

Communities that Care of Marinette & Menominee Counties



Our vision is to provide a community in which all area youth feel safe and connected; a community in which youth are empowered to be healthy, resilient, and compassionate members of society; and a community in which young people positively contribute and impact future generations.

Resource Assessment Report

September 2018 edition

Prepared by:

CTC Resource Assessment Workgroup

Sponsored by:

Menominee County ISD

NorthCare Network

Tri-City Area United Way

Resource Assessment Outline

- Key Accomplishments

- Introduction

- Resource Assessment

- Agencies Contacted

- Recommendations

- Conclusion

KEY ACCOMPLISHMENTS TO DATE:

- **50+** Community Leaders attended the Key Leader Orientation in August 2017.
- **70+** Community Members attended the two-day training session in October 2017.
- Seven active work groups were created
 - o Resource Assessment, Risk and Protective Factor Assessment, Funding, Youth Involvement, Mental Health Awareness & Suicide Prevention, Outreach, and Maintenance
 - Includes **50+** active community volunteers
- Local data was gathered and the Community Assessment was completed
- Data presentations were delivered to various community groups such as; Tri-City Area United Way board members, CTC Key Leader members, CTC Coalition members, and Marinette and Menominee Superintendents
- Top five priorities were released to the public
- Voting was held April 20th – June 1st and approximately 1100 community members submitted ballots on their top two choices out of the five
 - o Three were selected with the highest votes: Poor Family Management, Favorable Attitudes Towards Drug Use and Community Involvement for Prosocial Behavior
- Resource Assessment was completed and recommendations were released

INTRODUCTION:

What is Communities That Care?

Communities that Care of Marinette and Menominee Counties is a collaborative project of public and private health, education human service and civic organizations; local businesses; and citizens.

The Marinette & Menominee Communities that Care (CTC) prevention model strives to better the lives of our youth and in turn the entire community. This new program to our community will utilize resources that are already in place and will enhance what is proven to be effective within these resources. There are many great organizations and volunteers in the community, but there are no community driven goals for the youth. If there is no community goal or objective, the results are limited to only a select few and lack longevity. Our CTC, along with community leadership, are tasked with working to improve the key areas indicated by our community vote.

The Resource Assessment

The key goal of the Communities That Care system is for the community to develop a profile of the risk factors, protective factors that affect problem behaviors in their community. A plan will be developed for addressing these factors. The Resource workgroup participants have collected information about the resources that address the Marinette and Menominee counties priority risk and protective factors that were selected from community voting.

Communities That Care Resource Workshop Participants:

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CTC Coordinators: Cindy Grabowski & Karianne Lesperance

How the information was collected

During the Assessing Community Resources Workshop, workgroup members created a list of agencies, organizations and groups in the area that provide programming for youth.

Members of the Resource Assessment workshop, programming agency representatives and the coalition coordinators administered a survey to community agencies, and organizations on the list. As a result, workgroup members identified resources available to youth in the Counties that fit the criteria of tested and effective prevention strategies. Very few local agencies responded to the survey making it difficult to assess resources in our community. It has been determined through agency responses that few use evidence-based programming currently used in our community to address our priorities. To follow the national CTC model with fidelity, we must select evidence-based programs solely from the “Blueprints” website (www.blueprintsprograms.org). According to the website, Blueprints for Healthy Youth Development provides a registry of evidence-based positive youth development programs designed to promote the health and well-being of children and teens. Blueprints programs are family, school, and community-based and target all levels of need — from broad prevention programs that promote positive behaviors while decreasing negative behaviors, to highly-targeted programs for at-risk children and troubled teens that get them back on track. The evidence-based Blueprints model and promising programs will help us get a head start on preparing children for success with programs that have the highest standards in the field. Blueprints programs are identified based upon an initial review by CSPV of a program's evaluation evidence and a final review and recommendation from a distinguished Advisory Board, consisting of seven experts in the field of positive youth development. More than 1,500 programs have been reviewed, but less than 5% of them have been designated as model and promising programs. These programs will help young people reach their full potential by promoting positive youth development such as academic performance and success, emotional well-being, positive relationships, and physical health. Blueprints prevention and intervention programs also help young people to overcome challenges associated with violence, delinquency, and substance abuse. Blueprints continues to look for programs which meet the selection criteria.

WORKSHOP OVERVIEW:

The next sections of the report provide detailed information about the counties' resources and gaps, organized by priority risk factor.

Priority #1: Poor Family Management

Poor family management practices include having a lack of clear expectations for behavior; failure of parents to supervise and monitor their children (knowing where they are and who they're with); and excessively severe, harsh or inconsistent punishment. Children exposed to these family management practices are at higher risk for substance abuse, delinquency, teen pregnancy, school dropout and violence.

Findings:

Evidence-based programming that currently targets this priority in Marinette and Menominee Counties:

- **Strengthening Families (parents with children 10-14)** - The Strengthening Families Program is a 14-session, evidence-based parenting skills, children's social skills, and family life skills training program specifically designed for high-risk families. Parents and children participate in SFP, both separately and together. Group Leader Manuals contain a complete lesson for every session. Parents' and children's Handouts are also provided for every session

Strengths in our community regarding this program: Two years ago a large amount of professionals were trained in the program through Tri-City Area United Way. Since then, Strengthening Families has been conducted twice in our community, once in the City of Marinette (sponsored by Tri-City Area United Way) and the other in the County of Menominee (sponsored by Public Health Delta & Menominee Counties). The Healthy Youth Coalition has received small funding through the "Partnership for Success (PFS)" WI grant for the next few years to contribute to programs on the Marinette County side.

Gaps in our community regarding this program: Strengthening Families will now be replaced in the action plan of Public Health Delta & Menominee Counties with the Guiding Good Choices program. Tri-City Area United Way no longer has funding to provide for this to Marinette County, and has vocalized another agency overseeing it on the Wisconsin side. The Healthy Youth Coalition will also no longer be able to put funds toward this program in Marinette County after 2020. Unfortunately, even with the large amount of trained facilitators, gathering enough to hold a session has been a struggle for both agencies. This particular program only targets middle school youth.

Priority #2: Favorable attitudes Towards Drug Use

During the elementary years, children usually express anti-drug views. In middle school, as their peers participate in such activities, their attitudes may shift toward greater acceptance, which places them at higher risk. If youth believe that there is a favorable attitude toward drug use, they are more likely to start using. This may also increase other risk factors.

Findings:

Evidence-based programming that currently targets this priority in Marinette and Menominee Counties:

- **Botvin’s LifeSkills Training (6-8 grades)** - Botvin LifeSkills Training (LST) is an evidence-based substance abuse and violence prevention program that is uniquely designed to be flexible and interactive. The program can be taught either on an intensive schedule (two to three times a week) until the program is complete, or on a more extended schedule (once a week until the program is complete). Both formats have proven to be effective. While one year of LST has been proven to achieve measurable positive effects, multi-year implementation is strongly recommended. The LST program has been extensively tested and proven effective at reducing tobacco, alcohol, opioid, and illicit drug use by as much as 80%. Long-term follow-up studies also show that it produces prevention effects that are durable and long-lasting
- **Big Brothers Big Sisters of America** - Big Brothers Big Sisters (BBBS) makes meaningful, monitored matches between adult volunteers (“Bigs”) and children (“Littles”), ages 6 through 18, in communities across the country. BBBS develops positive relationships that have a direct and lasting effect on the lives of young people.
- **Strengthening Families (parents with children 10-14)**

Strengths in our community regarding the programs: Botvin’s is currently offered and implemented to all 6-8th grade classes in Menominee County. The Healthy Youth Coalition of Marinette & Menominee Counties and Public Health, Delta and Menominee Counties staff implement the program and both receive NorthCare Network state prevention money to do so. The only district in Marinette County currently implementing the program is Marinette School District. They have additional strengths incorporating the program in all 4th – 8th grade classes and are currently requiring staff to facilitate the program. Strengthening Families has been conducted twice in our community, once in the City of Marinette (sponsored by Tri-City Area United Way) and the other in the County of Menominee (sponsored by Public Health Delta & Menominee Counties). The Healthy Youth Coalition has received small funding through the “Partnership for Success (PFS)” WI grant for the next few years on the Marinette County side. Big Brothers Big Sisters of America has been around in Marinette & Menominee for many years and has made countless matches and successes.

