CHAPTER 7:

POSITIVE YOUTH DEVELOPMENT – SPECIAL CONCERNS

Key Benchmarks in this Chapter:

High School dropout rate

Teen pregnancy rate

Tobacco, alcohol, and other drug use rates

Juvenile crime rate

Child abuse and neglect rate

Key Chapter Topics:

ALCOHOL, TOBACCO, AND OTHER DRUG (ATOD)USE
- Drug use versus abuse
- Ineffective and effective approaches
- Supportive communities, neighborhoods, and schools
- Family Support and Supervision
- Positive Peer Relationships and Social Competence
- Educational Progress and Success
- Personal Characteristics, Distress, and Life Difficulties

JUVENILE DELINQUENCY AND CRIME
- Age of initiation and comprehensive efforts
- Supportive communities, neighborhoods, and schools
- Family support and supervision
- Positive peer relationships and social competence
- Educational progress and success
- Alcohol and drug use

(over)

TEEN SEXUALITY, PREGNANCY, AND PARENTHOOD

- Early and unprotected sexual activity
- Teen pregnancy and birth rates
- Gay, lesbian, and bi-sexual youth
- Sexual responsibility
- Positive peer relationships and social competence
- Effective reproductive health care
- Personal distress and sense of future

CHAPTER 7:

POSITIVE YOUTH DEVELOPMENT SPECIAL CONCERNS

Almost one-half of all youth, aged 10-17, experience some problem behaviors (Dryfoos, 1990). Youth who are at risk because of community, family, school, personal or other factors are more likely to experience problems, particularly when protective factors or developmental assets are lacking in their lives.

Three particularly critical issues in adolescence are:

- tobacco, alcohol, and drug use and abuse;
- juvenile crime and delinquency; and
- teen sexuality, pregnancy and parenthood.

Early use of tobacco, alcohol or other drugs is more likely to lead to chronic abuse and dependence.

The consequences of these problems in these areas can reach far beyond adolescence. For example, consider the following facts.

Tobacco, Alcohol, and Drug Use and Abuse

- Smoking is a leading contributor to long-term disability and early death; most regular smokers begin tobacco use before age 17 (Remington, 1997; USDHHS, 1996).
- Alcohol misuse among teens contributes to fatal accidents, homicides, crime, and delinquency. Early use of alcohol, or other drugs is more likely to lead to chronic abuse and dependence and to reduce personal and social well-being (Ellickson, 1997).

The earlier anti-social or problem behaviors begin, the more likely youth will become chronic offenders.

Juvenile Crime and Delinquency

- Crime, including juvenile crime, costs the nation billions of dollars annually; the earlier anti-social or problem behaviors begin, the more likely the youth will become a serious, chronic juvenile and adult offender.
- Beyond the social costs, the personal costs of juvenile crime include academic failure, unstable relationships, escalating violence and alienation, and adult crime.

Teen Sexuality, Pregnancy and Parenthood

Early childbearing costs the U.S. taxpayer $7 billion annually.

- Teens are at much greater risk of sexually transmitted diseases (STDs), including HIV/AIDS, than any other age group (USDHHS, 1996).

- Teen pregnancy and parenthood have potentially devastating social and personal costs (Maynard, 1997). Early childbearing costs U.S. taxpayers over $7 billion annually.

- Being a teen mother reduces the likelihood a woman will ever obtain a high school diploma and increases the likelihood of long work hours at marginal pay (Maynard, 1997).

- Teen fatherhood is associated with lower levels of educational achievement, reduced earnings, and reduced financial and social responsibility for off-spring (Maynard, 1997).

- Children born to teen parents are more likely to lack early emotional support and stimulation, achieve lower levels of education, experience poor health, and experience long-term dependence on public support including special or remedial education (Maynard, 1997).

- Children reared by teen mothers are also more likely to be victims of abuse and neglect, enter foster care, be incarcerated as juveniles and adults, and become teen parents themselves (Maynard, 1997).

Because of their powerful short- and long-term impact on well-being these three critical issues facing many youth are reviewed in this chapter:

- Alcohol, tobacco, and drug use and abuse;

- Juvenile crime and delinquency; and

- Teen sexuality, pregnancy, and parenthood.

SPECIAL YOUTH CONCERN:
Alcohol, Tobacco, and Other Drug Use and Abuse

Alcohol and other drugs are involved in most teen sexual activities, most teen suicides, and most delinquent offenses.

Drug use and abuse are highly dangerous activities for youth. Drug abuse negatively affects well-being, relationships, and academic performance. Further, alcohol and other drugs are involved in 75% of sexual activities which lead to teen pregnancies, 40% of fatal teen accidents, 30% of teen homicides, and most delinquent offenses.

Over 80% of adolescent suicide attempts and successful suicides involve drug overdoses. *At all ages,* alcohol or drug intoxication often immediately precedes suicidal behavior (Schuckit & Schuckit, 1989). In at least 50% of adolescent suicides, alcohol is found to have contributed significantly to the death (Schuckit & Schuckit, 1989).

Despite the dangers associated with its use, alcohol is the most frequently used, and abused, substance by youth and adults. Adolescents model adult patterns of alcohol and other drug use and the motivation to avoid alcohol is lower than for other drugs, especially among older teens (Ellickson & Bell,1990).

Some prevention programs simply are *not* effective. Prevention programs that have *little effect* on tobacco, alcohol, and drug use emphasize (Ellickson & Bell, 1990; Pentz, 1994):

- Information or knowledge alone;
- General social skills building;
- General self-esteem enhancement programs.

Information alone and general social skills or self-esteem enhancement have little effect on tobacco, alcohol, and drug use.

In contract, school based social influence models have shown great promise, particularly among young adolescents. *Effective social influence programs address:*

- the social pressures to use drugs;
- teach *specific* skills resistance to social pressures to use; and
- provide the motivation to use this knowledge.

Social influence programs have been successful in delaying the use of the "gateway drugs" of tobacco and marijuana among younger youth and others who are not regular users (Ellickson & Bell, 1990). Overall, however, the effects of all drug prevention programs are modest and

maintenance (or "booster") programs are required to sustain long-term effects (Ellickson & Bell, 1990; Pentz, 1994).

Prevention programs appear *least* effective:

- with older youth;
- with youth who already use substance(s); or
- in reducing alcohol use which is normative adult behavior in the U.S.

Reducing early use and any misuse of alcohol and tobacco are probably more realistic goals than eliminating use among adolescents.

Realistic goals. *Realistically prevention approaches can delay onset of experimental use and reduce (but not eliminate) use, particularly of alcohol (Schinke, Botvin, & Orlandi, 1991).* By high school graduation, over ninety percent of teens have used alcohol, two-thirds have used tobacco, and forty percent have used marijuana. The rate of binge drinking (5 or more drinks in a row in previous two weeks) increases from about 15% among 8th graders to 30% among 12th graders (USDHHS, 1996).

Given these facts, it is critical that prevention programs set *realistic* outcomes that recognize that,

- use of alcohol is normative among adults after whom adolescents model behavior;
- community norms greatly influence availability and acceptability of tobacco, alcohol, and other drug use (Remington, 1997).

Reducing *early* use and any *misuse* are probably more realistic goals than completely eliminating use among adolescents, particularly for alcohol and particularly older adolescents. In fact, limited experimentation with alcohol and tobacco appears to be a normative part of later adolescent development. While not desirable, *limited* experimentation with these substances may not warrant serious intervention with older teens.

The most aggressive responses are warranted by non-normative use.

Aggressive responses *are* warranted by non-normative use, including:

- ANY use of ANY substances by children under age 14.
- Older teens REPEATED and/or BINGE use of alcohol, marijuana, or tobacco.
- Older teens MISUSE of alcohol including driving under the influence and juvenile crime.

- Older teens use of ANY other substance.

Effective approaches. To reduce the non-normative use of tobacco, alcohol, and drugs, prevention and intervention strategies must reduce risk factors and build protective factors in children's and youth's lives. *The most effective approaches will be comprehensive, long-term (K-12) community-based, multi-component programs that include:*

- *primary prevention for all youth;*
- *early intervention and treatment for high-risk youth;*
- *developmentally appropriate education support from childhood through late adolescence.*

Such comprehensive programs will be best able to delay initiation of drug use and eliminate misuse and abuse (Pentz, 1994).

Drug use, school failure, behavioral problems, and personal distress often co-exist… effective interventions will address all at the same

Finally, serious drug use, school failure, behavioral problems and delinquency, and personal distress often co-exist and share several risk factors in common. Integrated efforts to simultaneously address these several problems are potentially *very* effective (Durlak, 1995). For example, among anti-social children extended interventions which include teacher training on proactive behavioral management, social skills training for children, *and* parent education have been demonstrated to:

- improve school performance and commitment,
- reduce drug use, and
- reduce early delinquent activity.

When needed, individual or family therapy is warranted to address underlying psychological distress. (See Durlak, 1995; Pentz, 1994; or Walker et al., 1995 for fuller reviews).

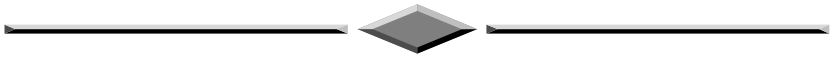
In order to build comprehensive, integrated approaches to substance use and abuse prevention, five issues must be addressed. These include:

- Supportive Communities and Neighborhoods.
- Family Support and Supervision.
- Positive Peer Relationships and Social Competence.

- Educational Progress and Success.

- Personal Characteristics, Distress, and Life Difficulties.

Research linking these issues to youths' substance use and abuse is presented in the following pages.



Tobacco, Alcohol and Drug Use

Supportive Communities, Neighborhoods, and Schools: Measurable Interim Outcomes

Positive community and neighborhood environments.

Positive, stable relationship with an adult.

Reduction of availability of tobacco, alcohol, and/or other drugs.

Rates of sales to minors.

Arrest and conviction rates for sales to minors.

Consistent enforcement of laws and regulations.

Rates of Minor in Possession and other juvenile offenses.

Youth's perceptions of assets:

- neighborhood and school attachment;
- opportunities and rewards for conventional involvement.

Youth's perceptions of risks:

- community, neighborhood, or school disorganization;
- norms favorable to drug use or other negative behaviors;
- availability of tobacco, alcohol, and other drugs.

Delayed use of "gateway" drugs: tobacco, alcohol, and marijuana.

Reduction of:

- repeated and/or binge drinking or other alcohol misuse;
- alcohol or other drug use combined with driving or other potentially dangerous activities.
- *any* other drug use and abuse.

Norms and advertising do influence the use of tobacco, alcohol, and other drugs.

Norms *do* influence the use of tobacco, alcohol, and other drugs among youth and adults. For example, over the past 30 years, countless efforts have attempted to decrease smoking among children by developing norms for social nonuse. As a result, smoking rates declined through the late 1970's. But in response to heavy marketing, smoking rates have increased again since the late 1980's. Smokeless tobacco use has also increased, especially among white, non-Hispanic males (USDHSS, 1996).

Today almost all smokers began *regular* smoking before age 17 (Remington, 1997). The reason for this widespread early use may well be found in community norms (Remington, 1997). Tobacco is:

- one of the most heavily advertised American products;
- cheap and accessible;
- appealing to youth because it is for "adults only."

To reduce tobacco use among children and youth, community norms that discourage tobacco use must be developed through:

- effective mass media;
- reduced access and opportunities for use; and
- strict enforcement of laws and regulations.

Although these ideas are best demonstrated by research on tobacco, the principles of restricting access and creating norms for non-use apply to alcohol and other drugs as well.

Mass media. Mass media marketing works - that is why tobacco and alcohol companies invest billions of dollars each year on advertising. The tobacco industry alone spends *$6 billion annually* on advertising.

Counter-advertising to reduce tobacco, alcohol, and other drug use can be effective...

Advertising increases youths' perceptions that substance use:

- is pervasive;
- has powerful personal advantages including "sex appeal" and stress reduction; and
- has positive social functions including enhanced social status and "maturity."

