THE 2010 COMMUNITY ACTION PLAN FOR GREATER ROCHESTER'S CHILDREN

Featuring The 2009 Community Status Report on Children and Youth

OCTOBER 2009

THE CHILDREN'S AGENDA
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THE 2010 COMMUNITY ACTION PLAN FOR GREATER ROCHESTER'S CHILDREN, FEATURING THE 2009 COMMUNITY STATUS REPORT ON CHILDREN AND YOUTH

In 2010-2015, The Children's Agenda will continue to lead our community to improve the lives of children in Monroe County by championing strategies so that:

- ✓ **Our children are born healthy into families who can provide them with safe and nurturing environments.**
- ✓ **Our children are prepared to learn and attend quality schools.**
- ✓ **Our children are prepared to be successful adults, who are responsible citizens and productive, happy members of our community.**

The 2010 Action Plan features *the 2009 Community Status Report on Children and Youth*, highlighting vital child data, noting important efforts underway in our community, and recommending the next important steps to solve our local problems. The Action Plan is based on what's needed the most and works the best, incorporating TCA's research of what works for addressing the areas where data clearly shows that change is needed.

The Children's Agenda

The 2010 Community Action Plan for Greater Rochester's Children and The 2009 Community Status Report on Children and Youth are projects of The Children's Agenda. The Children's Agenda is an independent and non-partisan organization that promotes evidence-based programs and policies for the health and well-being of children in Monroe County. The Children's Agenda is data-driven and research-based: we focus on what's needed the most and works the best.

Rochester's Heritage

The Greater Rochester community has a strong tradition of investing in people, especially children. Greater Rochester is home to one of the nation's first and most vibrant United Way chapters, the world-class and generous Rochester Area Community Foundation-- for over 100 years generous philanthropists from Joseph Wilson to Daisy Marquis Jones have invested dollars to make the quality of life better in our community. Forward-thinking innovators like George Eastman began the Center for Governmental Research. The University of Rochester Department of Pediatrics is nationally and internationally known for its leadership on community health issues.

When we come together, as leaders, funders, and decision makers, Greater Rochester has been very effective in moving our children towards success.

⇒ Our **foster care pediatrics program** is renowned nationwide and is perhaps the foremost model studied for replication in the United States.

⇒ Our **health insurance rates** are another community success: the majority of children across our community have access to health insurance coverage, thanks to the Monroe Plan, Monroe County Department of Health, and local hospitals and pediatric practices.

⇒ We are the home of some of the premier proven programs for treating **mental**

health concerns in young children at Mt. Hope Family Center, and helping young children with school problems with Children's Institute's Primary Mental Health Project.

⇒ **The Nurse Family Partnership Program**: In 2002, faced with dismaying numbers of child abuse and neglect, The Children's Agenda analyzed the problem and recommended two solutions. One focused on policy change, the second was an introduction of an evidence-based program that brings nurses and first-time moms together in a long term relationship that decreases child abuse while improving family stability and self-sufficiency. By coming together, the Greater Rochester community raised $300,000 in private dollars and the local program was initiated in 2006. This year TCA helped secure additional public funding and now 325 families are being served, and NFP will reach 350 by the end of 2009.

⇒ Most recently, under the leadership of the Greater Rochester Health Foundation, our community has come together to address the issue of **childhood obesity**, an issue of critical importance, as 30% of children across Greater Rochester are overweight.

Our children continue to face great challenges.

Our children, though, continue to face significant challenges. As shown in *The 2009 Community Status Report for Children and Youth,* children across Greater Rochester are faring worse in 2009 than they were in 2000 in critical areas such as child poverty and low birth weight. The City of Rochester has one of the worst infant mortality rates in New York State. Rochester's teenage pregnancy rate is among the worst in the U.S. and industrialized world. And our children lose their lives to violence all too often.

But, what if we could do better? What if we could eradicate child abuse? What if every mother who needed a safe, quality child care setting for her child could afford it? What if our most vulnerable youth spent less time on the streets and more time learning?

We *can* do better. Rochester is known nationwide for its entrepreneurship, generosity, and innovative models. We have demonstrated marked successes in foster care pediatrics, immunization rates, and mental health programs for young children. We need to push forward and have our next choices build on our past investments and intentions. It won't happen overnight. It won't even happen in a year. But change will begin. By taking the next critical steps now to take action on the few, important policies and program that can make a difference, things will get better and we can see real improvement in the well-being of our children by 2015.

Investing in What Works: Evidence-

The research is clear that children, adolescents, families, and our community face many problems that can actually be prevented – by expanding our investment in a continuum of programs and policies that work.

Based Programs

As a community we have invested in many worthy programs and we have started the rewarding but arduous process of making decisions that are based not just on good intention but also on research. We consider our strengths and resources when making choices.

No one program or policy is a "magic bullet". Instead, complex problems require complex solutions, and a continuum of effective supports is necessary in a community to ensure success for our children. Evidence-based, effective programs and policies imbedded in a system that looks across the continuum from pregnancy to childhood to adulthood will achieve this.

Evidence-based programs are programs that have been developed and evaluated by experts in the field. Briefly, The Children's Agenda considers a program to be evidence-based if:

- *Rigorous and repeated evaluation shows that the program produces positive results*
- *The results can be attributed to the program itself, rather than to other extraneous factors or events, and*
- *The evaluation is peer-reviewed by experts in the field.*

For more information on how to determine if a program is evidence-based, please see *Appendix A.*

Investing in evidence-based, effective programs for children helps the community-at-large both in the short and the long term. For example, investments that increase the number of children who attend high-quality child care reduce public investment down the road in remedial education, special education, public assistance, and criminal justice. These public investments are less because children who go to high- quality child care start school more ready to learn, are more successful in school, more likely to graduate from high school instead of failing and dropping out, and more likely to be self sufficient because they are working instead of living on public assistance or committing crimes and spending time in jail. Because of these long-term savings from a variety of public programs, cost-benefit studies of investing in child care have found that for every $1 invested, there is between a $6-$17 return on that investment. In addition, children are safe and nurtured in the here and now, and parents are able to be productive at work.

Programs delivered during childhood improve child outcomes and put vulnerable, high-risk children on the path to success; academic outcomes from early education need to be can supported and built on by a strong, high-quality public school system and a continuum of supports for children from birth to adulthood along a continuum:

- ⇒ incorporating prenatal care,
- ⇒ infancy and toddlerhood, when most brain development occurs,
- ⇒ early years of elementary school, which are critical to the later success of a child,
- ⇒ the middle school years which are a challenge for teachers and parents – not to mention the children living through them – and

⇒ support through high school – so that children become responsible, productive, happy, self-sufficient adults who contribute in vital ways to our community.

The 2010 Community Action Plan for Greater Rochester's Children:

- builds on the United Way-Community Foundation ACT Rochester project; we have analyzed data on children and present this data along a continuum in **The 2009 Status Report on Children and Youth,**
- considers three community-wide goals for our children,
- utilizes the latest research on what works for children, in order to build a continuum of successful strategies that target critical stages of development, resulting in multiple positive outcomes for children, families, communities, and taxpayers.

Three Goals for Every Child

Our community's choices and investments over the years, as well as conversations TCA has been having with community leaders, make clear that we all share 3 common goals:

- ✓ **Our children are born healthy into families who can provide them with safe and nurturing environments.**
- ✓ **Our children are prepared to learn and attend quality schools.**
- ✓ **Our children are prepared to be successful adults, who are responsible citizens and productive, happy members of our community.**

Three Strategies for Success

As a community that wants children safe and healthy living in families who can provide them with safe and nurturing environments, children who will succeed in school, and children who will succeed in life, The Children's Agenda has targeted three strategies that, if brought to capacity, will push us forward on the path to success:

- ⇒ **Expand NFP to reach every local family who needs it.**
- ⇒ **Expand Access to Quality Early Education for 0-5 year olds**
- ⇒ **Expand After-School Programs, including the Coping Power Program.**

TCA Key Considerations

As we embarked on this project, our key considerations for this work were:

- It must build on the strengths of our community and work with the community to make progressive, positive change for our children.
- Indicators must matter and must be actionable.
- Arguments around the 'right indicators' should be limited and instead focus should be directed towards movement overall in areas of child welfare and development.
- It is critical to consider Monroe County to its peers throughout the State.
- Work must connect with existing community reports, including the Community Foundation-United Way ACT Rochester project, as well as the Monroe County Department of Health Maternal Child Health Report Card.

Methods

The Children's Agenda was organized in 2004 to provide the community with research-based advocacy around children's issues. The Children's Agenda worked in concert with the Rochester Area Community Foundation and United Way ACT Rochester project; the Center for Governmental Research provided us with vital data.

To write this report, TCA:

- Analyzed data from New York State Cities, New York State Counties, New York State, the United States, and International comparisons of industrialized, economically advanced Countries to determine the areas where our children and youth face the greatest challenges;
- Reviewed current community efforts to address these key areas of need;
- Determined where the current policies and/or programs in place are not sufficient to address those needs;
- Reviewed local, national, and international research available of the best policy and program alternatives; and
- Met with Community Leaders to review the data and consider next steps.

For further details and source information, please see Appendices and Bibliography.

TCA Accountability

We will report back to the community annually regarding progress for each of these key strategies. Further, in Year 5 of this work plan (2015) we will undertake a comprehensive report detailing outcomes for children and youth and comparing these with the current status in our Community Status Report for Children and Youth. **We must be sure that we are achieving real and tangible outcome improvements for children and youth as a result of these efforts, no matter how daunting this may see.**

In the body of this current report, we also outline additional evidence-based, effective programs and policies that could be undertaken by community leaders and funders to improve measures of health and well-being for children and youth in our community. *The Children's Agenda would be eager to consult further with interested organizations and leaders.*

In the following report, we share the data regarding our community's children and youth, discuss strategies for improvement in their health and well-being, and outline concrete, practical next steps.

Please see The 2009 Community Status Report on Children and Youth, available at www.thechildrensagenda.org

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Community Goal #1: Our children are born healthy into families who can provide them with safe and nurturing environments.

The Issue Parenting is challenging, especially for parents who have few financial and social resources: teen mothers, single parents, and parents living in poverty. Unprepared parents are more likely to lack the resources to care for their child, bear low-birth-weight babies, have children who are neglected or abused, and have additional children closely following the birth of their first, often while still teenagers.

Best Solution ***Expand the Nurse-Family Partnership program to meet our local need: 1,000 families per year by 2015.***

The Research ***The Nurse Family Partnership (NFP)*** program has been called the "most effective program for vulnerable children and families ever created" by the Washington State Institute for Public Policy. It lays the foundation for children to succeed in life.

NFP is an evidence-based, effective nurse home-visitation program that improves the health, well-being, and self-sufficiency of low-income, first time parents and their children. In Monroe County, NFP currently serves 325 families. In 2006, The Children's Agenda led efforts to bring the NFP program, a national model, back to where it was founded and has recently been successful in obtaining significant additional public funding to support the program.

The NFP program is very effective for both the parents and children involved. The Nurse-Family Partnership home visiting program has been tested in three separate randomized controlled trials. These studies have found consistent improvements in maternal and child health for mothers and children visited by NFP nurses compared to those randomly assigned not to receive the program. There were consistent effects in at least two of the three trials in these domains:

- ***Improvements in women's prenatal health*** - Reductions in prenatal cigarette smoking and reductions in prenatal hypertensive disorders
- ***Reductions in children's healthcare encounters for injuries, child abuse, and neglect***
- ***Fewer unintended subsequent pregnancies, and increases in intervals between first and second births***
- ***Increases in father involvement and women's employment***
- ***Reductions in families' use of welfare and food stamps***
- ***Increases in children's school readiness*** - Improvements in language, cognition and behavior.

In addition, families that have been followed for fifteen years have these outcomes:

- Benefits to mothers who participated in the program included had 61% fewer arrests 72% fewer convictions, and 98% fewer days in jail

- Benefits to Children who participated in the program included *a* 48% reduction in child abuse and neglect, 59% reduction in arrests, and a 90% reduction in adjudications as PINS (person in need of supervision) for incorrigible behavior.

Home Visit Experience: Registered nurses, together with Nurse-Family Partnership clients and their families, engage in activities associated with the Nurse-Family Partnership goals during each home visit. These are:

- Improved Pregnancy Outcomes
  - Help clients obtain prenatal care from their physician
  - Help clients reduce their use of cigarettes, alcohol and illegal drugs
  - Teach clients about healthy nutrition during pregnancy
- Improved Child Health and Development
  - Help parents provide more competent care of their children in the first two years of life
  - Teach parents how to care for their children and provide them with a positive home environment
  - Teach parents how to nurture their children
  - Help parents create a safe environment, both within and around the home, where their child can live and thrive
  - Teach parents safe and consistent practices of child discipline
  - Help parents get proper health care for their child
- Improved Maternal Life Course Development
  - Teach young mothers to keep their lives on track and develop a vision for their own future
  - Help the mothers make reasoned choices about the partners, family and friends who are involved with their child
  - Help mothers plan future pregnancies
  - Help mothers continue their education and reach their educational goals
  - Help mothers find adequate employment

The Nurse Family Partnership (NFP) program has been demonstrated to reduce 75% of cases of child abuse and neglect in the first two years of life for children in high-risk families, and 50% of cases in long-term follow-up over 15 years. Many of the studies demonstrating the effectiveness of early childhood home nurse visitation programs in preventing child maltreatment were conducted by researchers at the University of Rochester here in Rochester, NY. These studies have used randomized controlled trials (the most rigorous form of study design) and have been published in the most prestigious medical journals. The studies have 15 year follow-ups on some of the families visited and have been validated in urban, suburban, and rural populations.

In addition to preventing child abuse, the NFP program has numerous other positive effects for the low income women and children involved. The women had fewer

subsequent pregnancies, markedly reduced criminal behavior, less behavioral impairment due to drugs and alcohol, and reduced use of welfare for up to 15 years after the birth of the child. In addition, in their adolescence, the children who had experienced the home visits had fewer arrests and convictions, fewer instances of running away, fewer sexual partners, and less use of alcohol, cigarettes, and illegal drugs.

For every 1,000 families served by Nurse-Family Partnership, over 30 years of research demonstrates that:

- 140 fewer children will be hospitalized for injuries in their first two years of life (Olds,1997);
- 3 fewer infants will die in their first year of life (Carabin 2005);
- 110 fewer children will develop language delays by age two (Olds 2002);
- 230 fewer children will suffer child abuse and neglect in their first 15 years of life (Olds et al, 1997, Olds et al, 1998); and
- 220 fewer children will be arrested and enter the criminal justice system through their first 15 years of life, among other outcomes (Olds 2008).

Cost-Benefit Analysis

Not only is home nurse visitation highly effective, it is cost-effective as well. Cost-benefit analyses have consistently and conservatively estimated that costs for the program are recovered by government by the time the child is between three and four years old.