Gaps in our community regarding the programs: Botvin’s does not have long-term funding for Marinette County. The Healthy Youth Coalition currently receives PFS dollars to offer the program to the school districts, but does not receive additional funds to provide staff to teach the program. They will no longer be able to provide funds to continue supporting training and materials to schools after 2020. Strengthening Families will now be replaced in the action plan of Public Health Delta & Menominee Counties with the Guiding Good Choices program. Tri-City Area United Way no longer has funding to provide for this to Marinette County, and has vocalized another agency overseeing it on the Wisconsin side. The Healthy Youth Coalition will also no

longer be able to put funds toward this program in Marinette County after 2020. Big Brothers Big Sisters have limited staff and funding resulting in less programming and matches in the counties.

Priority #3: Community Involvement for Prosocial Behavior

If youth are involved in community opportunities for prosocial involvement, rewards will go along with their participation and less poor behavior choices will be made. Goals associated with this factor are to create a system in place to ensure that all youth can be involved regardless of income, transportation, and family status.

Findings:

Evidence-based programming that currently targets this priority in Marinette and Menominee Counties:

- **Big Brothers Big Sisters of America**

(Repeated program from first priority. Please see above for strengths and gaps information).

RESOURCE ASSESSMENT ANALYSIS:

Workshop participants noted that our counties serve over 60,000 people, yet overall only implements three evidence-based Blueprints programs. Participants expressed concern that priority #1, in particular, has over 20 Blueprints programs available and we are only implementing one. This was the highest priority voted on among community members, but yet is the priority the group felt was not being targeted enough. It was also discussed that even though our counties are implementing few Blueprint programs, we tend to be targeting only middle-school aged youth. All other age groups tend to be missed, especially in Marinette County. Participants agreed that our agencies are implementing numerous programs that target our three top priorities, but are not all are Blueprints evidence-based. It was also mentioned that not enough community agencies were at the table when creating the agency contact list.

RECOMMENDATIONS:

Workshop participants spent hours of researching Blueprints programs online based off of the top three priorities. After a compilation of recommended programs from each group, participants narrowed down the list to the six top programs that seem feasible for our counties. The group tried to select the programs that targeted two or more of the priorities if possible. One program targets all three priorities and is noted with an asterisk symbol (*).

Recommended program #1: "Child First"

Priorities Addressed: Opportunities for Prosocial Behavior and Poor Family Management

DESCRIPTION OF PROGRAM

Child First is a two-generation, home-based, psychotherapeutic intervention that works with very vulnerable young children, prenatal through age 5 years, and their families, most of whom have experienced significant

trauma and adversity (including poverty, domestic violence, maternal depression, substance abuse, and homelessness). The goal is to decrease serious mental health concerns in child and parent, child developmental and learning problems, and abuse and neglect. It has two core components: (a) a system of care approach to stabilize and provide comprehensive, integrated services and supports to the child and his/her family (e.g., early education, housing, substance abuse treatment), thereby both decreasing stress and enhancing child development, and (b) a relationship-based approach to heal the effects of trauma and adversity by enhancing nurturing, responsive parent-child relationships and promoting positive social-emotional and cognitive development. The program is implemented in subject's homes to increase effectiveness and reduce barriers to treatment. The program implementation period is adjusted based on families' needs with an average duration of 6-12 months. Unique to the Child First intervention is that it provides intervention based on parental needs rather than based on a fixed curriculum. Each family is assigned to a clinical team, consisting of a licensed, master's level mental health clinician and a bachelor's level care coordinator. The care coordinator facilitates family engagement with multiple community services, while promoting adult executive capacity, including child development and early care and education, child and family health, parent support, adult education and employment, adult mental health and substance use, and social services and concrete needs. In contrast, the mental health clinician is responsible for therapeutic assessment and intervention, using a relationship-based, trauma-informed child-parent psychotherapy approach. This enhances parental reflectivity and empathy in order to improve parents' sensitivity and responsiveness to the child. Mental health consultation to early care and education is included for all children. All staff receive intensive reflective clinical supervision. The ultimate goal is to protect and heal young children and families from the impact of trauma and chronic stress.

AGE - Infant (0-2) & Early Childhood (3-4) - Preschool

Program Setting - Home

OUTCOMES

Comparing the Child FIRST intervention to a control group, the following significant program effects were reported by Lowell et al. (2011):

- Decrease in externalizing behavior (at the 6-month follow-up),
- Improvement in language skills (at both posttest and 6-month follow-up),
- Among parents, improvement in overall psychiatric well-being, lowering of depression symptoms (at 6-month follow-up), and reduction in stress (at posttest),
- Lower levels of involvement with Child Protective Services (at the 30-month follow-up),
- Increased access to community-based services (at both posttest and 6-month follow-up).

Risk Factors

- Individual: Antisocial/aggressive behavior*, Early initiation of antisocial behavior*, Physical violence*
- Family: Family conflict/violence*, Family history of problem behavior, Family transitions and mobility, Low socioeconomic status, Neglectful parenting*, Parent history of mental health difficulties*, Parent stress*, Poor family management, Unplanned pregnancy, Violent discipline*

Protective Factors

- Individual: Problem solving skills, Prosocial behavior*
- Family: Attachment to parents, Non-violent discipline*, Parent social support
- Neighborhood/Community: Opportunities for prosocial involvement

*Risk/Protective Factor was significantly impacted by the program.

START-UP COSTS

Initial Training and Technical Assistance

- Start-up fee for new agencies: \$25,000
- Start-up training fees: \$16,000 for Clinical Director/Supervisor; \$10,000 for each Clinician and Care Coordinator

Curriculum and Materials

- All curricula are included in training fees
- Sites must purchase copyrighted assessment forms

Materials Available in Other Language: All assessments and family materials are available in Spanish, however, the Manual, Toolkit, Distance Learning, and Learning Collaborative materials are only in English.

Licensing

Once initial training is completed, \$15,000 annually plus \$5,000 for each Clinician Team (a Clinical Team includes a Clinician and Care Coordinator)

Other Start-Up Costs

- Computers and other setup for new employees (will vary depending on what the agency need to purchase)
- Child First data system (Child First Comprehensive Clinical Record-CFCR) planning and setup
- Child First Clinical Teams from an affiliate agency should be located together. Space requirements include officers for confidential conversations and an available meeting room for group supervision. Children and families are not seen in the office.
- Staff time for participation in training
- Video cameras for Teams
- Therapeutic toys for home visits

INTERVENTION IMPLEMENTATION COSTS

Ongoing Curriculum and Materials

Assessments that are administered at baseline, 6 months, and discharge. The cost for assessments per team is estimated at a high of \$900/year.

