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Protecting Children From Substance Abuse: Lessons From Free to Grow Head Start Partnerships

Final Report

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I. INTRODUCTION

In 1994, the Robert Wood Johnson Foundation (hereafter, the Foundation) launched a five-year, $5.4 million pilot program involving six Head Start grantees, to design and develop "model substance abuse prevention projects that will strengthen both the families and neighborhoods of economically disadvantaged preschool children."[1] Following a two-year planning and development phase (Phase I), five of the six original projects went on to complete the three-year implementation phase (Phase II). The initiative, named Free to Grow, targets families and neighborhoods of Head Start children to create changes that will *free* young children *to grow* and flourish while at the same time protecting them from substance abuse and the problems associated with it. The five Phase II Free to Grow pilot projects were scattered across the United States, with sites in (1) Compton, California; (2) Colorado Springs, Colorado; (3) Owensboro, Hancock County, and Christian County, Kentucky; (4) the Washington Heights section of New York City, New York; and (5) the San Isidro ward of Canóvanas, Puerto Rico.

This report discusses the implementation experiences of these five Free to Grow projects: how the models developed, what challenges were encountered, how problems were overcome, and what lessons can be derived from the grantees' experiences to guide future substance abuse prevention efforts that focus on the early childhood period. This chapter begins with an overview of the program and the evaluation, along with a description of the communities targeted by the pilot projects. It continues with a brief description of each project, then presents a logic model for the program

[1]Free to Grow National Program Office. "Free to Grow: Head Start Partnerships to Promote Substance-Free Communities; Application for a Two-Year Project Development Grant." New York, NY: National Center for Children in Poverty, Columbia University School of Public Health, November 1993.

overall, showing the relationship between Free to Grow interventions and expected outcomes. The chapter concludes with a discussion of the evaluation and a review of the report's structure.

A. THE IMPETUS FOR FREE TO GROW

Substance abuse is one of the nation's most serious health problems. "There are more deaths, illnesses, and disabilities from substance abuse than from any other preventable health condition" (Institute for Health Policy 1993). More than one-quarter of the deaths in the United States each year are directly or indirectly caused by alcohol, illicit drug, or tobacco use (U.S. Department of Health and Human Services 1999). In addition to health concerns, other problems are associated with substance abuse, including prenatal drug exposure, family violence, child abuse, crime, neighborhood gang activity, and unemployment.

The Free to Grow concept builds on a growing body of research showing the importance of family and neighborhood characteristics in heightening or moderating the risk of developing substance abuse problems. The prevention approach is indirect; rather than targeting the child directly, the models are designed to reduce a child's vulnerability to substance abuse and related negative outcomes by strengthening their immediate environment--their family and neighborhood. A child's vulnerability to substance abuse is influenced by both risk factors and protective factors. Risk factors--family level factors such as alcohol, tobacco, and other drug (ATOD) use, limited bonding, and permissive or excessively punitive disciplining, as well as such neighborhood factors as extreme poverty, high crime rates, and drug dealing and ATOD sales to minors--have been shown to increase the chances that children will experience poor health and developmental outcomes, including substance abuse problems. In contrast, protective factors--such as supportive families, positive role models, and safe/nurturing school and neighborhood environments--provide resources and alternatives for the growing child.

Free to Grow's comprehensive and multifaceted approach, and its emphasis on intervening during the early childhood years, distinguishes it from most other substance abuse prevention programs, which focus largely on education and skill building among adolescents. Especially for higher-risk groups, concerns have been raised about whether traditional prevention strategies are a case of "too little too late." With initiation into alcohol and drug use starting at earlier ages, and heightened awareness of factors contributing to healthy child development in the earliest years, prevention researchers and program developers are beginning to look more closely at the developmental pathways of substance abuse in early childhood.

Through Free to Grow, the Foundation hoped to break new ground by working with local Head Start programs to develop and test comprehensive prevention models that focus on the early childhood period. The assumptions guiding Free to Grow strategies include the following:

- Changing known risk and protective factors will reduce the likelihood of later substance abuse and other high risk behaviors.
- Prevention strategies during the preschool years need to focus on a child's immediate environment, targeting families and neighborhoods rather than intervening directly with the child.
- Families will be better able to nurture and protect their children if they have a wide range of supports.
- Strengthened and supported families are more likely to resist abuse of alcohol and other drugs and to provide a stable, protective living environment for their children.
- A more stable and protected living environment in safer, less chaotic neighborhoods will help reduce the young child's vulnerability to substance abuse and other high-risk behaviors.

Head Start, since 1965 the nation's premier program for supporting and strengthening low-income families with young children, was viewed as a natural partner in this initiative because of its work with more than 800,000 vulnerable children and their families, its focus on comprehensive and

community-based strategies, and its presence in more than 2,000 communities across the nation. Effective implementation within the context of Head Start would give Free to Grow the potential for a significant impact on substance abuse problems throughout the United States.

B. THE FREE TO GROW COMMUNITIES

The Free to Grow target communities differed from each other in important respects, but each faced significant problems related to substance abuse. Table I.1 summarizes basic features of the Free to Grow communities. With the exception of San Isidro, where residents were almost 100 percent Puerto Rican, the racial and ethnic composition of populations in the Free to Grow target communities was mixed. In several target areas (the three Colorado Springs communities and two of the three Kentucky communities), the population is predominantly white, while, in the others, it is largely black or mixed. Other demographic issues--for instance, substantial population mobility in Colorado Springs, large numbers of immigrants in Washington Heights and in Compton, and a population shift among blacks and Hispanics in Compton--added further challenges to Free to Grow efforts.

All the communities targeted by Free to Grow face significant problems related to poverty, substance abuse, and related issues. Common problems include high rates of drug and alcohol use, HIV infection and AIDS, domestic violence, and child abuse or neglect. In several Free to Grow communities, the illegal drug market has become a dominant part of the local economy. In nearly all Free to Grow communities, gang and organized crime involvement in the drug trade made it difficult, even dangerous, for residents to speak out against or play a visible role in curbing these activities.

TABLE I.1

CHARACTERISTICS OF FREE TO GROW COMMUNITIES

Free to Grow Target Areas	Urban/ Rural	Population Size	Racial/Ethnic Percentages			
			White	Black	Other	Hispanic
DREW HEAD START, COMPTON, CALIFORNIA						
Compton	Urban	90,000		35		65
COMMUNITY PARTNERSHIP FOR CHILD DEVELOPMENT, COLORADO SPRINGS, COLORADO						
Stratton Meadows	Urban	6,000	73	10	5	23
Adams	Urban	2,900	62	27		29
Monterey	Urban	5,500	64	20	6	19
AUDUBON AREA COMMUNITY SERVICES, INC., OWENSBORO, KENTUCKY						
Owensboro/West End	Urban	6,000	67	33		
Hancock County	Rural	10,000	93	7		
Christian County/ Hopkinsville	Urban	4,000	14	83	3	
FORT GEORGE COMMUNITY ENRICHMENT CENTER, NEW YORK, NEW YORK						
Washington Heights	Urban	60,000		20		80
ASPIRA, INC. DE PUERTO RICO, CANÓVANAS, PUERTO RICO						
Canóvanas, San Isidro	Urban	7,500				100

C. THE FREE TO GROW GRANTEES

Table I.2 highlights features of the five Phase II grantees. The grantees are:

- Aspira, Inc. of Puerto Rico (Aspira) in Canóvanas, Puerto Rico
- Audubon Area Community Services (Audubon) in Owensboro, Kentucky
- Charles Drew University of Medicine and Science (Drew) in Compton, California
- Community Partnership for Child Development (CPCD) in Colorado Springs, Colorado
- Fort George Community Enrichment Centers (Fort George) in New York City, New York

The grantees represent a variety of mature, private, nonprofit organizations. Except for CPCD and Fort George, they have a mission broader than early childhood programming. They also brought to Free to Grow prior experience with related demonstrations or initiatives, and most had established relationships with substance abuse prevention and treatment resources. Two grantees--Aspira in Puerto Rico and Drew in California--were Head Start Family Services Center demonstration sites. These programs used a case management approach to enhance awareness and use of services and resources to address problems such as illiteracy, unemployment, alcoholism, and drug addiction.

Most of the grantees also had developed close relationships with local health and social services agencies. Audubon and CPCD were involved in interagency coalitions. Fort George had participated in Northern Manhattan Collaborates, a neighborhood-based coalition. Through Free to Grow, the grantees built on these experiences while expanding into new areas such as community action and intensive intervention with at-risk families.

TABLE I.2

CHARACTERISTICS OF THE PHASE II FREE TO GROW GRANTEES

Program Characteristic	Compton, California	Colorado Springs, Colorado	Owensboro, Kentucky	New York City, New York	Canóvanas, Puerto Rico
Grantee Agencies					
Name	Charles R. Drew University of Medicine and Science, Project Head Start	Community Partnership for Child Development	Audubon Area Community Services, Inc.	Fort George Community Enrichment Center	ASPIRA, Inc. de Puerto Rico
Organization Type	Private, nonprofit Teaching arm of the Los Angeles County Martin Luther King, Jr. Hospital	Private, nonprofit Early childhood education agency	Private, nonprofit Community action agency	Private, nonprofit Early childhood education agency	Private, nonprofit Community action agency
Year Established	1966	1988	1975 (merger of two agencies in operation since 1966)	1981	1969
Catchment Area	Cities of Compton, Lynwood, Carson, South Los Angeles, and Paramount	El Paso County	16 counties in western Kentucky	Washington Heights area of Manhattan Community District #12	Cities of Canóvanas, Carolina, Ceiba, Juncos, Loisa, Rio Grande, Rio Piedras, and Trujillo Alto
Experience with Other Demonstration Programs	Family Services Center Family Resource Center Follow Through Program Parent Enabler Project Los Angeles Mayors' Roundtable for Children Needles in the Sandbox (playground cleanup)	Parent Education and Support program (prevention of child neglect and abuse) Head Start Substance Abuse Prevention Demonstration First Visitor Program Early Head Start	Kentucky Educational Reform Act (KERA) Initiative Early Head Start	State- and city-sponsored alliances for neighborhood needs assessment and planning Parent Service Project	Family Service Center Head Start Family Child Care Parent and Child Center Early Head Start AIDS Education and Prevention Puerto Rican Coalition Against Alcohol Consumption by Minors (COPRAM)

SOURCE: Data abstracted from Free To Grow implementation grant applications, updated as applicable during evaluation site visits and related follow-up activities. Data are for 1998-1999 program year unless otherwise indicated.

