress toward Oregon's goals. These are:

- Oregon Benchmarks: aggregate social indicators such as statewide or county-wide rates of family poverty and juvenile crime.
- Program Performance Indicators: data or information on individual program efforts and outcomes.

Each type of indicator is discussed briefly below.

Oregon Benchmarks. Originally adopted in the early 1990's, Oregon Benchmarks rely on aggregated state (and in some cases regional, county, or local) data to provide a picture of Oregon's status relative to its various goals. For example, under the goal of "Nurturing Families, Thriving Children," Oregon identified several benchmark indicators, including statewide rates of child abuse, teenage pregnancy and parenthood, domestic violence, family poverty, and readiness to learn at entrance to kindergarten (Oregon Progress Board, 1994).

It is important to acknowledge the social, political, economic, and physical environments that can strongly influence the success of any program.

It is important to remember that benchmarks are indicators of our status relative to our goals. Benchmarks are not the goals themselves. Thus, the focus of OCCF and local CCF efforts is not solely on reaching these benchmarks, but rather on achieving the broader goals of healthy children, positive youth development, academic achievement for all children and youth, and nurturing families and communities.

For some of these goals, clear or powerful benchmarks have not been identified. For others, the benchmarks capture a minimum desired standard, not an ideal goal. For example, the lack of child maltreatment is one indicator of child well-being but it does not fully capture the goal of nurturing families. To more fully as-

sess progress toward Oregon's goals, benchmarks must be combined with performance indicators and other evidence of progress toward well-being for children, youth, and families.

Performance Indicators. Performance indicators tie long-term goals to specific program strategies and interim outcomes for children, youth, families, and communities.

There are three categories of program performance indicators—input, output, and outcome. All are important. Each provides vital and unique information about a program or other effort. The three categories of performance indicators are:

- **Input indicators.** What was invested in the effort? What resources (staff, skills, money, materials, and others) were allocated and used in the effort?
- **Output indicators.** What was done? What activities—educational workshops, newsletters, support groups, individual counseling, public awareness campaigns, or media events were undertaken? How long and how frequent were the activities? How many people participated? Was the intended participant group or audience reached?
- **Outcome indicators.** What resulted from the effort? What knowledge, skills, attitudes, or behaviors did participants demonstrate as a result of the intervention? Did risk factors for poor outcomes (such as teen pregnancy or alcohol abuse) decrease? Did protective factors (such as positive relationships or social support) increase? Did participants in the intervention demonstrate the desired behavior during and after the intervention period? Did teens avoid pregnancy, stay off drugs and alcohol, make academic progress? Did parents demonstrate positive parenting skills and create enriching home learning environments?

Most programs track input and output indicators. These provide essential information for understanding the nature and scope of prevention and intervention efforts. Outcomes or results of efforts are less often stated or tracked, but they are the critical third element if goals are to be effectively pursued and reached. As programs move to more fully assess outcomes, it is important to continue to track inputs and outputs as well. Results or outcomes make little sense without an understanding of the resources (inputs) and activities (outputs) that lead to these outcomes.

There are three categories of program performance indicators—input (what was invested?), output (what was done?), and outcome (what resulted?).

Ideally, performance outcomes are stated in the same terms as benchmarks. For example, if a community program addresses the state's benchmark of reduced juvenile crime, it is important for that program to track juvenile crime among participants. Stating performance outcomes in the same terms as benchmarks makes it easier to assess an individual program's contribution to achievement of the state's benchmarks and goals.

It is often not possible to directly use already collected benchmark data to assess the success of an individual program. Aggregate benchmark data cannot be used to assess outcomes of individual programs if:

- The program serves only part of the population included in the benchmark data. A very successful program that reduces delinquency among 100 at-risk teens is not likely to result in improvement in state or county-wide benchmarks on juvenile crime.
- Confidentiality or other data access problems limit identifying program participants in the aggregated benchmark data. A child abuse prevention program may serve 500 families in a large county. But confidentiality policies may limit identifying these families in the county or state records on confirmed child abuse and neglect cases.
- Benchmark data were collected or reported for periods of time that are not appropriate to evaluating a program. Readiness for school at age 5 is an Oregon benchmark. A parent education program may work with parents of infants and toddlers to increase the numbers of these children who are ready for kindergarten. The staff cannot, however, wait for these children to enter kindergarten in three to five years to determine the program's effectiveness.