Staffing

Qualifications:

- Master's level licensed Clinical Director/Supervisor, with 5 years' relevant experience
- Master's level licensed Mental Health/Child Development Clinician, preferably with 3 years' experience
- Bachelor's level Care Coordinator, who is familiar with community to be served and available services.
- Staff must be multicultural/multilingual reflecting population to be served. Salaries vary depending on local labor market.

Ratios:

- A full-time Clinical Director/Supervisor can oversee 4-5 teams

- A Child First Team (includes a full-time Mental Health/Child Development Clinician and a full-time Care Coordinator working together) typically carries a caseload of 12-16 families

Time to Deliver Intervention:

- Families receive visits twice per week during the assessment period (first month) and then once a week or more, depending on the needs of the child and family. Visits last 1-1.5 hours.
- After assessment, Clinicians and Care Coordinators may visit together or separately, based on the individual family needs.
- Services generally continue for six to twelve months but can go longer depending on the needs of the family.

Other Implementation Costs

- Clinician and Care Coordinator travel for weekly visits with each family reimbursed on a per mile basis.
- Child First expects some involvement of the agency leadership. Senior leaders are invited to attend training and are expected to participate in quarterly calls or in-person meetings with other Sr. Leaders.
- Site will likely require some administrative support for data systems and reporting (up to .5 FTE) and for inquiries and referral (.25 – 1.0 FTE).

IMPLEMENTATION SUPPORT AND FIDELITY MONITORING COSTS

Ongoing Training and Technical Assistance

Training cost is included in annual licensing fees, except in the case of training for new staff due to turnover where a fee may be charged.

Fidelity Monitoring and Evaluation

Currently included in annual licensing fees. Child First system user fees may be charged to sites in the future.

Other Implementation Support and Fidelity Monitoring Costs - None

OTHER COST CONSIDERATIONS

Child First works with a regional or state partner to build and support the infrastructure necessary to support a regional or state Child First network of sites. Replication of the Child First model usually occurs at various sites simultaneously for two reasons: (1) so there is a critical mass of teams to be trained as part of a Learning Collaborative, and (2) so that Child First is implemented as part of a larger early childhood system.

YEAR ONE COST EXAMPLE

The following Year 1 costs are based on an affiliate agency that trains one Clinical Director/Supervisor and four Child First Teams to serve 60 families in the first year of implementation. The example assumes that the program is implemented in a community service agency with appropriate space for private and group meetings and equipment for clinicians. Staffing costs include estimated salary and benefits for the level of experience required for the position. Staffing expenses will vary based on the local labor market.

Start-up Fee

\$25,000

Start-up Training Cost - Supervisor

\$16,000

Start-up Training Cost - Clinical Teams (\$10,000 x 8 staff)

\$80,000

Assessment - \$900 x 4
\$3,600
Staffing Costs for Full-Time Clinical Director
\$100,000
Staffing Costs for Full-Time Child Development Clinician (\$75,000 x 4)
\$300,000
Staffing Costs for Full-Time Care Coordinator (\$55,000 x 4)
\$220,000
Travel
\$10,000
Overhead and Office at 20% of staff
\$124,000

Total Year One Cost
\$878,600

For one community agency serving 60 families, the first year expense would be \$14,643 per family. The costs would decrease significantly in subsequent years as the initial start-up and training fees are start-up costs that would not be incurred beyond year 1. Child First analysis of average cost per family in Connecticut implementation is \$8,000 per family.

For additional information, visit <https://www.blueprintsprograms.org/factsheet/child-first>.

Recommended Program #2: “Family Foundations”

Priorities addressed: Poor Family Management

DESCRIPTION OF PROGRAM

Family Foundations is a universal prevention program developed in collaboration with childbirth educators to enhance coparenting quality among couples who are expecting their first child. The program consists of four prenatal and four postnatal sessions, run once a week, with each two-hour session administered to groups of 6–10 couples. Sessions are led by a trained male-female team and follow the Family Foundations curriculum. The female leader is a childbirth educator. Ongoing observation of sessions facilitates regular supervision discussions.

This program focuses on coparenting and the coparenting relationship, rather than other romantic relationship or parenting qualities. In assisting parents to work together supportively, the program content covers emotional self-management, conflict management, problem solving, communication, and mutual support strategies. The program organizes material into three major domains: Feelings, Thoughts, and Communication. These domains help participants remember and utilize program tools. Parenting strategies include an understanding of temperament, fostering children’s self-regulation, and promoting attachment security. However, as the focus is on coparenting, these topics are examined in terms of whole-family dynamics. The prenatal classes introduce the couple to themes and skills, and the postnatal classes revisit the themes once the couple has experienced life as parents and coparents. The delivery is psychoeducational and skills-based, with didactic presentations, couple communication exercises, written worksheets, videotaped

vignettes of other families, and group discussion. Skilled facilitators are able to maintain fidelity to the content while engaging parents in an interactive, supportive group learning context.

Developed as a universal group-format program, ongoing research is assessing adaptations of delivery, content, and target population. For example, an adaptation for high-risk, home-visited mothers and partners is currently in a research trial; an adaptation for low-income teens has been piloted; an online version for military reserve and National Guard families is being developed; and an enhanced version for couples at risk of family violence is planned.

AGE - Infant 0-2 and Adult

SETTING - Community, Hospital/Medical Center

OUTCOMES

At wave 2 (posttest, when children were about six months), the study (Feinberg & Kan, 2008) reported a significant intervention effect for:

- Fathers' coparental support, parenting-based closeness, and parent-child dysfunctional interaction
- Mothers' coparental support, depressive symptoms, and anxiety
- Father-reported infant soothability
- Child duration of orienting

At wave 3 (six-month follow-up, when children were about one year old), intervention participants showed improved (Feinberg et al., 2009):

- Mothers' coparenting competition, coparenting triangulation, warmth to partner, parenting positivity, coparenting inclusion, and negative communication
- Fathers' coparenting competition, coparenting triangulation, warmth to partner, parenting positivity, coparenting warmth, and parenting negativity
- Observed child self-soothing

At wave 4 (2.5-year follow-up, when children were three years old), intervention participants showed program effects for (Feinberg et al., 2010):

- Parent-reported parental stress, parental efficacy, coparenting quality, parenting overreactivity, parenting laxness, and physical punishment
- Mother-reported child total behavior problems, externalizing problems, aggression, and social competence
- Mother-reported child internalizing problems and attention/hyperactivity (boys only)

At wave 5 (six year follow-up, when children were 6-7.5 years old), intervention participants showed improvements in the following child outcomes (Feinberg, Jones et al., 2014)

- Teacher-reported anxious/depressed and internalizing problems
- Teacher-reported attention problems, aggressive behavior, and externalizing problems (boys only)

Pregnancy-related outcomes from mid-program showed a significant intervention effect (Feinberg, Roettger et al., 2014):

- Reduced levels of Caesarian birth

In Feinberg et al. (2015), the program had no main effects on birth weight, maternal length of hospital stay, or neonatal length of hospital stay, but it did help some subgroups by improving

- birth weight at low gestational age among parents with high economic strain or maternal depression
- newborn length of stay among parents with high economic strain, depression, or anxiety
- maternal length of stay among parents with high economic strain

At the 2-year follow-up assessment (approximately two years post-intervention when children were two years old), Jones et al. (2018) found that the intervention group (compared to the control group) showed significantly:

- Greater observational family interaction coparenting triadic relationship quality
- Lower observational family interaction coparenting negativity
- Lower observational family interaction parenting negativity
- Fewer parent-reported child internalizing behaviors
- Fewer parent-reported child nighttime wakings

SUBGROUP DETAILS

Some child outcomes showed an intervention effect only for boys. These included internalizing, attention/hyperactivity, and relationship satisfaction collected at wave 4 and attention problems, aggressive behavior, and externalizing at wave 5. Supplemental analysis, gathered during the Blueprints review, also showed that anxious/depressed and Internalizing was only significant for the boys at wave 5. Some child outcomes showed intervention effects across gender, but stronger effects for boys. These included total behavior problems, externalizing, and aggression from wave 4.