D. THE FREE TO GROW MODELS

Each Free to Grow grantee had a distinct vision for Free to Grow that would build on the strengths of existing programs and meet the unique needs of families and communities they served. Although specific features vary, the five projects share common goals and use similar strategies, which are captured in the logic model shown in Figure I.1. As it shows, the Free to Grow approach uses two core types of program strategies:

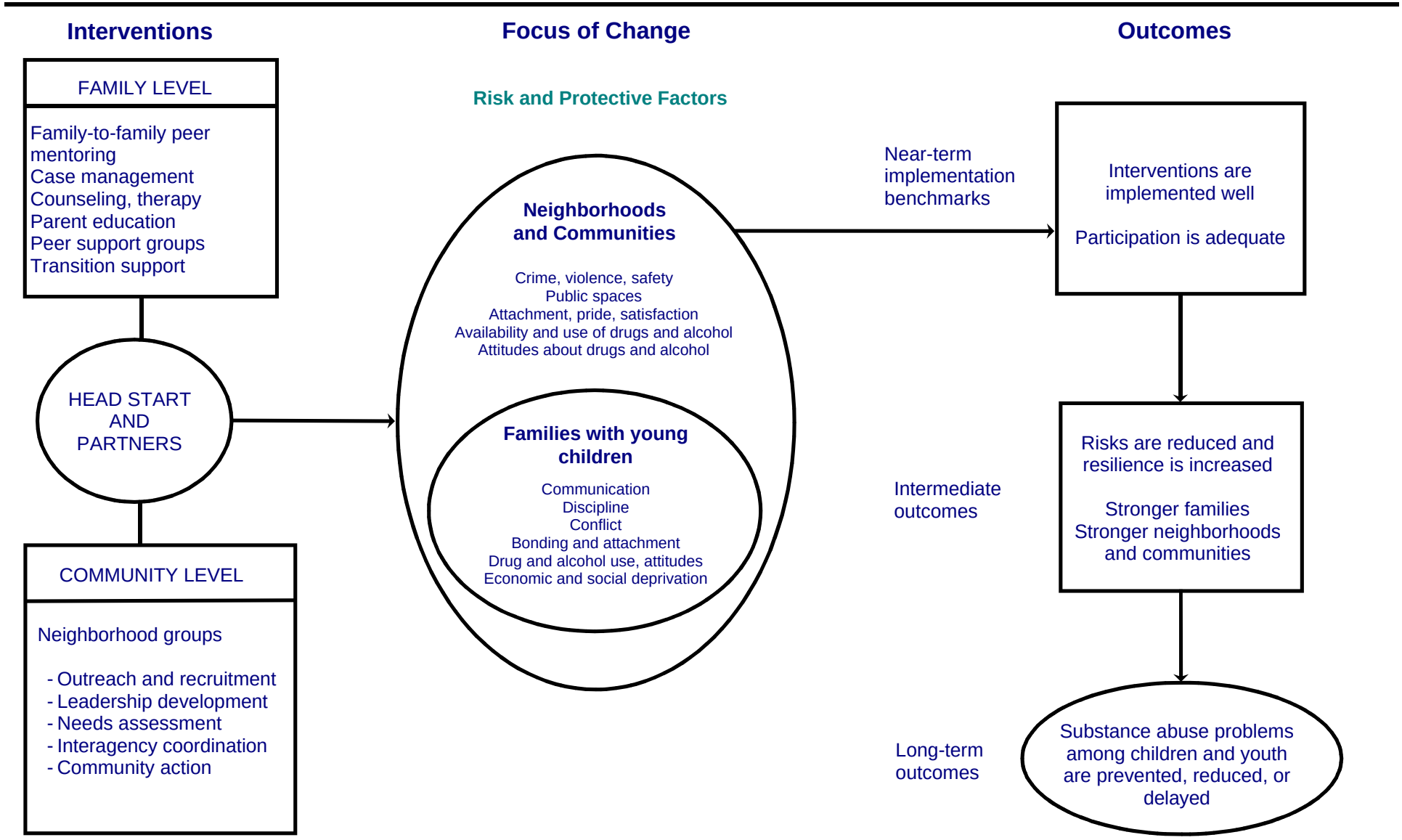
1. ***Family-Strengthening Strategies.*** Includes interventions such as family-to-family peer mentoring, case management, counseling and therapy, parent education, peer support groups, and support making the transition from Head Start to elementary school

2. ***Community-Strengthening Strategies.*** Uses neighborhood and community groups to assess needs, develop resident leaders, and support community action; uses interagency coordination to leverage support from partners and collaborators

The strategies address multiple family- and community-level risk and protective factors, which have been shown to influence substance abuse outcomes. The short-term outcomes are measures of implementation strength--the extent to which project strategies are implemented as intended and whether participation was adequate. If implementation is adequate, we would expect to see reductions in key risk factors and greater resilience among families and communities. In turn, by reducing risks and enhancing resilience, Free to Grow ultimately seeks to prevent, reduce, and delay substance abuse problems among children and youth.

Figure I.1

THEORY OF CHANGE FOR FREE TO GROW



For the most part, Free to Grow models operated first as separate programs with the idea that they would be integrated into Head Start after model components were refined and tested on a small scale. Projects focused on integration into Head Start during Phase II, with the hope that integration would provide the primary mechanism for sustaining Free to Grow into the future. Tables I.3 through I.7 at the end of this chapter provide an overview description of the five models in their final form, along with a summary of important accomplishments and implementation challenges.[2]

E. THE EVALUATION

The Foundation contracted with Mathematica Policy Research, Inc. (MPR) to evaluate the Free to Grow pilot program. Program planners and policymakers are typically anxious to learn what their efforts accomplish. But before putting a new initiative like Free to Grow through the scrutiny of an impact evaluation, the Foundation thought it prudent to test it on a small scale and assess the model development and implementation process so that refinements could be made prior to conducting a full-scale demonstration and impact evaluation. Consequently, the evaluation was designed to document the model development and implementation process and to derive lessons that would help shape a full-scale demonstration of the Free to Grow approach. It focused on outcomes in a preliminary, descriptive manner; in that sense, it provides some stepping-stones for a later assessment of impacts on key outcomes. Building on the evaluation of Phase I model development efforts,[3] the Phase II evaluation focused on questions in three areas: (1) model development and

[2]Additional information about each project can be obtained from the individual project profiles prepared by the evaluation team. See the page v of this report for information about obtaining these and other Free to Grow documents.

[3]See Love, John M., Irma Perez-Johnson, Alicia Meckstroth, and Andrew C. Samson. "Developing Head Start Partnerships for Substance-Free Communities: A Process Evaluation of Free to Grow, Phase I." Princeton, NJ: Mathematica Policy Research, Inc., December 1997.

implementation, (2) program outcomes and changes in families and communities, and (3) replication and sustainability.

The evaluation, a process study conducted in two phases, gathered information from Head Start and Free to Grow staff, parents, and community partners through site visits, telephone interviews, and focus groups. Additional information was obtained from grant applications and other documents produced by the projects and the Free to Grow national program office, housed at Columbia University's School of Public Health.[4]

F. STRUCTURE OF THE REPORT

The focus in this report is on the program overall, with the experiences of the individual pilot projects informing more generalized findings. It incorporates and builds on findings from the Phase I evaluation to provide a comprehensive description and assessment of the Free to Grow initiative. Chapter II summarizes the substance abuse prevention theory underlying Free to Grow, and Chapter III describes the Head Start context for Free to Grow. Free to Grow interventions and important implementation experiences are described in Chapter IV, followed in Chapter V by a description of outcomes targeted by the projects and preliminary evidence for the changes Free to Grow projects may have brought about during the pilot program. The final chapter provides an assessment of the Free to Grow experience and considerations for future replication.

[4]Six rounds of site visits (four during Phase I and two in Phase II) provided the primary data for the process evaluation. Additional information about the Head Start context for Free to Grow was obtained through interviews with Head Start national and regional officials. The final round of site visits also included focus groups with parents and with partner representatives. To learn more about the actual interventions, we held "case conferences" during the site visits that focused on the experiences of a sample of families being served by the projects, as well as on selected community-focused activities or events.

TABLE I.3

FREE TO GROW IN CANÓVANAS, PUERTO RICO

Aspira, Inc., of Puerto Rico's Free to Grow model used ***family-to-family peer mentoring*** to provide intensive support to Head Start families affected by substance abuse problems or identified as at risk for such problems. Based on the Latin concept of "compadre" (or godparent), carefully selected and trained "strong" families--the "compays"--served as peer counselors to assigned Head Start families from their same neighborhood. Displaying a deep commitment to the physical, emotional, and spiritual development of these families, a stable corps of about 45 volunteer compay families visited about 70 at-risk families semiweekly, providing information on available resources and linking them to appropriate services. Through their example, the compays also motivated these families to achieve lifestyle changes, spelled out in family service plans, thus strengthening the families and home environments of at-risk Head Start children.

An important feature of Aspira's prevention approach was the interrelated structure of its family and community strengthening strategies, which grew to complement and support each other. Many of the compay families emerged as prominent leaders in a three-level structure of neighborhood groups that worked in partnership with municipal officials, schools, the police, local recreational organizations, and other resources to improve the overall community environment. ***Sector groups*** brought concerned neighbors together to interact on a more regular basis, offer mutual support, and discuss issues of common concern. A ***community association*** allowed local residents to come together across sectors to address communitywide issues. Through the ***leaders group***, Aspira staff offered ongoing technical assistance and support to residents on matters related to civic leadership and activism. Resident-led efforts brought about increased police surveillance, improved lighting and garbage collection, canalization of sewer waters, and the preservation of the community's only elementary school--after it was damaged extensively in a hurricane and closed by education officials--among many other successes. Periodic ***educational and recreational activities*** for local residents and children--including a principally parent-staffed annual summer camp, for example--and a ***support group*** for those at-risk families who had met their goals of self-reliance also served to reduce isolation and to rebuild the social fabric of the targeted neighborhood.

By the end of the pilot project, Aspira had successfully integrated all of its Free to Grow model components into Head Start. From the outset, the compay peer-mentoring intervention was grounded in Head Start's family service structure and procedures, so it was integrated into Head Start by design. Compays were closely supervised and counseled by the program's family social workers, who could also intervene directly with participating at-risk families if needed. Free to Grow strengthened Head Start's service continuum to better address the needs of at-risk families, at the same time that it extended the program's focus and reach to the larger community where participating children and families lived. While the neighborhood groups were resident-driven and self-sustaining, Aspira restructured its parent involvement coordinator positions to institutionalize Head Start's support for community strengthening activities. Key staff for the pilot were also convened into a special technical assistance unit to train other Head Start staff on Free to Grow procedures and provide support as the compay model was replicated in other communities.