Counter-advertising to reduce tobacco, alcohol, and other drug use is meager compared to well-funded campaigns to promote tobacco and alcohol sales. Nevertheless, mass media efforts can be effective in reducing demand (Remington, 1997) when these media efforts are:

- carefully designed and *high* quality;
- targeted at youths' interests;
- built on high status figures and images; and
- *part of broader community efforts to reduce access and demand*.

Restricting exposure and access. Clean air ordinances restrict the locations where tobacco can be used and effectively reduce the public places where children and youth see adults smoke. Improved enforcement of laws restricting sales to youth reduce use by restricting access (Remington, 1997). Increased compliance with these laws by businesses is essential.

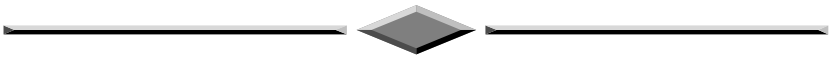
Costs also restricts youths' use of tobacco.

Costs also restricts youths' use of tobacco. For example, for every 10 percent increase in cigarette excise taxes, there is a 5 percent decrease in use among adults and a 10 to 15 percent decline among youth (Remington, 1997). In Canada tobacco excise taxes are now almost $4.00/pack, seven times the U.S. average. As Canadian excise taxes have risen, there have been dramatic decreases in the percentage of adults (32%) and youth (65%) who smoke.

Alcohol and other drugs. The principles of mass media and restricted access can be applied to other drugs, especially alcohol. Communities can reduce use and develop norms for non-use of tobacco, alcohol, and other drugs by:

- targeting youth with high quality, comprehensive mass media efforts;
- increasing and strictly enforcing all restrictions on access;
- strictly enforcing drunk driving, minor in possession, and other substance use and abuse laws;
- recognizing and rewarding merchants who restrict sales; and
- creating tobacco, alcohol, and other drug free settings, events, and opportunities for children, youth, and families.

Combined with other efforts aimed at building strong families and effective resistance skills, mass media, restricted access, and other positive community environments can contribute to the reduction of substance use and abuse.



Tobacco, Alcohol and Drug Use

Family Support and Supervision:
Measurable Interim Outcomes

Effective parental control; consistent monitoring and rule enforcement.	Reduction in repeated and/or binge drinking or other alcohol use, misuse.
Effective guidance at all ages.	Delayed use of "gateway" drugs: tobacco, alcohol, marijuana.
Effective supervision of children and youth before, during, and after school.	Reduction of other drug use and abuse.
Positive family interaction and communication skills.	Reductions in alcohol or other drug use in combination with driving, boating, skating, and other potentially dangerous activities.
Clear parental rules and expectations about tobacco, alcohol, and other substance use and abuse.	
Reduced child maltreatment at all ages.	

Research Linkages

Children and youth are at greater risk for substance use and abuse, if their:

- parents or older siblings are alcoholics, substance users or abusers;
- parents are inconsistent about expectations for substance use;
- parents poorly supervise or monitor behavior (Hawkins, Catalano, & Miller, 1992).

Poor parental monitoring and weak support increase adolescent substance abuse.

Poor parenting skills and lax family norms regarding substance use *increase* youths' risk of substance use. During early childhood poor parenting skills and poor bonding are related to increased drug abuse during adolescence (Brook, Brook, Gordon, Whiteman & Cohen, 1990; Hawkins, Lishner, & Catalano, 1987).

During adolescence, adolescent substance abuse is increased by poor parental monitoring and weak emotional support (Dryfoos, 1990; Stice, Barrera, & Chassin, 1993). Parental monitoring and support often decrease in early adolescent which is the highest risk period for initiation of problematic substance use because self-esteem may be lower and peer pressure strongest (Steinberg, 1991; Ellickson & Bell, 1990).

For young adolescents, home "alone" can be a very tempting (and dangerous) place.

Effective parenting and supervision. Clear, consistent rules and supportive discussions that acknowledge the young adolescents' concerns are critical to delay and reduce substance use. Monitoring is important especially during the after school hours; being unsupervised after school is related to higher rates of substance use and abuse as well as sexual activity, juvenile crime, and school problems (Steinberg, 1991).

Most of this unsupervised time is spent at home. In fact, for young adolescents, home "alone" can be a very tempting (and dangerous) place.

- Eighth graders who are unsupervised for 11 or more hours each week are *twice* as likely as supervised peers to use tobacco, alcohol, and marijuana (Steinberg, 1991).

- At home, after school, most youth first experience "independence" from adults, take their first drink of alcohol, and have their first sexual experiences.

To be most effective, *families, schools, and communities must share the responsibilities of youth supervision*. At all times, parents need to be able to answer the question, "Do you know *where* your kids are and *what* they're doing with *whom*?" Kids need the same information about their parents.

In short, effective support, supervision, and monitoring requires:

Families, schools, and communities must share the responsibilitie s of youth supervision.

- clear, consistent, and reasonable expectations regarding where, when, what, and with whom youth will spend their time;

- regular, easy, and positive contact with a supervising adult either in person or by phone;

- supervised after-school and evening activities that include an age-appropriate mix of arts, athletics, clubs, study groups, work, community service, unstructured "hang-out" or rest times, and other activities. (Research and guidelines for school age and youth activities are summarized in Chapter 9).

Authoritative parenting is the most effective parenting style (Lamborn, Mounts, & Dornbusch, 1991; Putallaz & Hefling, 1990), and is associated with lower rates of behavior problems, including substance use and abuse (Hawkins et al., 1992). Parents who are authoritative *balance* closeness and supervision with increasing autonomy for their adolescents (Baumrind, 1987).

Authoritative parents:

- are supportive and interested in their youths' activities;
- provide consistent high standards and rewards for meeting these; and
- encourage their youths' growing autonomy.

Effective interventions to increase parental skills include parent-child interaction training on family and behavior management practices and role-playing to build parenting skills. (Resources for developing more effective, authoritative parenting skills are summarized in Chapter 6 under family support.)

Family involvement in treatment. When youth are involved in drug abuse, families are critical to treatment. Parenting skills as well as family issues (including sexual or other abuse), are often important concerns that need to be addressed in treatment (Moran, Davies, & Toray, 1994). Especially when youth will return to the family environments following residential treatment, families must be actively involved in treatment and in after-care.

Families must be involved in treatment and in after-care…

young siblings are

Younger siblings, especially boys, are at greater risk of substance abuse when older siblings are "users" (Hawkins, Catalano, & Miller, 1992). Thus, treatment programs for older youth should collaborate with primary prevention efforts to target vulnerable younger siblings.

Tobacco, Alcohol , and Drug Abuse

Positive Peer Relationships and Social Competence: Measurable Interim Outcomes

Social competency including life skills, problem solving, delayed gratification, conflict resolutions, and refusal skills.	Reduction in repeated and/or binge drinking or other alcohol misuse.
Low levels of association with antisocial peers.	Delayed use of "gateway" drugs: tobacco, alcohol, marijuana.
School referrals for peer related problems.	Reductions in alcohol or other drug use in combination with driving, boating, skating, and other potentially dangerous activities.
Positive relationships with non-using and non-abusing peers.	Reduction of other drug use and abuse.
Beliefs about peer group drug use and attitudes.	

Research Linkages

Serious drug abuse often begins before age 15 and occurs as a result of poor peer interactions, antisocial behavior, and loneliness.

Social competence and serious drug use. Social competency reduces maladaptive behaviors including substance abuse (Walker, Steibler, & Eisert, 1991). While normative drug experimentation begins after age 14 in the context of peer interaction, *serious drug abuse often begins before age 15* and occurs as a result of poor peer interactions, antisocial behavior, and loneliness (Hawkins, Lishner, & Catalano, 1987).

- In particular, boys who are aggressive in early childhood (ages 5-7) are frequently rejected by conventional peers and adults; these children are at increased risk for serious drug abuse as older children and adolescents (Hawkins, Lishner, & Catalano, 1987).

Early identification and intervention are needed to reduce antisocial behavior in its *earliest* stages of development (Durlak, 1995; Walker, Colvin, & Ramsey, 1995). Effective interventions to reduce anti-social behaviors typically include *all* of the following:

- reward and praise of desirable behavior;
- parent-child interaction training;

- parent training on family and behavior management practices;
- social skills training for children; *and*
- role-playing to build skills (Walker, Colvin, & Ramsey, 1995).

Teacher training on proactive behavioral management is essential to assure that children who are anti-social receive the same "messages," expectations, and rewards at school and at home. (Also see Chapters 3 and 6, family support sections, for other parent education resources.)

Peers and substance use. Peer pressure to begin drug use appears to peak during middle school (Bogenschneider, 1996; Steinberg, 1991; 1993). Thus the early adolescent peer group is a critical target for prevention.

Peer-oriented substance abuse prevention programs must build social competence. Such programs are most successful when they:

- utilize cognitive behavioral approaches to develop positive social behavior (Durlak, 1995) and specific refusal skills (Ellickson & Bell, 1990);
- utilize modeling and role playing to increase peer interaction skills, social competency, and self esteem (Schinke, Botvin, & Orlandi, 1995); and
- address *specific* risky behaviors (substance use, early sexual involvement's, and others) as opposed to general social skills and self-esteem (Ellickson & Bell, 1990; Pentz, 1994).

Prevention programs must build drug refusal skills, and the motivation to use these skills, among 10-13 year olds.

The most successful prevention programs utilize a "social influence" or similar model to develop drug refusal skills, and the motivation to use these skills, among 10-13 year olds. Social influence programs are generally offered in schools with teachers and/or teachers and peers as leaders. *Prevention efforts using the social influence approach have been successful in delaying initiation of gateway drug use (cigarettes, alcohol, marijuana) for up to 2 years* (Ellickson & Bell, 1990).

Peer norms and attitudes about drug use influence the effectiveness of drug prevention programs (Hawkins, Lishner, & Catalano, 1987; McKinnon et al., 1991). Beliefs about peer use may be more important than actual substance use rates, thus bringing beliefs in line with reality could impact subsequent drug use. For example, many young adolescents really believe that "everybody is doing it." Data on actual peer drug use have been

Many young adolescents really believe that "everybody is doing it."

effectively used as part of social influence programs used to counter adolescents' over-estimates of drug use (Ellickson & Bell, 1990).

Finally, after school recreation programs that provide opportunities for involvement with pro-social youth and adults, skills for leisure activities, and bonding to pro-social others have proven to be effective prevention strategies (Tobler, 1988). Part of their success may be due to decreased unsupervised time. (See Chapter 9, Caring Communities and Systems for guidelines in school-aged and youth activities).

Resources. There are literally *thousands* of drug abuse prevention programs, models, curriculums, videos, and guides. *One* of the most effective (Ellickson & Bell, 1990) is *Project ALERT* which is based on the social influence model described earlier in this review. Designed for 6th to 8th graders, Project ALERT builds an interactive video-based curriculum and includes a required 6-hour training for teachers. Teacher training and all materials cost $88 per teacher. An optional Teen Leader program is available. *Project ALERT* focuses on alcohol, tobacco, marijuana, and inhalants. Its effectiveness has been *demonstrated* with both high and low risk students. For more information contact: (800) ALERT-10 or fax (213) 623-0585.

Other resources to build social competency among youth are reviewed in Chapter 6, Positive Youth Development-Peer Relationships. Although few of these resources *directly* apply to drug use prevention, the techniques (active involvement and practice to develop individual student's refusal skills) and principles (limit-setting, conflict resolution) can be useful if adapted to address specific substance abuse issues and skills.

Alcohol, Tobacco, and Other Drug Use

Educational Progress & Success:
Measurable Interim Outcomes

Regular school attendance.	Reduction in repeated and/or binge drinking or other alcohol misuse.
Average or above academic progress.	Delayed use of "gateway" drugs: tobacco, alcohol, marijuana.
Average or above achievement test scores in basic skill areas.	Reduction of other drug use and abuse.
Average or above GPA.	Reductions in alcohol or other drug use in combination with driving, boating, skating, and other potentially dangerous activities.
No or few behavioral referrals.	
Positive commitment to school.	