RISK FACTORS

- Family: Family conflict/violence, Parent aggravation*, Parent stress*, Poor family management, Psychological aggression/discipline, Violent discipline

PROTECTIVE FACTORS

- Individual: Skills for social interaction*
- Family: Attachment to parents, Non-violent discipline*

*Risk/Protective Factor was significantly impacted by the program.

START-UP COSTS

Initial Training and Technical Assistance

The cost of an on-site training workshop is \$3,000, plus travel and lodging expenses for the trainer(s). Open-enrollment workshops for multiple sites are \$375.00 per person for the full training. The training workshops are 2 1/2 days in length -- 1.5 days for overview and prenatal content, and one day for review and postnatal content. An on-site training is accompanied by one hour of post-training technical assistance on a complimentary basis, with additional technical assistance available.

Local supervisor(s) should also be trained, and then observe trainee facilitator sessions and provide supervision support to enhance fidelity and group-leading quality.

Curriculum and Materials - \$325/manual

Licensing - None.

Other Start-Up Costs

DVD/laptop and projector, if not already available.

Videotaped review of new trainee practice session, \$100 (optional).

Inexpensive dinner for participants if desired; babysitting for postnatal classes if desired.

INTERVENTION IMPLEMENTATION COSTS

Ongoing Curriculum and Materials

\$30/couple for workbooks.

Staffing

Two co-facilitators (male and female) lead the sessions. Facilitators should have experience and comfort in working with families and in leading groups/classes. The training provides the key information for them to deliver the program effectively.

IMPLEMENTATION SUPPORT AND FIDELITY MONITORING COSTS

Ongoing Training and Technical Assistance

No ongoing training is required. An optional videotape review of class is \$100.

The first hour of technical assistance is free with the on-site training. Thereafter, \$50-\$100/hour by phone as needed.

Fidelity Monitoring and Evaluation

An observer at one to two classes per cohort, especially for new trainees, is optimal. Fidelity observation forms are provided for each session.

Ongoing License Fees - None

Other Implementation Support and Fidelity Monitoring Costs - None

YEAR ONE COST EXAMPLE

This example assumes that a community-based organization would deliver the Family Foundations program on-site to 4 cohorts, each including 10 couples. Two co-facilitators (male and female) would be contracted to lead the sessions.

On-site training 2 1/2 days

\$3,000

Trainer travel expense

\$1,500

Facilitator manuals: 2 x \$325

\$650

Parent workbooks: 10 couples x 4 cohorts x \$30/workbook

\$1,200

Facilitator salaries: 2 facil x 2 hr x 8 sessn x 4 cohort x \$25/hr

\$3,200

Total Year One Cost

\$9,550

The Year One expense for delivering the program to 40 couples would be \$238.75 per couple. If space on-site is unavailable, an additional cost would be incurred to rent space for the parent group sessions. Other optional costs may include an inexpensive dinner and childcare.

For more information, visit <https://www.blueprintsprograms.org/factsheet/family-foundations>

Recommended Program #3: “Guiding Good Choices”

Priorities Addressed: Favorable Attitudes towards Drug Use and Poor Family Management

DESCRIPTION OF PROGRAM

Guiding Good Choices (GGC) is a family skills-training program for parents and their middle-school aged children. The program is based on the social development model and its primary objectives are to enhance protective parent-child interactions and to reduce child risk for early substance use initiation. GGC consists of a five-session, multimedia drug resistance and education program for adolescents and their parents. Adolescent participants are required to attend one session which teaches peer resistance skills. The parents receive four sessions of instruction including material on the (a) identification of risk factors for adolescent substance abuse and a strategy to enhance protective family processes; (b) development of effective parenting practices, particularly regarding substance use issues; (c) family conflict management; and (d) use of family meeting as a vehicle for improving family management and positive child involvement. Each session runs approximately two hours in length.

Specifically, Session 1 creates opportunities for involvement and interaction in the family and rewarding children's participation in the family. Session 2 establishes clear family rules about substance use, monitoring the behavior of children, and disciplining children. Session 3 teaches children skills needed to resist peer influences to use drugs. Session 4 focuses on reducing and managing anger and family conflict. Session 5 focuses on expressing positive feelings and developing bonding.

AGE - Early Adolescence (12-14) - Middle School

PROGRAM SETTING - School

OUTCOMES

In a study of families of sixth graders enrolled in 33 rural schools in 19 counties in a Midwestern state: Youth in the GGC (Guiding Good Choices) group who had not initiated substance use at the time of the one-year follow-up were more likely to remain in the no-use group through the two-year follow-up than control group adolescents.

Youth in the GGC group who had initiated substance use at the one-year follow-up were more likely to have remained in their one-year follow-up substance use status through the two-year follow-up than control group youth.

Although substance use rates increased among all groups over the course of the study, transitions to substance use at the two-year follow-up were significantly lower among intervention group adolescents.

At the 3.5-year follow-up, the GGC group showed significantly lower alcohol initiation scores than the control group.

At the 3.5-year follow-up, new user proportions were lower (marginally significant) among GGC adolescents than among controls for lifetime drunkenness and lifetime use of marijuana.

At the 3.5-year follow-up, among those adolescents who had used alcohol and tobacco during the past month and marijuana during the past year, GGC adolescents had a lower frequency of past month drinking than the control group.

PDFY adolescents were 37% less likely to have initiated marijuana use over the course of the study than

control youth (marginally significant).

At the 3.5-year follow-up, GGC adolescents demonstrated a reduction in the growth of adolescent alcohol use from ages 12 - 15 1/2.

Across five waves of data, GGC was significantly associated with a slower rate of increase in polysubstance use (alcohol, tobacco, and marijuana) and general delinquency (e.g., theft, vandalism, violence) over time, compared with controls.

From wave 1 to wave 5 (6th to 10th grades), GGC participants had significantly lower rates of increasing alcohol use when compared to controls.

From 6th through 12th grade, GGC reduced the rate of increase in depressive symptoms, compared with controls.

From wave 1 to wave 6 (6th to 12th grades), participants in the GGC group showed slower overall growth in tobacco use relative to controls (as measured by a tobacco composite use index and lifetime cigarette use).

Program Effects on Risk and Protective Factors:

GGC promoted improvements in the quality of parent-child relationships (only 1 of 6 tests, father only), proactive communication between parent and child, and child management skills (Pilot Study: Spoth et al., 1995; Kosterman et al., 1997).

GGC increased protective parenting behaviors, parent-child affective quality, and general child management skills (Efficacy Study: Spoth, Redmond, & Shin, 1998).

At a 3.5-year follow-up, PDFY adolescents significantly strengthened parental norms against alcohol and other drug use by adolescents over time (Efficacy Study: Park et al, 2000).

SUBGROUP DETAILS

The program is designed for use with all ethnic groups, but virtually all of the study participants were Caucasian.