When a program cannot rely directly on benchmark data to assess its outcomes, outcomes can still be related to benchmarks.

- Outcomes can be stated in the same behavioral terms as benchmarks such as alcohol use or sexual activity. Available records or program participants' self reports on this behavior can then be used to assess the effectiveness of the program.
- Programs can track outcomes in terms of other behaviors that are reliably related to a benchmark. For example, the parent education program that seeks to improve the readiness for kindergarten of toddlers can track parent behavior (such as creating a stimulating home learning environment) and toddler's abilities (such as pre-literacy skills). These parental behaviors and toddlers' abilities are strongly related to readiness for school at age 5 (Caldwell & Bradley, 1994).

Programs aimed at improving the high school graduation rate or reducing juvenile crime could assess such interim outcomes as:

- Commitment to school
- Attendance
- Behavioral referral and
- Grades.

These interim outcomes are strongly related both to eventual graduation and to juvenile crime prevention.

When interim outcomes are strongly and empirically related to longer-term goals, the achievement of these outcomes is evidence of progress toward those goals.

Are we making progress?

Taken together, program performance indicators, statewide and local benchmark data, and other community indicators can reveal our progress toward our long-term statewide goals. As we move toward positive youth development for all youth, we should see evidence of:

- Increased community opportunities for youth.
- More effective family support and supervision.
- Increased social skills and academic progress.

These interim outcomes will occur before we see statewide reductions in teen pregnancy or juvenile crime. Tracking these interim outcomes will inform us of where we are relative to state goals and benchmarks. Knowing this will allow for mid-course corrections and targeting resources into the most effective strategies.

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Prepared for Oregon Commission on Children and Families by Oregon State University Family Policy Program in conjunction with the OSU Extension Service Family Development Program. Contributors: Sandra Bailey, Ph.D.; Sally Bowman, Ph.D.; Ronald Dowd, Ph.D.; Claudia Hatmaker, Ph.D.; Tammy Henderson, M.S.; Katherine LeBlanc, Ph.D.; William McGuigan, B.S.; Rachel Ozretich, M.S. January 1997.

Assessing Success for Oregon's Healthy Start

Here's how family wellness outcomes have been linked to goals and benchmarks to measure the success of the Healthy Start Program in Oregon.

Healthy Start offers support to all families with newly born children, targeting first-birth families as they make the transition into parenthood. Almost 80 percent of first-birth families in the 12 participating counties were reached by Healthy Start during fiscal year 1995–96. Just 7 percent of them declined Healthy Start service.

All families reached by Healthy Start are screened for characteristics that may put them at risk for poor child or family outcomes, including child maltreatment.

Families with few, if any, risk characteristics are offered basic, short-term support services. Families with higher levels of stress and at risk for poor outcomes are eligible for longer-term intensive support. About two-thirds of the families received short-term basic service. One-third were eligible for longer-term service, but not all were served because intensive support services were full. About 25 percent of Healthy Start families in FY 95–96 received intensive service.

Healthy Start has made progress toward the following Oregon benchmarks.

Children will be ready for school at kindergarten age.

- More than 90 percent of babies from higher risk families are developing normally.
- 100 percent of the children whose development is outside the normal range have been referred for intervention services.
- 78 percent of Healthy Start's higher risk families consistently engage in positive parent-child interactions.
- 59 percent are creating well above average learning environments for their young children.

Families are linked to health care providers.

- Almost all of Healthy Start's children from higher risk families have a primary health care provider and 89 percent are receiving regular well-child checkups.
- 89 percent of the parents also have a primary health care provider and 85 percent never use costly emergency room services for routine health care.

Children are immunized.

- 90 percent of Healthy Start's babies from higher risk families are up-to-date with immunizations in comparison to 71 percent of Oregon's two-year-olds who are adequately immunized.
- More than 90 percent of Healthy Start's children from higher risk families will be immunized at age 2.

Risk of child maltreatment is reduced.

After 12 months of Healthy Start intensive support, higher risk families experience reductions in several risk factors, including chaotic lifestyles, untreated substance abuse or mental health problems, and the use of harsh punishment.

Quality of family life is improved.

After receiving 12 months of intensive service:

- 60 percent of higher risk families report that need for housing, food, and other basic resources are almost always met.
- 62 percent of higher risk families demonstrate consistently positive family functioning, including providing nurturing care for their children.