Research Linkages

School failure is *the* common marker for all high risk behavior, including alcohol and drug use and abuse (Dryfoos, 1990). School failure, school attendance, and substance use are closely and reciprocally linked (Dryfoos, 1990; Durlak, 1995; Hawkins, Lishner, & Catalano, 1987):

School failure is the common marker for all high risk behavior.

- children and youth who use and abuse substances are more likely to do poorly in school;
- children and youth who are doing poorly in school are more likely to abuse drugs.

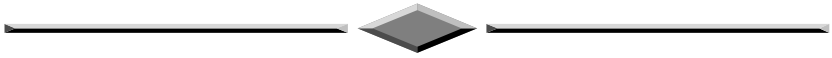
For example, when children experience academic and behavioral problems in elementary school they are more likely to abuse substances during middle and high school (Hawkins, Lishner, & Catalano, 1987). Thus, early identification and response to school behavior and academic problems are essential to reduce the substance use and school failure (Durlak, 1995).

By high school, teens who have poor grades and a low commitment to school are much more likely to use alcohol regularly than those having average or above grades and higher attachment to school.
Because drug use, school failure, and social-behavioral problems often co-exist, integrated efforts to simultaneously address these several problems are potentially *very* effective (Durlak, 1995). For example, interventions which *combine* teacher training on proactive behavioral management, social skills training for children, and parent education have been demonstrated to:

Drug use, school failure, and social-behavioral problems often co-exist, integrated efforts to simultaneousl y address these several problems are potentially very effective.

- improve school performance and commitment;
- reduce drug use; and
- reduce early delinquent activity (see Durlak, 1996, or Walker et al., 1996 for reviews).

Other specific strategies for increasing school attachment, progress, and success are reviewed in Chapter 8 on Educational Progress and Success. Strategies for improving peer relationships in the context of schools are reviewed earlier in this chapter and in Chapter 6, Positive Youth Development.



Alcohol, Tobacco, and Other Drug Use

Personal Characteristics, Distress, and Life Difficulties: Measurable Interim Outcomes

Sense of personal control/self-efficacy.	Reduction in repeated and/or binge drinking or other alcohol misuse.
Depression or other mental health issues or symptoms.	Delayed use of "gateway" drugs: tobacco, alcohol, marijuana.
Utilization of appropriate mental health and other personal services.	Reductions in alcohol or other drug use in combination with driving, boating, skating, and other potentially dangerous activities.
Stability of access to basic resources (housing, food, transportation, health care).	Reduction of other drug use and abuse.
Self reported sensation-seeking or risk-taking behavior.	

Research Linkages

Sensation Seeking and Risk-Taking

Compared to adults, adolescents take more risks, and seem less concerned about possible negative outcomes of potentially "dangerous" behaviors. Most research indicates that, in fact, youth make decisions in the same *way* as adults but youth may perceive benefits and risks quite differently (Steinberg, 1993).

Youth make decisions in the same way as adults but youth may perceive benefits and risks quite differently.

Information about probable risks of drug use may be helpful for teens who lack accurate knowledge of risks. Such information should not, however, exaggerate risks or it will be disregarded as worthless. Further, information *alone* is not likely to change behavior (Ellickson & Bell, 1990).

Some teens use drugs *because* they like risks. Adolescents who abuse substances are more likely than non-abusers to have a predisposition for risk-taking and sensation-seeking behaviors (Hawkins, Lishner, Jenson, & Catalano, 1987; Higgins, 1988; Newcomb & Bentler, 1989). To be effective for youth who seek sensation and risk taking, interventions must provide opportunities for healthy, high stimulation alternatives perhaps through adventure and/or recreational programs (Tobler, 1988).

Although sensation seeking and risk-taking behaviors are normal for many youth, *extreme, dangerous risk taking and repeated disregard for personal safety, especially when combined with drugs or alcohol, are warning signs for suicide (Steinberg, 1993). Immediate assessment and intervention are needed. (See below and pages 20-21 of Chapter 6 for further discussion of adolescent depression.)*

Depression, anxiety, and panic attacks, especially before the age of 15, are highly correlated with alcohol and other drug abuse.

Personal Distress

While drug experimentation usually occurs in the context of social and peer interaction, *serious drug abuse* is more likely to occur among adolescents who experience:

- anti-social behavior and loneliness;
- depression and emotional distress; and/or
- environmental stressors (Hawkins, Lishner, & Catalano, 1987; Newcomb & Bentler, 1989).

Anti-social behavior and loneliness. Among both children and youth, anti-social behavior and aggression often leads to rejection by peers (Walker, Colvin, & Ramsey, 1995). Peer-rejected children and youth subsequently experience more social and behavioral problems (Hawkins & Catalano, 1990; Parkhurst & Asher, 1992), including alcohol and drug use and abuse.

Depression and related issues. Drinking or drug use can exacerbate adolescent mood swings and intensify almost all major medical disorders - both physical and mental. Depression, anxiety, and panic attacks, especially before the age of 15, are also highly correlated with alcohol and other drug abuse (Botvin, 1985; Dryfoos, 1990; Higgins, 1988; Steinberg, 1991). Depression is particularly common among girls (Steinberg, 1993). In both genders, however, depression is a significant contributor to high risk behaviors, including drug abuse and suicide.

Family history of psychiatric depression, aggressive-impulsive-violent behavior, poor parent/child relationships, and lack of supportive social networks outside the family increase the likelihood of adolescent substance abuse, depression (Chartier & Rainier, 1984; Steinberg, 1993) and suicide (Goodwin, 1989; Schuckit & Schuckit, 1989)

In most suicides, alcohol or other drugs play a significant role.

Affective disorders, including depression and bi-polar disease ("manic depression") are present in well over half adolescents who commit suicide; *most* adolescents who suffer from these disorders drink heavily and experience *increased* depressed feelings and suicidal behavior as a result

(Schuckit & Schuckit, 1989). In fact, in most suicides, alcohol or other drugs play a significant role (Schuckit & Schuckit, 1989).

Life difficulties. Situational stress also contributes to substance abuse. For example, work-related stress is common among adolescents especially those who work long hours while going to school (Steinberg, 1991). Adolescents in 9th and 10th grade who work more than 15 hours/week, and 11th and 12th graders who work more than 20 hours/week are at greater risk for drug and alcohol use than those who have less-demanding work schedules (Steinberg, 1991).

Drug abuse is more common among youth who lack stable access to basic resources.

Similarly, drug use and abuse are more common among youth who are stressed by poverty and the lack of stable access to adequate basic resources, including housing, health care, and positive opportunities. Among homeless youth, drug abuse is particularly high.

Effective interventions. Effective interventions to reduce serious substance abuse must address *individual* youths' sources of distress and difficulty.

Effective interventions must address <u>individual</u> youths' sources of distress and difficulty.

- Early intervention is critical to reduce anti-social behavior that leads to peer-rejection and loneliness (Walker, Colvin, & Ramsey, 1995). (Also see social competence sections in Chapters 5 and 6.)

- Treatment of underlying depression or other mental health problems is essential (Durlak, 1995; Schinke, Botvin, & Orlandi, 1991; Schuckit & Schuckit, 1989). (Also see Chapter 6, Positive View of Self.)

- Stable access to basic resources (housing, food, health care) and positive work, school, and other opportunities are essential. (Also see Chapter 3.)

SPECIAL YOUTH CONCERN:
Juvenile Delinquency and Crime

Research Linkage. Public concern with reducing juvenile crime has never been higher. Factors that are associated with reductions in juvenile delinquency and crime are reviewed on the following pages. These factors include:

- Supportive Communities, Neighborhoods, and Schools
- Effective Family Support and Supervision
- Positive Peer Relationships and Social Competence
- Educational Progress and Success
- Alcohol and Substance Abuse

Effective juvenile crime prevention will build on the above factors and create comprehensive approaches that address the individual needs and resources of at-risk youth (Dryfoos, 1990). Before reviewing each factor in greater depth, two issues are reviewed: age of initiation and comprehensive interventions.

Age of initiation: Early versus late bloomers. "Early bloomers" are youth who initiate anti-social or problem behaviors *before age 15*, often as early as ages 4 to 8. These youth are the most likely to become serious juvenile and adult offenders. Typically, parents of "early bloomers" lack family management skills and have substance abuse, criminal, and/or social problems.

Early bloomers" who initiate anti-social or problem behaviors before age 15, are the most likely to become serious juvenile and adult offenders.

"Late bloomers" are youth who engage in delinquent behaviors for the first time *after age 15*. These youth are more likely to have poor parental supervision, negative peer pressures, and limited opportunities for positive community roles. “Late bloomers” are less likely to become repeat, violent offenders than are “early bloomers.” Recent analysis of youth offenders in Lane County, Oregon, indicates that about 20% of youth offenders commit 80% of the crimes. Most of those offenders are “early bloomers.”

Although both early and late initiators of delinquent behaviors are viable targets for prevention and intervention, effective efforts will address the unique needs of each group. Further, because “early bloomers” commit the most, and most serious, crimes, they must be aggressively targeted.

Comprehensive prevention and intervention. Successful juvenile crime prevention and intervention efforts must address the changing needs and contexts of children, young adolescents, and older adolescents. *No one strategies will be effective with all children and youth, whose lives vary in terms of risk and protective factors, family and school contexts, and other critical issues.*

Nevertheless, effective strategies share several characteristics (Dryfoos, 1990; Mulvey, Arthur, & Reppucci, 1993). The most powerful approaches:

- integrate families, schools, and other agencies to simultaneously address *many* aspects of youths' lives;
- emphasize early, comprehensive, long-term and individualized efforts that match services with specific client needs;
- respond to the differing needs of children and youth, early bloomers and late bloomers through developmentally appropriate interventions;
- emphasize cognitive and behavioral change, educational success, and the development of life skills.

More intense, behavioral, skill-oriented programs with multiple components that address complex needs are most effective in reducing recidivision.

Such interventions must be long-term in order to reduce the long-term risk processes that face many higher-risk children and youth (Andrews, Unger, & Hage, 1990; Mulvey, Arthur, & Reppucci, 1993; Tremblay & Craig, 1994). (Also see review in Martin, Morgane, & Patton, 1996.)

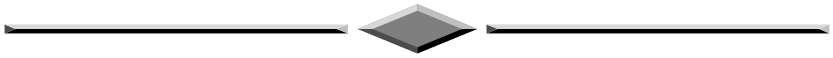
Ineffective efforts. Some prevention and intervention efforts are consistently *ineffective* (Lipsey, 1992; also see review in Martin, Morgane, & Patton, 1996). The least effective approaches to reducing delinquent behavior are short-term efforts that primarily focus on one risk factor (Tremblay & Craig, 1994). For example, research has established that *ineffective* approaches include:

- general discussions, camping, field trips, “scared straight” visits to prisons;
- assessments and/or referrals *without* follow-up comprehensive services;
- mandatory school attendance *only*.

"Insight" counseling or psychodynamic counseling (which are not behavioral, or skill-oriented) have likewise *not* been effective in reducing juvenile crime rates or recidivism (Martin, Morgane, & Patton, 1996.)

Overall, five specific factors must be addressed by prevention and early intervention efforts aimed at reducing juvenile delinquency and crime. These factors are reviewed on the following pages. The factors include:

- Supportive Communities, Neighborhoods, and Schools
- Family Support and Supervision
- Positive Peer Relationships and Social Competence
- Educational Progress and Success, and
- Alcohol and Substance Abuse



Juvenile Delinquency and Crime

Supportive Communities, Neighborhoods, and Schools: Measurable Interim Outcomes

Lower youth crime rates including MIP and vandalism.

Consistent enforcement of laws and regulations including alcohol and tobacco sales to minors.

Positive community and neighborhood environments.

Positive, stable relationship with adult.

Commitment to school, community, and neighborhoods.

Increased neighborhood and school safety, cohesion, and/or positive opportunities.

Youth's perceptions of assets:

- neighborhood attachment;
- opportunities and rewards for conventional involvement.

Youth's perceptions of risks:

- community or neighborhood disorganization;
- norms favorable to drug use or other negative behaviors;
- availability of alcohol, drugs, and handguns.