RISK AND PROTECTIVE FACTORS

Risk Factors

Individual: Early initiation of drug use*, Favorable attitudes towards antisocial behavior, Favorable attitudes towards drug use, Substance use*

Peer: Interaction with antisocial peers

Family: Family conflict/violence, Neglectful parenting, Parent aggravation, Parental attitudes favorable to drug use, Poor family management*

Protective Factors

Individual: Clear standards for behavior, Refusal skills, Skills for social interaction

Peer: Interaction with prosocial peers

Family: Attachment to parents*, Opportunities for prosocial involvement with parents, Rewards for prosocial involvement with parents

*Risk/Protective Factor was significantly impacted by the program.

START-UP COSTS

Initial Training and Technical Assistance

A one-time group leader training is required. A 3-day on-site training for up to 12 participants is \$4,200 plus travel.

Curriculum and Materials

The Core Program Kit, used by 2 workshop leaders, costs \$881.00 (quantity-based discounts are available).

Materials Available in Other Language: The Core Program Kit is available in Spanish at same cost as English language version.

Licensing - None

Other Start-Up Costs

Recruiting participants and local sponsors may involve time from the staff of the community-based organization (CBO) that is home to the program.

INTERVENTION IMPLEMENTATION COSTS

Ongoing Curriculum and Materials

Family Guides, at one per family, cost \$13.99 each. Miscellaneous supplies such as name tags and pens are needed.

Staffing

Workshops are led by one parent and one person with workshop leader experience. The experienced person is frequently a teacher or counselor who leads groups outside normal working hours. These leaders are paid on a per-session basis from \$25 to \$100 per session, sometimes extra for preparation. Supervision is provided by the CBO.

Other Implementation Costs

Space and equipment are usually contributed by the CBO.

IMPLEMENTATION SUPPORT AND FIDELITY MONITORING COSTS

Ongoing Training and Technical Assistance

T.A., as needed, is available by phone at \$100 per hour and on-site at \$1200 per day plus travel.

Fidelity Monitoring and Evaluation

Workshop leaders complete Workshop Leader's Rating Sheets, which are then discussed among workshop leaders and supervisors.

Ongoing License Fees - None

OTHER COST CONSIDERATIONS - None

YEAR ONE COST EXAMPLE

In this example, a community based organization (CBO) wishes to offer a Guiding Good Choices program using 10 workshop leaders working in teams of two to offer the five-session groups eight times per year (40 groups per year). Below are expected expenses for the first year of implementation:

Standard 3-day training for workshop leaders and CBO supervisor

\$6,200*

Program Kits for each leader team @ \$881 x 5

\$4,405

Family Guides @ \$9.82 (quantity discount) x 400 families

\$3,928

Leader Stipends @ \$100/session, inc. preparation x 400 sessions

\$40,000**

Total Year One Cost

\$54,533

If each group has ten families, the total families served is 400 and the per family cost would be \$136.33. If leader stipends are not required, the per family cost would be \$36.33.

*includes \$2,000 for travel/expenses, which is a high-end estimate

**although workshop leaders are generally not paid stipends if the duty is part of their regular job description with the organization paying for the training

For additional information, visit <https://www.blueprintsprograms.org/factsheet/guiding-good-choices>

Recommended Program #4: "Project Northland"

Priorities Addressed: Opportunities for Prosocial Involvement and Favorable Attitudes towards Drug Use

DESCRIPTION OF PROGRAM

Project Northland provides six years of comprehensive programming for students beginning in sixth grade. Phase I provides programming for 6th, 7th, and 8th graders. Each of the three years of programming has a specific theme and incorporates individual, parent, peer, and community participation. The students receive skills training in communicating with their parents about alcohol (6th grade), dealing with peer influence and normative expectations about alcohol (7th grade), and understanding methods that bring about community-level changes in alcohol-related programs and policies (8th grade).

Phase II of the program is designed to help maintain the effects through high school. Phase II intervention strategies include community organizing, parent education, youth development, media, and school curriculum. The five intervention strategies are designed to increase community efficacy to enact changes in policies and practices related to high school students' alcohol use.

Sixth grade: The "Slick Tracy Home Team Program" consists of four weekly sessions of activity-story books which the students complete as homework with their parents. The books also include information on young adolescent alcohol use for parents. Small-group discussions about the books are held during school, and an evening fair at which students' posters and projects are displayed. Community-wide task forces are created and include members from a cross section of the communities: government officials, school and business representatives, law enforcement personnel, health professionals, youth workers, parents, concerned citizens, clergy and adolescents.

Seventh grade (1992-93): The "Amazing Alternatives! Program" includes the following: an eight-week peer- and teacher-led classroom curriculum using interactive activities related to themes of why young people use alcohol and alternatives to use, influences in terms of drinking, strategies for resisting those influences, normative expectations that most people their age do not drink, and intentions not to drink; a peer participation program called T.E.E.N.S. creates alternative alcohol-free activities outside the classroom using adult volunteers; parental involvement through the use of booklets mailed to parents includes behavioral prescriptions for parents and activities for parents and children to complete as well as updated information on the program and its events.

Eighth grade: "PowerLines" consists of an eight-session classroom curriculum that introduces students to the "power" groups within their communities that influence adolescent alcohol use and availability and teaches community action/citizen participation skills. Students interview parents, local government officials, law enforcement personnel, school teachers and administrators, and retail alcohol merchants about their beliefs and activities concerning adolescent drinking and conduct a town meeting to make recommendations for community action to prevent alcohol use. A theater production is performed at each school for classmates, parents and community members. T.E.E.N.S. continues to provide alternative activities in all intervention school districts. A newsletter written by and for eighth grade students is sent to parents and peers. Last, the community-wide task force continues in its activities to limit access to alcohol.

Ninth grade: During the interim Phase (1994-1996), a brief five-session classroom program entitled "Shifting Gears" is implemented. This program focuses on pressures to drink and drive or to ride with a drinking driver, the influences and tactics of alcohol advertising, and ways to deal with those influences. No programs are implemented in grade ten.

Eleventh and twelfth grades (1997-1998): Phase II consists of five components designed to reinforce and complement the previous goals of Project Northland. The "Class Action" program is implemented during Phase II, containing a substance abuse prevention curriculum that can be used as a booster session for the Project Northland series or as a stand-alone curriculum. "Class Action" builds upon the early adolescent interventions with new strategies for the cohort's last years in high school while emphasizing changes in the social environment of young people. The 6-session curriculum is based on the social influences theory of behavior change, where students are asked to debate and discuss the social influences to use alcohol and the negative consequences those influences have not only on the individual teen, but on the community as a whole. Through an innovative, civil-trial approach, Class Action challenges high-school students to examine the real-world consequences, both legal and social, of teen alcohol use. The program is peer-led and uses interactive methods to accomplish its instructional goals. Students debate and discuss the consequences of substance abuse, thus changing the social norms around alcohol use and changing negative peer pressure into positive peer pressure.

Community and parent components of Project Northland are also continued during the implementation of "Class Action." Eleven Action teams, representing all communities and ranging in size from 5 to 12 members are formed and asked to encourage community adoption of institutional or policy solutions to underage drinking through a number of sponsored activities and awareness campaigns. For the parent component, a postcard campaign is designed to increase awareness about alcohol-related issues and encourage specific actions to keep adolescents alcohol free. A total of 11 postcards designed to correspond to events sponsored by the action teams are mailed to the cohort's parents at 6-week intervals. A new parent-child intervention, "Sound OFF!", is used in the senior year to encourage parents and their seniors to communicate about alcohol. A series of three mailings are sent to parents and seniors in November, January, and February with discussion questions regarding teen drinking. Students are asked to answer the questions and return the mailer to the researchers.