TABLE I.4

FREE TO GROW IN OWENSBORO, KENTUCKY

Audubon Area Community Services developed a model that combines grassroots community action with intensive case management for high-risk families. Neighborhood leaders and other community residents--formally trained in ***leadership development and community action planning skills***--came together with program staff and representatives from key resource agencies in ***community coalitions.*** These coalitions developed and implemented a wealth of educational activities and action plans that addressed community-level risk and resiliency factors related to substance abuse. In addition, a restructured Head Start family service program integrated Free to Grow's ***intensive case management services*** agencywide, providing all Head Start family advocates with the skills and time to provide case management services to all families. The advocates focused on delivering intensive, individualized services to high-risk families, which numbered over 40 in the target communities.

Building on a history of strong collaborations and partnerships, Audubon's Free to Grow program achieved significant community-level victories, including the institutionalization of a community policing program in the original target area, improved parent support programs, after-school recreational and tutoring opportunities for elementary children, and a public-private collaborative effort to develop a new playground. Local residents also sought to strengthen the enforcement of laws prohibiting alcohol sales to minors and to change local probation and parole guidelines to help keep drug dealers off their streets. In addition, Audubon implemented an ambitious expansion plan by replicating its Free to Grow model in two separate communities, which required developing new partnerships and cultivating a new set of grassroots community leaders in each community.

Audubon Head Start was quite successful in implementing its Free to Grow model and, by the end of the pilot project, had successfully integrated all of its Free to Grow model components into its Head Start structure. To facilitate this process, Audubon created a new Family and Community Team that included all family advocates, other family service staff, and Free to Grow's community development staff. As part of its organizational restructuring, Audubon institutionalized its three key Free to Grow community development staff positions into its Head Start structure. By doing so and garnering support from key community partners, Audubon secured the sustainability of its Free to Grow model over time. Strong strategic planning and leadership skills from the Head Start director and management team facilitated this process. To strengthen the implementation of its Free to Grow strategies, Audubon's organizational capacity-building efforts were designed to refine its case management assessment tool and to provide staff with ongoing training and technical assistance.

TABLE I.5

FREE TO GROW IN NEW YORK, NEW YORK

The Fort George Community Enrichment Center, located in the Washington Heights neighborhood of New York City, used its Free to Grow project to extend the reach of Head Start and address the unique acculturation needs of its predominantly immigrant Latino client population. It also prepared parents to participate in community efforts to address substance abuse and related issues. The effort, called Project Right Start, developed a distinctive ***oral and cultural history program*** that used a series of hands-on activities to allow immigrant parents to explore the strengths of their roots and the isolation, stresses, and challenges of the immigrant experience. The intent was to increase self-esteem and awareness and thereby reduce the risk of alcohol and drug abuse among participating families. ***Women's support and education groups*** further expanded parent involvement opportunities within Head Start to enhance participants' knowledge of parenting skills, health, life skills, and other issues related to substance abuse.

Fort George also expanded the work of existing Head Start ***parent committees*** to engage participants in educational activities and community-focused efforts to prevent and combat substance abuse. These committees played an important role in connecting parents with information and resources in the community--such as those involving citizenship--and supporting neighborhood safety efforts. In close collaboration with local police, for example, dozens of Head Start parents were formally trained as "block watchers" to identify and report potential crimes confidentially to the police. Parents also worked with neighborhood bodegas to enforce laws regarding the sale of alcohol and tobacco to minors. To facilitate their work, the Right Start participants received structured, specialized ***substance abuse prevention training*** and ***leadership training.***

Fort George has developed a promising model for substance abuse prevention. Its group-based approach targeted a broad range of Head Start parents and addressed varied needs. It also built directly on Head Start's traditional parent involvement committee structure while expanding the focus of the committees to encompass community issues and civic activism. Numerous challenges, however, hindered Fort George's efforts to implement the project fully. Although Head Start staff ultimately assumed responsibility for most Right Start components, Fort George was unable to secure the long-term sustainability of its distinctive oral and cultural history group. At the end of Phase II, this component was still being led by paid consultants, and Head Start was uncertain about its ability to find resources to retain their services. Moreover, although Head Start staff worked with key consultants to lead the substance abuse and leadership trainings, staff training modules were not developed, and institutionalization of these trainings was not secure.

Despite being located in New York City--a community replete with grassroots organizations and an activist spirit--Fort George was, for the most part, unable to formalize procedures to help parent leaders transition into other civic activism roles or to connect Right Start efforts to the community improvement agendas of other local groups. These shortfalls stemmed from agency difficulties developing staff capacity for the Right Start community-strengthening work and were exacerbated by Fort George's special administrative challenges. As a small Head Start delegate, Fort George had limited autonomy and flexibility to organize resources or to access additional funds. In turn, it was difficult for Fort George to formulate and pursue creative strategies to implement or sustain new efforts. Recurring financial crises demanded the attention of Fort George's administrators, thus detracting from their focus on Right Start implementation.

TABLE I.6

FREE TO GROW IN COLORADO SPRINGS, COLORADO

The Community Partnership for Child Development (CPCD) model extended the traditional reach of its Head Start program. Neighborhood-based ***family advocates*** worked to build an effective continuum of care for families with children from birth to age 8. These Free to Grow workers served as outreach staff for the Head Start program and case managers for pre- and post-Head Start families, providing hundreds of referrals to community agencies for needed services. ***Neighborhood family councils*** strengthened the overall health of the three targeted neighborhoods by bringing local residents and agency representatives together to address high-priority community concerns. Resident-led initiatives in these three neighborhoods included graffiti removal, improved lighting of public spaces, better playground facilities, and expanded educational and recreational opportunities for young children. In addition, a formal referral partnership between CPCD and the Department of Health for ***substance abuse treatment and family counseling*** services through a dedicated counselor dramatically improved access to services for families with young children in the target neighborhoods. Innovative community- and home-based approaches to treatment succeeded in bringing about 67 such families--originally fearful of the stigma of substance abuse--into counseling.

In the politically conservative Colorado Springs environment, CPCD has always had to be vigilant about protecting its programs and its supporters. As Free to Grow work evolved over time to focus more heavily on resident-driven community groups, CPCD found itself in a difficult position. It recognized the importance of grassroots efforts to make neighborhoods and service delivery systems more responsive to the needs of families. However, it also worried about the impact on the agency if these groups became critics of the same schools and agencies that CPCD depended on for political and financial support. Largely for this reason, CPCD decided that it could not retain direct responsibility for the Free to Grow councils as the end of the pilot project approached. Since the work of neighborhood family advocates had also evolved over time to principally support the councils, these positions were not integrated into Head Start either. Fortunately, key partners stepped forward to assume responsibility for sustaining the Free to Grow councils and most of the project's community-strengthening work. As planned, the Department of Health also integrated the substance abuse counselor's position into its treatment programs and modified its outreach procedures to more effectively serve higher-risk families and neighborhoods, thus institutionalizing Free to Grow's counseling component. CPCD also plans to continue providing training for Head Start staff in substance abuse prevention, and it may support a family advocate position to provide outreach and serve as liaison to the neighborhood councils.

TABLE I.7

FREE TO GROW IN COMPTON, CALIFORNIA

Charles R. Drew University of Medicine and Science, through its Project Head Start, developed a model of civic organizing and communitywide mobilization that uses Head Start centers and community schools as the hubs for its "Safe Space" campaign. The program's slogan, "Children Deserve a Safe Space to Live Somewhere on This Planet," captures in compelling simplicity the spirit of the Compton effort. The goals of civic organizing differ from community organizing in their emphasis on building relationships and on making residents active participants in community institutions and governance. ***Safe-space task forces*** were established in two elementary schools and four Head Start centers, where parents worked to improve the physical, social, and cultural environment of some of the toughest schools in the country. Both elementary schools became Drug Free School Zones as a result of task force efforts. Other accomplishments included working with local police to establish graffiti removal and school watch programs, getting crosswalks and speed bumps installed around school property, and convincing the school district to add classroom space at the elementary schools rather than transferring students to the middle schools.

A ***community coalition*** composed of more than 40 residents and agency representatives met regularly and sponsored many citywide activities to increase awareness and change community norms around substance abuse. The project also recruited and trained former Head Start parents to serve as Free to Grow ***parent advocates***. Ten of these advocates stayed with the project, recruiting other parents and providing support for the safe space task forces and other project activities. Building on youth development principles, more than a dozen local youth also served as Free to Grow ***youth advocates.*** Trained in substance abuse prevention and given leadership and organizing skills, youth advocates planned social events for local youth and advocated for stronger enforcement of a local ordinance governing storefront advertising for alcohol and tobacco products.

Although the project continually demonstrated success in grassroots organizing, it lacked the skills to overcome major obstacles in the community and Head Start/grantee environment. By the end of the pilot program, all the project components except one elementary school task force had ceased operation. The parent advocate component suffered because the positions did not pay well and did not satisfy new welfare reform employment rules. The project also struggled to gain support from school and Head Start staff for many of the task forces, and the coalition and most of the task forces never became self-sustaining. At the community level, major performance problems within the school district, combined with tensions between blacks and Hispanics, made Free to Grow work all the more important but also much more difficult. Perhaps the greatest obstacles involved leadership changes and serious performance problems at the grantee and Head Start level. With attention focused squarely on addressing performance deficiencies to save its Head Start program, Drew Head Start had only preliminary ideas about how it might sustain certain Free to Grow principles and no firm plans for sustaining any of the components as implemented. In addition to skills in grassroots organizing, succeeding in this type of environment requires significant relationship-building skills, which the project lacked. Given the magnitude of the contextual problems, however, almost anyone would probably have struggled in this environment.

II. THE PREVENTION THEORY UNDERLYING FREE TO GROW

Over the past decade, researchers have made significant progress in understanding the etiology of substance abuse problems and in identifying promising preventive approaches. Their focus has nevertheless been mainly on the period of adolescence and young adulthood--when substance abuse problems begin to show. Much less attention has been paid to young children and their families, for whom prevention should be expected to have the greatest social benefit. As summarized by Kaufmann and Dodge (1997), the rationale for an increased focus on prevention activities during the younger years stems from research data and experience across multiple fields, including health, mental health, child welfare, education, substance abuse, and juvenile justice. These researchers note that:

- Many problem behaviors in older children and adolescents--including drug abuse, chronic delinquency and antisocial behavior, school failure, depression, and suicide--are believed to originate in early childhood. Their prevention in early childhood may avoid significant personal and social costs later in childhood and adolescence (Institute of Medicine 1994).

- Increasingly, evidence indicates that many mental and related disorders are responsive to primary prevention efforts (Institute of Medicine 1994). Most promising among these are those targeting the risk and protective factors.

This chapter outlines the risk and protective factor framework underlying Free to Grow prevention programs. First, we explore these factors from the ecologic domains of (1) young children and their families, and (2) the communities in which these families live. We then summarize science-based principles that can guide prevention efforts such as Free to Grow.