Research Linkages

Community disorganization, high mobility, vandalism, low quality housing, low neighborhood attachment, and a lack of concern for youth are associated with problem behaviors among children and youth. These conditions lead to weak connections between residents and few norms for positive youth behavior (Bogenschneider, Small, & Riley, 1990).

Juvenile delinquency can be reduced through comprehensive community mobilization, provision of social opportunities, delinquency prevention curriculums in school, and after school and evening recreation programs (Jones & Offord, 1989). Broad-scale community-wide prevention programs, however, are generally less effective than targeting high-risk youth and high-risk neighborhoods (Spergel, 1986; National Council on Crime and Delinquency, 1995).

Further, to be effective, community efforts must be combined with more comprehensive strategies that also address family, school, and personal risks (Dryfoos, 1990).

Juvenile delinquency can be reduced through comprehensive initiatives that address community, family, school, and personal risks.

Among community level efforts to reduce delinquency, several community policing tactics appear to be effective, including (Goldstein, 1994):

- increased motorized patrol in marked cars in high-crime locations;
- increased police efforts directed at high risk times, places, and persons;
- foot patrols and citizen contact patrols that build partnerships between the community and the police.

Other highly effective community and justice strategies include (National Council on Crime & Delinquency, 1995):

Community policing and justice strategies can be effective.

- swift, consistent consequences for anti-social behavior including enforcement of curfew laws, minor in possession (MIP), and driving under the influence of intoxicants;
- victim-offender mediation reconciliation efforts; and
- opportunities for, and recognition of, positive involvement in community, school, extracurricular, and other activities, including teen courts that *involve* at-risk and offending youth in positive roles.

[Also see Chapter 6, Positive Youth Development, and Chapter 7, Alcohol and Drug Usage, for discussion of other strategies to increase community well-being related to positive youth development.]

Juvenile Delinquency and Crime

Family Support and Supervision: Measurable Interim Outcomes

Reduced child abuse and neglect.	Positive family adult interactions and communication skills.
Parental adult use of consistent, non-abusive punishment and positive reinforcement at all ages.	Effective responses to children and youths' anti-social or aggressive behavior.
Parental adult use of authoritative parenting style at all ages.	Clear parental adult expectations about appropriate behavior.
Age appropriate supervision and monitoring of children and youth.	Lower rates of juvenile offenses, including MIP, vandalism, and curfew.

Research Linkages

Thirty to 40 percent of child anti-social behavior can be accounted for by family interaction patterns.

A healthy home environment is the single most important factor in preventing delinquency (Wright & Wright, 1994). It is estimated that 30 to 40 percent of child anti-social behavior can be accounted for by family interaction patterns (Patterson, 1986; Yoshikawa, 1994).

Parenting that is too harsh, inconsistent, strict, uninvolved, or ineffective is very strongly predictive of antisocial, aggressive, and/or delinquent behavior in childhood and adolescence (Hawkins, et al., 1987; Patterson, 1986; Yoshikawa, 1994). Children who are abused, who grow up in homes with considerable conflict, and/or who are inadequately supervised, are at greatest risk of becoming delinquent (Wright & Wright, 1994).

Monitoring and supervision. Parents or guardians must adequately monitor their child's whereabouts and friends. Effective monitoring is associated with *reduced*:

- influence by negative peers;
- juvenile crime;
- drug abuse (Finigan, 1996; Search Institute, 1996).

More positively, parents can encourage the development of positive peer relationships in several ways (Search Institute, 1996), including:

- getting to know their children's friends and their families;
- supporting positive peer activities through transportation, monitoring, interest, and other *actions*;
- welcoming peers into their home and activities;
- giving teens space and time to be with their peers.

Arbitrary rules, set without input or discussion, can lead to rebellion.

Teens need the opportunity to explore and develop friendships. Arbitrary rules, set without input or discussion, can lead to rebellion. In contrast, clear, reasonable, negotiated expectations, and consistent enforcement are beneficial and support positive development. (See Chapter 6 for further discussion.)

Building parent skills. Short term, parent training *alone* is unlikely to have much effect on families who are plagued by *multiple* risk factors such as instability, high unemployment, poverty, conflict, illness and crisis (Fraser, Hawkins, & Howard, 1988; Dryfoos, 1991). More comprehensive interventions are essential for these high risk families. As a part of these efforts, parent training is essential.

Parent training should build skills in positive reinforcement, nonabusive punishment, contingency contracting, family problem solving, and child and family management skills.

All parent training should build *skills* (not just knowledge) in positive reinforcement, nonabusive punishment, contingency contracting, family problem solving, and child and family management skills. Such training may involve parent mentors or other in-home instruction. Effective, skill-building parent training has been shown to limit delinquent anti-social behavior (National Council on Crime and Delinquency, 1995; Walker et al., 1995).

Because ineffective parenting is often related to parental aggression, many parents need support to identify interpersonal triggers of aggression and to respond more appropriately (Satterfield, Satterfield, & Schell, 1987). Thus, social skills training for children *and* parents should focus on:

- improving interpersonal skills;
- making verbal requests;
- handling anger; and

- mastering "look and listen" techniques for regaining self control (Kazdin, Siegel, & Bass, 1992; National Council on Crime and Delinquency, 1995).

For example, anger management programs such as RETHINK can assist parents to identify and redirect inappropriate anger. Such programs can be an effective part of comprehensive interventions for higher-risk families. (See next section and Chapter 6 for further discussion and resources.)

The most successful programs build skills in children, parents, and teachers.

In addition, when schools are ineffective in responding to anti-social or other problematic behaviors, the problems of ineffective or harsh parenting are compounded. Thus, the most successful programs *combine* home based parent training, children's social skills training, and school based behavioral management to develop adaptive behavior in children (Durlak, 1995; Tremblay & Craig, 1996; Walker, Colvin, & Ramsey, 1995).

As is true of all interventions directed toward reducing delinquency, early, comprehensive, and long-term interventions are most successful (Dryfoos, 1990; Durlak, 1995).

Juvenile Delinquency and Crime

Positive Peer Relationships & Social Competence: Measurable Interim Outcomes

Lower rates of youth crime, including MIP and vandalism.	Low association with violent or delinquent peer groups.
Lower rates of youth-on-youth crime *and/or* victimization.	Positive involvement with pro-social peers and adults.
Reduced aggression and anti-social behavior.	Effective conflict resolution, anger management, and/or refusal skills.
Reduced referrals and/or suspensions for peer conflict or school behavior problems.	

Research Linkages

To halt the cycle that leads from early anti-social behavior to delinquency, early intervention is essential.

Early anti-social behavior. Weak relationships with pro-social peers and strong association with troubled peers contribute to serious delinquent behavior (Hawkins, Lishner, & Catalano, 1987; Walker, Colvin, & Ramsey, 1995). Such relationships often begin with early anti-social behavior and subsequent rejection by prosocial children and adults. This rejection increases association with delinquent or troubled peers, weakens bonds to conventional society, and increases delinquency (Thornberry et al., 1991).

Effective interventions. To halt the cycle that leads from early anti-social behavior to delinquency, early intervention is essential. Comprehensive programs which combine school and family behavioral management approaches can reduce early anti-social behavior (Durlak, 1995; Walker, et al., 1996). Because young, anti-social children often have parents who lack parenting skills, successful interventions include parents as well as children.

For example, the *First Steps Program* reduces anti-social behavior in young children by combining:

- intensive parent *and* teacher training and skill building on behavior management;
- social skills training for anti-social children;

- consistency across home, school, and other social settings (Walker et al., 1995).

The *Interpersonal Cognitive Problem-Solving (ICPS)* training program has also been demonstrated to reduce impulsive and aggressive behaviors in young children, with long lasting effects. This program focuses on developing interpersonal problem-solving skills to reduce withdrawn and/or anti-social childhood behavior (Shure & Spivak, 1988; Shure, 1997). The most recent version of the *ICPs program are entitled I Can Problem Solve* (Shure, 1997). The *I Can Problem Solve* training programs are available for parents of 4 to 7 year olds, as well as for preschool and early elementary teachers. Among preschool to early elementary school aged children, the *I Can Problem Solve* programs have been proven to:

- improve peer relationships;

- reduce problem behaviors including withdrawal *and* aggression.

(For further description of social competence in early childhood, see Chapter 5, Healthy, Thriving Children.)

Conflict resolution and peer mediation programs can reduce persistent anti-social behavior (National Council on Crime and Delinquency, 1995) as well as encourage the development of positive social skills among *all* youth (Johnson & Johnson, 1996). Conflict resolution and peer mediation training are especially important among older grade school and middle school children because of the expansion of peer orientation and peer pressure in early adolescence. Successful programs focus on developing interpersonal skills including problem solving, positive communication, active listening, trust, and mutual respect (Durlak, 1995). Skill-building and integration of conflict resolution and mediation skills into *every day* life at school are essential (Johnson & Johnson, 1996).

All effective programs ACTIVELY involve children and youth.

All effective programs to improve peer relationships and social competence *actively* involve children and youth. For example, curriculums that teach prosocial behavior, interpersonal problem solving skills, and anger management often use group discussion, modeling, storytelling, and role playing to develop skills among high-risk youth (Committee for Children, 1992; Durlak, 1995; Johnson & Johnson, 1996). Using prosocial peers in interventions has been shown to be a successful approach when youth leaders have adequate training and ongoing supervision (Durlak, 1995).

(See Chapter 5 (Healthy, Thriving Children) and Chapter 6 (Positive Youth Development) for fuller review of social competence.)

Positive peer and social opportunities. After school and evening recreation, sports, arts, and drama programs can reduce unsupervised time, offer positive opportunities for peer involvement, and thus create attachment to conventional peers and activities (Jones & Offord, 1989).

Single activity programs alone are less likely to reduce juvenile crime than are early, long-term, comprehensive efforts.

A link to the "world of work" can also aid youth to gain social skills, responsibility, and a positive sense of the future. Strategies that link youth to the world of work include volunteer community service, paying high-risk older youth to become tutors for young children, school credit for work experience, and life-planning and career exploration programs integrate work experience with academic programs (Dryfoos, 1990).

Single activity programs *alone*, however, are much less likely to reduce juvenile crime and its related risk factors than are early, long-term, community-based, comprehensive efforts that address multiple risks (Mulvey, Arthur, & Reppucci, 1993).

Juvenile Delinquency and Crime

Educational Progress and Success: Measurable Interim Outcomes

Regular school attendance.	No or low behavioral referrals.
Average or better academic progress.	Positive commitment to school.
Average or better achievement test scores.	Participation in extracurricular school-based activities.
Average or better GPA.	Youth crime rates including MIP and vandalism.

Research Linkages

Poor school achievement is strongly associated with antisocial behavior and delinquency.

Nationwide, almost 1/5 of high school seniors read 4 or more years *below* grade level (Dryfoos, 1990). Poor school achievement is strongly associated with antisocial behavior and delinquency (Dryfoos, 1990; Hawkins, et al., 1987; Yoshikawa, 1994). Poor attendance, behavior problems, hyperactivity and attention deficit disorders all increase the risk of academic failure and subsequent alienation and delinquency.

School transitions. Transitions from one school to another or from grade to middle school or middle school to high school are points of increased vulnerability for youth, particularly those youth who are already at-risk. School transitions are frequently accompanied by:

- increased anti-social behavior and substance abuse and
- decreased academic achievement, extra-curricular activities, and psychological well-being (Eccles, et al., 1993; Hawkins et al., 1987).

Reducing behavior problems and improving academic success demands that students be supported during these critical transitions.

Reducing behavior problems. Although schools are the settings for academic failure, they can also be the setting for successful efforts to reduce behavioral problems and increase academic success (Dryfoos,

1990; Durlak, 1995; Graham, et al., 1997; National Council on Crime and Delinquency, 1995; OJJDP, 1995, pp. 67-72). Successful school-based behavior management strategies share several characteristics. Specifically, successful school efforts to reduce behavioral problems:

Schools can be the setting for successful efforts to reduce behavioral problems and increase academic success.