Print media campaigns are also implemented. The first targets young adults with the theme of "Don't provide to those under age 21." Other print media include calendars for alcohol merchants, newsletters for students and adults, and a celebration poster for the many participants in Project Northland over the years of the study.

In addition, youth action teams are formed in Phase II. Young people are recruited for participation in teams to affect alcohol use among their peers. The teams meet as an extracurricular activity, assisted by adult coordinators.

AGE - Early Adolescence (12-14) - Middle School, Late Adolescence (15-18) - High School

PROGRAM SETTING - School

OUTCOMES

Minnesota Study (Perry et al., 1996, 2002)

- Students in the intervention drank significantly less and reported less alcohol onset than control students at the end of 8th grade.
- Students in the intervention group who were never-drinkers at the beginning of sixth grade not only drank significantly less than students in the control group, they also smoked fewer cigarettes and used less marijuana at the end of the eighth grade.
- Project Northland was effective in changing Peer Influence to use alcohol and Perceived Access to alcohol by the end of Phase I (8th grade), but these psychosocial variables were not affected during Phase II (grades 11 and 12).
- Students in the intervention schools were significantly less likely to increase their Tendency to Use Alcohol and binge drinking, and marginally less likely to increase past month alcohol use during grades 11 and 12.

Significant Program Effects on Risk and Protective Factors:

- Normative expectations about how many young people drink, parent-child communication about the consequences of alcohol use, and the importance of reasons for not using alcohol were also impacted by the end of grade 8.
- The intervention reduced the ability to purchase alcohol in off-sale outlets during Phase II of implementation (grades 11 and 12).

SUBGROUP DETAILS

Project Northland reduced alcohol use among primarily white students from rural, lower-middle- to middle-class counties in Minnesota. However, it failed to have much influence on primarily African-American and Latino students in Chicago. In a study in Croatia, the intervention did not significantly affect male students, but was highly significant for females on the Tendency to Use Alcohol Scale that combines intentions with behavior.

RISK AND PROTECTIVE FACTORS

Risk Factors

- Individual: Favorable attitudes towards drug use, Substance use
- Peer: Peer rewards for antisocial behavior, Peer substance use
- Family: Parental attitudes favorable to drug use
- Neighborhood/Community: Community disorganization, Laws and norms favorable to drug use/crime*, Low neighborhood attachment, Perceived availability of drugs*

Protective Factors

- Individual: Perceived risk of drug use, Prosocial involvement, Refusal skills
- Peer: Interaction with prosocial peers
- Family: Opportunities for prosocial involvement with parents, Parental involvement in education, Rewards for prosocial involvement with parents
- School: Opportunities for prosocial involvement in education, Rewards for prosocial involvement in school
- Neighborhood/Community: Opportunities for prosocial involvement, Rewards for prosocial involvement

*Risk/Protective Factor was significantly impacted by the program.

START-UP COSTS

Initial Training and Technical Assistance

Training can vary in cost depending upon location. If trainees travel, Project Northland involves a two-day training at a cost of \$350 per trainee and Class Action involves a one-day training at \$175 per person. Travel is an additional cost. On-site training is available for \$2,200 per day plus trainer travel estimated at \$1,000. On-site training can include up to 24 participants.

A train-the-trainer model is also available.

Curriculum and Materials

There are 4 components to the curriculum, each purchased separately:

- Slick Tracy-\$195/curriculum
- Amazing Alternatives-\$195/curriculum
- Power Lines-\$210/curriculum
- Project Northland Program Guide-\$195 each
- Project Northland (grade 6-8) collection-\$595 (includes 1 each of the above)
- Class Action-\$595/curriculum

Materials Available in Other Language: All the parent components of Project Northland for 6th, 7th, 8th grades and high school are available in Spanish at no additional cost.

Licensing - None

Other Start-Up Costs - None

INTERVENTION IMPLEMENTATION COSTS

Ongoing Curriculum and Materials

An estimated \$2.60 per student should be budgeted for materials and supplies.

Staffing

The program is implemented by teachers during the regular school day.

Other Implementation Costs

Since the program includes extensive community and parental components, it is strongly recommended that the budget for Project Northland include \$7,500 for a part-time Program Coordinator.

IMPLEMENTATION SUPPORT AND FIDELITY MONITORING COSTS

Ongoing Training and Technical Assistance

Ongoing training through web conferencing is free. Consultation is available for \$125 per hour but is rarely needed.

Fidelity Monitoring and Evaluation

Self-monitoring tools are included with the curricula.

Ongoing License Fees - None

YEAR ONE COST EXAMPLE

The following cost example would permit implementation of Project Northland/Class Action in two middle/junior high schools and one high school. Each middle school would have ten classes for each of grades 6-8, with 250 students per grade. Approximately 250 students would receive the Class Action curriculum in High School.

12 Project Northland collections @ \$595

\$7,140

Class Action Curriculum

\$595

On-site training for 12 middle school teachers (two days of training and 2 high school teachers (1 day of training)

\$6,200

Trainer travel and expenses

\$1,000

Total Year One Cost

\$14,935

With this model, 750 middle school students and 250 high school students would participate in Year One for a cost per student of roughly \$15.00.

For more information, visit <https://www.blueprintsprograms.org/factsheet/project-northland>

Recommended Program #5: "Raising Healthy Children"*

Priorities Addressed: Opportunities for Prosocial Involvement, Favorable Attitudes towards Drug Use and Poor Family Management

DESCRIPTION OF PROGRAM

Elementary School Program: Raising Healthy Children (RHC) is a multifaceted program with components focusing on classroom teachers, parents, and students, with the goal of decreasing the negative impact of the student in the classroom by providing services to the family. The teacher intervention includes a series of workshops for instructional improvement in classroom management. Workshops focus on instructional strategies shown to be effective in mainstream classrooms in reducing academic risks and early aggressive behaviors while enhancing protective factors among elementary students. Workshop topics include proactive classroom management, cooperative learning methods, strategies to enhance student motivation, student involvement and participation, reading strategies, and interpersonal problem-solving skills. Teachers from the same school attend workshops together to foster and reinforce shared learning experiences. In addition, after each workshop, RHC project staff provide classroom coaching for teachers. After the first year of the project, teachers participate in monthly booster sessions to further reinforce RHC teaching strategies. Teachers are also provided a substitute for a half-day so they can observe other project teachers using RHC teaching strategies in their classrooms.

Implementation of the RHC program for parents is conducted by school-home coordinators (SHCs) who are classroom teachers or specialists with experience in providing services to parents and families. Parent training and involvement are offered through various mechanisms such as five-session parenting group workshops, selected topic workshops, and in-home problem-solving sessions. Topics for parent training include family management skills and "How to Help Your Child Succeed in School." In addition, monthly newsletters are sent to parents to reinforce and extend parenting content regarding the RHC intervention. The student intervention consists of summer camps targeting students with academic or behavioral problems who are recommended by teachers or parents. In addition, in-home services are provided for students referred for behavior or academic problems.

Extending the Program through Middle and High School: If the program is extended into middle school and high school, there are individual, family, and teacher components offered. Individual interventions include after-school tutoring and study clubs during grades 4-6 and individualized booster sessions and group-based work during middle and high school years. Social skills booster retreats are also offered during middle school to provide peer intervention strategies for students to learn and practice social, emotional, and problem-solving skills. Group and individual interventions are offered to families during grades 1-8. During high school, booster sessions are delivered through home visits in which both parents and students complete assessments that cover specific developmental risk areas. The sessions are individualized to target specific skills identified through the assessment process. Teachers receive staff development workshops through grade 7.