Selected Resources on Prevention, Smoking, Substance Use, and Juvenile Crime

Compiled by Kirsten D. Linney
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Room 323 Lowell Hall
Madison, WI 53703
(608) 263-4432

Statewide Resources

Alliance for a Drug-Free Wisconsin
Claude Gilmore, Director
Division of Child and Family Services
1 W. Wilson Street, Room 851
P. O. Box 7851
Madison, WI 53711
(608) 266-9354

Legislative Audit Bureau
Jennifer Noyes, Program Evaluation Director
131 W. Wilson Street, Suite 402
Madison, WI 53703
(608) 266-2818

The Legislative Audit Bureau recently published an evaluation of prevention programs for children, youth, and families in Wisconsin. This report overviews 88 different programs in Wisconsin and is available at no charge by contacting the Legislative Audit Bureau.

Office of Justice Assistance
Mr. Mike Derr, Juvenile Justice Specialist
222 State Street, 2nd Floor
Madison, WI 53702
(608) 266-7639

Prevention Coordination Committee
Dennis Kirchoff, Deputy Administrator
Division of Children and Family Services
Department of Health and Family Services (DHFS)
1 W. Wilson Street, Room 550
P. O. Box 8916
(608) 267-3687
email: kirchdj@dhfs.state.wi.us

Mr. Kirchoff also serves as Chair of the DHFS Prevention Coordination Committee. This Committee is comprised of individuals from various divisions within DHFS, other state departments and agencies, councils, and coalitions. The committee communicates across these various groups as well as with the University system on planning and implementing prevention activities. This group has been used by legislative councils to serve as a sounding board for ideas and recommendations in the area of prevention.

Tobacco Free Wisconsin Coalition
David Ahrens, Director
Susan Latton, Outreach Director
1930 Monroe Street, Suite 302
Madison, WI 53704
(608) 255-0058 or (608) 265-6386

Wisconsin Positive Youth Development Initiative, Inc.
Sue Allen
110B S. Main Street
P. O. Box 490
Plainfield, WI 54966-0490
(715) 335-6100
(715) 335-6105 (fax)

Wisconsin Prevention Network
Cindy Rewolinski, Director
711 W. Capitol Drive, Room 210
Milwaukee, WI 53206
(414) 264-2660

National Resources

American Cancer Society
1599 Clifton Road, NE
Atlanta, GA 30329
1-800-ACS-2345

Centers for Disease Control and Prevention

Office on Smoking and Health
4770 Buford Highway, N.E.
Mail Stop K-50
Atlanta, GA 30341
(404) 488-5701

The Office on Smoking and Health coordinates efforts to prevent and stop tobacco use. They provide information on and assistance with developing tobacco control plans, coalition development, communication strategies, and community outreach. A related website from this organization on tobacco information and prevention is: www.cdc.gov/nccdphp/osh/tobacco.htm

Coalition on Smoking or Health
1150 Connecticut Avenue, NW, Suite 820
Washington, DC 20036
(202) 452-1184

This coalition is a project of the American Cancer Society, the American Lung Association, and the American Heart Association. They maintain an information network on state legislative activity.

Juvenile Justice Clearinghouse
Box 6000
Rockville, MD 20850
1-800-638-8736

The Juvenile Justice Clearinghouse was established by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) as a component of the National Criminal Justice Reference Service. The Juvenile Justice Clearinghouse is responsible for the coordination and distribution of OJJDP publications as well as information regarding research, training, and program initiatives sponsored by OJJDP.

National Clearinghouse on Alcohol & Drug Information
1-800-729-6686
www.health.org/pubs/makelink/ml-collg.htm

This organization also creates "Prevline," an on-line prevention resource site, where you can find searchable databases as well as substance abuse prevention materials dealing with alcohol, tobacco, and other drugs.

National Women's Resource Center
515 King Street, Suite 410
Alexandria, VA 22314
(703) 836-8761

The National Women's Resource Center deals with prevention and treatment of alcohol, tobacco, and other drug abuse, in addition to mental illness. This Center can provide information and research findings on various health-related issues of concern to women of all ages.

School Programs to Prevent Smoking: The National Cancer Institute Guide to Strategies That Succeed
The National Cancer Institute
Office of Cancer Communications, Building 31, Room 10A24
Bethesda, MD 20892
1-800-4-CANCER

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