- intervene early, often targeting school transition points;
- use proactive classroom management strategies including behavioral monitoring and positive reinforcement of attendance and other desired behaviors;
- provide positive, supportive relationships and contact adults *in* the school setting;
- apply swift, consistent consequences for anti-social behavior;
- closely monitor and structure activities inside *and* outside the classroom;
- social and material reinforcement of desired behavior (Durlak, 1995; Walker et al., 1995).

For example, *The School Advisors Program* is a primary prevention that uses volunteer teacher advisors to meet each week with small groups of 3-7 students. The goal is to form close, supportive relationships between the students and an adult in the school. This program has been demonstrated to buffer the academic and social programs often experienced in the transition from elementary to junior high (middle school) (Graham et al., 1997).

Similarly, school mentoring programs build close youth-adult relationships. School mentoring programs have successfully reduced adolescent truancy among high risk youth. In successful programs, adult mentors support high risk youth, challenge youths' illogical thinking, *and* reward youths' positive behavior (National Council on Crime and Delinquency, 1995).

Effective school-based strategies can enhance academic success.

Enhancing academic success. In addition to reducing behavioral problems, effective school-based strategies can enhance academic success. Academic success is, in turn, strongly associated with reduced risk of delinquent behavior. Effective strategies to improve academic success (OJJDP, 1995, pp. 67-72, 127-128) include:

- reduced class size especially in the early grades;

- individualized and "continuous progress instructional" techniques that provide sufficient time and assistance to master learning (also see Durlak, 1995);

- school within a school strategies that create smaller, more personal units;

- "someone who cares" strategies that link young adolescents to supportive, long-term relationships with adults in the school setting (Graham et al., 1997).

These strategies are effective for all students and may be especially important for those at academic risk (Durlak, 1995).

In addition, at-risk students can benefit from:

- comprehensive, interagency truancy reduction strategies (OJJDP, 1995);

- financial and other incentives for youth to remain in school, make progress, and complete education (Greenwood, 1996);

- alternative programs to serve youth who cannot effectively participate in regular school (Durlak, 1995);

- employment and vocational training efforts that include an intensive *educational component* and recognition for academic work and success (OJJDP, 1995).

Other school-based interventions that have positive effects include peer mediation, conflict resolution and violence prevention curriculums.

Peer mediation, conflict resolution, and violence prevention curriculums in the schools have also demonstrated positive effects on anti-social behavior and delinquency (National Council on Crime and Delinquency, 1995). (Also see previous section on peers, as well as Chapters 6 and 8 for further discussion.)

Juvenile Delinquency and Crime

Alcohol, Tobacco, and Other Drug Use: Measurable Interim Outcomes

Delayed use of "gateway" drugs: tobacco, alcohol, marijuana.	Reduction of any other drug use and abuse.
Reduction in repeated and/or binge drinking or other alcohol misuse.	Sustained participation in effective treatment.

Research Linkages

Most juvenile crimes involve alcohol or other drug use.

Strategies to reduce juvenile crime must involve aggressive efforts to prevent and treat substance abuse

- Minor in possession (MIP) is among the most common juvenile offenses.
- Alcohol and other drugs lower inhibitions and lead youth into behaviors that would otherwise be avoided.
- Virtually *all* violent juvenile crime is committed under the influence of alcohol or other drugs.

Among youth who commit serious and/or repeated offenses, substance abuse is particularly common. This is not surprising given the fact that the risk factors for juvenile crime are identical to the risk factors for serious alcohol and drug use – early anti-social behavior, ineffective parenting, child maltreatment, and school failure.

Despite the strong association between substance use and juvenile crime, in most communities juvenile offenders receive little, if any substance abuse treatment.

- For example, it is estimated that of the 25% juvenile offenders who enter treatment, about 50% do not complete this treatment (Moran, Miller, & Abel, 1996).

Strategies to reduce juvenile crime *must* involve aggressive efforts to prevent and treat substance abuse, including alcohol use. For further discussion, see earlier discussion of tobacco, alcohol, and other drug use in the previous section of this chapter.

SPECIAL YOUTH CONCERNS:
Teen Sexuality, Pregnancy, and Parenthood

Teens are sexual beings.

Teens are sexual beings. At no point in life are people more aware and more sensitive to their gender than in adolescence. The importance of gender in adolescence has many sources - physical, psychological, social, and societal. For example,

- physically, adolescence is marked by puberty and the development of sexual characteristics (such as breasts and menarche in girls; facial hair and muscular strength in boys) and eventually fertility;

- psychologically, adolescents are creating their identities as "man" or "woman" and seek to communicate their gender through clothes, language, and movement;

- socially, most adolescents experience their first romantic relationships; and

- societally, adolescents experience a highly "sexualized" world - sex sells products, makes us laugh, and dominates popular music, television, and film.

Fundamentally, adolescent sexuality is not a problem.

While sexuality is a normal and necessary part of life, in today's society, adolescent sexuality is often seen as a problem. Depending on one's values perspective, the "problem" of adolescent sexuality may be sexual activity, pregnancy, abortion, or sexually transmitted disease. While each of these issues can present significant health and social risks to teens, their children, families and society, *it is important to recognize that, fundamentally, adolescent sexuality is not a problem.*

Solutions to the problems that *may* accompany sexuality must always remember this essential truth….sexuality and sexual expression are natural, healthy part of a celebrated life. The challenge is to develop healthy responsible sexual behavior and to avoid the terrible costs of early and unprotected sexual activity.

Early and unprotected sexual activity. Once young people become sexually active, over 70% experience sexual intercourse a second time within six months (USDHHS, 1996). *Age of first intercourse is the critical indicator of risk for early pregnancy and sexually transmitted diseases (USDHHS, 1996).*

Youth who are sexually active early in adolescence are exposed to risks for longer period of time and

- are generally more sexually active and have more partners;
- are less likely to use contraceptives, and
- are more likely to conceive because of the lack of effective contraceptive use - at least half of all teen pregnancies occur within the first six months of first intercourse; 20% occur within the first month (USDHHS, 1996; Zabin & Hayward, 1993).

Half of all teen pregnancies occur within six months of first intercourse.

Risk factors for early and unprotected sexual activity. Several interrelated risk factors are predictive of early initiation of sexual activity, unprotected sexual activity, high risk behaviors such as multiple partners, and early childbearing (Miller, 1995). These risk factors include:

Family Issues
- Poverty
- Growing up in a single parent household, particularly if the mother was a teen parent
- Sexually active older siblings
- Family acceptance of sexual activity, poor parental monitoring and poor communication
- History of child maltreatment, including sexual abuse

Peer Relationships and Social Competence
- Sexually active friends
- Low social competence including ineffective refusal skills

Lack of a Positive Future and Personal Distress
- School failure and perception of few life options
- Alcohol, other drug use, or other psycho-social "deviance"
- Homelessness and sexual exploitation

Lack of Access to Effective Education and Reproductive Health Care
- Limited understanding of sexuality, personal risks, and contraception
- Limited access and utilization of effective STD screening and treatment, contraception and other reproductive health care

When these risks are faced by teens who lack significant developmental assets or protective factors, the result is often early sexual activity and higher rates of STDs, early pregnancies, and early childbearing.

Teen Pregnancy and Birth Rates

Since the early 1980's, Oregon's teen pregnancy rates have risen or fallen slightly each year - hovering at around 18 per 1,000. Teen abortion rates have dropped since the early 1980's; currently about 1/3 of all teen pregnancies end in abortion (Oregon Department of Human Resources, 1995).

Over 70% of the births to Oregon teens are to unmarried persons (Oregon Department of Human Resources, 1995). Regardless of marital status, giving birth as a teen, especially as a young teen, increases the risk of poor outcomes for families and children (USDHHS,1996).

Regardless of marital status, giving birth as a teen increases the risk of poor outcomes for mothers, fathers, and especially, children….

Teen pregnancy is overwhelmingly costly for teens, their children, and society (Maynard, 1996; Oregon Department of Human Resources, 1995). Even a short delay of child-bearing increases the likelihood of positive outcomes. For example, compared to women who give birth at age 20 or older,

- Teen mothers are more likely to receive late and inadequate prenatal care, achieve less formal education, work more hours, and be single mothers over longer periods of time.

- Fathers of children born to teen mothers are less likely to be involved socially or financially in their children's lives, achieve less education, and earn less; when these fathers do accept the responsibility for their children, they often must work more in order to offer support .

- Children born to teen mothers are *overwhelmingly* more likely to:

    - be low-birth weight and born in poorer health;

    - have their health care paid for by public source;

    - be abused or neglected;

    - be placed in foster care;

    - be involved in juvenile and adult crime;

    - drop out of school; and

    - become teen parents (Maynard, 1996).

It is now estimated that, if childbearing were delayed just a few years to age 20-21, taxpayers would save between $6 BILLION to $9 BILLION annually (Maynard, 1996).

Early Childbearing and Teen Parenting

Adoption placement. Among teens who bear children, the overwhelming majority retain custody. Fewer than 3% of teen mothers place their children for adoption (USDHHS, 1995). Several forces work against placing a child for adoption. Among these forces are the great emotional pain of placement, the lack of peer support, and frequent parental pressure to maintain custody (Donnelly & Voydanoff, 1996).

Teen mothers who place their children for adoption benefit socially.

Nevertheless, adoption placement is an important option for teen parents. The limited research that exists on teen mothers who place their children for adoption indicates that, overall, the birth mothers benefit socially. Compared to teens who retain custody, teens who place children for adoption are more likely to:

- achieve higher educational levels, vocational training, employment and income;
- delay marriage and subsequent pregnancies; and
- engage in less risky sexual behavior.

Feelings of loss, mourning, and resentment are common among birth mothers of all ages.

Despite these social advantages, birth mothers who place their children for adoption are more likely report some psychological disadvantages including regret over their decision and the pain of loss (Donnelly & Voydanoff, 1996). Feelings of loss, mourning and resentment are common among birth mothers of all ages.

Placing a child for adoption is an extremely difficult, complicated decision with long-term impacts. Some evidence suggests that pre-placement adoption counseling is associated with *higher* rates of placement, (Miller, 1995) in part because mothers may see adoption not as rejection but as the way to promote her baby's most positive future (Ooms, 1995).

Overall, birth mothers, and fathers, if they are available, should be supported to consider adoption and if adoption is chosen, supported by pre and post-placement counseling (Donnelly & Voydanoff, 1996). Such support should be offered to *all* birth parents including the increasing number who place children through private, non-agency services.

Supporting teen parents. Over 93% of teens who give birth retain custody of their children (USDHHS, 1995). This decision has *potentially* negative consequences for mothers and children. These include higher rates of prolonged single parenthood, higher rates of child maltreatment, and poorer health, social, and educational outcomes for children and mothers (Maynard, 1996).

Many teens can be good parents if they receive the encouragement and resources that

Many teens can be good parents *if* they receive the encouragement and resources that they and their children need. For most teen families this means active, early, and prolonged support, including aggressive efforts to:

- provide early and comprehensive prenatal care including assistance to stop tobacco, alcohol, and other drug use during (and after) pregnancy;
- reduce poverty through the adequate public support, establishment of paternity and child support, *and* completion of education, job training and placement;
- assure adequate basic resources, including stable, safe housing, transportation, nutrition, clothing, child supplies and equipment, and other essentials;
- assure adequate health care for children and families, including family planning services;
- assure needed mental health and substance abuse care and treatment;
- develop effective informal support systems to foster self-sufficiency;
- develop competence to be nurturing parents.

High risk teen families continue to need

Such support can be best offered through programs that intervene early and comprehensively and that support young parents through home visitation, connections with needed services, and support over several years (Dryfoos, 1990; Futerman, 1997; Ooms, 1995; Zabin & Hayward, 1993).

An example of such a comprehensive program is Oregon Healthy Start (See end of Chapter 2 for fuller description). In Oregon Healthy Start, over 30% of the high risk parents who receive intensive weekly home visitation and other supports are under age 18. At the end of 12 months of such

support, these parents demonstrate improved parenting skills and decreased risk of poor child outcomes; children are growing and developing normally and most are up-to-date on immunizations. Nevertheless, these high risk, teen families continue to need support (Pratt, Katzev, & Henderson, 1996).