A. RISK AND PROTECTIVE FACTORS

Risk factors are conditions that increase the likelihood that an individual will develop a disorder. Considering young children specifically, Grizenko and Fisher (1992) defined risk factors as “factors

that increase a child's vulnerability or the likelihood that he or she will develop difficulties in situations of stress, even minor stress." An important consideration is that, while risk factors increase the probability that a particular negative outcome will occur, they do not necessarily *cause* the outcome to occur. Young children may not yet display symptoms or precursors of substance abuse problems, nor is substance abuse a certainty in the future course of events in their lives.

Protective factors, in turn, are conditions that prevent or modify risks or that improve circumstances so as to reduce the likelihood of the undesirable outcome. The constructs of protective factors and resilience attempt to capture characteristics of individual children or the environment in which they function that help them successfully negotiate their exposure to risk. As Garmezy (1993) notes: "There are children who, despite their exposure to multiple risk factors, do not show the dire consequences that have been reported. For these children, it is necessary to search for the presence of protective factors that presumably compensate for those risk elements in their lives and environments." Rutter (1987) describes protective factors or processes as including those that (1) reduce the risk impact; (2) reduce the likelihood of negative chain reactions; (3) establish, maintain, or promote self-esteem and self-efficacy; and (4) open up opportunities. Rutter also concludes that protective mechanisms operate at key junctures in the lives of children and youth, helping them negotiate developmentally important transitions (in school, for example) or manage risky situations (adolescent peer pressure, for example).

Risk and protective factors may manifest themselves at the individual, family, or community level. In the following pages, we discuss the evidence on risk and protective factors for the principal domains targeted by Free to Grow prevention efforts: (1) the families of young children, and (2) the communities in which these families live. We summarize the evidence on risk and protective factors at the individual level, together with family influences on substance abuse. Although individual factors are important, Free to Grow interventions do not target them directly. We close the section

with discussions of how risk and protective factors interact to influence the probability of substance abuse and considerations for special target populations.

1. Family Influences on Substance Abuse

Families affect children's lives and behavior in a number of ways. Families are responsible for providing physical necessities, support, learning opportunities, and moral guidance; parents (or parent figures) also help children develop self-esteem and problem-solving skills. Risk and protective factors at the family level are described below.

a. Family and Individual Risk Factors

A family history of alcoholism increases the risk of alcoholism in children. There is well-established evidence of the genetic transmission of a propensity to alcoholism in males (see Hawkins et al. 1992), and Kendler (1992) reported a similar genetic component in female alcoholism. Beyond a biological influence, other family characteristics or behaviors also predict greater risk of alcoholism and other drug abuse (see Table II.1):

- ***Parental or Sibling Use of Alcohol and Other Drugs.*** Generally, the more members of the household that use or abuse a substance, the greater the child's risk of initiating use early in life. Moreover, involving children in parental alcohol or drug use behavior also increases their risk for early initiation, which is one of the strongest predictors of drug abuse, alcoholism, and addiction (Robins and Przybeck 1985).

- ***Attitudes Favorable for Alcohol and Drug Use.*** Research indicates that permissive parental attitudes toward drug use, as perceived by children, may be of equal or greater importance than actual parental drug use in determining adolescents' use of drugs, regardless of race or ethnic background.

- ***Poor Parenting Practices.*** Risk for drug abuse appears to be increased by poor parenting practices, which include unclear expectations for children's behavior, poor monitoring of behavior, few and inconsistent rewards for positive behavior, and excessively severe and inconsistent punishment for unwanted behavior.

TABLE II.1

FAMILY FACTORS ASSOCIATED WITH RISK FOR SUBSTANCE ABUSE

STUDY (Population Studied in Parentheses)	GENERAL DESCRIPTION OF FINDINGS
1. Parent or Sibling Use of Alcohol and Other Drugs	
Goodwin 1985 (adults); Cloninger et al. 1985 (adults); McDermott 1984 (adolescents); Kandel et al. 1978 (adolescents)	Parental and sibling alcoholism or use of illicit drugs increase risk of alcoholism, drug use initiation, and drug abuse in children.
Ahmed et al. 1984 (children)	Number of household drug users and degree of children's involvement in parental drug-taking behaviors are the best predictors of children's expectations to use and actual use of drugs.
Brook et al. 1988 (adolescents)	Older brothers and parents each have an independent effect on younger brothers' use of substances. Older brothers' and peers' drug modeling are more strongly associated with younger brothers' use.
2. Attitudes Favorable for Alcohol and Other Drug Use	
Hansen et al. 1987; Barnes and Welte 1986; Brook et al. 1986; McDermott 1984; Jessor et al. 1980 (all adolescent studies)	Perceptions of parent permissiveness influence drug and alcohol use more than actual parental drug use. This relationship has been shown to hold for whites, Hispanics, blacks, Native Americans, and Asian Americans.
Kandel et al. 1978 (adolescents)	Initiation into substance use is preceded by values favorable to its use.
3. Poor Parenting Practices	
Kandel and Andrews 1987; Penning and Barnes 1982 (both adolescent studies)	Lack of or inconsistent parental discipline, low parental educational aspirations for children predict initiation into drug use.
Reilly 1979 (adolescents)	Common characteristics of families of drug abusers include negative communication patterns; inconsistent, unclear behavior limits; unrealistic parental expectations; and miscarried expressions of anger.
Shedler and Block 1990; Baumrind 1983 (both adolescent studies)	Parental permissiveness or unclear expectations for behavior; little encouragement or few rewards for positive behavior; and excessively severe, inconsistent punishment for unwanted behavior increase risk for drug abuse.

TABLE II.1 (continued)

STUDY (Population Studied in Parentheses)	GENERAL DESCRIPTION OF FINDINGS
4. Inadequate Parental Involvement	
Brook et al. 1980	Lack of maternal involvement in activities with children is related to drug use initiation.
Ziegler-Driscoll 1979 (adults); Kaufman and Kaufman 1979 (adolescents); Stanton and Todd 1979 (adolescents)	Overinvolvement by one parent, accompanied by distance or permissiveness by the other, is associated with risk for substance abuse.
5. Family Conflict	
Rutter and Giller 1983 (adolescents); Farrington et al. 1985 (children); Simcha-Fagan et al. 1986 (adolescents)	Children raised in families with high levels of conflict are at risk for delinquency and illegal drug use; extent of continuing conflict is associated with higher likelihood of antisocial behavior, both in intact families and in families broken by separation or divorce.
Wilson and Herrestein 1985 (general population)	No independent contribution of parents' marital dissolution to delinquent behavior, including substance abuse.
6. Low Levels of Bonding Within Family	
Penning and Barnes 1982; Kandel et al. 1978 (adolescents)	Lack of parent-child closeness related to drug initiation.
Brook et al. 1990 (adolescents)	Poor parenting practices, high levels of conflict in the family, and low bonding between parents and children increase risk for several health and behavior problems, including substance abuse.
7. Extreme Economic Deprivation	
Brook et al. 1990 (adolescents)	Low socioeconomic status in childhood is related to greater drug use.
Farrington et al. 1985 (children)	Poverty is associated with childhood conduct problems, as well as juvenile delinquency and chronic offenses.
Robins and Ratcliffe 1979 (adults)	Extreme poverty increases risk of alcoholism, drug abuse in adults who were antisocial as children.

SOURCE: Adapted from Hawkins et al. (1992).

- ***Inadequate Parental Involvement with Child.*** Familial risk factors include limited involvement by the mother in activities with children and a pattern of overinvolvement by one parent and distance or permissiveness by the other.

- ***Family Conflict.*** Children exposed to high levels of family conflict appear at risk for both delinquency and illegal drug use. However, there does not appear to be a direct independent contribution of divorce or separation to these behaviors. Moreover, the extent of *continuing* family conflict appears to be an important influence on the likelihood of antisocial behavior in children (an individual risk factor for substance abuse).

- ***Low Levels of Bonding Within the Family.*** Parent-child interactions characterized by lack of closeness appear to be related to initiation of drug use. In predicting substance abuse, family structure has been found to be less important than children's attachment to their parents.

- ***Extreme Economic Deprivation.*** Indicators of socioeconomic disadvantage--including poverty, overcrowding, and poor housing--have been shown to be associated with an increased risk for childhood conduct problems and delinquency. When poverty is extreme and occurs in conjunction with childhood behavior problems, it has been shown to increase risk for later alcoholism and drug problems.

- ***Other Family Factors.*** Maternal depression, mental illness, criminality, and substance use have been associated with individual risk for substance abuse (not shown in table). For instance, studies have linked maternal depression and mental illness to punitive parenting behaviors, poor social adaptation, cognitive deficits, and anxiety and aggression in children (Constantino1992; and Watt et al. 1984).

Individual Risk Factors. Some children appear to be at greater risk for drug abuse by virtue of their temperament and early behavior problems. As summarized by Hawkins and Fitzgibbon (1993), important individual risk factors include physiological vulnerability (genetic factors); difficult temperament or avoiding personality; early and persistent behavior problems (including early aggressive behavior in boys); hyperactivity/attention-deficit disorders; academic failure beginning in the early elementary grades; peer rejection or alienation as early as age 7; low commitment to education (in childhood and early adolescence); attitudes or beliefs favorable to drug use; early onset of drug use; and association with drug-using peers (in adolescence). Kaufman and

Dodge (1997) expand this list, noting other factors that place children at risk for psychopathology, including communication disorders, developmental delays, and a history of abuse and neglect.

b. Family and Individual Protective Factors

The research on protective factors in families is less developed than the research on risk factors. Nevertheless, there is evidence that certain family characteristics can buffer the effects of both biological and psychosocial risk factors in childhood. Following the structure used by Kumpfer and Alvarado (1995), family protective factors and processes can be summarized as follows:

- ***Supportive Family Environment.*** Researchers have found that supportive family environments lead to competent, motivated, and successful youth. Protective factors among children exposed to extreme stress because of highly disturbed family circumstances include an external support system that encourages and reinforces the child's own coping efforts (Garmezy 1985; and Masten and Garmezy 1985). Research by Wills and Cleary (1996) suggests that high parental (emotional and instrumental) support both reduces the effect of risk factors and increases the effects of protective factors.

- ***One Caring Adult.*** Positive interpersonal relationships with one caring parent (most often the mother) or another adult are a major protective factor against drug use. A supportive relationship with one parent may also provide a substantial protective effect for children living in severely discordant homes (Rutter 1985).

- ***Parental Disapproval of Substance Use and Clear Standards for Nonuse.*** Parents' disapproval of children's use of substances and setting clear standards for nonuse are significant protective factors against use (McIntyre et al. 1990).