In a 2005 RAND study, cost savings to government alone were at least four times greater than the cost of the program in a child's lifetime. This study found a net benefit to society of $34,148 (in 2003 dollars), which equals a $5.70 return per dollar invested in Nurse-Family Partnership, with the bulk of the savings accruing to government in reduced health care, educational, social services and criminal justice expenditures (Karoly 2005).

Similarly, the Washington State Institute for Public Policy Independent Study conducted a cost analysis in 2004 and found savings of $17,200 in benefits per child served. The Children's Agenda has performed a projected cost-benefit analysis for home nurse visitation for our community that is *conservative* and based on *government costs only*. Based on this conservative analysis of projected program effects, the NFP program is revenue neutral approximately 3 ½ years from its start. Over the first 15 years of the child's life, the program returns approximately 3.6 dollars for every dollar invested (government dollars only).

The State of Pennsylvania began implementing the Nurse Family Partnership statewide in the mid 1990's. State leaders allocated $20 million for replication of the program in communities throughout the State. In 2008, an analysis by Pennsylvania State University demonstrated nearly $100 million in savings in reduced spending on crime, public assistance, substance abuse, and child abuse (Prevention Research Center, 2008).

The 2009 Community Status Report: Tracking the Data

With regard to specific indicators in our Community Status Report, research shows that NFP:

- Decreases child abuse, neglect, and injuries by 48%
- Increases families self-sufficiency and increases involvement of both parents in a child's life
- Improves low birth-weight for some at-risk pregnancies, including those of women who smoke. It also decreases low birth-weight by decreasing subsequent teen pregnancies.
- Decreases the likelihood of repeat teen pregnancy and markedly reduced involvement in crime for parents and the children born into the program as they grow older.
- Decreases violence and crime immediately and in the long-term.

Next Steps

Monroe County has pushed forward to initiate this program locally, which currently serves 325 families. **To move things forward to help parents be ready to provide children with safe and nurturing families, The Children's Agenda will champion the following:**

- **Expansion of the NFP program capacity to serve 500 families by 2011.**
- **Continued careful tracking of key data to show improvements in health and well-being of the children and families served.**
- **Linking NFP with quality child care and early learning programs; further developing a system of early services.**

Community Goal #2: Our children are prepared to learn and attend quality schools.

The Issue

Too many children are arriving at school ill prepared to learn, with learning delays and behavior issues already established, setting them up for an academic life of trying to keep up while keeping out of trouble.

Research has shown that:

- the majority of brain development happens during the first five years of life and,
- the setting that children spend their time in has a major impact on that development.

As family work dynamics have changed over the last 30 years, 70% of families in Monroe County do not have a stay-at home parent and their children are spending their first years in child care settings (Pryor 2007). Given the research on brain development, it is vital that these settings be of high-quality so that our children are not simply safe while their parents work, but are prepared well for the years ahead.

Best Solution

By 2015, increase the number of children in quality child care and early learning settings by 20%.

The Research

In short, if children can spend their first years in a quality setting, they will be more ready for school and life. If they spend it in a setting that is low-quality, a place where the caregiver has little education, where there are few books, where a television is on most of the day, the child will be far more likely to end up on the first day of kindergarten with learning delays and behavior problems established. Infants and children who are rarely spoken to, who are exposed to few toys, and who have little opportunity to explore and experiment with their environment may fail to fully develop the neural connections and pathways that facilitate later learning (Zero to Three, 2000). Despite their normal genetic endowment, these children are at a significant intellectual disadvantage and are likely to require costly special education or other remedial services when they enter school (Zero to Three, 2000).

High-quality child care settings give children a safe place to go while their parents work, research has demonstrated that by attending child care that is of high-quality instead of low they improve math and reading achievement, reduce their use of costly special education services, and increase their chance to graduate from high school (Campbell 2002, Schweinhart 2004).

High-quality center based child care and early childhood education has been demonstrated to:

- decrease children's learning and behavioral problems on school entry,
- improve their high-school graduation rates,
- improve their long-term health status, including decreasing mental health, concerns and substance abuse,

- decrease their involvement in crime and the criminal justice system as youth and adults, and
- increase their productivity and economic well-being as adults.

There are two studies that are frequently cited for research on high-quality early care and education: The Perry Preschool Project and the Abecedarian Project. These programs began in the 1960s and served children from disadvantaged households. 20, 30, and 40 year follow-ups have strong results demonstrating that children who attend high-quality child care and education are more likely than their peers to do well in school and in life.

The Perry Preschool Project (HQECE) was a program in North Caroline in the 1960s which provided high-quality preschool education to three- and four-year-old African-American children living in poverty. The program was delivered 5 mornings a week, about 75% of children attended for 2 year. Average child-teacher ratio was 6:1. It has had both promising evaluation with positive outcomes as well an undergone a randomized control trial which showed multiple positive effects, including long-term positive effects, over 20 years of research. At the 27 and 40-year follow ups, research showed that participants had completed an average of almost 1 full year more of schooling, spent an average of 1.3 fewer years in special education services, 44% higher high school graduation rate, much lower proportion of out-of-wedlock births, 50% fewer teen pregnancies, 46% less likely to have served time in jail, 33% lower arrest rate for violent crimes, 42% higher median monthly income, 26% percent less likely to have received government assistance in the past 10 years. Key components of the The Perry Preschool Project include:

- two school years (at ages 3 and 4);
- taught by certified public school teachers with at least a bachelor's degree.
- The average child-teacher ratio was 6:1.
- The curriculum emphasized active learning, in which the children engaged in activities that (i) involved decision making and problem solving, and (ii) were planned, carried out, and reviewed by the children themselves, with support from adults.
- provided a weekly 1.5-hour home visit to each mother and child, designed to involve the mother in the educational process and help implement the preschool curriculum at home.
- The program's cost was approximately $11,300 per child per school year (in 2007 dollars).

The Abecedarian Project (HQECE) was initiated in 1972 in Michigan and provided educational child care and high-quality preschool on a full-day, year-round basis. The program had a low teacher-child ratio. It has had promising evaluations with positive outcomes, including a randomized control trial which showed strong effects, including high school graduation rates, college attendance, ability to earn a wage, and decreased teen pregnancy. There were multiple academic effects including improved achievement in reading, math, and IQ scores. There have been long term follow ups (over 20 years) to check on the children in the program which showed the effects this

program had over the life of the child. This is a well-regarded, well-referenced study and it was well-designed, with low attrition and long-term follow up through age 21. However, it was also a small study, with large demonstration dollars invested in it, and we are still discovering as a community how to replicate these findings. Key components of the Abecedarian Project include:

- Full-day program
- Year-round basis
- Low teacher-child ratio (ranging from 1:3 for infants to 1:6 for 5-year-olds)
- Systematic curriculum of "educational games" emphasizing language development and cognitive skills.
- The average annual cost of the intervention was about $13,900 per child in 2002 dollars.

These two projects do highlight important characteristics of quality care, which research has confirmed in other studies as well, including:

- highly skilled teachers, with minimum education requirements
- small class sizes and small adult-to-child ratios
- age-appropriate curricula and stimulating materials in a safe physical setting
- a language-rich environment,
- warm, responsive interactions between staff and children, and high and consistent levels of child participation.

Cost-Benefit Analysis

Cost-Benefit Analysis: Cost-benefit analysis conducted of high-quality early education and care programs have shown tremendous returns on investment (ROI). In their analysis of Federal spending priorities, the Brookings Institute released a report in 2007 which selected early education and care as its number one priority for *expanded* government funding for children "even in a time of fiscal austerity" specifically because of the positive outcomes, sound cost-benefit ratios, and strongest evidence of returning economic value (Isaacs, 2007).

	Abecedarian Project	**Perry Preschool**	**Meta Analysis by Washington State**
Age of child	0-5	3-4	3-4
Length of program	5 years of full-day, full-year schooling	2 years of half-day schooling for 9 months	2 years of half day schooling for 9 months
Benefit-Cost Ratio	$3.23	$5.15-$17.1	$2.36

- Washington State created a conservative estimate of investing in early education and care: they analyzed forty-eight programs, including Abecedarian and Perry Preschool, assumed only 50% of the impact that the model programs like Abecedarian and Perry produced, and only considering tax dollar savings. They conservatively estimated a benefit of $2.36 for every dollar invested.

- The Federal Reserve Bank of Minneapolis has conducted analysis of these programs and concluded that the public rate of return on investing in early childhood is 12%; if the increased future earning of program recipients is included this number jumps to 16% (Grunewald 2006).
- Nobel Laureate Economist James Heckman has stated that "Early education offers the most cost-effective path to a whole range of social benefits: not just higher future incomes for participants, but a more productive workforce, greater economic growth, lower crime rates, smaller prison populations, and substantial savings for taxpayers (Heckman, 2007)."

The 2009 Community Status Report: Tracking the Data

With regard to specific indicators in The 2009 Community Status Report on Children and Youth:

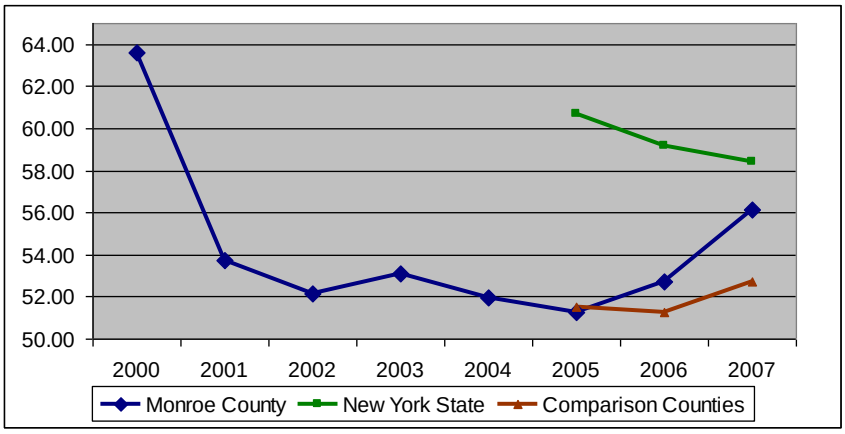
- Our County percent of children in subsidized child care has been higher than comparison counties, but after decades of progress, we have recently struggled to maintain enrollment and eligibility levels.

- High-quality Early Education and Care impacts school attendance and high school graduation.

- Children who were a part of the high-quality early care and education Perry Preschool program were followed until they were 40 years old and were found to be 44% more likely to have graduated from high school when compared to their peers. (Schweinhart et al, 2004)

- High-quality early education and care decreases teen pregnancy and markedly improves involvement in youth violence and crime for the children involved as they grow older. These are both areas where we are struggling tremendously as a community and where our rates are markedly worse than comparison communities locally, nationally, and internationally.

Rate of 15-19 year old girls with a pregnancy



- Girls in the Perry Preschool Project were 50% less likely to have a pregnancy as a teen as compared to their peers[i], and girls in the Abecedarian Project were 58% less likely to have a pregnancy as a teen as compared to

their peers (Schweinhart, 1993).

Current Barriers to Accessing High-Quality Care: Supply and Cost

High-quality early care and education make an enormous difference to very vulnerable children and bring a sound return on investment for tax payers. However, there are two barriers that families face in trying to access high-quality early education and care:

- Current high- quality programs are expensive; cost is a major barrier for families desiring them;
- Many local programs- whether in homes or centers – are not yet of the quality they need to be to see the outcomes our children and community demand.

Cost: A year of full-time, high-quality care for an infant is approximately $10,000. A single parent with two children and an income of $22,000 (125% of the Federal Poverty Level) struggles to cover these high costs, making high-quality care financially impossible. Child care subsidies offer critically needed financial aid for parents who are trying to keep children in safe, consistent, high-quality care while living on very tight family budget. Thus, for children living in poverty, child care subsidies can open the door to a high-quality experience which leads to better success in school and life.

Greater Rochester has a history of aggressively utilizing these subsidies, often being a leader in the State. In 2001, 13,575 Monroe County children aged 0-12 received child care subsidies. In the first months of 2006, that number, due to a combination of local policy change and State funding shifts, had dropped to 8,400. Further change, due again to State cuts and responding local policy changes, dropped that number to about 7,000 in January 2009. In response to the dwindling numbers, and the effect this had on both employability of parents as well as the potentially disastrous effects on child outcomes, the Greater Rochester community came together in Fall 2008 to advocate as one to the State for a restoration of our Child Care Block Grant allocation, Federal dollars distributed by the State to the County for the purpose of subsidizing low-income, working families. In May 2009 we were successful: $7.8M of our $8M request was restored to our allocation for a total of nearly $40M for child care subsidies. This increased allocation means that more low-income, working families can afford high-quality care. Policy change at the County happened immediately, increasing the eligibility level to 165% of the Federal Poverty line, and by the end of July 2009 513 additional families were receiving subsidies. This increase shows the quick and important work of the County and the community to get families back into the program when the State increased our allocation.

Unfortunately, even with the success this spring, less than 40% of working families in need of help to afford child care in Monroe County are able to receive this financial aid.

Quality: *Increase the quality of care delivered to children*

All children – regardless of age and regardless of chosen environment - deserve quality child care. Furthermore, the community benefits from saved tax dollars due to reduced expenditures in education, public assistance, and criminal justice services avoided over the long term.

Rochester has a strong, impressive history of partnership and progressive thinking in the field of early education, with long-standing work that has resulted in high-quality care:

- High utilization rate of City Pre-Kindergarten programs,
- Early Childhood Development Initiative (ECDI): a community-wide effort to help families access high-quality settings for their children.
- City Pre-K classrooms for three and four year olds are some of the best in the Country. RECAP (Rochester Early Childhood Assessment Partnership) is a community-wide effort that is dedicated to improving the quality of early education and care. The 11th Annual RECAP Report released Fall 2008 found that Rochester continues to have among the highest quality 3- and 4-year old center-based child care in the United States and Europe, as well as demonstrating continued improvement over our past performance.

But many child care settings, particularly those serving children aged 0-3 years, have not had their quality assessed; at the least it can be assumed that the quality varies across providers; it is feared that many settings may be quite low in quality, and therefore not producing the results that research shows are possible for our children and community.

Next Steps

To ensure our children are getting what they need during these critical years, The Children's Agenda will lead the community to:

- **Collaborate: The Children's Agenda will convene a 2010 community leadership team to develop community standards and identify and establish policies to make us the premier community in NY State for this issue.**
- **Research: establish a number of children currently participating in evidence-based, high-quality early education programs.**
- **Fight for increased Federal dollars: the Federal government needs to expand its investment in early childhood in order to serve the children who are currently eligible for subsidies;**
- **Advocate to the State to maintain our hard-won allocation increase, which is spent on both access, through subsidies, and quality, by compensating those programs with the highest standards of care at a higher level; and**
- **Coordinate between our early childhood programs and across systems to ensure that more programs are meeting national standards for child- to staff ratios, staff qualifications, and parent involvement.**

Community Goal #3: Our children are prepared to be successful adults, who are responsible citizens and productive, happy members of our community.