Each component of support needed by teen parents is described in greater detail in other chapters of this guide. For example, see:

- Chapter 3 Strong, Nurturing Families (access to basic resources, family emotional climate, social support, parent-child relationships);
- Chapter 4 Child Maltreatment;
- Chapter 5 Healthy, Thriving Children (prenatal care, nutrition and other physical needs, safe environments).

The particular needs of high risk teens must be aggressivel y served.

Achieving Positive Sexual Outcomes for Teens

To delay sexual activity, reduce STDs among teens, and reduce rates of teen pregnancy requires comprehensive community based efforts. These efforts must respond to the needs of *all* adolescents for education, social competency skills, and reproductive health care. In addition, because adolescents who are personally and socially disadvantaged are at the greatest risk of teen pregnancy and parenthood, the particular needs of these *highest risk teens* must be aggressively served (Dryfoos, 1990).

Five factors affect rates of early sexual activity, STDs infections, and early pregnancy among teens. These factors are:

- Sexual Responsibility
- Positive Peer Relationships and Social Competence
- Access to Reproductive Health Care
- Personal Distress and Lack of a Positive Future

These five factors are discussed in the following sections. As youth, families, schools, and communities work toward positive sexual development for teens, two issues must be addressed: gender-specific programs and gay, lesbian, and bi-sexual youth.

Gender-specific? There is little research evidence that gender-specific educational approaches are desirable, nevertheless, many educators believe that separating the genders for at least *some* discussions makes sense. Among young teens, discussing personal, sexual issues can be very difficult especially when members of the opposite sex are present.

Girls seem more open in girls-only groups that focus on their specific needs and concerns, including sexual abuse and other sexuality issues (Oregon Girls Advocate, December 1991; June 1992). Nevertheless, since most sexual issues involve the opposite sex, some integration of boys and girls is probably reasonable.

Gay, lesbian, and bi-sexual youth. Except for abortion, no issue is more likely to generate intense controversy than is homosexuality. While about 90% of adults develop a solid heterosexual preference, it is likely that more than 10% of youth experience some homosexual feelings and activities during adolescents (Steinberg, 1993).

Gay, lesbian, and bi-sexual youth are growing up in a very heterosexual world; as a result, the normal, youthful questioning of identities and futures can be intensified by feelings of isolation. Peers can be especially hostile toward youth who are perceived to be homosexual (Steinberg, 1993), thus homosexual youth often face the struggle of finding sexual identity without peer, or other, support.

Gay, lesbian, and bi-sexual youths' needs must be

Because homosexual activities may include behaviors that put youth at high risk for STDs including HIV/AIDS, it is critical that gay youths' needs be appropriately addressed in sexuality education and other interventions. Finally, given that pregnancy is not a risk in homosexual behavior, it is important for adults and youth to define other reasons for abstinence.

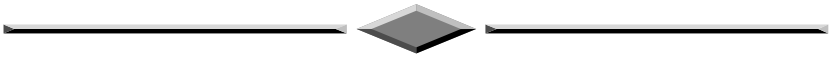
Resources

In Oregon, *many* organizations and agencies are committed to reducing the negative outcomes of early sexual activity and childbearing. For a comprehensive view of Oregon's strategies, contact:

- ***Oregon Action Agenda on Teen Pregnancy***
  Julia Cooley
  Oregon Governor's Office
  State Capital Building
  Salem, OR
  (503) 378-6895

- ***OCCF Teen Pregnancy Prevention Efforts***
  Connie Carley, Coordinator
  Oregon Commission on Children and Families
  530 Center Street, Suite 300
  Salem, OR 97310
  (503) 373-1283

- ***Oregon Health Division, HIV/STD Program***
  800 NE Oregon Street, Suite 215
  Portland, OR 97232
  (503) 731-4029



Teen Sexuality, Pregnancy and Parenthood

Sexual Responsibility:
Measurable Interim Outcomes

Delayed sexual intercourse.	Knowledge of STDs, personal risk factors, and /or resources for condoms and testing.
Decreased interval between time of first sexual activity and effective use of contraceptives.	Reduce rates of high risk behavior.
Effective and consistent contraceptive use with every intercourse.	Reduced rates of STDs.
Effective and consistent condom use with every intercourse.	Effective parental monitoring of behavior, clear expectations, and open communication.

Research Linkages

Adolescent Sexuality and Sexual Expression

Over the last century, the age at which young people reach sexual maturity has declined. The average age of menarche, marked by a girl's first period, is now 12.5 years. Boys have less precise markers of sexual maturity, but by age 14 almost all have experienced nocturnal emissions (Zabin & Hayward, 1993).

A "biological disconnect" exists between age of sexual maturity and socially sanctioned adult sexual

In contrast, the age of social maturity, as defined by completing school, independent living and marriage, has increased. The result is a "biological disconnect" exists between age of sexual maturity and socially sanctioned adult sexual expression.

Sexual expression, however, does not wait for adulthood. Sexual activity, defined as having experienced sexual intercourse, is one form of sexual expression. Kissing, hugging, petting, and other non-intercourse methods of sexual expression generally precede intercourse and are common among adolescents.

Frequency of adolescent sexual activity. Sexual intercourse among adolescents is related to age of onset of puberty, gender and age (Miller, 1995; USDHHS, 1996). National statistics indicate that:

- By age 16, 21 % of females and 41% of males have had intercourse;
- By age 18, 52% of females and 64% of males have had intercourse;
- By age 20, 76% of females and 80% of males have had intercourse.

Forty percent of Oregon high school students have had sexual intercourse in the past 3 months.

Among Oregon youth, 21% of adolescents had sexual intercourse before age 15 and 32% before age 17 (Oregon Health Trends, 1996). Forty percent of Oregon high school students have had sexual intercourse in the past 3 months. Again males were more likely to report sexual activity than were females.

Rates of first sexual intercourse are also related to race and ethnicity, although these differences have been declining over the past decade (Zabin & Hayward, 1993; USDHHS, 1996). Black teens, Hispanics, and Native Americans generally experience first intercourse earlier than non-Hispanic whites. It is important to remember, however, that this racial association is more related to other factors (such as socio-economic status and one's sense of future) rather than to race itself.

Sexually transmitted diseases. Sexually transmitted diseases (STDs) include gonorrhea, chlamydia, syphilis, genital herpes, HIV/AIDS, and other conditions. Rates of HIV/AIDs infection are extremely high among teens as evidenced by the fact that most persons with AIDS were infected in their teens. Overall, sexually active teens are at higher risk of STDs, than any other age group (Zabin & Hayward, 1993); rates are particularly high among minority youth.

Sexually active teens are at higher risk of STDs than any other age group.

The high risk of STDs among teens has several sources. Compared to adults, teens, especially younger teens, engage in higher risk sexual behavior, do not REGULARLY use condoms, do not understand their PERSONAL risk for sexually transmitted diseases (STDs), and do not to receive timely treatment for STDs (Zabin & Hayward, 1993).

Consistent use of condoms is associated with lower rates of STD infection. Nevertheless, the risks of sexual activity and STDs remain high among teens because many teens do not use condoms regularly or reliably.

- While, the rate of condom use rose from 20% to 54% between 1979 and 1991. Almost 50% of sexually active teens do NOT use condoms to prevent STDs or pregnancies. Thus, STD infection and pregnancy rates continue to be high among teens, especially younger and minority teens (USDHHS, 1996; Zabin & Hayward, 1993).

Oregon data are no more encouraging. The 1995 Oregon Youth Risk Behavior Survey revealed that among almost 14,000 Oregon youth who were surveyed, (Oregon Health Trends, 1996) knowledge of HIV/AIDS has *decreased* since 1993. In addition,

Among Oregon youth, knowledge of HIV/AIDS has <u>decreased</u> since 1993.

- About 40% of Oregon youth are sexually active, often with multiple partners, yet over 1/3 do not use condoms regularly;
- Condom use is no higher among youth who believe they are at high risk of STD infection;
- Only 80% of sexually active youth knew where to get condoms and only 78% knew where to get tested for HIV/AIDS.

Overall, Oregon teens are not well-informed about the risk of HIV/AIDS nor do they see themselves as at risk despite high risk behavior.

Abstinence is the *only* completely effective protection from STDs and pregnancy. Developmentally, abstinence is clearly the most desirable choice especially for young adolescents who are most vulnerable to sexual exploitation, emotional devastation, STDs, and pregnancy. Thus abstinence must be strongly encouraged.

Initiation of sexual activity increases dramatically within the first year of high school.

At the same time, however, initiation of sexual activity increases dramatically within the first year of high school (Oregon Health Trends, 1996). Ignoring this fact and wishing that all teens would abstain from sexual intercourse until marriage is not effective. Comprehensive sexuality education and access to reproductive health care must occur *before* sexual activity is initiated.

Increasing Sexual Responsibility Among Adolescents

Resources for increasing sexual responsibility among teens abound. These resources generally seek to:

- Delay of onset of sexual activity and/or
- Insulate teens from harmful outcomes of sexual activity through effective use of contraceptives to prevent STDs and pregnancy (Howard, 1996).

Specific approaches include:

- sexually education programs that include specific information on STDs, personal risks, and contraceptives;
- increased social competence around sexual issues, including refusal skills to achieve abstinence and sexual protection;
- early and comprehensive reproductive health care; and
- life options programs that serve higher risk groups by improving skills and opportunities (Ooms, 1995; Zabin & Hayward, 1993).

Sexuality information must be made available <u>before</u> youth begin sexual exploration.

Sexuality education is a vital *first* step in increasing responsible sexual behavior and must be available *before* youth begin sexual exploration. Early sexual experiences, including sexual intercourse, are rarely planned or premeditated. Compared to older teens and adults, young teens rarely seek information about contraception or STD protection until *well* after their first intercourse (Zabin & Hayward, 1993).

- The average length of time between first intercourse and visits to clinics for contraceptives is 11 months - up to 23 month delays have been reported in studies of younger teens.
- Many teens delay screening and treatment for STDs because they do not recognize the symptoms.
- Many adolescent women delay early prenatal care because they do not recognize they are pregnant.

Proactive education is critical to reverse these facts.

Parents' roles. Parents who effectively communicate with their children and adolescents create an important foundation for responsible sexual behavior. Children and youth *do* learn values from their families and open family communication is the best way to be sure that parental values and expectations are communicated.

Parent communicatio n can help teens to be more

Parent communication can also help teens to be more responsible when they are sexually active. For example, daughters who reported talking with their mothers about contraception were three times more likely to use an effective method compared to daughters who had not talked with their mothers (Newcomer & Udry, 1985). Overall, open communication is associated with more responsible use of contraceptives (Miller, 1996).

Not all parental communications "get through" to teens, however. Parents are twice as likely to report discussing sexual issues with their teens than their teens are to report discussing sexual issues with their parents. Fully half of parents report conversations about sexual issues, while less than 25% of their teens recall such conversations. Thus parent-child communication may not be sufficient to provide teens with accurate, accessible information (Bogenschneider, et al., 1996).

Of Oregon parents, almost 80% favor <u>required</u> sex education in the schools.

In fact, *most parents do not want the full responsibility for sexuality education*, including contraceptive and STD education. A statewide study of 3,100 parents in Wisconsin found that over 90% believed that schools should teach about AIDS, other STDs, and the value of abstinence, and over 85% believed that schools should teach effective contraceptive methods (Bogenschneider et al., 1996). A 1996 survey of Oregon parents found that almost 80% favor *required* sex education in the schools (Oregon Action Agenda on Teen Pregnancy, 1997).

Parents need support to communicate openly about sexuality. This support should include:

- strategies for initiating conversations;
- information for accurately answering questions; and
- encouragement to be proactive in their conversations with their teens.