- ***High Expectations for Performance.*** High expectations by parents (as well as school personnel and community members) for children and youth are a major protective factor (Benard 1990). Expectations, however, should be within appropriate developmental levels, or the child may develop a "failure syndrome" (Kumpfer and DeMarsh 1986).

- ***Other Family Protective Influences.*** While less thoroughly researched, additional protective family factors and processes may include (1) family structures with no more than four siblings; (2) extended family or friend support networks; (3) maintaining family routines and rituals; (4) opportunities for meaningful family involvement; (5) active parental support with academic, social, and life skills development; (6) family religious involvement and/or family values education; and (7) parent involvement in selecting positive friends and activities.

Individual Protective Factors. An individual factor highlighted in most of the literature on resilience is having the "ability to bond," which is highly correlated with positive outcomes for children (Catalano and Hawkins 1996). Since strong bonding with parents who are abusing drugs may promote a youth's drug use, in such cases the ability of the child to bond with *other* caring adults may be an actual resilience factor (Foshee and Baumann 1992). Another characteristic of resilient children is that they "adaptively distance" from substance-abusing family members (Berlin et al. 1988). Other individual protective factors include high intelligence or intellectual ability (there appears to be no relationship between low intelligence and drug abuse, however); an easy or positive disposition; good problem-solving skills (resourcefulness); religiosity; and belief in one's own self-efficacy (Garmezy 1985; and Rutter 1985).

2. Community Influences on Substance Abuse

Communities play critical roles in the lives of young children. While this ecologic view of the impact of a community on children's development is widely accepted, the bulk of research has focused on the influences of family and peer groups. Brooks-Gunn et al. (1993) note that research on the effects of communities on child development has been hampered by the absence of data combining information at the individual, family, and neighborhood levels. Despite these difficulties, these and other researchers have found, as would be expected, that communities do impart considerable advantages and disadvantages to the children who grow up in them. Below, we discuss community risk and protective factors for substance abuse.

a. Community Risk Factors

Important community factors contributing to risk for substance abuse include the following (see Table II.2):

TABLE II.2

COMMUNITY FACTORS ASSOCIATED WITH RISK FOR SUBSTANCE ABUSE

STUDY	GENERAL DESCRIPTION OF FINDINGS
1. Norms Favoring Alcohol and Drug Use	
Flasher and Maisto 1984; Vaillant 1983; Watts and Rabow 1983; Robins 1984; Johnston 1991	Alcohol and drug use are associated with sociodemographic factors and group norms.
2. Availability of Alcohol and Drugs	
Gorsuch and Butler 1976	Increased alcohol availability is associated with increases in drinking prevalence, amount of alcohol consumed, heavy use of alcohol.
Gottfredson 1988; Maddahian et al. 1988; Dembo et al. 1979	Availability affects use of alcohol and illegal drugs.
3. Neighborhood Disorganization	
Murray 1983; Herting and Guest 1985; and Wilson and Herrnstein 1985; Fagan 1988; Sampson 1986; Simcha-Fagan and Schwartz 1986; Sampson et al. 1981	Neighborhood characteristics, such as high population density and lack of natural surveillance of public places, high residential mobility, physical deterioration; high concentration of poverty; and high crime are related to drug abuse, as well as juvenile crime and levels of drug trafficking.
Gardner et al. 1994	Risk factors for alcohol and other drug abuse include community disorganization, lack of community bonding, lack of cultural pride, lack of cultural competence, inadequate youth services, and a lack of opportunities for prosocial behaviors.

SOURCE: Adapted from Hawkins et al. (1992).

- ***Norms Favoring Alcohol and Drug Use.*** Like any other product, the consumption of alcohol, tobacco, and drugs has been found to be affected by price and laws regulating their use (not shown in table). Not surprisingly, alcohol consumption rates also vary among different ethnic groups, in the extent to which members find consumption socially acceptable.

- ***Availability of Alcohol and Drugs.*** The use of drugs and alcohol has been found to be higher in neighborhoods where they are readily available.

- ***Neighborhood Disorganization.*** Few studies of neighborhood characteristics have explicitly examined their relationship with drug abuse. It has been noted, however, that neighborhoods characterized by concentrated poverty, high population density, lack of natural surveillance of public spaces, high residential mobility, physical deterioration, high rates of adult crime, and higher rates of violence also have high rates of juvenile crime and illegal drug trafficking. Moreover, children who grow up in disorganized neighborhoods may face greater risk for a range of problem behaviors, including drug abuse.

b. Community Protective Factors

As Wandersman and Nation (1998) note, the research associating resilience with community is sparse but suggests that neighborhoods supplement the family- and individual-level factors associated with resilience by providing a context in which children can be exposed to positive influences. These researchers identify the following as factors contributing to children's resilience in the face of structural and economic disadvantage: (1) healthy neighborhood institutions; (2) an abundance of positive role models; (3) opportunities to link children to caring adults; (4) strong social networks (dense adult friendship networks); and (5) collective efficacy (social cohesion combined with the willingness of residents to intervene for the common good).

Communities can also enhance a family's capacity to care for its children. A study of 160 families in 10 neighborhoods showed that, when parents are more connected with other parents in their communities, their children benefit (Cochran et al. 1990). Larger networks had a positive effect on the parents' ability to deal with stress, mothers' perceptions of self and their children, fathers' involvement in childrearing, and children's self-esteem and school success. In some circumstances,

they also reduced the probability of mental and physical illnesses. Similarly, Garbarino and Kostelny (1992) demonstrate the importance of strong social networks in preventing child abuse (an individual risk factor) even in areas of concentrated poverty.

3. Interaction Among Risk and Protective Factors

To understand how risk and protective factors influence the likelihood of substance abuse problems, one must consider both their individual and their combined effects. Available research evidence suggests that the degree to which these factors influence children and families depends on (1) the number of risk factors experienced simultaneously, (2) their intensity and duration, (3) the interactions between risk and protective factors, and (4) the developmental level of the child (Institute of Medicine 1994).

First, risks appear to have a multiplicative effect: the greater the number of risk factors to which an individual is exposed, the greater the probability of drug abuse (Bry et al. 1982; Newcomb et al. 1986; and Scheier and Newcomb 1991). Risk is also believed to increase with prolonged exposure to risk factors over time. Thus, resilience should not be viewed as invulnerability. As Garmezy (1993) notes: "Even resilient children will eventually succumb to risk in absence of external support."

Research by Newcomb and Felix-Ortiz (1992) suggests that risk and protective factors are not simply the opposite ends of the same continuum but, rather, "partly related yet partly distinct constructs." These researchers found that the absence of risk is not necessarily equivalent to protection and that, while some risk and protective factors are clearly related, some are more powerfully protective than risk-inducing. Newcomb and Felix-Ortiz also found that, in relation to drug use, increasing protective factors may have less impact than intervening early and moderating risk before it reaches high levels.

Finally, different risk factors are salient at different periods of development. For instance, peer influences gain importance during adolescence (Hawkins et al. 1985). However, family factors are important at all stages of development and have been shown not to lose importance over time relative to school, peer, and other factors.

4. Considerations for Special Populations

Before reflecting on the implications of research on risk and protective factors for prevention programs, it is important to consider the extent to which findings remain valid across special populations. Following, we summarize findings on the influences of race or ethnicity and urban-rural residence on substance abuse.

Race and Ethnicity. Kumpfer and Alvarado (1995) note that ethnicity per se has not been found to be an inherent risk factor for drug use in youth, but that differential family acculturation and role reversal (including the loss of parental control by immigrant parents who are less acculturated than their adolescent children) have been established as correlates of substance use. Kumpfer and Alvarado also note that researchers have had difficulty confirming the hypothesized protective effect of cultural identification or pride on substance use, but they add that youth with multicultural competencies appear to be at lower risk. Noting that more than half the children living in poverty are members of ethnic minorities, these researchers conclude that substance abuse in ethnic families may be related less to ethnicity and more to socioeconomic conditions influencing these families.

Catalano et al. (1992) review the literature on family predictors of substance use, comparing findings for the general population with findings for three ethnic groups (black, white, and Asian); they also examine rates of substance use initiation in a sample of urban fifth-grade students, exploring ethnic similarities and differences in predictors. These researchers found significant ethnic differences in patterns of substance use initiation, as well as in family management practices,

involvement in family activity, parental disapproval of children's drinking, and family structure. From their analyses, Catalano et al. conclude that family characteristics and processes may not exert the same influences across racial or ethnic groups. Their findings lend support to the importance of cultural relevance in prevention programs.

Urban-Rural Differences. Oetting et al. (1997) note that rural and urban America differ in many ways but that drug use is now a common phenomenon throughout the country. These researchers found that, while at one time rural children and adolescents appeared to be protected from drug use, the prevalence of drug use is now fairly constant across communities, regardless of population density and proximity to urban centers. They conclude that the factors important in understanding drug abuse among rural youth are similar to those for their urban counterparts but add that more research is needed to understand the influences of rural communities on substance abuse.

B. OPERATIONALIZING A RISK-RESILIENCY FRAMEWORK

The scientific evidence on risk and resilience provides a framework for prevention, helping program designers and evaluators develop and test effective interventions. In this section, we outline science-based principles for preventive efforts that focus on families with young children.

1. Science-Based Principles for Prevention Efforts

From the evidence discussed, substance abuse prevention researchers have distilled important principles to guide prevention efforts, including those focused on the period of early childhood. Specifically, early childhood prevention programs should:

- ***Employ diverse strategies, targeting multiple risk factors across domains.*** As was noted, risks may be present in several domains. The presence of multiple factors and a greater length of exposure to risk factors also appear to exacerbate risk. Therefore, available evidence suggests that multicomponent prevention strategies focused on

reducing multiple risk factors across domains may yield larger and more enduring effects than interventions targeting single factors or a single domain.

- ***Reduce risk while simultaneously bolstering resilience.*** Individual, family, and community risk and protective factors interact to produce desired or undesired outcomes. Moreover, some risk factors (for instance, excessively punitive disciplining) can be modified, while others (a family history of alcoholism, for example) cannot. Therefore, interventions that focus simultaneously on reducing risk and on enhancing protective factors to mediate or moderate the effects of exposure to risk hold great promise.

- ***Tailor interventions developmentally.*** Different risk factors are salient at different periods of development; therefore, it is important to adjust prevention efforts based on the developmental stage of their targets. Since family must be considered the principal influence on young children's vulnerability and/or resilience to substance abuse, early preventive interventions should target explicitly family predictors of later drug abuse.