The Issue

Our community faces tremendous challenges in terms of our youth: too many of our youth are not prepared to be successful adults. The average of gang entry by Rochester Youth is 13 years. Our City's teen pregnancy rates are among the worst in the United States. Homicide is the leading cause of death for Rochester teens. While short term trends for the graduation rate show that RCSD schools are on the rise, we hover close to where we were 10 years ago – with half of our children not graduating from high school.

These are huge issues that affect children individually and our community at large. While there are many roots to these problems, our community's approach to the hours after-school offer an opportunity for making the problem better – or worse. Our local trends match national research: 2:30-6:00 p.m. are when children and youth are most likely to be victims or perpetrators of a crime. Teens unsupervised after-school are four times more likely to have committed a crime and used illegal drugs than teens with after-school programs (Fight Crime Invest in Kids 2003). The after-school hours present an opportunity to support our children and youth's learning and development by offering programming based on evidence and best practice.

Recently, though, our community has been hurt by funding reductions. Monroe County has seen decreased State and Federal after-school funding the last two years compared with other communities in New York State. From 2002-2007 Rochester received roughly $2.2 Million to serve roughly 1,600 children at 16 locations with after-school services at no cost to the participants. In a City with a 43% of children living in poverty, this was a critical service that has nearly disappeared. Almost all of this Federal funding is now gone. Over the last two years, Rochester has only received one grant from this funding stream, serving approximately 400 children at 4 schools: **we've lost ¾ of our capacity of these quality, no-charge programs. Comparatively, during the past two years, Buffalo has received a total of 9 grants, Yonkers a total of 4 grants, and Syracuse a total of 3 grants— Rochester has received 1.** These are large grants supporting quality after-school programs free of charge – a great resource for the families of our community, now lost and unlikely to be replaced with local dollars.

Changes like these have limited our children's access to safe, quality places to go after-school. As family work dynamics have changed over the last 30 years, the majority of children are ending up unsupervised after-school. 70% of Monroe County families have no stay-at-home parent (Pryor, 2007), yet a Children's Agenda inventory in 2007 found that fewer than 10% of children ages 5-17 participate in structured after-school programs (Lee-Davis & Kaczorowski, 2007).

Best Solution ***Expand quality after-school programs, including The Coping Power Program***

The Research Over the past 10 years there has been markedly increased interest in after-school programming: demand for programming has increased steadily, along with our understanding of what works and what doesn't. Much like the established research for high-quality early education and care, research has found that after-school programs can meet working families' needs, improve child outcomes, and benefit the whole community. Working parents need safe settings for their children to be in after-school so that they can work productively and without interruption. Children, when given the opportunity to attend quality after-school programs, are more likely to graduate from high school, less likely to be involved with crime, and less likely to become pregnant as teenagers. Effective, quality after-school programs are critical in improving outcomes for children and communities.

After-school programs come in all shapes and sizes. Those that are more comprehensive, with a variety of skill-building opportunities, homework and tutoring time, and recreational activities have the best outcomes. The Harvard School of Education released a 2008 report which reviewed many after-school programs from across the Country. Their meta-analysis concluded that there are four key components of successful programs (Little et al, 2008):

- Appropriate supervision and structure
- Well prepared staff with advanced credentials
- Intentional programming with opportunities for autonomy and choice
- partnerships with a variety of stakeholders, including parents, schools, and recreation centers

The researchers at Harvard concluded, "The common thread in all these studies is that balancing academic support with engaging, fun, and structured extracurricular or co-curricular activities, which promote youth development in a variety of real-world contexts, appears to support and improve academic performance."

One example of this type of after-school program is ***The Carrera Program.*** The *Carrera Program* has been designated a "top-tier" program by the Coalition for Evidence-Based policy because of the solid research behind it (www.evidencebasedprograms.org). "Multi-site randomized controlled trial shows sizable reductions in teen pregnancy and births, and increases in high school graduation and college enrollment" (www.evidencebasedprograms.org). *Carrera* has had promising evaluations with positive outcomes in research, including randomized controlled trials at multiple sites. These trials showed strong positive effects, including a long-term follow-up that followed the youth involved over 2 years after they finished the program. Positive effects included reduced teen pregnancy and increased graduation rates. Randomized control trials included 3- and 7-year follow-ups which have demonstrated increased graduation rates, college enrollment, a significant delay in the onset of sex, an increase in the use of condoms, and reduced pregnancy and birth rates (Philliber, 2002) As compared to girls in the

control group, girls in the Carrera group were:

- 40% less likely to have ever been pregnant (15% of Carrera group females had been pregnant vs. 25% of control group females).
- 50% less likely to have ever given birth (5% vs. 10%).
- More than twice as likely to be using Depo-Provera -- a hormonal contraceptive -- at last intercourse (22% vs. 9%).

Consistent with the findings by the Harvard study referenced above, *Carrera* is a year-round, comprehensive youth development approach for economically disadvantaged 13-15 year olds, 5 days a week, 3 hours a day after-school. It includes a community service component (for which youth are paid stipends), academic help and tutoring, job search help, arts and sports, as well as access to free health care and reproductive care. Some key components of Carrera include:

- Daily academic assistance (e.g., tutoring, homework help, assistance with college applications);
- Job Club 1-2 times per week, including such activities as learning to complete a job application and interview for a job;
- Family life and sex education 1-2 times per week, led by a reproductive health counselor;
- Arts activities 1-2 times per week (e.g. music, dance, writing, or drama workshops); and
- Individual sports activities 1-2 times per week (e.g. tennis, swimming, martial arts).
- free mental health and medical care through alliances with local health care providers.
- Reproductive health care, including physical exams, testing for sexually transmitted infections, a range of contraceptive options, and counseling.

The Teen Outreach Program (TOP) has a similar approach. It is based on the theory that adolescent problem behaviors can be prevented by enhancing normative processes of social development (www.childtrends.org). TOP has had promising evaluations which showed positive outcomes in research, and it has had a randomized control trial. The design of the RCT was not perfect and further research is necessary, but the positive evaluations included comparison groups, show promising results for youth in terms of reduced suspensions, improved academic outcomes, and decreased teen pregnancies: During the intervention period, Teen Outreach students were significantly less likely than control students to have failed a course or to have been suspended from school. Fewer Teen Outreach students than control students dropped out of school or became pregnant; however, the study sample was too small to permit analyses on these outcomes (Philliber, S. & Allen, J. P. (1992). Life Options and Community Service: Teen Outreach Program. In B. C. Miller, J. J. Card, L. Paikoff, & J. L. Peterson (Eds.), *Preventing adolescent pregnancy: Model programs and evaluation* (pp. 139-155). Newbury Park, CA: Sage Publications.).

TOP includes a comprehensive youth development approach, volunteer service learning, health education, including sex education. It has:

- a life skills curriculum for 12- to 17-year-olds that aims to prevent negative youth behaviors, such as school failure and early pregnancy.
- Trained facilitators deliver the curriculum in weekly classes throughout the school year.
- Participants discuss topics such as goal-setting, peer pressure, relationship dynamics, values, and communication skills.
- Teens enrolled in *TOP* must also plan and carry out a community service project. These projects require a minimum of 20 hours of service and can include activities such as fund raisers, graffiti removal, tutoring, volunteering at food pantries, petition drives, or other student-initiated activities.

TASC Programs are after-school programs for elementary and middle school students. TASC Programs have promising evaluations with positive outcomes for youth that emphasize academic enrichment, homework assistance, the arts, and recreation. Positive outcomes include higher test scores, more high school credits earned, and improved school attendance rates. Please note: Evaluations have demonstrated effects, but they have not yet conducted randomized control trials. TASC programs are provided to thousands of elementary and middle school children living in New York City. Their website (www.tascorp.org) lists key components:

- Variety of activities connected to but distinct from what's offered during the school day, including academic support, arts, sports and community service
- Low student-to-staff ratio of ten-to-one
- Diverse staff of teachers, artists, college students, parents and other community members
- Based in schools
- Operated by community-based organizations in close partnership with school leaders
- Operate three hours a day every day school is in session
- Offer snack or supper
- Offer open enrollment to all children in a school
- Employ a full-time, paid site coordinator

The Coping Power Program is not a comprehensive after-school program, but instead has a very targeted focus. The Coping Power Program was created to reduce violence and aggressive behavior in youth and it works primarily with students who have behavior issues in fourth and fifth grade, including aggressive tendencies. Given that early aggressive behavior is a strong predictor of future aggressive behavior, Coping Power is an opportunity to catch and correct behavior before it snowballs into something graver: deadly behavior for the child and the community. The Coping Power program has been shown in a long-term study to produce reductions in drug dependence, teen pregnancy, and criminal activity. The program was brought to Rochester 5 years ago by two doctors at the University of Rochester who were looking to reduce the violence in our schools and on our streets. They reviewed the evidence and found that Coping Power works. They met and worked

with the researchers behind Coping Power to best adapt the program for our community while maintaining fidelity to the original curriculum of goal setting, organizational skills, recognizing negative feelings, and anger management. RCP has been operating at School #35 for 4 years and School #28 since 2008. The program is small: 85 students participate, yet the school where the program has been for four years has seen a decrease in violence and aggressive incidents *school-wide*. Both the Rochester Area Community Foundation and United Way support the program and it is being seriously considered by the Robert Wood Johnson Foundation for expansion in Rochester.

Cost-Benefit Analysis

Research on the costs and benefits of high-quality, comprehensive after-school programs is limited with further analysis needed.

The John D. and Catherine T. MacArthur Foundation, in discussing the need for further cost-benefit analysis of socially-desirable policies, suggests "…a school district may have to increase spending to establish an after-school program. The district is likely to weigh this expenditure against the perceived benefit it will have on the educational mission of the school system. If the program also reduces delinquency and adult crime in the long term (when students have left school), then it may produce savings for the criminal justice and social welfare systems. A comprehensive analysis that identifies net savings in terms of all government expenditures could pave the way for the city, county, or state governments to share costs for the after-school program with the school district" (MacArthur Newsletter, Summer 2009).

Programs that have similar characteristics to those of quality after-school programs have shown a strong return on investment. The Washington State Institute for Public Policy has conducted a meta analysis of the costs and benefits of youth development programs, finding that benefits range from $3.14 to $28.42 for every dollar invested (Aos, 2004).

In addition, policy makers should consider the high costs of services for troubled youth who have not had the opportunity to receive preventive services. Kelly Reed, current Commissioner of Human Services in Monroe County, states "the average taxpayer cost for one youth to be incarcerated in New York State is about $100,000 per year. Quality programs for youth help our kids be productive and our community and taxpayers save dollars." That's one reason Fight Crime: Invest in Kids has made after-school a key part of its School and Youth Violence Prevention Plan. Fight Crime, an organization of more than 3,000 police chiefs, sheriffs, and prosecutors states, "quality youth development programs can cut crime immediately and transform this prime time for juvenile crime into hours of academic enrichment, wholesome fun and community service" (Fight Crime Invest in Kids: School and Youth Violence Prevention Plan, 2007).

The 2009 Community Status Report: Tracking the Data

With regard to specific indicators in The 2009 Community Status Report on Children:

- After-school programs can decrease violence and crime. Homicide is the leading cause of death for youth in Rochester. Our homicide rates for black males in the City are staggeringly worse than the County and NY State.
- After-school programs decrease teen pregnancy. Rochester and Monroe County's teen pregnancy rates are worse than comparison cities and counties and have worsened over the past 5 years. The City of Rochester teen pregnancy rates is among the worst in the United States and among industrialized nations.
- Improve school attendance and graduation. Although our City and County graduation rates are improving, progress has been sporadic and not consistent over the past 5 years.

Next Steps

Monroe County has made important strides in after-school over the last few years. We have completed 2 inventories in 7 years to better understand the landscape of programs available and are in year 3 of a 3 year pilot to evaluate local programs to determine the their level of quality. The Mayor of Rochester and RCSD Superintendent Brizard created a community taskforce during the summer of 2008 to consider how to best create a system of after-school to provide services to as many children as possible. **To move things forward for youth, The Children's Agenda will champion the following:**

- **Expand the Coping Power Program to four new schools in 2010; because of its targeted focus and one-day of programming a week, we see this being implemented as part of a comprehensive systemic approach to violence prevention in the Rochester City School District.**
- **Collaborate to bring Coping Power Program to scale to meet the local need by 2015 to serve all the fourth and fifth graders in need of the program. Programming should be combined with other evidence-based programs for youth, including PAThS, a social cognitive developmental program for all students now in place at 20 City of Rochester elementary schools, and Primary Project an effective one-on-one behavioral program for students too young for Coping Power (k-3) development and implemented by Children's Institute here.**
- **Provide after-school programming to at least 300 more Rochester students in 2010.**
- **Expand quality after-school opportunities by advocating for increased 21st Century After-School grant dollars and Advantage After-School Funding.**

How is "evidence-based" determined? Please find below one paradigm for considering levels of evidence that indicate that a program or policy is evidence-based.

Step 1. Review the Science and Research Literature to see if the literature shows positive outcome for this type of program/intervention; check if evaluation to date of this specific program shows outcomes that are positive. Learn from existing evaluations and research; don't do things already shown not to work and don't reinvent the wheel.

Step 2. Is there a meaningful outcome? Ideally, a meaningful outcome is an understandable, objective measure of behavior. For example, an important, practical outcome may be decreases school absences, versus scoring 50 points on a new rating scale invented specifically for the evaluation.

Step 3. Is there "Peer-reviewed" (reviewed by independent experts in the field) research on this particular program/intervention that is published in scientific journals? This is important because an independent review eliminates the developer's likely bias towards a positive effect. ****A third tier program has research that has been assessed in peer-reviewed journal.**

Step 4. Did the evaluation include a Comparison Group that did not participate in the program/intervention? The Comparison Group should be as similar as possible to the group that does not receive the program. This helps control for trends that can be naturally occurring: some situations improve (or worsen) by themselves. ****A second tier program has completed an evaluation with a comparison group, ideally in an randomized control trial (RCT).**

Step 5. Evaluation should avoid potential biases in selection nand differences beween the groups that are difficult to see or measure. The ideal is to run a RCT. These are expensive, but show true evidence of effectiveness by comparing those who receive the intervention with those who in the comparison group that are selected by chance. This is the best way to assure the 2 groups being compared are truly equal, and this must be checked at beginning and end.

Step 6. Is there more than one randomized controlled trial, or one that is conducted at more than one location/site? This indicates the programs ability to be replicated and further strengthens the findings of the evaluation. It minimizes the likelihood of chance in producing the positive outcome(s) and shows that the program works other than under unique scientific circumstances.