Proactive conversations are needed because most parents *under-estimate* their children's sexual involvement. If parents wait until they think that sexual activity is likely, it is probably too late. For example, among an survey of 1,300 parents of high school students, over 77% of parents reported that it was "highly unlikely" that their child was sexually active;

Parents under-estimate their children's sexual involvement.

yet over 40% of their children were sexually active (Bogenschneider et al., 1996). Parents' perceptions that their children are not sexually active may limit effective, proactive family communication about sexuality, STDs, and contraception.

Schools, churches, and other settings. Schools are an important setting for basic sexuality education Zabin & Hayward, 1993). For example, in Oregon, an updated curriculum guide is available for kindergarten through 12th grade. The guide is entitled:

AIDS: The Preventable Epidemic

The guide includes updated supplemental reading for 9-12th grades - ***Straight Talk: HIV/AIDS and other STDs*** (3rd edition). Guides are available to each Oregon school. For further information on this or related resources, contact the:

Oregon Health Division, HIV/STD Program
800 NE Oregon Street, Suite 215
Portland, Oregon 9721-0050
(503) 731-4029

The shared concern with protecting children and youth can form a common ground within diverse communities.

Churches, synagogues, youth groups, and other organizations are also vital settings through which to reach children and youth. While the values perspectives of these groups may differ, the *shared concern* with protecting children and youth from the risks of early and unprotected sexual activity can form a common ground within diverse communities (Luke & Neville, 1996.)

Health providers, including public health clinics and private providers, also have important access to youth. *Proactively* providing reproductive and sexually information and services can increase youth's knowledge of sexuality, risks, and appropriate use of contraception, and resources (Frost & Forrest, 1995). An Oregon example is found in Tillamook County where the Health Department has incorporated appropriate reproductive information and family planning services into ALL office visits by females from ages 10-45 (Luke & Neville, 1996.)

Information alone, however, is not enough to change behavior.

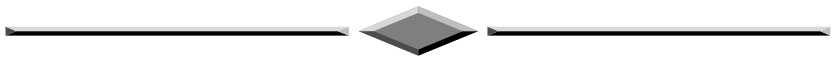
More than information. Accurate, timely information is critical. *Information alone, however, is not enough to change behavior.* Interventions also must build the social skills that will enable teens to *be* sexually responsible and provide proactive reproductive health care. These issues are reviewed in the next sections of this chapter.

Excellent reviews of programs that have *proven effective in delaying initiation of sexual activity and improving contraceptive use among sexually active teens* are found in:

Bogenschneider, K., Bell, M., & Linney, K. (Eds.). (1996). Teenage Pregnancy Prevention: Programs that Work. Madison, WI: School of Family Resources, University of Wisconsin-Madison.

Frost, J. & Forrest, J. (1995). Understanding the impact of effective teen pregnancy prevention programs. Family Planning Perspectives, 27, 188-195.

USDHHS (1995). Report to Congress on Out-of-Wedlock Child-bearing. Washington, DC: USGPO. DHHS Pub. No. (PHS) 95-1257.



Teen Sexuality, Pregnancy and Parenthood

Positive Peer Relationships and Social Competence: Measurable Interim Outcomes

Positive relationships with peers who practice abstinence and sexual responsibility.	Decreased interval between time of first sexual activity and effective use of contraceptives.
Increased peer norms for abstinence and sexual responsibility.	Effective and consistent contraceptive use with every intercourse.
Commitment to and practice of abstinence.	Effective and consistent condom use with every intercourse.
Increased refusal skills and commitment to delay sexual activity.	Reduce rates of high risk behavior. Reduced rates of STDs.
Delayed sexual intercourse.	Reduced teen pregnancy.

Peers and Sexuality

Achieving positive peer norms requires working within groups of teens, building individual skills, and commitment to positive behavior.

Peer norms, expectations, and pressure are enormously important during adolescence, especially among young teens (Steinburg, 1991). While often thought of as negative, peer norms can encourage positive behavior, including abstinence and sexual responsibility.

Achieving positive peer norms requires working within *groups of teens,* building *individual skills, and commitment* to positive behavior. Positive peer norms for sexual behavior can be achieved through abstinence promotion and other "responsible sexuality" programs delivered by religious groups, schools, or other community based groups (Ooms, 1995).

Despite this variety of settings, approaches are most effective when "social influence" principles are utilized (Ellickson and Bell, 1990; Frost & Forrest, 1995; Zabin & Hayward, 1993). Social influence model programs:

- provide *accurate* information about sexuality, risks, and contraceptives;

- build and practice *specific skills* for refusing sexual activity, refusing high risk sexual behavior, and/or using appropriate contraceptive devices for protection from STD infection and pregnancy; and

- build the motivation and support to use knowledge and refusal skills.

There is ample evidence that information alone is not sufficient to assure sexual responsibility or other desirable behaviors. Teens need to develop the skills to say "no" or to otherwise assert their needs. Social influence model programs:

Teens need to say "no" or to otherwise assert their needs.

- acknowledge and build upon peer group experiences;

- utilize role-playing, active problem-solving, peer leadership and modeling, and other techniques to stimulate *high* levels of *active* involvement;

- focus on real issues and situations facing teens; and

- build and practice specific skills and strategies.

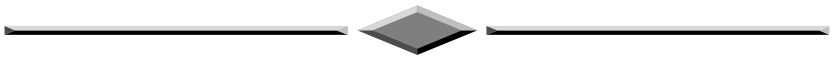
(Further discussion of social influence model principles is found in the earlier section of this chapter: Alcohol, Tobacco, and Other Drugs.)

Program resources. *One* program that utilizes an active, skill-building approach is the Oregon *STARS Program (Students Today Aren't Ready for Sex). STARS* is modeled after the *Postponing Sexual Involvement (PSI)* program which was developed by Dr. Marion Howard and Marie Mitchell, Emory University, Atlanta, GA. PSI has been demonstrated to be successful in delaying sexual initiation and increasing contraceptive use among low and high risk male and female middle school students (Frost & Forrest, 1995; Howard & McCabe 1990; 1992).

The Oregon *STARS* program focuses on abstinence. *STARS* utilizes trained peer leaders to develop refusal skills among middle school aged children in order to postpone sexual initiation. Now operating in several Oregon counties, early *STARS* evaluation results are positive. *STARS* is one major strategy of the Oregon Action Agenda on Teen Pregnancy (1997).

For more information and a descriptive video on *STARS,* contact:

Kay Carlisle, State Program Director
STARS
Multnomah County Health Department
426 SW Stark
Portland, OR 97204
(503) 248-3056 extension 28020#
or
David Rianda, Executive Director of the *STARS* Foundation of Oregon
522 SW 5th Ave, Suite 301
Portland, OR 97204
(503) 226-0849
(Contact Mr. Rianda for *STARS* community and resource development or to access the *STARS* information video.)



Teen Sexuality, Pregnancy and Parenthood

Effective Reproductive Health Care: Measurable, Interim Outcomes

Rates of youth participation in reproductive care, including education, prevention, and treatment.	Availability of comprehensive, quality prenatal services.
Easy, immediate access to reproductive care for contraception and other reproductive care.	Normal birth weight.
Movement of sexually active youth to effective contraceptives and STD protection.	Full term delivery.
Easy, immediate access to screening and treatment for STDs.	Parent knowledge of risks, pregnancy, labor and delivery, and newborn care.
Immediate family planning services following birth or abortion.	Preventive care for newborn infants.
Delayed subsequent pregnancy.	Avoidance of tobacco, alcohol, or non-prescription drugs during pregnancy.

Research Linkages

Reproductive health care is essential to serve teens before and after they become sexually active (Zabin & Hayward, 1993). These interventions insulate teens who are sexually active (or may become so) by empowering these teens to practice "safer sex", to delay child-bearing through the consistent use of effective contraceptives, and to identify and treat sexual health issues.

Reproductive health care is essential to serve teens before and after they become sexually active.

Delaying Coital Contact

Interventions to delay first intercourse and support abstinence can be successful if they occur early enough. When early sexual initiation is the norm in a population, programs that urge, "Just say no" are not enough. Frank discussions of sexuality with youth as they approach puberty, during their early pubertal years, and frequently thereafter are essential.

Schools must be active in sexuality education since many families do *not* engage their youngsters in open or effective discussions about sexuality (Bogenschneider, et al., 1996). Effective strategies to delay sexual activity or negotiate contraceptive use include:

- Age-appropriate sex education information and decision-making/interpersonal skill development before and during early puberty.
- Combining information with discussion of reasons for delay or protection, opportunities to practice interpersonal and decision-making skills, and opportunities to understand the risks of even one or two acts of unprotected sex.
- Specialized training for educators and medical care providers on the norms of the populations they serve and sexual issues of concern to the young people.

Contraceptive Services

1 in 4 women most at risk of unintended pregnancies do not use contraceptives … poor, very young women are most likely to have unprotected

Contraceptive counseling and prescription are at the core of medical family planning services offered through private physicians and family planning clinics. Non-prescription contraceptive methods are widely available at drug stores, supermarkets, and other commercial outlets. Yet approximately 1 in 4 women most at risk of unintended pregnancies do not use contraceptives. Poor women and very young women are most likely to have unprotected sex (Brown & Eisenberg, 1995).

Family planning services have several major benefits for teens.

- Easy access to contraception reduces the pregnancy rate.
- Pregnancy detection and pregnancy counseling insure that early prenatal care can be initiated if pregnancy tests are positive.
- Safe and early pregnancy termination services be offered.
- Following negative pregnancy tests, contraceptive counseling support subsequent effective contraceptive *use*.
- Contraceptive counseling after the birth of a child reduces the likelihood of early repeat pregnancies (Zabin & Hayward, 1993).

For young people, access to family planning services is constrained by a number of factors. Teens may lack knowledge about contraceptives or be misinformed about the risks of unprotected sexual activity. Teens frequently:

- delay seeking family planning services for *many months after* they become sexually active;
- fear they cannot access services and retain their anonymity;
- lack knowledge about where to get services; or
- lack resources, including money and transportation to services (USDHHS, 1995).

School-based clinics that provide explicit counseling about sexuality and contraceptio n can delay sexual onset, reduce frequent of coitus and improve contraceptive use.

The availability of contraceptives and other reproductive services through a clinic network, decreases the number of abortions and births. Too often, however, traditional approaches and facilities have not been tailored to meet the needs of teens and have tended to offer "*too little, too late*" (Zabin & Hayward, 1993, p. 92).

Effective interventions include intensive outreach and counseling to reach youth in a timely manner. School-based clinics that provide *explicit* counseling about sexuality and contraception can delay sexual onset, reduce frequent of coitus and improve contraceptive use (Zabin & Hayward, 1993).

Other Functions of Reproductive Services

Sexually transmitted diseases. Sexually transmitted diseases (STDs) are increasingly common. Teens need specific information on how to detect them, and how to avoid these infections. Many diseases are symptom free, or have symptoms that adolescents may not recognize.The spread of the HIV virus into teenage populations may be more common than is currently recognized, especially among populations where IV drug use is prevalent (USDHHS, 1996).

Teens need specific information on how to detect them, and how to avoid these STD infections.

Medical practitioners in family planning clinics and other settings may not examine clients for STDs, in turn, many STD clinics fail to describe contraception to sexually active teens. Because of the dangers involved, medical practitioners have an ethical obligation to include information and, if the client is (or may be) sexually active, examination for symptoms of STDs.

Pregnancy resolution decisions. Unmarried teens need counseling and assistance in pregnancy resolution decisions. A full range of options includes abortion, adoption, and child-rearing. No one option is right for all young women. Adoption is estimated to occur for less than 3% of all non-marital births. Most teen pregnancies now end in non-marital childbearing or abortions (about one-third) (USDHHS, 1995).

Adoption is a viable alternative for many teens.

Adoption relinquishment is a viable alternative for many teens. Yet studies show that health care professionals and social workers rarely present adoption as an alternative. Adoption increases with sensitive adoption counseling (Resnick, 1992). Program practices most closely associated with higher rates of placement for adoption include:

- providing adoption counseling for *all* clients;
- involving the client's family in the pregnancy resolution counseling;
- client meeting with young women who had previously chosen to place their babies for adoption.