- ***Give priority to families highest at risk and ensure that programs are of sufficient intensity and duration.*** The accumulation of risk factors in early childhood can lead to a variety of physical and mental health problems throughout the life span. Intervening early offers the potential to reach children and families before risk factors become well established. Prevention programs targeting families with long-term, multiple problems are more likely to succeed if they are intensive, comprehensive, and ongoing.

- ***Implement programs that are tailored to local needs and culturally sensitive.*** To be most effective, prevention programs must employ the best science-based strategies and match these to assessed needs in the target population. Botvin (1997) also found that, while generic curricula can be used effectively with multiethnic populations, culturally adapted curricula can strengthen their preventive effects.

2. Why Free to Grow Is State-of-the-Art Prevention

When the Foundation launched Free to Grow, the initiative was to be guided by three principles: (1) begin early (with young children, rather than adolescents), (2) target *both* family and community environments (not just the child or the child and his or her family), and (3) focus on high-risk populations.

In Chapter I, we described briefly the five Free to Grow substance abuse prevention models. These models employ a variety of prevention strategies, ranging from educational activities for parents to the promotion and support of collective action to improve local conditions. The extent

to which these strategies have been evaluated rigorously--either alone or in combination--for their substance abuse preventive effects varies.[1] As a program concept, however, Free to Grow clearly represents a cutting-edge application of the research on risk and protective factors. In particular, three features set this initiative apart from current prevention efforts:

1. Free to Grow seeks to leverage and enhance the preventive effects of a comprehensive early childhood education program: Head Start. Furthermore, the targets for the initiative are not the Head Start children, but rather the families of these children, other significant adults in their lives, and the neighborhoods of these economically disadvantaged preschoolers. In this manner, Free to Grow acknowledges the complex ways in which individual, family, and community variables interact to influence the developing child.

2. Free to Grow is not a curricular intervention; instead, it defines prevention in the broadest possible sense. The Foundation gave Free to Grow grantees the flexibility to define the needs of the families and communities they served. The end result was five models designed to address risk and enhance protective factors comprehensively at the family and community levels and tailored to specific, identified needs and resources within these domains.

3. Most Free to Grow grantees sought to identify Head Start families at higher risk of developing substance abuse or related problems. At the same time, Free to Grow models were developed and pilot-tested in high-risk communities, where substance abuse problems are easily recognized and have a clear, undeniable impact on the daily lives of all young children and their families. Thus, Free to Grow offers the potential to reach those who can benefit most directly from prevention and early intervention.

[1]We did not conduct a rigorous literature review on the research evidence on prevention strategies. However, we did gather pertinent information on recent evaluations of programs or prevention strategies that resemble Free to Grow efforts.

III. THE HEAD START CONTEXT FOR FREE TO GROW

To better understand how the Head Start program context contributed to the experiences of Free to Grow grantees, we undertook a special study of Head Start. We examined the structure and capabilities of the program, characteristics of the population and communities served, and current program priorities. In discussions with Head Start officials in the Free to Grow sites, we explored the challenges and rewards of conducting substance abuse prevention within Head Start, as well as how programs in Free to Grow sites compared to other Head Start programs.

Information was gathered primarily through interviews by telephone with Head Start program directors (in Free to Grow and other sites), officials from the regional offices of the Administration for Children and Families (ACF), and officials from selected federal agencies concerned with child-focused substance abuse prevention.[1] In addition, the second round of site visits to the Free to Grow grantees (spring 1999) included an intensive look at the role of the Head Start context in the process of Free to Grow integration. Understanding how attributes of the host Head Start programs and their grantee agencies facilitated (or hindered) successful integration of Free to Grow helped us to anticipate how the process might unfold if replication were to be attempted in new agencies. Additional information was gathered from Head Start program information reports (PIR data), Head Start documents on the implementation of program performance measures and revised performance standards, recent legislation reauthorizing the Head Start program, and preliminary findings from the Head Start-sponsored Family and Child Experiences Survey (FACES). This chapter provides

[1]The other federal agencies included the Substance Abuse and Mental Health Services Administration (SAMHSA), specifically the program officer for Starting Early Starting Smart (SESS), and the National Institute on Drug Abuse. Since fall 1997, the Head Start Bureau has been collaborating with SAMHSA for implementation of SESS, a substance abuse and mental health initiative. SESS programs target children ages 0 to 7 and their families and are housed within either primary health care or early childhood education settings, including Head Start.

an overview of the national Head Start program and the characteristics of the Free to Grow Head Start programs.

A. ATTRIBUTES OF THE NATIONAL HEAD START PROGRAM

Head Start is a federally funded program that provides comprehensive developmental services for low-income, preschool children and social services for their families. The program is administered by the Head Start Bureau at the Administration on Children, Youth and Families (ACYF) of the ACF in the U.S. Department of Health and Human Services (DHHS). Since its creation in 1965, three important principles have guided the program:

1. ***Comprehensive Services.*** Comprehensive and individualized services promote the development and social competence of children and their families.

2. ***Family Focus.*** Services should be centered on the individual needs of families, and parents should be encouraged to participate in all aspects of the program.

3. ***Community Partnerships.*** Programs should focus on the concerns of each unique community and should create linkages and partnerships with other service providers and leaders in the community.

In fiscal year 1998, Head Start served approximately 822,000 low-income children and families through a national network of more than 2,000 grantees and delegate agencies (Head Start Bureau 1999; and U.S. Department of Health and Human Services 1996). Over its almost 35-year history, the program has served more than 17 million children and their families.

1. Common Program Features

Head Start programs provide a range of activities and services designed to promote the intellectual, physical, social, and emotional development of children in the context of their individual families, communities, and cultures. Every child is exposed to a variety of learning experiences

through classroom-based, home-based, combination (that is, of center- and home-based services), or locally designed options. In addition, all children are involved in a comprehensive health program, which includes medical, dental, nutritional, and mental health services. To ensure that each child receives adequate and relevant services, Head Start also makes cultural competence and sensitivity an explicit goal for service delivery.

Head Start also stresses the importance of parents as partners for the healthy development of children by encouraging their involvement in the children's education, program planning, and operating activities. Many Head Start parents serve as members of policy councils or committees and, through these, have a voice in administrative and managerial decisions. One of the primary goals of Head Start is to help "strengthen the skills of parents to better nurture and provide for their children" (Head Start Bureau 1999). Participation in classes and workshops on child development, along with staff visits to the home, enable parents to learn about the needs of their children and about educational activities that can take place at home.

Throughout its 35-year history, Head Start has maintained high standards of excellence and a commitment to continuous quality improvement. The program's innovative spirit is reflected in the fact that DHHS and Congress have continually made investments to introduce new initiatives or increase the scope and capacity of Head Start services. For example, the 1994 reauthorization of the Head Start Act established a major new program effort called Early Head Start (EHS). Recognizing the powerful research evidence on the critical importance of the period from birth to age 3 for the healthy growth and development of children, the EHS program seeks to expand the benefits of Head Start to low-income families with children under the age of 3 and pregnant women.[2]

[2]In fiscal year 1997, $159 million was used to support 173 EHS projects in all 50 states, the District of Columbia, and Puerto Rico; by 1999, more than 500 EHS grantees had been funded.

Detailed program performance standards have played a central role in the Head Start program since the 1970s. In 1994, Head Start collaborated with early childhood program practitioners to review, update, and expand the program's performance standards.[3] The resulting Revised Head Start Program Performance Standards were published for comment in November 1996 and became effective on January 1, 1998. These standards have (1) provided a uniform definition of quality for the community-based organizations that administer Head Start, (2) served as a training guide for staff and parents on the key elements of quality, (3) articulated a vision for service delivery to young children and families, and (4) provided the regulatory structure to monitor and enforce quality services in Head Start.

Several support mechanisms help ensure that the organizations administering Head Start programs have the resources to meet these high standards. An integral part of the national program structure, a national training and technical assistance (T/TA) network comprised of regional Quality Improvement Centers (QICs), a National T/TA Resource Center (NRC), and a Head Start Publications Management Center, among other resources, provides local Head Start grantees with continuous support. Supplementing these national T/TA resources, "Quality Improvement Funds" were appropriated in the Head Start Reauthorization Act of 1994. From 1992 to 1997, Head Start programs across the country were competitively awarded more than $567 million to renovate facilities, hire additional staff, and make other important investments. Additional quality improvement resources were set aside in the 1998 reauthorization of the Head Start Act.

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[3]This review--the first revision of Head Start's Program Performance Standards in more than 20 years--was prompted by findings of the Advisory Committee on Head Start Quality and Expansion. In its December 1993 report, *Creating a 21st Century Head Start*, this committee recommended that program standards be reviewed and revised to reflect (1) the changing nature of the Head Start population, (2) the evolution of best practices, (3) program experience with the existing standards, and (4) pending program expansion (U.S. Department of Health and Human Services Federal Register 1999).

Head Start services are administered through grantees and delegate agencies that include school systems, community action agencies, government agencies, and other types of organizations (Table III.1).[4] Although the average program enrollment is approximately 450 children, programs range dramatically in size, with some serving fewer than 20 children and others serving more than 6,000 children (Table III.1). Despite this diversity in program size and the mode of service delivery, a complete set of services is provided by all Head Start programs as specified by the revised program performance standards.

2. Characteristics of Communities and Families Served

Head Start programs operate in all 50 states, the District of Columbia, Puerto Rico, and the U.S. territories and collectively serve an extremely diverse group of families and their children. Head Start children come from a wide range of ethnic backgrounds, with more than 20 percent of the children in 1997 speaking a primary language other than English in their homes. During the 1997-1998 program year, Head Start programs also reported that almost 55 percent of enrolled children lived in one-parent households, and almost 13 percent of their enrollment consisted of children with disabilities (Table III.2).

[4]Federal grants for Head Start programs are awarded to local public or private nonprofit agencies by the 10 ACF regional offices and the Head Start Bureau's American Indian and migrant program branches. Some programs are administered through an arrangement where the grantee organization enters into agreements with other agencies to operate the program. In this arrangement, the "delegate agencies" operate the program with oversight and other direction provided by the "grantee agencies."

TABLE III.1

HEAD START PROGRAM CHARACTERISTICS

		Grantee and Delegate Agencies[a] (Percent Distribution)
Agency Type		
Community action agencies		32.5
Nonprofits (public or private)		19.1
School systems		35.8
Government agencies		6.5
Indian tribes		6.0
Number of Children Enrolled		
Fewer than 100		16.2
100 to 249		29.4
250 to 499		28.3
500 to 999		16.5
1,000 or more		9.6
Average Number of Children Enrolled:	441.1	
Estimated Average Class Size:	24.0	

SOURCE: Head Start Annual Program Information Report (1997-1998).

[a]Data pertain to grantees and delegates who directly operate programs.