Step 7. Was there a Long Term Follow-up, conducted at least 18 months after the program was completed? Was there a meaningful difference (even if statistically different, it should have practical, "real-life" meaning) in terms of the positive effect(s) demonstrated? This is a real measure of the program/intervention's power: it makes a lasting and meaningful difference. An example of the latter is a difference of being absent 1 more day per school year vs. 20 more days per school year even if both were statistically truly significant. ****A top tier program has conducted a RCT with at least two sites and has meaningful outcomes, ideally reinforced by a long-term follow-up evaluation.**

The Continuum Continues: Putting the Paradigm to Use to Find Solutions

The intent of The 2009 Community Status Report on Children and Youth is to monitor vital indicators measuring child health and well-being. The 2010 Action Plan for Greater Rochester's Children focuses on the next three critical steps to move those indicators in the right direction: improving the health and well-being of our children and youth. Our report offers in-depth detail on the next three steps: expanding the Nurse Family Partnership to meet the local need, expanding access to high-quality early education programs, and expanding access to high-quality after-school programs. These, however, are not the only solutions to the challenges that we face as a community, and it is important that we share some information on additional community solutions.

With the above paradigm in mind, we have selected programs which are all either 1st or 2nd tier and fall within the continuum and goals represented by the Community Action Plan for Children.

Evidence-Based Programs for Children and Youth	
1st Tier	Abecedarian Project, an example of high-quality early care & education
1st Tier	Big Brothers Big Sisters, mentoring
1st Tier	Carrera, an example of high-quality after-school programming
1st Tier	Multidimensional Treatment Foster Care (MTFC)
1st Tier	Nurse Family Partnership Program (NFP)
1st Tier	PAThS, emotional-social curriculum
1st Tier	Perry Preschool, an example of high-quality early care & education
2nd Tier	Coping Power, a program to reduce aggression in Elementary Children
2nd Tier	Functional Family Therapy, an intervention for troubled youth (FFT)
2rd Tier	Incredible Years, parent coaching and early education
2nd Tier	Life Skills Training
2nd Tier	Multi-Systemic Therapy, an intervention for troubled youth (MST)
2nd Tier	Parents as Teachers, parent coaching (PAT)
2nd Tier	Teen Outreach Program, an example of quality after-school (TOP)

The programs below all exist currently in our community to varying degrees thanks to public and private funders. We would be excited to partner with the community to continue to consider further challenges and solutions around our children and youth.

The Big Brothers Big Sisters Program (BBBS) is a volunteer mentoring program for 6-18 year olds, predominantly from low-income, single-parent households, with adult volunteer mentors who are typically young (20-34) and well-educated (the majority are college graduates).

- BBBS has tremendous research behind it including promising evaluations with positive outcomes and Randomized Controlled Trials at multiple sites with strong positive effects, including over the long term after youth have finished the program. Positive effects include decreased drug use and decreased violent behavior.

- In 2004, the national average cost of making and supporting a match is approximately $1,300 in 2007 dollars.

http://evidencebasedprograms.org/Default.aspx?tabid=146
http://www.bbbs.org

Functional Family Therapy (FFT) is a structured family-based intervention program that services youth ages 10-18, and their families, whose problems range from acting out to conduct disorder to alcohol/substance abuse. FFT strives to increase protective factors and reduce risk factors in the family,

- Programs typically accessed through juvenile courts.
- In its meta-analysis of prevention and early intervention programs, the Washington State Institute for Public Policy found a benefit of $13.25 for every $1 invested in this program (AOS 2004).

http://www.ncjrs.gov/pdffiles1/ojjdp/184743.pdf
http://www.fftinc.com/

The Incredible Years Program (IY) is designed to promote emotional and social competence in order to prevent and reduce behavior problems in children aged 2-8.

- There are 3 curriculums: one for children, one for teachers, and one for parents. The Parent Training Curriculum is the most well-evaluated. It has had both promising evaluations with positive outcomes as well as multiple Randomized Control Trials, There were positive effects, but significance needs to be further researched and long term effects have not yet been demonstrated.
- One-time costs include leader training ($400 - $500 per leader trained in Seattle or $1,500 per day for on-site training) and program materials ($1,500 per series). Ongoing costs include consultation ($500 per year) teacher-training classroom-management curriculum (based on 15 teachers per workshop and classrooms with 24 children, suggested budget is $510 per teacher or $21 per student), parent groups ($476 per parent includes childcare costs for child during parent group time), small child treatment groups ($775 per child), Dinosaur Curriculum ($135 per child). Incredible Years currently gets both public and private funding and is being offered through Family Resource Centers and Mt. Hope.

http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=131
http://www.colorado.edu/cspv/blueprints/model/programs/IYS.html

Life Skills Training is a substance abuse prevention program for sixth and seventh graders which is taught by classroom teachers, who are trained in the program. Life Skills has a strong research background, including 14 randomized control trials which have found that children who receive *Life Skills Training* are 21% less likely to smoke cigarettes, 23% less likely to use marijuana, and 11% less likely to have ever been drunk.

- Teachers provide the program to students in 15 classroom sessions, each approximately 40-45 minutes in length
- Teachers first explain a variety of life skills (e.g. giving assertive responses in a social interaction) and demonstrate how to use it
- Curriculum materials cost approximately $8 per student per year, and the teacher training workshops cost approximately $235 per teacher (2009 dollars)

http://evidencebasedprograms.org/wordpress/?page_id=128
http://www.lifeskillstraining.com/

Multidimensional Treatment Foster Care (MTFC): MTFC is a foster care program for severely delinquent youth. Rather than placing these delinquent youth in residential care facilities, MTFC places youth with families who have received training in behavior management, and emphasizes preventing contact with delinquent peers.

- Foster parents track and regulate the youths' behaviors using a point system, with youths receiving points for positive behaviors and losing points for negative behaviors.
- There have been two randomized control trials of MTFC which show particularly outstanding results for girls: more than 50% reduction in criminal referrals and days in locked settings, and roughly 40% reduction in pregnancy rates, two years after randomized assignment. For boys, evidence of reductions in criminal activity is promising but requires further research.
- The program provides both individual and family therapy and costs about $3,600 per month (2009 dollars), which is 30 to 50 percent lower than the cost of treatment in a group residential care facility in Oregon (where the studies of the program were conducted).

http://toptierevidence.org/wordpress/?page_id=313
http://www.mtfc.com/

Multi-Systemic Therapy (MST): MST is a treatment program for juvenile offenders. It uses a combination of empirically-based treatments (e.g. cognitive behavior therapy, behavioral parent training, functional family therapy) to address multiple variables (i.e. family, school, peer groups) that have been shown to be factors in juvenile behavior.

- Masters-level therapists work with youth and families at the youth's home and community locations (e.g. school, recreation center). The therapists are available to the youth and his/her family 24 hours a day, 7 days a week.
- Each therapist has a small caseload (between one and five families) and the average treatment lasts for four months, with the therapist spending several hours per week with the youth and his/her family.
- The cost is $5,800 (in 2007 dollars) per youth treated.
- There have been four randomized control trials of MST, 3 in the United States and one in Canada. Two of the U.S. studies showed important results in terms of reduced arrests of juveniles, including reduced violent offenses and drug offenses. There was low attrition with both studies and long-term follow-up. The Canadian study did not find the same dramatic results in terms of arrest reductions.

http://www.mstservices.com/
http://evidencebasedprograms.org/wordpress/?page_id=120

Parents as Teachers (PAT): PAT is a parent education program that incorporates home visits and group sessions from the third trimester of pregnancy through the child's third year, with continued limited service and support through age five.

- The program includes screening for developmental delays.
- The program has had promising evaluations with positive outcomes as well as undergone a randomized control trial. Multiple RCTs have not yet been conducted, and strong positive effects through an RCT have not been demonstrated, nor have long-term effects.
- Positive effects which are promising include academic achievement and an increase in parent knowledge of development and parent participation in child's school. Both Mt. Hope and Family Resource Centers are trained and offer PAT programs to the community.

http://www.opfibti.org/pat/resources/PAT_ResearchSummary_Dec20_2007.pdf
http://www.parentsasteachers.org/site/pp.asp?c=ekIRLcMZJxE&b=272091

The PAThS Program promotes emotional and social competencies and reducing aggression and behavior problems in elementary school-aged children.

- Ideally it should be initiated at the entrance to schooling and continue through Grade 5.
- PAThS has undergone three randomized controlled trials at multiple sites which showed strong positive effects for children. Positive effects include reduced aggressive behavior, increased self control, and improved academic outcomes.
- Total cost estimates, including complete training and ongoing technical assistance, depend on how existing support staff (e.g., counselors, head teachers) is utilized in the program. If a counselor is used in the role of curriculum consultant (at least a .5 FTE), curriculum and training costs for the first year of operation for an elementary school would be approximately $12,000, or $25 per student. Costs in later years would be substantially reduced to about $10 per student, given the expectation of low to moderate staff turnover.

http://www.colorado.edu/cspv/blueprints/model/programs/PATHS.html
http://www.modelprograms.samhsa.gov/pdfs/model/PATHS.pdf

Evidence-Based Programs that improve outcomes for children, youth, families, the community, and tax-payers											
	NFP	**High-quality ECE**	**PAT**	**IY**	**Coping Power**	**Carrera & TOP**	**MTFC**	**MST & FFT**	**Big Brothers Big Sisters**	**PAThS**	**Life Skills**
Goal #1: Our children are born healthy into families who can provide them with safe and nurturing environments.											
Reduced child abuse and neglect (1)	**X**										
Reduced child deaths (11)	**X**										
Reduced health care encounters & hospitilizations for injuries or ingestions for child (9) (10)	**X**										
Reduced time on public assistance (5) (14) (15)	**X**										
Reduces domestic violence (21)	**X**										
Decreased parent separation (18)	**X**										
Reduced parent substance abuse (19)	**X**										
Reduced multiple pregnancies of mom (78), (6), (16), (20)	**X**		**X**								
Reduced subsequent low birth weight newborns (17)	**X**										

	NFP	High-quality ECE	PAT	IY	Coping Power	Carrera & TOP	MTFC	MST & FFT	Big Brothers Big Sisters	PAThS	Life Skills
Goal #2: Our children are prepared to learn and attend quality schools.											
Prevented gross motor skill delay (74)		**X**	**X**								
Improved language skills (75)		**X**	**X**								
Increased school readiness (76)		**X**	**X**								
Increased School Attendance (22)		**X**									
Reduced Special Ed Services (23) (79)		**X**	**X**								
Increased Academic Outcomes (12) (29) (31) (30) (73) (13) (77)	**X**	**X**	**X**						**X**	**X**	
Reduced child problem behaviors (70) (71) (72) (80)		**X**		**X**	**X**					**X**	
Goal #3 Our children are prepared to be successful adults, who are responsible citizens and productive, happy members of our community.											
Decrease youth arrests & criminal activity (2) (3) (50) (51) (54) (55) (56) (58) (57) (43) (44) (45) (46) (47) (48) (49) (52) (53)	**X**	**X**					**X**	**X**			
Decreased teen pregnancies (26) (36) (37) (38) (61)		**X**				**X**					

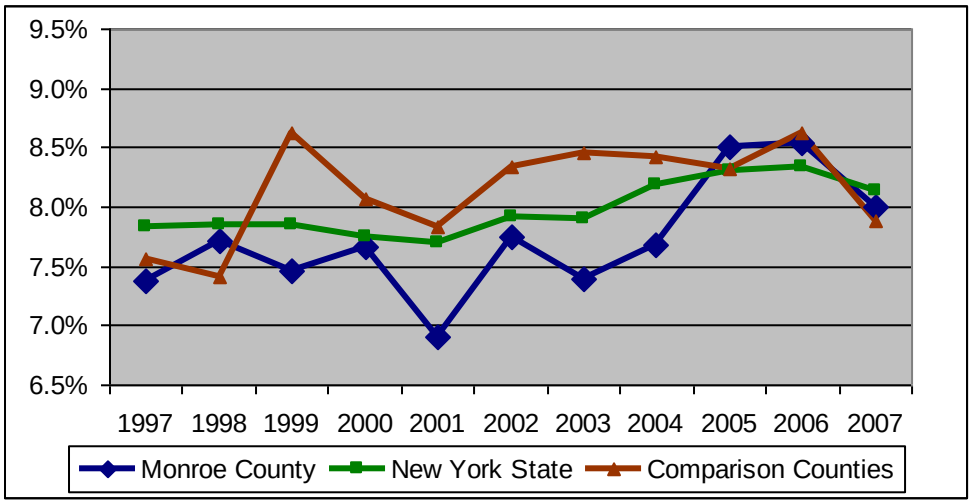
	NFP	High-quality ECE	PAT	IY	Coping Power	Carrera & TOP	MTFC	MST & FFT	Big Brothers Big Sisters	PAThS	Life Skills
Decreased out-of-wedlock births (25)		X				X					
Decreased use of public assistance (5) (14) (15) (27) (28)	X	X									
More likely to be working (35) (39)		X				X					
Increases academic outcomes (40) (60) (68) (69)		X				X		X	X	X	
Decreased disruptive teen behavior at (65) (67)	X	X			X		X	X	X		
Decreased substance abuse (62) (63) (64)					X			X	X		X
Reduced suspension rates (59)					X						
More likely to graduate from high school (24) (41)		X				X					
Increase College Attendance (33) (34) (42)		X				X					
Improved family functioning (66)								X			

Appendix A: Explaining the Indicators in the 2009 Community Status Report on Children and Youth, as found on report pages 8-9

Percent of Babies with Low Birth Weight

How it is measured: # of Babies with low birth weight divided by the number of live births.

Why it matters: Low Birth Weight is a measure of child health at birth and of increased risk to life and health in early days of life, associated with a greater risk to cognitive and physical development through childhood, associated with the mother's health and socio-economic status.



Monroe County's percentage of babies with low birth-weight is equal to comparison counties, the State and the Nation, but worse than International rates that have been achieved by almost all developed countries. City of Rochester is worse than the County and slightly worse than comparison cities.