Safe Drivers Wanted High School Program: The "Safe Drivers Wanted" component consists of family-based driving sessions and is administered as part of the RHC intervention to families and teens approaching driving age. The sessions are administered when the oldest participants are in ninth grade. The Safe Drivers Wanted sessions attempt to improve teens' decision-making skills with respect to driving, explain current driving laws, clarify parents' driving guidelines, and help families develop a plan for monitoring compliance with those guidelines as well as provide appropriate consequences. By improving teen decision-making skills, parent and teen understanding of driving laws, and parent management of teen driving, these sessions attempt to lessen impulsive behavior and risk taking, negative peer influences, and driving under the influence of alcohol or drugs. The transition-to-driving lessons used in this component build upon the foundation of the earlier delivered interventions. They reinforce (or act as booster sessions for) the application of family processes taught during the elementary and middle school periods specific to driving experiences. The sessions are delivered by school-home coordinators via individual home visits (typically about 90 minutes in length) to parents and students. Visits follow standard manualized protocols. Self-study materials are mailed to families living 25 miles outside the local area. The non-local families receive follow-up phone calls from the SHCs to review materials and address family-specific issues. Families with the in-person visits have the opportunity for guided skills practice, while families receiving the mailed materials are urged to practice the skills on their own.

The first transition-to-driving session is designed to provide information and skills to parents and teens about healthy development and risk taking as teens reach driving age. The session and materials review risk taking related to driving age and teach teens skills for making healthy decisions and choices. The second driving session is provided after the teens obtain their license and is designed to assist families in being specific about driving expectations in order to complete a driving contract.

AGE - Late Childhood (5-11) - K/Elementary, Early Adolescence (12-14) - Middle School, Late Adolescence (15-18) - High School

SETTING - School

OUTCOMES

At 18 months post-test, first- and second-grade students who started the program, relative to controls, showed significantly:

- Greater increases in teacher- and parent-reported academic performance and commitment to school.
- Greater increases in teacher-reported social competency and smaller increases in teacher-rated antisocial behaviors, but no significant difference by parent and self-report.

During the middle to high school periods (with exposure to intervention materials/boosters through grade 10), intervention students, relative to controls, showed:

- Decline in the frequency of alcohol use, but no significant differences in alcohol use versus nonuse.
- Greater linear decline in the frequency of marijuana use, but no differences in marijuana use growth rates.
- No change in cigarette use-versus-nonuse or frequency of cigarette use.

In 11th or 12th grade, intervention students in the Safe Drivers Wanted program, relative to controls, showed:

- Lower likelihood to drive under the influence of alcohol.
- Lower likelihood to ride in a car with someone under the age of 21 who had been drinking.
- No significant differences with respect to receiving traffic tickets or getting into accidents.

Long-term results from the Seattle Social Development Project (elementary version of Raising Healthy Children), showed:

- Positive program effects on school bonding and achievement and reductions in grade repetition, lifetime violence, and heavy alcohol use at age 18.
- Improved positive functioning in school and/or work, more high school graduates, better emotional and mental health, fewer with criminal records, fewer involved in selling drugs, and fewer females who had been pregnant or had given birth by age 21, relative to controls.
- Improved educational and economic attainment, improved mental health, and reduced lifetime sexually transmitted infections, but no significant effects on crime or drug use at ages 24 and 27.

SUBGROUP DETAILS

Raising Healthy Children was implemented with a predominantly Caucasian (82%) sample of elementary school children enrolled in public schools in suburban Seattle. No analysis of effects by race was performed. Antisocial behavior was reduced in both males and females. Females had significantly higher increases in prosocial skills as compared to males.

RISK AND PROTECTIVE FACTORS

Risk Factors

Individual: Early initiation of antisocial behavior, Favorable attitudes towards antisocial behavior, Favorable attitudes towards drug use, Substance use

Peer: Interaction with antisocial peers

Family: Family conflict/violence, Parental attitudes favorable to antisocial behavior, Parental attitudes favorable to drug use, Poor family management

School: Low school commitment and attachment*, Poor academic performance

Neighborhood/Community: Laws and norms favorable to drug use/crime

Protective Factors

Individual: Problem solving skills, Refusal skills, Skills for social interaction

Peer: Interaction with prosocial peers

Family: Attachment to parents, Opportunities for prosocial involvement with parents, Parent social support,

Parental involvement in education, Rewards for prosocial involvement with parents

School: Opportunities for prosocial involvement in education, Rewards for prosocial involvement in school

Neighborhood/Community: Opportunities for prosocial involvement, Rewards for prosocial involvement

*Risk/Protective Factor was significantly impacted by the program.

START-UP COSTS

Initial Training and Technical Assistance

Depending upon the number of teachers participating, the average cost of the three year teacher training program for the Raising Healthy Children program is \$950 per teacher per year for the first two years and \$500 per teacher for the third year. This includes training, travel, and materials. For parenting workshop facilitators, there are six parenting programs available and the cost to train in each is \$4,200 for 12 participants plus trainer expenses.

Curriculum and Materials

Training materials for teachers cost \$125 per teacher over the initial three-year training process. Parent workshop guides are \$465 per leader. Family guides for the parent program are \$15 per family covering the five sessions. Guiding Good Choices and Supporting School Success are available through the Channing Bete Company. The Raising Healthy Children parenting program, Moving into Middle School, Stepping Up to High School, and Safe Drivers Wanted programs are available through the Social Development Research Group. Materials Available in Other Language: Parenting materials (Guiding Good Choices and RHC parenting) are available in Spanish at same cost as English language version. Teacher materials have not been translated.

Licensing - None

Other Start-Up Costs

Administrators and principals should be involved in program implementation and may wish to be included in teacher training. The district provides in-service time for the staff development sessions.

INTERVENTION IMPLEMENTATION COSTS

Ongoing Curriculum and Materials

Replacement teacher materials may be needed due to wear. Family session guides cost \$15 per family.

Staffing

Teachers deliver the program in the regular classroom. Parent group facilitators and home visitors typically receive about \$25 per hour. There are no special qualifications for facilitators beyond being trained. It is recommended that the family groups be offered twice during the academic year and that home visits occur as needed.

Other Implementation Costs

A .5 FTE teacher coach is recommended for a school of about 500 students. This can be provided by time freed from an existing master teacher's duties. New teachers to the district will need to be trained. The coach should also have three days of coaching observation by the RHC trainer at a cost of \$4,500 plus travel. A .5 FTE family program coordinator is also recommended. Existing school staff can be used, if available. Conducting the camp requires a full-time teacher for three weeks and an hourly aide during the two-week-long day camp. A modest supply budget is also needed (about \$300-\$500).

IMPLEMENTATION SUPPORT AND FIDELITY MONITORING COSTS

Ongoing Training and Technical Assistance

Train the trainer models for teachers are being developed. Capacity Building Training of Trainers for parent groups is \$4,500 for classroom instruction followed by at least one two-day observation by the trainer. For the parent groups, the parenting coordinator is expected to observe sessions using a fidelity checklist. Workshop leaders complete an implementation checklist and pre/post tests, all provided by the purveyor with no extra cost. Optional T.A. is available from the purveyor at \$1,200 per day plus travel.

Fidelity Monitoring and Evaluation

Teacher coaches are responsible for assuring teacher fidelity to the model through classroom observations and use of a coding scheme. The parent coordinator observes parent groups to assure fidelity.