TABLE III.2

CHARACTERISTICS OF CHILDREN AND FAMILIES SERVED BY HEAD START

	Grantee and Delegate Agencies[a]
Characteristics of Children	
Distribution of Children by Ethnicity	
American Indian	3.4
Asian	2.1
White	30.9
Black or African American	36.1
Hispanic	26.7
Native Hawaiian	0.8
Distribution of Children by Dominant Language	
English	77.2
Spanish	19.1
Native American, Asian, Other	3.7
Percent of Children Enrolled Medicaid or EPSDT	65.0
Percent of Children with Disabilities[b]	12.6
Percent of Children with Emotional or Behavioral Disorders[c]	4.2
Characteristics of Families	
Distribution of Families by Family Type	
Two parent	40.3
One parent	54.6
Other	5.1
Distribution of Families by Employment of Head of Household	
Full-time	45.9
Part-time	16.4
Unemployed	37.8
Distribution of Families by TANF Receipt	
Less than 25	31.9
25 to 50	40.2
50 to 75	20.9
75 to 100	6.9
Percent of Families Receiving TANF	38.3
Percent of Families Needing Additional Community Services[d]	61.3
Percent of Families with Additional Service Needs[e]	
Emergency/Crisis Assistance	43.2
Mental Health Counseling	22.5
Education, Literacy, or Employment Training	39.7

SOURCE: Head Start Annual Program Information Report (1997-1998)

[a] Data pertain to grantees and delegates who directly operate programs.
[b] Data pertain to children determined by a multidisciplinary team to have a disability.
[c] Data pertain to children whose primary disability is an emotional or behavioral disorder.
[d] Data pertain to families who were identified as needing additional services at any time during the operating period.
[e] Data pertain to families needing additional community services. Note that families may need more than one type of service.

Within this diversity, all children served by Head Start live in economically disadvantaged households.[5] During the 1997-1998 program year, the heads of household in about 38 percent of Head Start families received Temporary Assistance for Needy Families (TANF); more than half were unemployed or employed only part-time. In addition, nearly two-thirds of Head Start children were enrolled in Medicaid, qualifying for early and periodic screening, diagnosis, and treatment (EPSDT) services for medical and dental care. Moreover, Head Start programs reported that more than half of their families needed additional community services, such as emergency or crisis assistance (in such areas as food, housing, clothing, and transportation), mental health intervention (including substance abuse prevention and treatment services), and education or employment training (Table III.2).

Although lack of definitive data prevents an accurate estimate of the prevalence of substance abuse problems and related risk factors among Head Start families and communities, a sizable portion do live in neighborhoods with concentrated poverty, limited economic opportunities, and ready availability of alcohol and other drugs. Nearly 2,400 primary parents and caregivers were interviewed through the FACES survey (a study of a nationally representative sample of Head Start programs, staff, parents, and children). Of these, approximately 28 percent reported witnessing nonviolent crimes (such as drug dealing and theft) in their neighborhood within the past year, and nearly 30 percent reported seeing or hearing violent crimes in their neighborhood within that same time frame (Zill et al. 1998).[6] Moreover, information collected during Free to Grow site visits and

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[5]To qualify for Head Start services, families must meet established low-income guidelines. The Family Income Guidelines published yearly in the *Federal Register* are used to determine Head Start eligibility for low-income families. While the majority of Head Start families have incomes below the poverty line, the Head Start Act permits families with incomes above the poverty line to be served by the program, so long as the total does not exceed 10 percent of enrollment.

[6]As the initial step in a longitudinal study to assess the performance of the Head Start program, (continued...)

context study interviews confirms that Head Start serves communities with high levels of risk factors associated with the use and abuse of drugs.

Community Voices: Needs of Head Start Families and Communities That Relate to Substance Abuse

The prevalence of specific (community and family) risk factors . . . will vary from program to program. Generally speaking, Head Start's service population is not markedly different from the general population. Family stress, (inadequate) access to needed services, lack of neighborhood cohesion, family history of alcoholism, and drug use are all problems that exist among Head Start families. -- Head Start Director

The availability of drugs and the prevalence of substance abuse problems is very high in the communities served by some of our Head Start delegates. These are issues that they worry and often talk about, but there is almost a deadening of their urgency. These problems are so severe that, after a while, they become accepted as the norm in their day-to-day work. In recent years, [our delegates'] attention has also shifted a bit away from substance abuse problems and more to their symptoms--issues like community violence, inadequate housing, or child neglect--or the reasons why these problems exist--issues like family stress, unemployment, and lack of child care. Substance abuse prevention is still perceived as working exclusively with people with alcohol or drug problems. --Head Start Director

To ensure that Head Start programs make available relevant and appropriate services to families in high-risk communities, the revised performance standards emphasize the importance of identifying family and community needs. This important objective is supported through the use of family partnership agreements and comprehensive community assessments.

First, Head Start staff and families work together to develop Family Partnership Agreements (FPAs) that define family goals and service needs. Head Start programs use the FPAs to guide their work with families and other community organizations, to ensure that families receive services such as emergency assistance with food and housing, opportunities for continued education and training, employment services, and parent education on and counseling for issues such as substance abuse and child abuse and neglect.

Second, Head Start programs are required to conduct a comprehensive community assessment every three years, with yearly updates, to determine community demographics, the number of eligible

[6](...continued)
ACYF contracted with Westat, Ellsworth Associates, Abt Associates, and the CDM Group to conduct the 1997 field test of FACES.

children, the needs of eligible children, and other resources available in the community. The programs are then required to develop explicit goals and objectives to tailor their services to be responsive to these needs. These assessments help Head Start programs better understand the problems facing the families and the communities they serve.

3. Head Start Services and Collaborations

Head Start strives to offer a set of comprehensive services to satisfy the diverse needs of Head Start families and communities. All grantees provide preschool education designed to stimulate children's intellectual and emotional growth. Head Start children also receive important health services such as immunizations; medical, dental, and mental health services; and nutrition to ensure their physical and mental well-being. Parents are given opportunities to contribute to program decisions through policy councils and are encouraged to participate in child development workshops and adult education classes.

Despite these efforts, Head Start recognizes that, alone, it cannot meet the needs of the families it serves. Thus, Head Start has established a history of partnering with public agencies and other community resources, to enhance families' access to essential services. Reflecting the need to support the educational success of participating children, the most prominent Head Start partner is public elementary schools; these collaboration efforts center on easing the transition of Head Start children from preschool to kindergarten. In addition, Head Start programs collaborate extensively with public health and education departments to secure needed services for participating children. Local schools and other community agencies often are major partners in helping children with disabilities. Other Head Start partnerships facilitate service coordination, including referrals and interventions to meet family needs for transportation, emergency housing assistance, TANF and other public assistance, child protective services, services for domestic violence victims, mental

health counseling, and substance abuse treatment. Head Start's community collaborators frequently help make available information or educational sessions for parents on a wide range of practical topics, such as child development and disciplining, family communication, health and nutrition, budgeting, and stress management. As appropriate, parents may also be linked to direct services from these same resources.

When given special resources, Head Start programs have demonstrated the capacity to expand the scope of their collaborations beyond service coordination. Most notably, in the 1990s, Head Start implemented three national initiatives that included a focus on substance abuse: (1) the Family Service Center Demonstration, (2) the Substance Abuse Initiative, and (3) the Comprehensive Child Development Program. Each initiative aimed to improve service integration and enhance collaborations with community organizations in areas of special needs, including substance abuse prevention, identification, and treatment.

4. Head Start Staff and Training

Local Head Start grantees employ a multifaceted staff to deliver a wide range of services (Table III.3). As required by the revised performance standards, each center-based or combination grantee must staff a teacher and a teacher aide or two teachers in every classroom. The primary responsibilities of these classroom staff are to plan and implement learning activities for the children and to help encourage parents to be their child's primary teacher. In home-based and combination programs, home visitors work with an average of 10 to 12 families (a maximum of 12 families) to complete their FPA, provide referral services, and coordinate socialization activities with other children and families.

TABLE III.3

HEAD START STAFF CHARACTERISTICS

	Grantee and Delegate Agencies[a]
Early Childhood Staff	
Teachers and Family Child Care Providers	
Average number on staff [b]	20.3
Average number hired during year due to turnover [c]	3.2
Teacher Aides	
Average number on staff [b]	21.0
Average number hired during year due to turnover [c]	5.0
Home Visitors	
Average number on staff [b]	6.3
Supportive Staff	
Average Ratio of Families to Family Service Workers	50.7
Parent Involvement Services	
Agencies with expert on staff (percentage)	69.9
Average years in position[d]	6.5
Family and Community Partnership Services	
Agencies with expert on staff (percentage)	75.6
Average years in position[d]	6.2
Health Services	
Agencies with expert on staff (percentage)	84.7
Average years in position[d]	6.6
Percent of Agencies with a Given Type of Mental Health Professional	
None	1.2
Psychiatrists	27.8
Psychologists	67.5
Psychiatric nurses	3.9
Social workers	50.5
Marriage or family therapist	27.2
Distribution of Agencies by Hours per Week Mental Health Professional Spends at Center (Percentages)	
More than 20	19.5
6 to 20	28.3
Fewer than 6	18.9
On call	33.2
Average Percentage of Staff that Are/Were Head Start Parents	30.6

SOURCE: Head Start Annual Program Information Report (1997-1998)

[a]Data pertain to grantees and delegates who directly operate programs.
[b]Data pertain to grantees who reported having staff of this kind.
[c]Data pertain to grantees who reported having hired some staff of this kind during the program year due to turnover.
[d]Data pertain to grantees with expert on staff.

In addition to these educators, most centers employ a range of other positions. Family service workers help families complete their FPA, develop family advocacy, coordinate outside services when needed, and arrange referrals. On average, programs employ one family service worker for every 50 families. The great majority of programs also employ experts in the specialized fields of health, parent involvement, and family and community partnership service. More than 98 percent of grantees staff at least one mental health professional as well.

Volunteers are an important part of Head Start. Programs encourage and use as many community volunteers as possible in their service delivery. Parents and grandparents of Head Start children, retired people, high school and college students, and other individuals assist with indoor creative play, transportation, parent education, renovation of centers, recruiting and instructing other volunteers, and other activities.

Several staffing characteristics must be noted when exploring Head Start as a context for Free to Grow. Like many other early childhood education programs, Head Start struggles with relatively high staff turnover among frontline staff. In fiscal year 1997-1998, the average program had a turnover of nearly 16 percent among teachers and 24 percent among teacher aides (Table III.3). The availability and qualifications of Head Start's mental health professionals can vary widely across programs. Though an important resource, most mental health staff are not full-time employees; in fact, a majority spend fewer than 20 hours per week at Head Start centers (Table III.3). In addition, it seems that the level of training of mental health experts is quite variable, ranging from a bachelor's degree in social work to a doctoral degree in psychiatry.