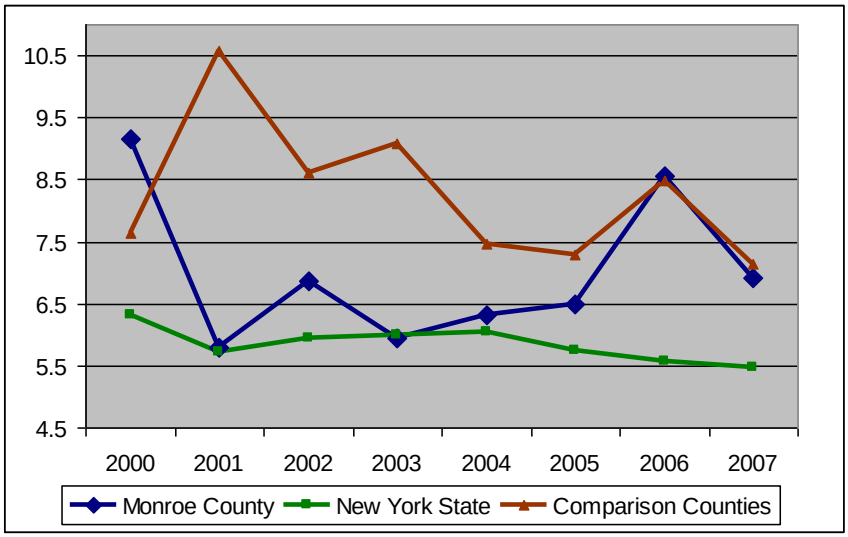
Percent of Babies with Low Birth Weight											
	1997	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
New York State	7.8%	7.8%	7.8%	7.7%	7.7%	7.9%	7.9%	8.2%	8.3%	8.3%	8.1%
Monroe	**7.4%**	**7.7%**	**7.5%**	**7.7%**	**6.9%**	**7.7%**	**7.4%**	**7.7%**	**8.5%**	**8.5%**	**8.0%**
Erie	7.8%	7.6%	8.6%	8.2%	7.8%	8.7%	8.5%	8.4%	8.2%	8.9%	7.8%
Onondaga	7.3%	7.2%	8.6%	7.9%	7.9%	8.0%	8.4%	8.5%	8.4%	8.4%	7.9%
Rochester											10.8%
Syracuse											9.8%
Buffalo											10.4%

Sources: NYS DOH 2007 for Cities and NYS; CGR Counties 2007 (pulling from same source); National is from Child Trends and is 2000 & 2005; have contacted for updated numbers because they have a new report pending; International is from Unicef report and is 'most recent available'; note from the WHO 'in many developing countries the majority of infants were not weighed at birth'.

Infant Mortality Rate (IMR)

How it is measured: Number of infant deaths per 1,000 live births.

Why it matters : A standard indicator of child health, UNICEF states that IMR "reflects child's access to adequate nutrition, clean water, basic preventative health services'; also can be interpreted as a measure of how well each country lives up to an ideal of protecting every pregnancy (UNICEF 2004).



Monroe County's infant mortality rate is better than it was in 2000 but continues to have a higher rate than Onondaga County, New York State, the U.S., and the International rate. City of Rochester is worse than comparison cities.

According to the Center for Disease Control, the several decades of decline began stalling in 2001 when the rates increased for the first time in 50 years. Overall, the U.S. infant mortality rate increased from 6.78 deaths per 1,000 births in 2004 to 6.86 deaths per 1,000 births in 2005. The CDC attributes the higher rates in large part to low birth-weights, shorter gestation periods and premature births. Possible contributors also include higher rates of poverty, limited access to health care and dietary differences.

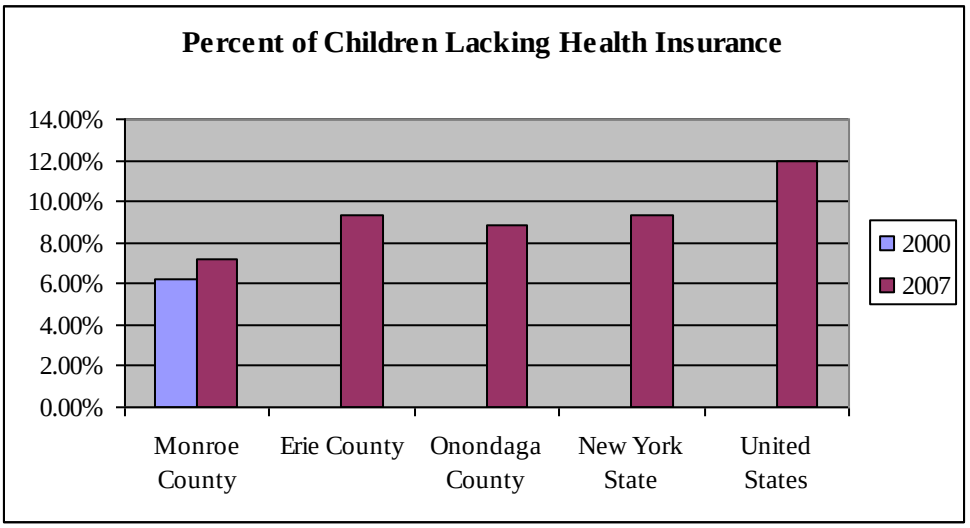
Infant Mortality Rate								
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
New York State	6.3	5.7	5.9	6.0	6.0	5.8	5.6	5.5
Monroe	**9.2**	**5.8**	**6.9**	**5.9**	**6.3**	**6.5**	**8.6**	**6.9**
Erie	7.5	8.5	8.2	9.4	7.4	8.2	8.9	7.8
Onondaga	7.8	12.6	9.1	8.7	7.5	6.4	8.0	6.5
Rochester								11.7
Syracuse								10.8
Buffalo								8.9

Sources: NYS DOH 2007 for Cities and State. CGR Counties 2007 (pulling from same source). Available from ACT back to 2000. National 2000 and 2006 number from CDC. US International Ranking fell from 12 in 1960 to 23rd in 1990 to 29th in 2004. International from Unicef report ' most recent available.'

Percent of children under 18 who don't have health insurance

How it is measured: Census analysts have created county and state estimates of people with and without health insurance coverage by age. Estimates are adjusted so that, before rounding, county numbers sum to their states and similarly the states sum to the Annual Social and Economic Supplement (ASEC) of the Current Population Survey (CPS) national estimates. We have developed experimental County and State estimates of people with and without health insurance coverage by age.

Why it matters: Enrollment in health insurance is one aspect of access to the medical care system and to maintaining good health.



Children Lacking Health Insurance		
	2000	2007
Monroe County	6.20%	7.20%
Erie County		9.30%
Onondaga County		8.80%
New York State		9.30%
United States		12.00%

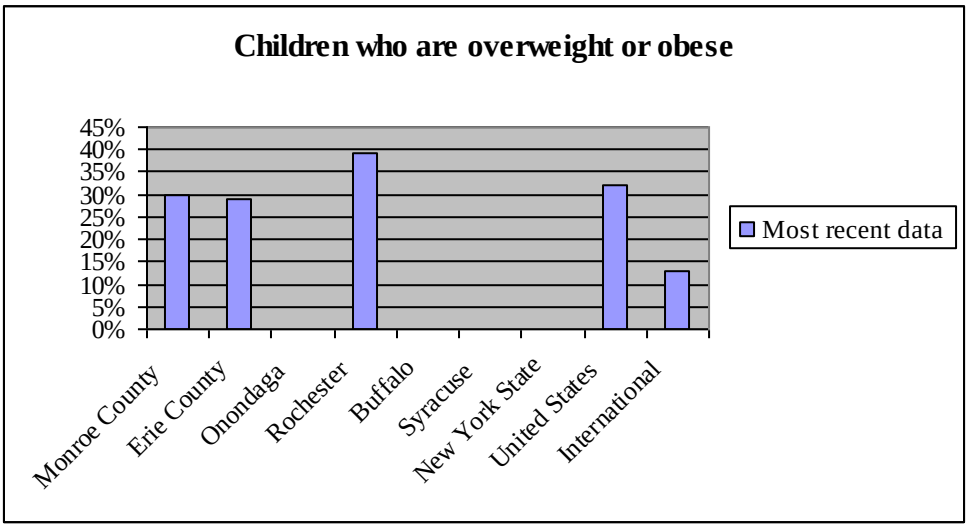
Monroe County and the City of Rochester have a higher rate of children who have health insurance than the State and the Country. Monroe County is comparable to comparison Counties. Comparison city and trend data are not currently available. Strong local efforts by the Monroe Plan, Finger Lakes Health Systems Agencies, local pediatricians and pediatric offices over the last decade, in addition to recent New York State policy that expanded eligibility, have had the impact of cutting through the disparity between the City of Rochester and the surrounding towns and suburbs.

***Sources**: Health insurance data from CGR-recommended site using CENSUS SAHIE data (Small Area Health Insurance Estimates). 2000 available; 2005 for breakdown of 19yo & under is not yet posted. City number is from MCDOH report card which quotes PACE data from 2002-2003 school year for school children uninsured.*

Percent of children who are overweight

How it is measured: Children over 85th percentile for Body Mass Index (overweight and obese) divided by total number of children.

Why it matters: Being overweight as a child is associated with health issues, some extreme, in adolescence, young adulthood and throughout life.



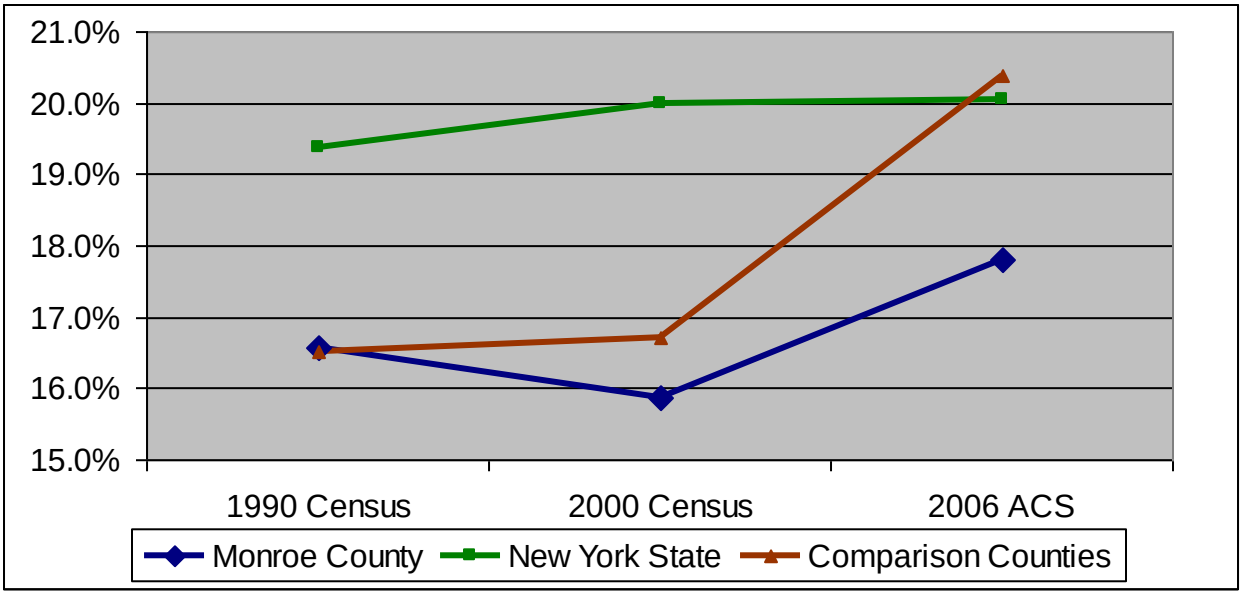
Children who are overweight or obese	
	Most recent data
Monroe County	30%
Erie County	29%
Onondaga	*NA*
Rochester	39%
Buffalo	*NA*
Syracuse	*NA*
New York State	*NA*
United States	32%
International	13%

Childhood overweight and obesity are increasing throughout the Country. Sample data suggests that the rate in Monroe County has stayed relatively consistent over the last 10 years, increase from 29% to 30%, which is comparable to Erie County and the United States on average. With 40% of children living in the City of Rochester overweight or obese, the city is significantly worse, and the International comparison to both the City and County-wide number is embarrassing. Comparison city and trend data are not currently available.

Sources: *Steve Cook from the University of Rochester Medical Center provided info for Rochester and Monroe County; research done in Erie County provided information for that region, JAMA was used for National estimates, and UNICEF provided an international estimate.*

Percent of Children Living in Poverty

How it is measured: Ratio = Total Children (Less than 18 years) in Poverty according to Federal Poverty guidelines (http://aspe.hhs.gov/poverty/09poverty.shtml) divided by the Total Number of Children (0-17 years).
Why it matters: Children growing up in poverty are more likely to be in poor health and have behavioral difficulties, more likely to become pregnant in teen years, to be unemployed, to need public financial assistance, and less likely to be 'ready for school'.



More children in Monroe County and City of Rochester are living in poverty in 2006 than were in 2000. City of Rochester has more children living in poverty than the State or the Country. While it is comparable to Buffalo and Syracuse, all three of these cities rank in the 20 worst in the Country. These rates are deplorable and signify an unacceptably large number of children affected.

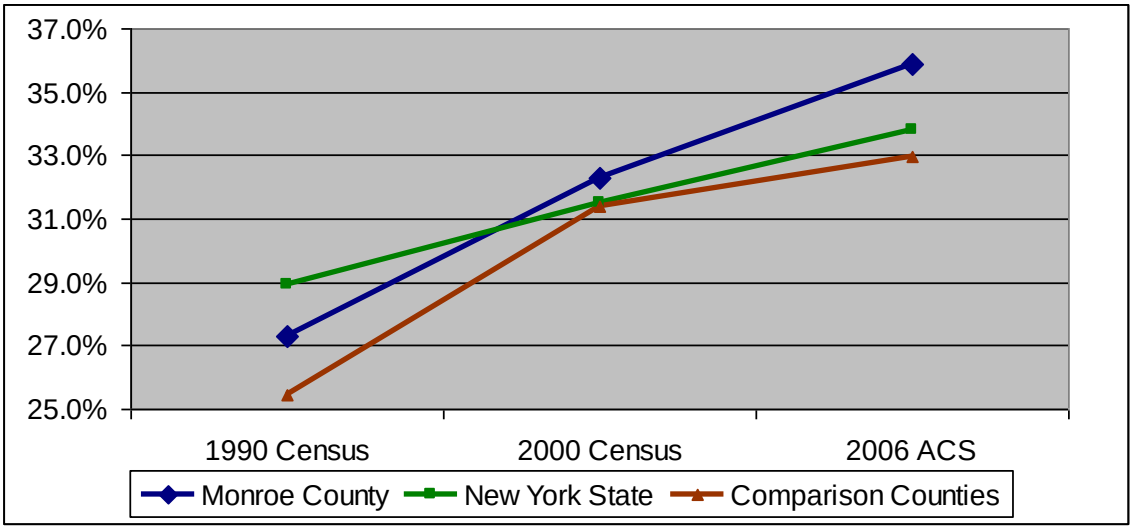
Children Living in Poverty			
	1990 Census	**2000 Census**	**2006 ACS**
New York State	19.4%	20.0%	20.0%
Monroe	**16.6%**	**15.9%**	**17.8%**
Erie	18.7%	17.6%	21.5%
Onondaga	14.3%	15.8%	19.2%
Rochester			**42.70%**
Syracuse			44.50%
Buffalo			40.60%

***Sources**: City data 2005-2007 from American Community Survey 3-Year Estimates. County data provided by the Center for Governmental Research. International data from UNICEF and is for % of children living below 50% of the median income.*

Percent of Children in single parent families

How it is measured: Measured as the number of children living in single parent households divided by the total number of children.