Counseling approaches such as these may shift a young woman's thinking from "*adoption as a rejection of her baby to adoption as the best way to promote her baby's future well-being*." (Ooms, 1995, p. 247).

Abortion ends about one-third of teen pregnancies. Abortion is less likely when teens have:

- a strong, stable relationship with a partner;
- are highly religious; and
- live in a geographic area with few family planning services.

Abortion rates may also be influenced by parental notification laws but the evidence is inconclusive (Miller, 1995). Some argue that such laws make teens wary of any contact with health care professionals and may prevent the teens from accessing prenatal care.

Most pregnant adolescents choose to have and rear their babies.

Most pregnant adolescents choose to become teen mothers. In part this is because attitudes toward non-marital *child-rearing* have changed radically over the past several decades. Peers often urge pregnant teens not to even consider "giving their babies away." Partners promise support if their girlfriends will keep and raise their babies. Parents often rally and provide emotional and tangible support when the grandchild is

born (Ooms, 1995). The many issues facing young women who choose to rear their children are discussed in greater detail earlier in this chapter.

Prenatal care for young mothers. Adolescent mothers are at high risk for poor birth outcomes, due to their young age. Healthy outcomes can be achieved for both teen mothers and infants *if* reproductive health services include:

Healthy outcomes can be achieved for both teen mothers and

- early, comprehensive prenatal care;
- high quality obstetrical care, and
- post-natal assistance, including home visitation for most teen mothers.

Teens benefit from a multidisciplinary approach. Most of the problems they face are social in nature and cannot be addressed solely by medical and nursing services (Zabin & Hayward, 1993). In addition, teen mothers must also have immediate access to family planning services in order to delay subsequent pregnancies.

Resource

There are many effective approaches to offering reproductive health care to adolescents. Several are noted in Chapter 5 (prenatal care) or throughout this chapter. In addition, an effective approach to reproductive health care for teens has been developed by Tillamook County, Oregon Health Department. This program is:

YOU FIRST: Contraceptive Access within 48 Hours
This program assures that teens are first in line to receive contraceptives at the county family planning clinic. The result has been a 3.5 times greater number of teens using the clinic. The clinic offers counseling on abstinence, condom use, and other contraceptives. The county also has incorporated appropriate family planning services into ALL office visits by females from ages 10-45. For further information, contact the:

Tillamook County Health Department
Tillamook, Oregon.

Teen Sexuality, Pregnancy and Parenthood

Personal Distress and Lack of a Positive Future: Measurable Interim Outcomes

Delayed sexual intercourse.	Regular school attendance.
Decreased interval between time of first sexual activity and effective use of contraceptives.	Average or better academic progress.
Effective and consistent contraceptive use with every intercourse.	Average or better achievement test scores.
Effective and consistent condom use with every intercourse.	Average or better GPA.
Reduce rates of high risk behavior.	Positive commitment to school.
Reduced rates of STDs.	Stability of access to basic resources (housing, food, transportation, health care).
Reduced teen pregnancy.	Utilization of appropriate mental health and other personal services.
Rates of prosecution of sexual predators including statutory rape.	Depression or other mental health issues or symptoms.

Personal Distress

"The most effective contraceptive is a real future."

Personal distress and lack of a positive future are major risk factors.

When Marion Wright Edelman of the Children's Defense Fund made this statement, she spoke the truth. Personal distress and lack of a positive future are *central* among the many risk factors for early sexual activity and early childbearing.

Poverty, peers, and norms are not as likely to lead to pregnancy as the strong personal belief that one has a brighter future if childbearing is delayed. When young women initiate sexual activity early, and especially when they bear children in their teens, a positive future becomes a more distant, and for many, an unattainable goal (Maynard, 1996).

The Roots of vulnerability. What leads young women to believe their futures are dim? The beginnings of these beliefs are found in childhood and early adolescence.

- *Future goals are strongly related to school success*. Girls who are sexually active early in their early teens, tend to have poor school records, low intellectual abilities, and few academic or career goals; almost 50% of adolescent mothers have dropped out of school *prior* to becoming pregnant (Chase-Lansdale & Brooks-Gunn, 1994).

  Higher achievers and girls with future educational and vocational goals do become sexually active, but they tend to be older and more reliably use contraceptives to protect themselves from STDs and to avoid pregnancy (Miller, Card, Paikoff, & Peterson. 1992).

The beginnings of sexual vulnerability are found in childhood and early

- *Child maltreatment, especially sexual abuse, reduces victim's sense of self and increases emotional vulnerability*. Over half of pregnant teens have childhood histories of abuse – many continue to be abused during adolescence (Zabin & Hayward, 1994; See Chapter 4, Child Maltreatment).

- *Most teen mothers are the children of teen mothers*. This fact is related in part to the poverty in which many of these children grow up *and* to the weak parenting skills of their young mothers. Compared to children of mothers who began childbearing after age 20, pre-school children of teen mothers show delays in cognitive and social functioning.

  By adolescence, academic achievement is dramatically lower and there are much higher rates of behavior problems in school, delinquency, drug use, early sexual activity, and teen pregnancy (Maynard, 1996; Chase-Lansdale & Brooks-Gunn, 1994; Zabin & Hayward, 1994).

- *Weak or conflictual relationships with parents* contribute to problem behaviors including drinking and drug use, sexual activity, and early pregnancy.

- *Running away, and especially homelessness*, puts adolescent girls at great risk for sexual activity, sexual exploitation, sexually transmitted diseases, and pregnancy.

Over 35% of homeless girls have been sexually abused as children; almost half report sexual coercion while homeless; many engage in "survival sex" or prostitution; 20% become pregnant annually, twice the average rate (Biglan et al., 1995).

Adolescent girls do not become pregnant in 15 minutes at age 15, it takes years and begins in early childhood.

- *Sexual coercion and exploitation* comes in many forms – forced rape, emotional manipulation, survival sex, drug or alcohol-induced "consent," and others. What each form of exploitation has in common with all other forms is the greater vulnerability of girls compared to the greater power of their male partners. In fact, most teen mothers become pregnant by men in their 20's or beyond – yet few of these adults take contraceptive, or parental, responsibility (Zabin & Hayward, 1994).

- *Teen parenting* puts teens at great risk. The issues (poverty, vulnerability, low achievement, exploitation, depression, and others) that contributed to a first pregnancy are exacerbated by the stresses of parenting a young child – usually without a stable partner. In fact, by the time their babies are one year old, depression rates among teen mothers are significantly higher than older mothers (Chase-Landale & Brooks-Gunn, 1994).

  These issues increase the risk of child maltreatment and of subsequent pregnancy. Among the teens at highest risk for pregnancy are teens who are already mothers (Zabin & Hayward, 1994).

In sum, there are *multiple, inter-related* elements that weave the web of early sexual activity, teen pregnancy, and childbearing. Rejection, abuse, isolation, exploitation, and failure create vulnerable children and teens. Adolescent girls do not become pregnant in 15 minutes at age 15. For most, it takes years and begins in early childhood.

Building Strengths Among High Risk Teens

To decrease vulnerability, responses must be multi-dimensional.

Many, interacting factors contribute to the personal distress that makes teens vulnerable to early sexual activity, STDs, pregnancy, early childbearing, and teen parenthood. To decrease this vulnerability responses must be multi-dimensional. Programs that focus *only* on sex education, employment training, communication, *or* self-esteem enhancement have *not* been successful especially with higher risk teens.

The most promising approaches increase socio-cognitive skills, increase contraceptive access and use, *and* reduce the specific risk factors facing at-risk teens (Chase-Lansdale & Brooks-Gunn, 1994; Miller 1995; Zabin &

Hayward, 1994). Because these risk factors are multi-dimensional effective responses are comprehensive, and individualized.

Comprehensive efforts combine protection for vulnerable teens, supports to address individual risks, and comprehensive reproductive care, life skills, and education

- Among the approaches demonstrated to be effective are *school-linked, full reproductive health services* for junior and senior high school students. Such services offer education *integrated with* medical and counseling services. Such comprehensive programs have been successful in:

    - reducing early sexual activity and frequency of sexual activity among girls who were already sexually active;
    - increasing timely utilization of contraceptive services and effective use of contraception; and
    - reducing pregnancy rates among participating girls, especially those who were active for over two years (Zabin, 1992; also see Miller et al., 1992).

- *Healthy Start* is an early intervention, home visitation program that serves higher risk families with newborns through preschool years. Many of the parents served are teens. *Healthy Start* has been demonstrated to be effective in reducing child maltreatment, improving parenting skills, increasing access to needed basic resources, and increasing effective utilization of health care including family planning.

  Comprehensive, long-term support for teen parents is critical to breaking the cycle of teen parents raising future teen parents. (See Chapter 3, Nurturing Families and Chapter 4, Child Maltreatment for other practices to support teen parents.)

- Homeless teens, teens who are failing in school, teens suffering from depression or other mental health issues, teens who use alcohol or drugs, and teens who lack stable access to essential resources are at great risk for sexual exploitation, early sexual activity, STDs, and pregnancy. Their *individual* needs must be *comprehensively* addressed. Strategies for doing so are discussed throughout the various sections of this guidebook.

- Finally, a critical component of effective support for vulnerable teens is aggressive sanctions against sexual exploitation and coercion. Particular targets for such sanctions should be repeat sexual predators.

The best hope of delaying early sexual activity and childbearing will be comprehensive efforts that combine protection for vulnerable teens, supports to address individual risks, *and* comprehensive reproductive care, life skills, and education.

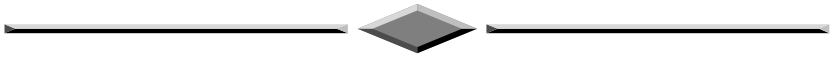


Table 7-1
Oregon's 1997 Benchmark Indicators[a] Related to OCCF Wellness Goal: Positive Youth Development/ Special Youth Concerns - Substance Use and Abuse, Juvenile Crime and Delinquency and Teen Pregnancy and Parenthood

	1990	1995/96	2000	2010
EDUCATION BENCHMARKS				
• **High school drop out rate (#22)[b]**	**6.6**	**7.4**	**5.7**	**4.6**
• Percentage of 8th graders who achieve established skill levels (#23)[b]				
a. Reading	---	89%	92%	100%
b. Math	---	84%	89%	100%
• Percentage of high school students that have completed a structured work experience, including a practicum, clinical experience, community service learning, or school-based enterprise program (#25)	---	21%	65%	100%
• Percentage of Oregon adults (age 25 and older) who have completed high school or an equivalent program (#27)	85%	91%	94%	100%
HEALTH AND PROTECTION BENCHMARKS				
✔ • **Pregnancy rate per 1,000 females age 10-17 (#43)**	**19.7**	**19.2**	**15**	**10**
• Annual percentage of new HIV cases with an early diagnosis (before symptoms occur) (#47)	72%	78%	85%	98%
✔ • **Percentage of 8th grade students who used: (53)**				
a. Alcohol in the previous month	**23%**	**30%**	**26%**	**21%**
b. Illicit drugs in the previous month	**14%**	**22%**	**15%**	**12%**
c. Cigarettes in the previous month	**12%**	**22%**	**15%**	**12%**
PUBLIC SAFETY BENCHMARKS				
✔ • **Total juvenile arrests per 1,000 juvenile Oregonians per year (#65)**	**46.5**	**58.6**	**46.5**	**37.2**
• Percentage of students who carry weapons (#66)	---	19%	15%	9%
DEVELOPMENTAL BENCHMARKS (No baseline or targets are yet established)				
• Percentage of students who attain a Certificate of Initial Mastery (CIM) (Developmental Benchmark #14)	---	---	---	---
• Percentage of students who attain a Certificate of Advanced mastery (CAM) (Developmental Benchmark #15)	---	---	---	---
• Juvenile Crime Index (Developmental Benchmark #20)	---	---	---	---

[a] Oregon Shines II: Updating Oregon's Strategic Plan, 1997; Oregon Progress Board.
[b] Benchmark number in Oregon Shines II
✔ Key Benchmark to be tracked by Progress Board
Bold = Benchmark tracked by OCCF, 1995-97