Ongoing License Fees - None at this time

OTHER COST CONSIDERATIONS - None

YEAR ONE COST EXAMPLE

This example will involve implementing RHC in one school with 12 teachers and four workshop leaders. Coach and parent coordinator are contributed by the school. The following costs can be projected:

Year 1 Teacher Training @ \$950 x 12

\$11,400

Workshop Leader Training with travel (3 @ \$4,200)

\$14,600

Materials for Teacher (\$125 x 12)

\$1,500

Family Guides (360 @ \$15)

\$5,400

Workshop Leader Wages @ \$25/hour for 3 hours/session

\$18,000

Coaching Observation (\$4,500 + travel)

\$6,000

Total Year One Cost

\$56,900

In this illustration, if there are 25 students per class, 300 students would participate at a cost of \$190 per student.

For additional information, visit <https://www.blueprintsprograms.org/factsheet/raising-healthy-children>

Program Recommendation #6: "Safe Dates"

Priorities Addressed: Opportunities for Prosocial Involvement

DESCRIPTION OF PROGRAM

Safe Dates is a dating violence prevention program that provides male and female middle/high school students with the skills to prevent dating violence by changing dating violence norms and gender stereotyping,

improving conflict-management skills, help-seeking behavior, and other cognitive factors associated with help-seeking.

The *Safe Dates* program includes school (primary prevention) and community (secondary prevention) activities. School activities promote the primary prevention of dating violence perpetration by changing norms associated with partner violence, decreasing gender stereotyping, and improving conflict management skills. Community activities promote secondary prevention by changing those same variables and by also changing beliefs about the need for help, awareness of services for victims and perpetrators of partner violence, and help-seeking behavior. Community activities also enhance the availability of dating violence services from which adolescents can seek help. School activities include: a theater production performed by peers, a 10-session curriculum (45-50 minutes per session), and a poster contest. The 45-minute theater production, about how an adolescent victim of dating violence seeks help with her violent relationship, addresses many of the mediating variables related to help-seeking. The poster contest is described during day 10 of the curriculum, and interested students develop posters that address themes in the *Safe Dates* curriculum. The poster contest is designed to give adolescents another exposure to messages about dating violence. Posters are displayed in the classroom and judged by students to determine the top three posters in the school, each of which earns a cash prize.

Booster sessions are administered three years post-intervention. The booster consists of an 11-page newsletter mailed to the adolescents' homes and a telephone call from a health educator approximately four weeks after the mailing. The newsletter contains worksheets based on the *Safe Dates* school curriculum for adolescents to complete. The health educators answer questions, provide additional information when needed, and assess completion of newsletter worksheets.

Although the school component has primarily been implemented by regular classroom teachers as a part of required health education classes, the curriculum could also be delivered by community leaders or as a part of a youth-group activity, provided all of the sessions are completed and a high level of attendance is assured. Topics covered in the curriculum include: defining caring relationships, defining dating abuse, why people abuse, helping friends, overcoming gender stereotypes, equal power through communication, how we feel/how we deal, and preventing sexual assault. Community activities consist of special services for adolescents in abusive relationships (e.g., a crisis line, weekly support groups, materials for parents) and community service provider training.

AGE - Early Adolescence (12-14) - Middle School

PROGRAM SETTING - Community (e.g., religious, recreation), School

OUTCOMES

- *Safe Dates* is effective in preventing and reducing violence perpetration among teens already perpetrating dating violence.
- *Safe Dates* resulted in less acceptance of dating violence, stronger communication/anger management skills, less gender stereotyping, and greater awareness of community services.

Compared to the control group, participants in the treatment group schools showed the following improvements at one-month follow-up:

- 25% less psychological perpetration;
- 60% less sexual violence perpetration;
- 60% less violence perpetrated against a current dating partner.

At one-year follow-up (Foshee et al., 2014), participants in the treatment group showed the following improvements compared to participants in the control group:

- 12% lower rates of reported peer violence victimization
- 23% lower rates of reported peer violence perpetration among a subsample of minority students
- 31% lower odds of carrying a weapon to school

Follow-up results at one year showed a relapse in behavioral outcomes, but at four year follow-up, the following results were found among Safe Dates participants compared to the control group participants:

- Between 56 - 92% less reported physical, serious physical, and sexual dating violence perpetration and victimization;
- Adolescents who received Safe Dates reported perpetrating significantly less psychological, moderate physical, and sexual dating violence perpetration at all four follow-up waves;
- Safe Dates-only adolescents who reported no severe physical perpetration or average amounts of severe physical perpetration at baseline reported significantly less severe physical perpetration than control group adolescents at each of the four follow-up waves.

SUBGROUP DETAILS

Safe dates had been proven equally effective for Caucasians and culturally diverse audiences.

Risk Factors

- Individual: Favorable attitudes towards antisocial behavior*
- Peer: Interaction with antisocial peers

Protective Factors

- Individual: Prosocial involvement
- Family: Attachment to parents
- Neighborhood/Community: Opportunities for prosocial involvement

*Risk/Protective Factor was significantly impacted by the program.

START-UP COSTS

Initial Training and Technical Assistance

One-day implementation training for teachers who will be delivering Safe Dates curriculum: \$175 per teacher for participation in open enrollment training at Hazelden plus transportation and teacher time or \$2,200 for Hazelden trainers to come on-site and deliver training to a group of teachers plus Hazelden trainer travel costs + teacher time.

Curriculum and Materials

\$225.00 for teacher manual that includes a CD-ROM with student and parent materials.

Licensing - None

Other Start-Up Costs - None

INTERVENTION IMPLEMENTATION COSTS

Ongoing Curriculum and Materials

\$16.63 per class (estimate of materials and supplies required for each classroom of 30 students and 45 parents/guardians.)

Staffing

- *Qualifications*: No specific requirements, though intervention typically delivered by classroom teachers or counselors in classrooms.
- *Ratios*: No specific requirements, though designed as a classroom intervention so typical ratio is 1 teacher to 25 – 30 students.
- *Time to Deliver Intervention*: 15 teaching hours to implement training with one class (includes delivery of ten 50-minute training sessions plus preparation time for sessions).

Other Implementation Costs

Because training is typically delivered in classrooms, there are not usually any additional space, transportation or administration costs associated with implementation.

IMPLEMENTATION SUPPORT AND FIDELITY MONITORING COSTS

Ongoing Training and Technical Assistance

Occasional web training and consultation on “frequently asked questions” is available free of charge from Hazelden; if more in-depth consultation is required, the fee is \$125.00 per hour.

Fidelity Monitoring and Evaluation

Fidelity monitoring tools are included with teacher manual and are generally used by teachers delivering the program.

Ongoing License Fees - None

Other Implementation Support and Fidelity Monitoring Costs - None

OTHER COST CONSIDERATIONS

The majority of the costs incurred are up-front costs for teacher training and curricula. Once these investments are made, there is little additional cost to implement the model, making this a very low cost model over time. The major resource required to sustain the program is dedicating teaching time to the delivery of training.

YEAR ONE COST EXAMPLE

A school wishing to implement Safe Dates with 20 teachers, each with a class of 25, could expect the following costs:

Initial on-site training for 20

\$2,200

Trainer travel

\$2,000

Materials for 20 classrooms @ \$225

\$4,500

Total Year One Cost

\$8,700

With 500 students taught, the cost per student would be \$17.40.

For additional information, visit <https://www.blueprintsprograms.org/factsheet/safe-dates>

CONCLUSION:

The goal of the final recommendations is to select all or narrow down the above programs to which organizations and agencies could add on or replace in their current programming action plan in order to reach most of the intended recipients within Marinette & Menominee Counties. This will be completed at the Community Action Planning (CAP) session that will be held at a later date.