Why it matters: Both the number and the type of parents (i.e., biological, step) in a child's household can have strong effects on their well-being. Single-parent families tend to have much lower incomes than do two-parent families, but research indicates that the income differential accounts for only about one-half of the negative effects of parent absence on many areas of child well-being, including health, educational attainment, behavior problems, and psychological well-being. Among young children, for example, those living with no biological parents or in single-parent households are less likely than children with two biological parents to exhibit behavioral self-control. Young children with single parents are also more likely to be exposed to high levels of aggravated parenting.(ChildTrends, 2002)
[1]



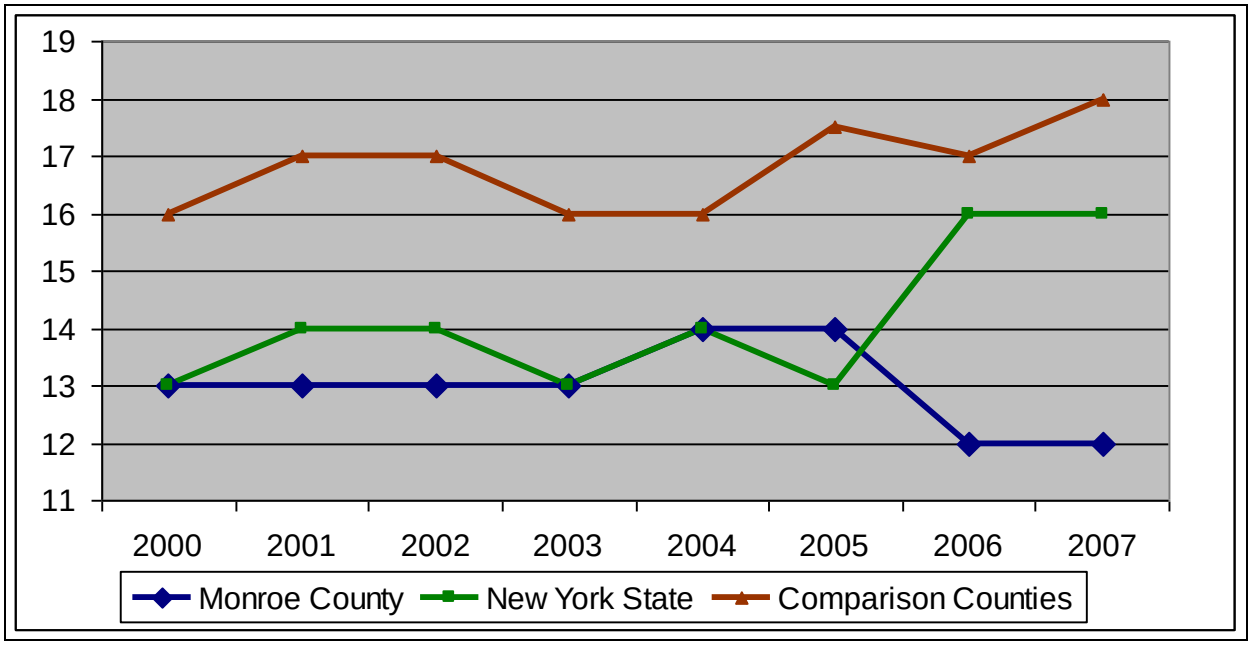
More children in Monroe County and City of Rochester are living in single parent families in 2006 than were in 2000. City of Rochester has more children living in single parent families than in the past than the County, State, and Country. Again, the City is comparable to Buffalo and Syracuse, but all three cities are far too high.

Children in Single Family Homes			
	1990 Census	2000 Census	2006 ACS
New York State	28.9%	31.5%	33.8%
Monroe	**27.3%**	**32.3%**	**35.9%**
Erie	26.4%	30.9%	33.1%
Onondaga	24.5%	31.9%	32.8%
Rochester			**68.0%**
Buffalo			62.0%
Syracuse			65.0%

Sources *Single parent data available for 2005-2007 American Community Survey 3-Year Estimates. International number from UNICEF is for 2001, is for 11/13/15 year olds.*

Rate of Indicated reports of child physical abuse and neglect

How it is measured: Rates of children/youth in indicated reports (i.e., found valid upon investigation) of physical abuse, sexual abuse, and neglect per 1,000 youth ages 0-17.



After slowing inching up, Monroe County's rate of children with indicated reports of abuse has decreased slightly 2 years in a row and is doing better than the comparison Counties and the State. City level data is not available at this time.

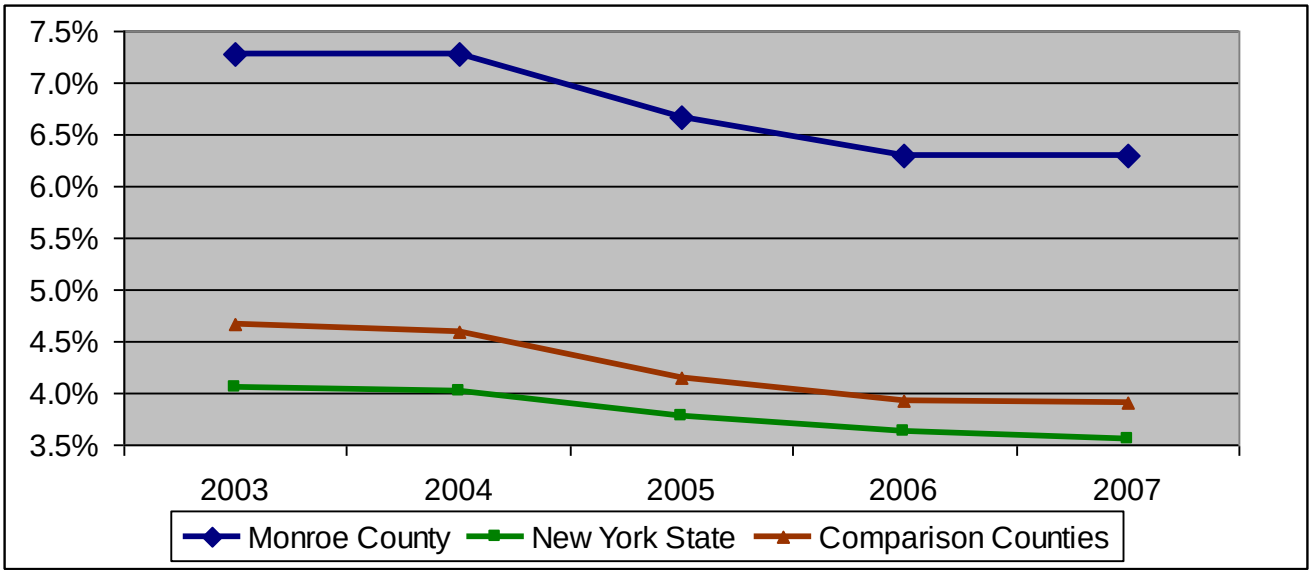
Rates of Child Abuse and Neglect								
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
New York State	13	14	14	13	14	13	16	16
Monroe	**13**	**13**	**13**	**13**	**14**	**14**	**12**	**12**
Erie	14	14	14	12	14	15	16	16
Onondaga	18	20	20	20	18	20	18	20
Note: Rates are per 1,000 youth. Data from NYS Kids Well-being Indicator Clearinghouse.								

***Sources**: Child abuse report data available for 2000-2007. County level data provided by the Center for Governmental Research. Comparable County to County and to State; no city or Country data readily available.*

Percent of Children in Subsidized Child Care

How it is measured: Children under age 13 receiving subsidized childcare divided by the total number of children under age 13.

Why it matters: Subsidies are a critical component to linking low-income working families with quality child care because quality child care is expensive and low-income working families' budgets are tight. Another critical aspect of supporting children's development during 0-5 years.



Monroe County continues to make subsidies available to working-poor families at a higher rate than the comparison Counties and the State, however fewer County children are using subsidies in 2007 than in the past, marking a reversal of decades of progress. Comparison city data is not currently available. These rates are strongly linked to State and Federal funding levels.

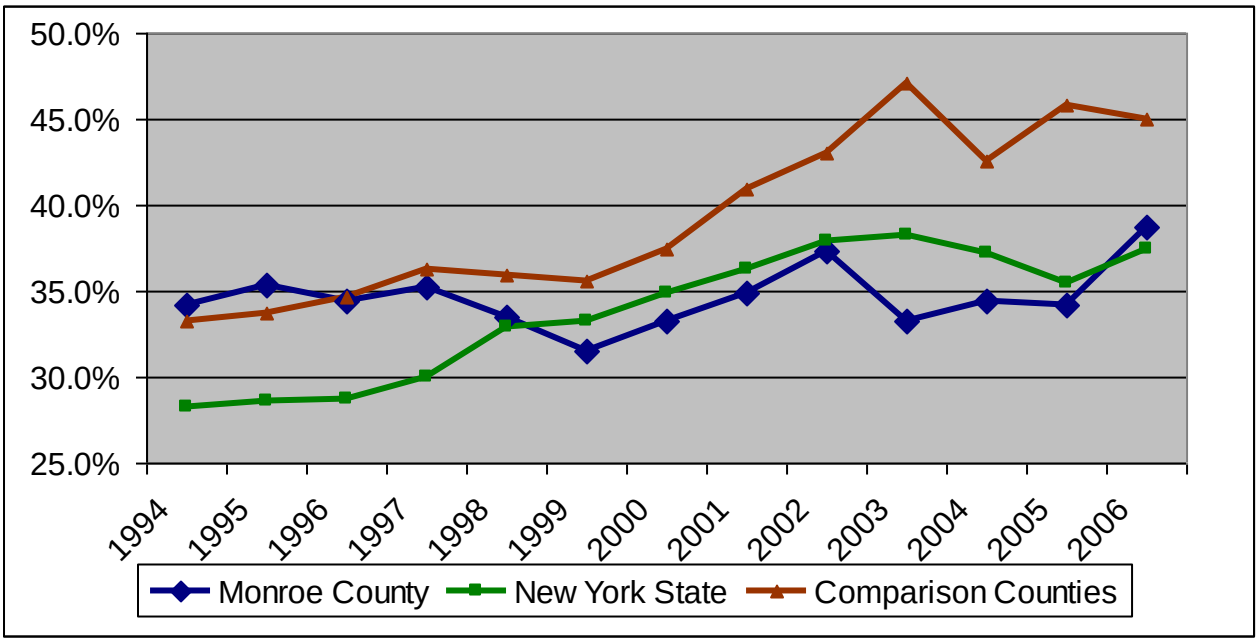
Percent of Children in Subsidized Care					
	2003	**2004**	**2005**	**2006**	**2007**
New York State	4.0%	4.0%	3.8%	3.6%	3.6%
Monroe	**7.3%**	**7.3%**	**6.7%**	**6.3%**	**6.3%**
Erie	5.8%	5.4%	4.5%	4.1%	4.2%
Onondaga	3.6%	3.8%	3.8%	3.8%	3.6%

Sources *CGR supplied data on percent of children under age 14 in subsidized care 2003-2007. City, National, International not available.*

Percent of Pre-kindergarten Participation

How it is measured: Total Pre-k enrollment for Monroe County 3- and 4-year old children divided by the eligible population (3- and 4-year olds).

Why it matters: Critical part of a community's effort to support children's development during 0-5 years.



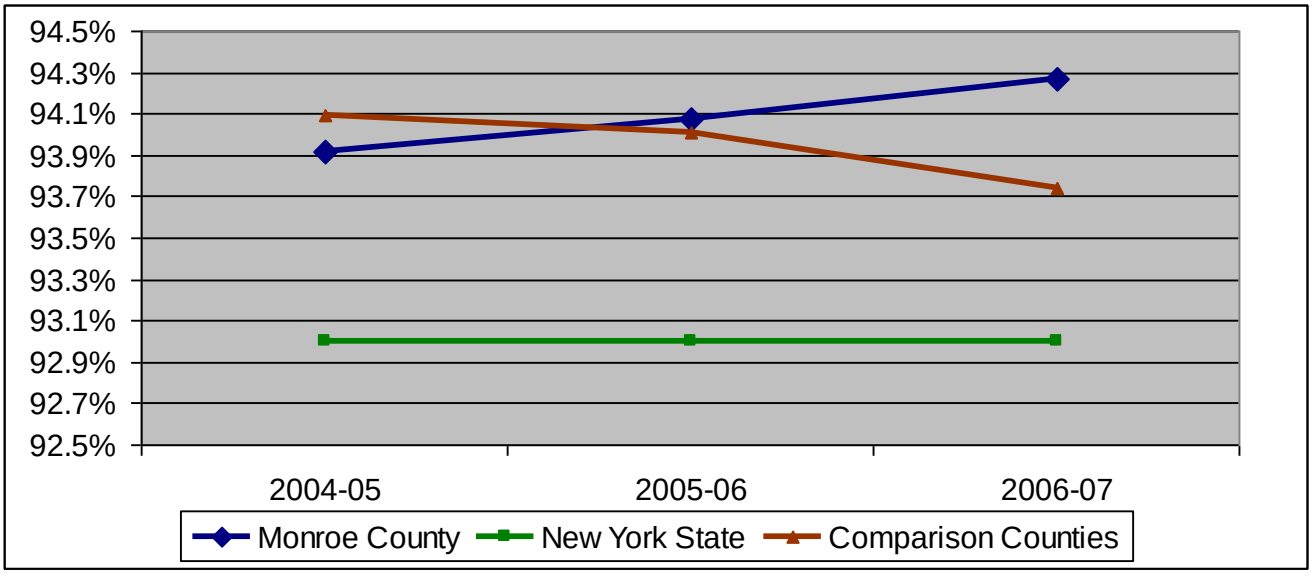
More children in Monroe County are participating in publicly-financed PreK than were in the past, and Monroe County has a higher rate of participation than New York State, but a lower rate than the comparison Counties. Comparison city data is not readily available. While the official Rochester number is 51%, it represents a percent of three and four year olds. Actual percent of 4 year olds enrolled in UPK programs in the City of Rochester is closer to 75%

Pre-K Participation Rate										
	1997	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
New York State	30.0%	32.9%	33.2%	34.9%	36.3%	37.9%	38.3%	37.2%	35.5%	37.5%
Monroe	**35.2%**	**33.5%**	**31.6%**	**33.3%**	**34.8%**	**37.4%**	**33.3%**	**34.4%**	**34.2%**	**38.8%**
Erie	34.9%	36.3%	36.4%	38.3%	44.2%	46.4%	47.2%	46.4%	46.4%	49.9%
Onondaga	37.6%	35.6%	34.7%	36.7%	37.7%	39.6%	46.9%	38.7%	45.1%	40.2%
Rochester										51%

Sources: *Data supplied by the Center for Governmental Research. City number from the New York State Department of Education. National and International numbers are not measured in the same way and are therefore not comparable.*

Elementary (k-6) & Secondary (7-12) Attendance Rate

How it is measured: Attendance rates are calculated by dividing total aggregated attendance by total possible attendance.



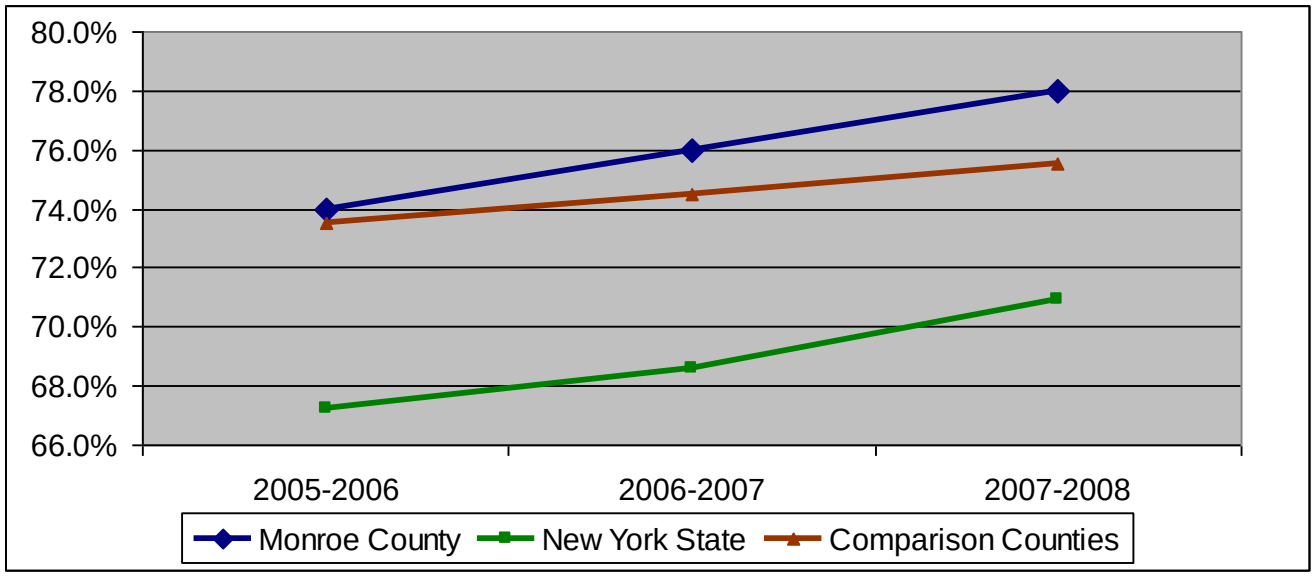
Monroe County and City of Rochester school attendance is comparable to or higher than other communities.

Attendance Rate			
	2004-05	**2005-06**	**2006-07**
New York State	93.0%	93.0%	93.0%
Monroe	**93.9%**	**94.1%**	**94.3%**
Erie	93.9%	93.6%	93.2%
Onondaga	94.3%	94.5%	94.3%
Rochester	89%	89%	91%
Syracuse	92%	92%	91%
Buffalo	90%	89%	87%

Sources *County and State data provided by the Center for Governmental Research. City data from the New York State Department of Education.*

4-year Graduation Rate

How it is measured: Cohort of students who graduate 4 years after entering 9th grade compared to the total number of students who entered 9th grade 4 years prior (e.g., graduates in 2005 compared to the number of students in 9th grade in 2001).



Monroe County's graduation rate is slightly better than it was in 2000 and is better than comparison Counties and New York State. Recent City data show the City of Rochester is on the rise. Nonetheless, more than 50% of students not graduating is unacceptable because of the long-term implications for each student and for the community as a whole.

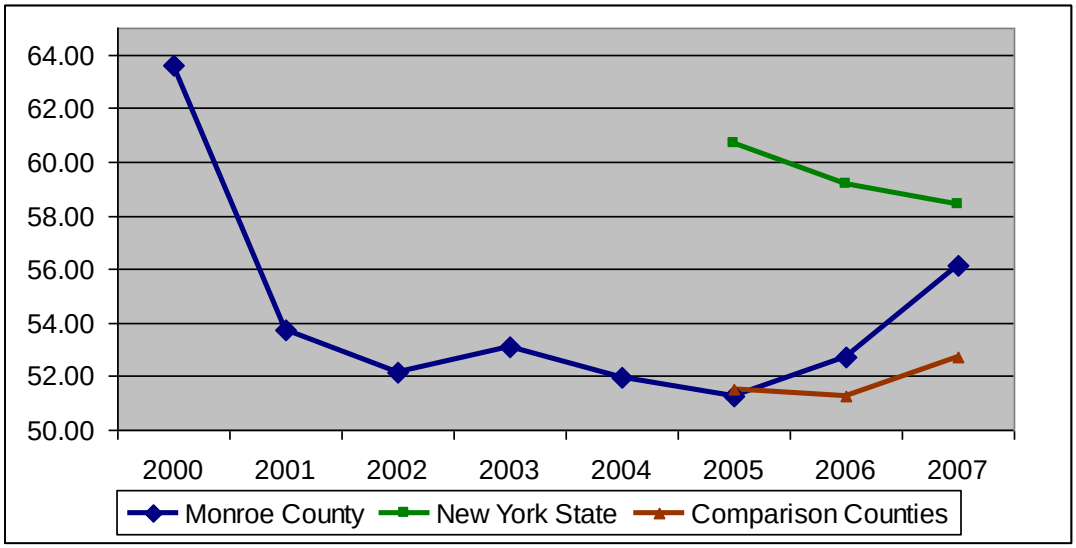
4 year Cohort Graduation Rate for Students earning a Regents or Local Diploma. Numbers are for students who graduate 4 years (June) after entering (September).			
	2005-2006	**2006-2007**	**2007-2008**
New York State	67.2%	68.6%	70.9%
Monroe	**74.0%**	**76.0%**	**78.0%**
Erie	74.0%	74.0%	76.0%
Onondaga	73.0%	75.0%	75.0%
Rochester	37.0%	44.0%	48.0%
Buffalo	50.0%	45.0%	52.0%
Syracuse	48.0%	49.0%	47.0%

Sources June 22, 2009 by NYSED Information and Reporting Services: http://www.emsc.nysed.gov/irts/pressRelease/20090622/home.html

Rate of 15-19 year old girls with a pregnancy

How it is measured: Pregnancies in girls 15-19 year olds per 1000 girls aged 15-19.

Why it matters: The majority of teen pregnancies are unplanned. Children born to teen moms are associated with tremendous challenges throughout life, including more likely to live in poverty, to not be ready for school, and to get pregnant themselves as teens.



After years of dropping, local numbers and National trends began to increase in 2006 which was first in 14 year period of continuous decline from 1991-2005. Monroe County has more teen pregnancies than comparison Counties but fewer than State. City of Rochester is frighteningly high as compared to anyone else; comparison city data are not currently available. International comparisons show that the United States could do much better in improving teen pregnancy and birth rates. These data show that U.S. teens' sexual behavior is similar to teens of other developed countries in terms of when they start to have sex and how often they are having it. Yet, U.S. teens are less likely to use contraception or to consistently use more effective methods of contraception when compared to the teens of other developed countries. Recent data show that 77% of the decline in teen pregnancy rates during the 1990s among U.S. teens aged 15–17 years is because teens have increased their use of contraception and 23% of the decline is because teens are having less sex (UNICEF, 2001).

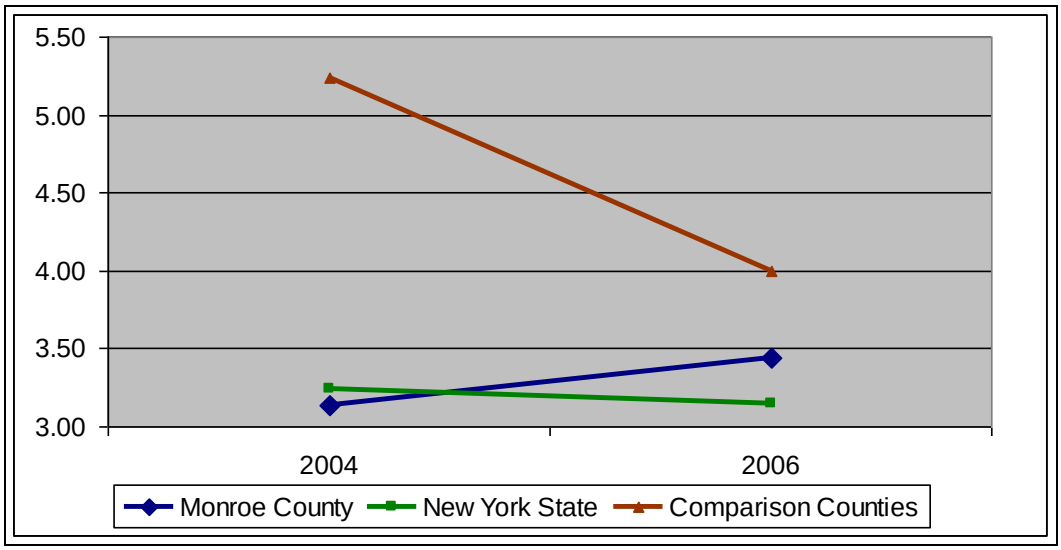
Teen Pregnancy Rate (rate per 1,000 15-19 year old girls)								
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
New York State						60.70	59.20	58.40
Monroe	**63.58**	**53.74**	**52.18**	**53.07**	**51.95**	**51.25**	**52.74**	**56.14**
Erie						52.80	53.10	54.80
Onondaga						50.30	49.40	50.70
Rochester			104.85				109.28	116.18
Buffalo								109.20
Syracuse								87.80

Sources: *Buffalo & Syracuse from New York State Department of Health. Monroe County, Erie, Onondaga, & City of Rochester Data from Monroe County Department of Health. U.S. is provided by the Guttmacher report using US DHHS National Center for Health Statistics. UNICEF estimates International rates of most economically advanced Countries and is births to 15-19 year olds in 2003.*

Percent of Juvenile Delinquent Petitions

How it is measured: Total petitions brought before judges divided by the number of youth between 10-15 years taken into custody by police or probation officer.

Why it matters: Measure of how the police deal with the youth that they interact with, as well as a community's capacity for screening.



Current data shows that Monroe County has a slightly higher rate of Petitions for Juvenile Delinquents than the State, but lower than Erie and Onondaga Counties. City-level data and long-term trend data are not currently available.

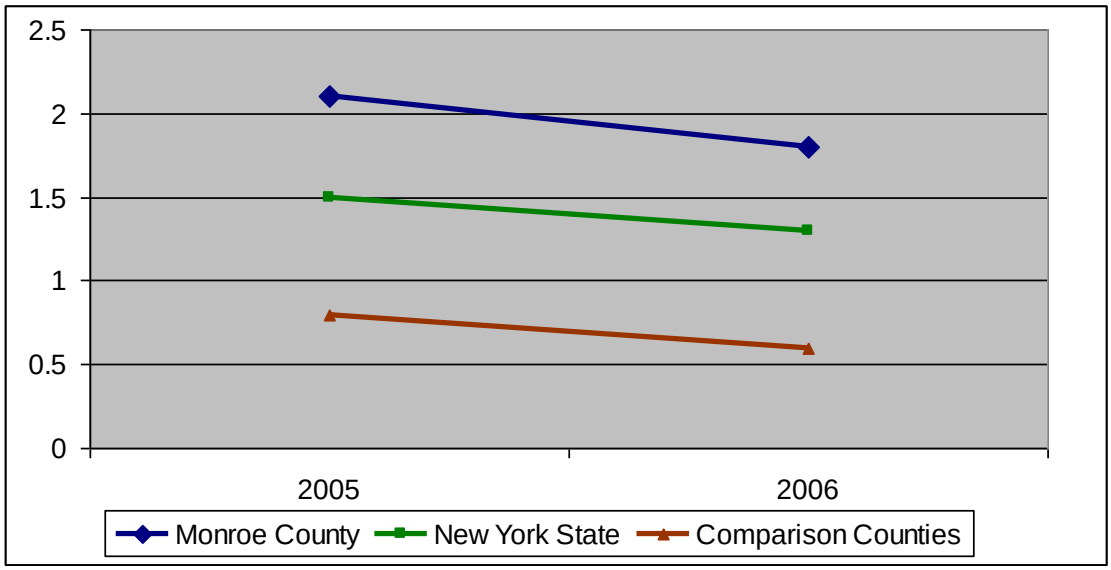
Juvenile Delinquent Petitions			
	Percent	**Percent**	
	2004	**2006**	
New York State	3.24	3.15	
Monroe County	3.14	3.44	
Erie County	3.95	3.88	
Onondaga County	6.53	4.12	
Note: calculations for full petitions: pulled total populations & populations over 18 from Census			

Sources: *Petition data collected from the Kids Well-being Indicator Clearinghouse for 2004, 2005, 2006 (comparison here 2004 v 2006) which uses data from the NYS Office of Court Administration. City level data not available and comparisons outside of the State are not comparable.*

Rate of Juvenile Delinquent Placements by Court

How it is measured: Rate is the number of children and youth aged 10-15 years that are placed out of home by the Court per 1,000 youth taken into custody by police or probation.

Why it matters: Measure of how judges deal with youth they interact with, as well as a community's capacity to have detention-alternative options.



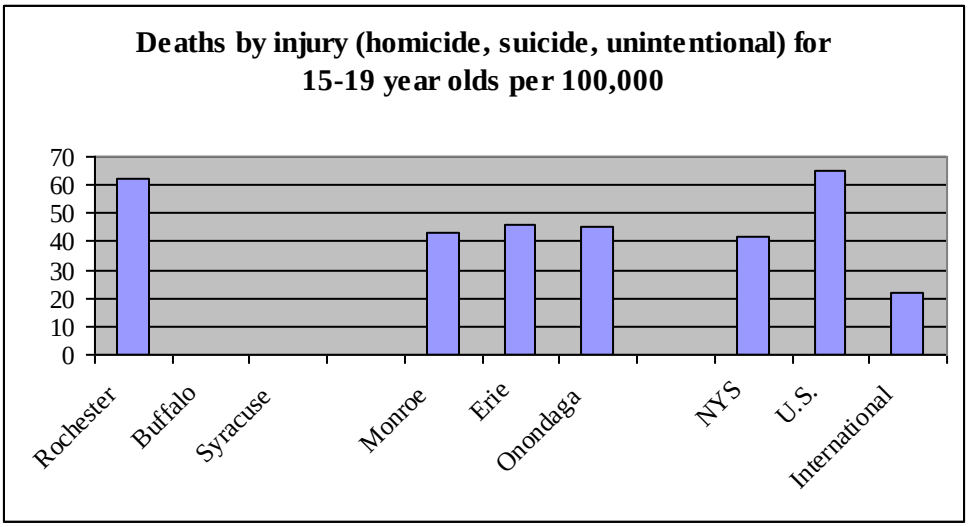
Current data show that adjudicated Juvenile Delinquents in Monroe County are much more likely to be removed from their home than adjudicated JDs in comparison Counties and the State. City-level data and long-term data are not currently available.

Court Dispositions - JD Placements by Court rate/1,000 youth ages 10-17			
	rate/1,000	**rate/1,000**	
Region	**2005**	**2006**	
New York State	1.5	1.3	
Monroe County	**2.1**	**1.8**	
Erie County	0.7	0.8	
Onondaga County	0.9	0.4	

Sources: *Data compiled using the State Kids Well Being Indicator Clearinghouse from 2005 & 2006 which are the only years available at this point using NYS Office of Court Administration data.*

Rate of Deaths to Teens for 15 and 19 year olds

How it is measured: Number of deaths due to injury (unintentional, suicide, homicide) per **100,000** 15-19 year olds. International rates for 0-19.



Monroe County has a lower rate of deaths of 15-19 year olds than the comparison Counties and the National rate, but is slightly worse than State. City-level data and long-term data is not available at this The City of Rochester is much worse than the County.

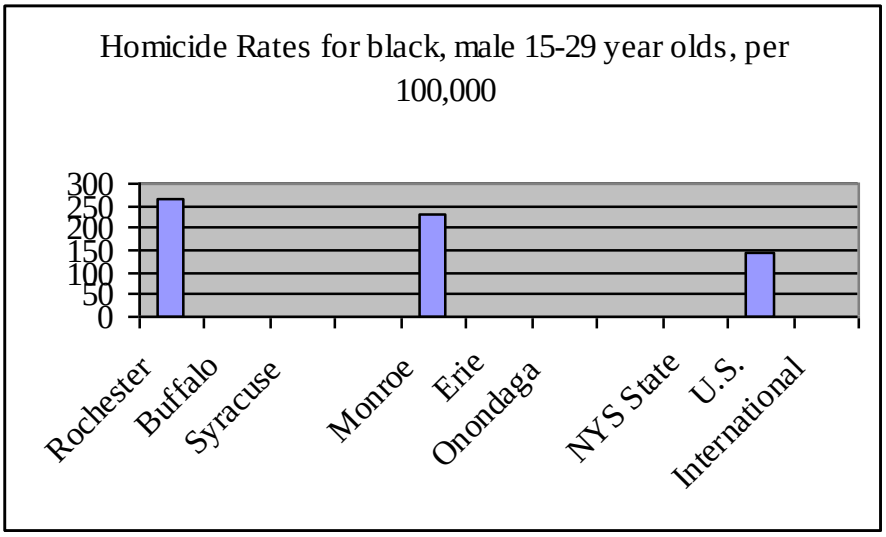
Deaths by injury (homicide, suicide, unintentional) for 15-19 year olds per 100,000	
Rochester	62
Buffalo	*NA*
Syracuse	*NA*
Monroe	43
Erie	46
Onondaga	45
NYS	42
U.S.	65
International	22

Sources: *NYS DOH has 2007 City and County and State data; Annie E Casey has 2005 National data. International is deaths from accidents and injuries per 100k under 19 yo, avg of latest three years available from UNICEF report.*

Homicide Rates for black, male 15-29 year olds per 100,000

How it is measured: Rates of black, males aged 15-29 divided who have been homicide victims by the total number of black males aged 15-29.

Why it matters: Young males, particularly young black males, are disproportionately involved in homicide compared to their share of the population. According to the U.S. Department of Justice, black males 18-24 years old have the highest homicide victimization rates. Their rates have been more than double the rates for black males age 25 and older and almost 4 times the rates for black males 14-17 years old (Department of Justice, 2005 Homicide Statistics).



Monroe County has a much higher rate of homicides of black, male, 15-29 year olds than the National rate. City of Rochester is even worse than the County. City and County comparison data as well as trend data are not currently available.

Homicide rates for black, male 15-19 year olds per 100,000	
Rochester	264
Buffalo	*NA*
Syracuse	*NA*
Monroe	229
Erie	*NA*
Onondaga	*NA*
NYS State	*NA*
U.S.	147
International	*NA*

Sources *Dr. Klofas, Rochester Institute of Technology*

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Appendix C: Full Description of Benefits, as referred to in the Evidence-Based Interventions Grid, p 31-32

1. 48% fewer officially-verified incidents of child abuse and neglect (an average of 0.26 incidents per nurse-visited child versus 0.50 per control group child). For child

2. 59% fewer self-reported arrests (an average of 0.15 versus 0.37). For child

3. 57% fewer self-reported convictions and probation violations (an average of 0.10 versus 0.23). This effect was statistically significant at the .10 level, but not the .05 level. For child

4. 57% fewer self-reported convictions and probation violations (an average of 0.10 versus 0.23). This effect was statistically significant at the .10 level, but not the .05 level. For child

5. 20% less time spent on welfare (an average of 53 months per nurse-visited woman versus 66 months per woman in the control group). This effect was statistically significant at the .10 level, but not the .05 level.

6. 19% fewer subsequent births (an average of 1.3 births versus 1.6).

7. 61% fewer self-reported arrests (an average of 0.13 versus 0.33).

8. 72% fewer self-reported convictions (an average of 0.05 versus 0.18).

9. 23% fewer health care encounters for children's injuries or ingestions (an average of 0.43 encounters per child in the nurse-visited group vs. 0.56 in the control group).

10. 78% fewer days hospitalized for injuries or ingestions (an average of .04 days versus .18 days).

11. # Lower mortality rate (0.4% of the children in the nurse-visited group died before age 9 vs. 1.9% of children in the control group). This effect was statistically significant at the .10 level, but not the .05 level. Most excess deaths in the control group were attributable to causes that are often preventable (e.g., injury, SIDS).

12. Scored 9 percentile points higher on Tennessee state reading and math achievement tests in grades 1-3 than their counterparts in the control group (the nurse-visited group scored in the 45th percentile, versus the 36th percentile for their control group counterparts).

13. Had 10% higher reading and math grade point averages in grades 1-3 than their control group counterparts (2.68 vs. 2.44).

14. 12% less time on welfare during the nine years (5.2 months per year for the nurse-visited women vs. 5.9 months per year for control group women).

15. 10% less time on food stamps during the nine years (7.0 months per year vs. 7.8 months per year).

16. 13% fewer subsequent live births (an average of 0.81 births vs. 0.93).

17. 33% fewer subsequent low birth weight newborns (an average of 0.18 low birth weight newborns vs. 0.27). This effect was significant at the .10 level, but not the .05 level.

18. 18% more time with their current partner (an average of 61.6 months vs. 52.4 months).

19. 41% fewer substances used in the past three years – i.e. marijuana, cocaine, or moderate-heavy alcohol use (an average of 0.10 substances vs. 0.17). This effect was significant at the .10 level, but not the .05 level.

20. 20% longer interval between the women's 1st and 2nd births (24.5 months for the nurse-visited women vs. 20.4 months for the control group).

21. Lower percentage of women experienced domestic violence from their partner in the past 6 months (7% versus 14%).

22. Completed an average of almost 1 full year more of schooling (11.9 years vs. 11 years)

23. Spent an average of 1.3 fewer years in special education services — e.g., for mental, emotional, speech, or learning impairment (3.9 years vs. 5.2 years)

24. 44 percent higher high school graduation rate (65 percent vs. 45 percent)

25. Much lower proportion of out-of-wedlock births (57 percent vs. 83 percent)
26. 50 percent fewer teen pregnancies on average (0.6 pregnancies/woman vs. 1.2 pregnancies/woman)
27. 42 percent higher median monthly income ($1,856 vs. $1,308)

28. 26 percent less likely to have received government assistance (e.g. welfare, food stamps) in the past ten years (59% vs. 80%)
29. An increase of 1.8 grade levels in reading achievement
30. An increase of 1.3 grade levels in math achievement

31. A modest increase in Full-Scale IQ (4.4 points), and in Verbal IQ (4.2 points).
32. Completion of a half-year more of education
33. Much higher percentage enrolled in school at age 21 (42 percent vs. 20 percent)
34. Much higher percentage attended, or still attending, a 4-year college (36 percent vs. 14 percent)

35. Much higher percentage engaged in skilled jobs (47 percent vs. 27 percent)

36. Much lower percentage of teen-aged parents (26 percent vs. 45 percent)

37. 40% less likely to have ever been pregnant (15% of Carrera group females had been pregnant vs. 25% of control group females).
38. 50% less likely to have ever given birth (5% vs. 10%).

39. 16% more likely to have had some work experience (89% of the Carrera group had work experience vs. 77% of the control group).
40. Positive effects on some educational outcomes (PSAT scores and college visits) but not others (e.g. grades).

41. 30% more likely to have graduated high school or obtained a G.E.D. (86% of the Carrera group had graduated or obtained G.E.D. vs. 66% of the control group).

42. 37% more likely to be enrolled in college (63% vs. 46%)

43. 26% of the Multisystemic Therapy group had been arrested at least once, compared to 71% of the control group participants.

44. 88% reduction in the average number of arrests, versus the control group (0.45 vs. 3.88).

45. Multisystemic Therapy recidivists' arrests were for less serious offenses.

46. 50% of the Multisystemic Therapy group had been arrested at least once, compared to 81% of the control group.

47. 14% of the Multisystemic Therapy group had been arrested for a violent offense, compared to 30% of the control group.

48. 13% of the Multisystemic Therapy group had been arrested for a drug offense, compared to 33% of the control group.

49. 54% reduction in the average number of arrests, versus the control group (1.8 vs. 4.0).

50. 57% reduction in the average number of days incarcerated as an adult, versus the control group (582 vs. 1357).

51. The Multisystemic Therapy group had 75% fewer official adult convictions for aggressive crimes than the control group (and significantly fewer self-reported aggressive crimes)

52. 23% less likely to be re-arrested (67% of the Multisystemic Therapy group had been re-arrested at least once, versus 87% of the control group).

53.39% fewer arrests and arraignments per youth over the two years (1.4 vs. 2.3)

54. Much lower percentage with one or more official criminal referrals for violent offenses (21% of the Multidimensional Treatment Foster Care group had a criminal referral vs. 38% of the control group)

55. Much lower percentage with two or more official criminal referrals for violent offenses– 5% vs. 24% (However, the study does not report whether this difference in violent offenses is statistically significant.)

56. The percentage of youth with *self-reported* violent offenses declined by 62% in the Multidimensional Treatment Foster Care group over the two years, compared to a 28% decline for the control group.

57. 69% fewer days spent in locked settings — i.e., detention facilities, correctional facilities, jail, or prison during the previous two years (an average of 47 days for the Multidimensional Treatment Foster Care group vs. 149 days for the control group, according to the youths' self-reports).

58. 55% fewer official criminal referrals per youth (1.38 referrals vs. 3.04 referrals).

59. The TOP participants' school suspension rate decreased by 24 percent over the course of the study (from 17 percent at baseline to 13 percent at posttest), while the control group experienced a 21 percent increase in suspension rate (from 24 percent at baseline to 29 percent at posttest).

60. The TOP group's course failure rate decreased by 12 percent after the study (from 30.3 percent to 26.6 percent), whereas the control group experienced a 24 percent increase in failure rate (rising from 38 percent to 47 percent).

61. Program participation had a significant impact on the pregnancy rate among female participants, with the TOP pregnancy rate decreasing 31 percent (from 6 percent at baseline to 4 percent at posttest), and the control group's pregnancy rate decreasing only 2 percent (10 percent at baseline to 9.8 percent at follow-up).

62. 41% to 66% reduction in substance abuse from intake to program completion. Treatment gains were maintained up to 1-year posttreatment

63. 93% of youth receiving MDFT reported no substance-related problems

64. 64% to 93% of young adolescents receiving MDFT reported abstinence from alcohol and drug use at 1-year followup

65. MDFT decreased delinquent behavior and affiliation with delinquent peers significantly more than peer group treatment. In addition, MDFT clients were less likely to be arrested or placed on probation than group clients

66. MDFT decreased family conflict, improved parenting practices, and improved family functioning to a greater extent than family group therapy or peer group therapy

67. MDFT clients showed a significantly greater decrease in disruptive school behaviors and absences than youth receiving comparison treatment

68. MDFT clients return to school and receive passing grades at higher rates (43% in MDFT vs. 17% in family group therapy and 7% in peer group therapy)
69. MDFT clients also show significantly greater increases in conduct grades than peer group treatment

70. * BASIC Parent-Training group mothers reported significantly less-frequent problem behaviors than did control group mothers. There were no significant differences between the groups in the total number of behavior problems reported.

71. * Independent observations of children's behavior found that treatment group children showed significantly fewer submissive behaviors (e.g., approval-seeking or help-seeking) and negative behaviors (e.g., pouting, ridicule) and higher rates of positive-affect behaviors (e.g., smiling, expressions of affection) than control group children. There were no significant differences between the groups in the frequency of non-acceptance behaviors (e.g., frustration, ignoring) and dominance behaviors (e.g., criticizing, refusing to comply).

72. Scott et al. (2001) compared mothers in the BASIC Parent-Training group with control group mothers and found that BASIC group mothers had significantly fewer reports of children's antisocial behavior, hyperactivity, deviance, total behavior problems, the three most-serious behavior problems for each child (determined by parents), and daily reports of total problems.

73. NPAT children scored significantly higher than did comparison children on longitudinal math achievement, with an average math score in the 82nd percentile compared with the 74th percentile.

74. Drazen and Haust's (1993) study of 40 at-risk PACT (Parents and Children Together, a replication of the PAT program) and control group participants found significantly more control participants than PACT participants had gross motor developmental delays on the total score of the developmental screening test.

75. Drazen and Haust's (1993) study of 40 at-risk PACT (Parents and Children Together, a replication of the PAT program) and control group participants found PACT students scored significantly higher than control students on language skills with significantly fewer PACT graduates (30 percent) than control students (65 percent) scoring below their age level on the test.

76. The larger evaluation of PACT including 41 treatment and 412 comparison children (Drazen and Haust, 1995) found the following: Children whose families participated in PACT had significantly higher school readiness scores on the three tests that were used (kindergarten, math, and reading readiness) than those whose families did not participate.

77. The larger evaluation of PACT including 41 treatment and 412 comparison children (Drazen and Haust, 1995) found the following: PACT children also had significantly higher grades in kindergarten than did control children, with computed averages of 95 percent versus 93 percent.

78. The four-group randomized control trialby Wagner, Cameto, and Gerlach-Downie (1996) found that significantly fewer PAT-only mothers than control group mothers had multiple pregnancies during this period (1.4 percent versus 4.8 percent). No significant differences were found among the PAT-only, case management, or combined intervention (PAT plus case management) groups.

79. A significantly lower proportion of PACT participants than control participants were enrolled in remedial special education in first grade (14 percent versus 31 percent).

80. Moreover, the positive intervention effect on covert delinquency was apparent only for the children who had been in the Coping Power condition that had both the parent and child components.