It is also important to acknowledge that almost one-third of all Head Start staff--primarily early childhood education staff--are former Head Start parents (Table III.3). Grantees make a significant effort to enable qualified and motivated parents to obtain jobs at the Head Start centers. Even though volunteers and parents bring many advantages, many enter their positions with little or no formal

training in early childhood education, social work, or crisis management. Similarly, many volunteers do not have previous experience or formal training related to providing services to low-income children and families.

Head Start provides continuous training to staff at all levels and to volunteers. As specified in the revised performance standards, programs are required to develop a structured system for staff training and development that allows staff to continue their academic education whenever possible. Notably, Head Start created the Child Development Associate (CDA) credentialing program, which gives professional and nonprofessional employees the opportunity to pursue certification in early childhood education while working in Head Start. In fact, all EHS and Head Start staff working with infants, toddlers, and preschoolers are required to obtain a CDA or equivalent credential within six months of hire. According to the 1997 Head Start Program Information Report, approximately 90 percent of all Head Start teachers interviewed had early-childhood credentials (Zill et al. 1998). Head Start also uses the regional QIC network to provide T/TA support to local grantees; QICs provide on-site technical assistance, as well as telephone consultations, training conferences and seminars, and a range of additional services.[7]

5. Current Program Priorities and Future Directions

As Head Start moves into the 21st century, the program has reaffirmed its commitment to three important goals: expansion, quality, and community partnerships. These priorities are confirmed in the 1998 reauthorization of the Head Start Act and the Revised Head Start Program Performance Standards through dedicated funds, new initiatives, and a continued commitment to excellence.

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[7]QICs assist Head Start regional offices in planning and implementing annual grantee conferences; providing orientation and training workshops to new program directors and component coordinators; helping local grantees plan for staff development and training; and providing intensive on-site technical assistance to individual programs that have special needs, initiatives, or problems. QICs also help grantees plan for staff development and training.

Expansion. Since its creation in 1965, the Head Start program has expanded dramatically. Funding for Head Start grew from $2.2 billion in fiscal year 1992 to $3.6 billion in fiscal year 1997, an increase of more than 50 percent. These additional funds have allowed Head Start to serve more children and families, enhance the quality of its services, launch the new EHS initiative for infants and toddlers, and improve its research. Head Start funding for fiscal year 2000 totals $5.3 billion. Moreover, President Clinton has committed his administration to future funding increases with the goal of serving 1 million children in Head Start by the year 2002.

Quality. Implemented in 1998, the Revised Head Start Program Performance Standards "reflect a combination of sound practice, research, and a focus on quality in working to enhance young children's development" (Head Start Bureau 1999). The new standards stress the need to correct program deficiencies and help programs better understand and address the needs of the families and communities they serve. Using "Quality Improvement" funds, Head Start programs have been able to increase staff training and salaries, purchase insurance to allow expansion of the program, hire additional staff to reduce child-staff ratios, and improve coordination with other service providers. Funds dedicated for improved "Training and Technical Assistance" helped programs encourage professional development, allow for program expansion, respond to local needs, and work toward full-working-day and full-calendar-year programs.

Community Partnerships. The Revised Performance Standards and Head Start Act of 1994 also focus on the importance of collaboration and partnership. Head Start programs are now required to play a larger role in the community as advocates for the needs of young children from low-income families. They must take steps to develop ongoing relationships with health care, mental health, and nutritional service providers, child care providers, child protective services, local elementary schools, family preservation and support services, and organizations that serve children with disabilities.

6. Opportunities for Substance Abuse Prevention Within Head Start

The Foundation recognized the potential benefits of designing the Free to Grow program to build on the strengths of Head Start. Head Start is an early childhood program that reaches a broad base of families at risk for substance abuse and related problems. Head Start has also made an ongoing commitment to build staff and program capacity to meet the changing needs of its children and families, which can facilitate the incorporation of new strategies such as Free to Grow. Collaborations with a wide range of community resources allow local programs to provide a comprehensive set of services for Head Start families and communities. These efforts exhibit Head Start's innovative spirit, commitment to continuous quality improvement, and dedication to providing effective, efficient, and relevant services to low-income children and families. Nevertheless, the diversity of individual Head Start programs makes it difficult to generalize about the types of expertise and past experiences that Free to Grow may build on. Therefore, it is important to examine the characteristics of Free to Grow Head Start programs. We turn to these in the following section.

B. CHARACTERISTICS OF THE FREE TO GROW HEAD START PROGRAMS

All the Free to Grow grantees, with the exception of Fort George (which is a Head Start delegate agency), are also Head Start grantees, which gives them the flexibility to think creatively about service enhancements, staffing, and other considerations to develop, pilot-test, and incorporate Free to Grow strategies into ongoing Head Start operations. In size, the Free to Grow Head Start programs range from approximately 350 children (Fort George) to almost 3,000 (Audubon). The

TABLE III.4

CHARACTERISTICS OF THE PHASE II FREE TO GROW GRANTEES AND THEIR HEAD START PROGRAMS

Program Characteristic	Compton, California	Colorado Springs, Colorado	Owensboro, Kentucky	New York, New York	Canovanas, Puerto Rico
Program Structure	Grantee agency	Grantee agency	Grantee agency	Delegate agency	Grantee agency
	Center-based, half-day	Center-based, half-day (full day every other day for Free to Grow)	Center-based, half-day	Center-based, half-day	Home-based (80 percent), center-based, combined options, and family child care
	Medically fragile program for drug/alcohol-exposed children (both center- and home-based services)				
Size	1,774 children	831 children	2,740 children	346 children	584 children
	86 classes in 24 sites	34 classrooms in 17 elementary schools; 6 school districts	59 centers in 16 counties	11 classrooms in two sites	17 communities
Population Characteristics	48 percent Black 6 percent Other	60 percent White 20 percent Black	76 percent White 23 percent Black 1 percent Other	98 percent Hispanic (all races)	100 percent Hispanic (all races)
	46 percent Hispanic (all races)	19 percent Hispanic (all races)			
Services and/or Program Components	Education Health Nutrition Mental Health Social Services Parent Involvement Special Services Training Facilities (transportation)	Education Family Services Health/Nutrition (including mental health) Transportation Recruitment and Enrollment Transition Support Special Needs	Education Health and Safety Nutrition Mental Health Disability Services Family Advocate Case Management Community Development Parent/Family Partnerships Special Projects	Education Health and Nutrition Social Services Parent Involvement Program Adult Education	Education Social Service Health Mental Health Nutrition Family and Community Partnerships Specialized Services Unit Training and Technical Services Unit Design and Management Unit

SOURCE: Data abstracted from Free To Grow implementation grant applications, updated as applicable during evaluation site visits and related follow-up activities. Data are for the 1998-1999 program year unless otherwise indicated.

New York grantee (Fort George) is average size for a Head Start delegate agency, although it has the smallest enrollment among the Free to Grow sites. Head Start programs in the other four sites are larger than most Head Start or early childhood education programs, suggesting that they are relatively complex, sophisticated organizations.

While their programs differ, all the Free to Grow grantees made available through their Head Start programs a range of services extending beyond education and health services for children. All grantees made available family social services, services for children with special needs, and parent involvement programs. Also, with the exception of Fort George, all grantees made directly available mental health and other specialized services to Head Start families.[8] The Free to Grow grantees also had a wealth of experience with special demonstrations and initiatives that supported their work for Free to Grow. CPCD in Colorado was the host of a Head Start Substance Abuse Prevention (SAP) demonstration project. Two grantees--Aspira in Puerto Rico and Drew in California--were Head Start Family Services Center demonstration sites, with experience using case management to address problems such as illiteracy, unemployment, alcoholism, and drug addiction. Drew was also involved with the Council on Perinatal Substance Abuse of Los Angeles County and sponsored public forums on perinatal substance abuse issues.

[8]At Fort George, mental health and other specialized services had to be accessed through the New York Head Start super-grantee.

IV. FREE TO GROW INTERVENTIONS AND IMPLEMENTATION

Specific features of the interventions and their implementation varied across the five Free to Grow projects, although there were common themes. All the projects set out to build on local Head Start program strengths, fill gaps in the spectrum of available services, and use methods tailored to local family and community circumstances. To varying degrees, they did this by enhancing the complement of Head Start services available for high-risk families, supporting grassroots community organizing and action, and cultivating partnerships within their community. This chapter describes the projects as they looked at the end of the initiative and summarizes important aspects of their implementation experience, including their family- and community-focused interventions, partnerships with other organizations, expansion into new areas, integration of the models into Head Start, and plans for sustaining Free to Grow in the future. The discussion in this chapter is descriptive. The following chapter provides an assessment of the strength of implementation along various dimensions and insights into the factors that influence success.

A. PROJECT OVERSIGHT AND STAFFING STRUCTURE

Although the Free to Grow projects were overseen and supported by the Head Start director and management team, the level of oversight and guidance provided by Head Start varied widely by site. In both Kentucky and Puerto Rico, the directors played an important role not only in designing the interventions, but also in providing active guidance and support to project staff. In most projects--all but New York--a full-time Free to Grow project director coordinated the ongoing implementation of the project. The projects also varied in the extent to which they used traditional Head Start staff, created new positions, and/or relied on consultants or contractors (see Table IV.1). In two projects--Kentucky and Puerto Rico--existing Head Start staff took on family-strengthening

TABLE IV.1

FREE TO GROW STAFFING, BY SITE

California	Colorado	Kentucky	New York	Puerto Rico
Project Coordination and Management				
FTG Project Coordinator	FTG Project Coordinator	Head Start Family and Community Team Manager	— (Phase I only)	FTG Project Director
Head Start Staff Conducting Free to Grow Work				
Not Applicable[1]	None	Family Development Specialist Family Advocates Program Assistants	Education Coordinators Family Service Coordinators Social Service Workers	Lead Family Social Worker Family Social Workers Psychologist (Part-Time)
New Positions Added for Free to Grow				
Community Organizers Parent Advocates (Paraprofessionals)	Neighborhood Family Advocates Outreach workers (Paraprofessionals)	Family and Community Specialist Community Development Specialist Community Advocates	None	Community Development Specialist Volunteer Mentor Families
Others Involved in Operating Project Interventions				
None	Health Department	None	Specialized Consultants	None

responsibilities while new staff were hired to implement Free to Grow community-strengthening work. New York's project used a combination of Head Start staff and several consultants to operate Free to Grow. The Colorado project created new Free to Grow positions to implement both its family and community work. In addition, both California and Puerto Rico involved parents and other community residents as peer mentors and advocates. Though paid stipends, these individuals

[1]California's Free to Grow project did not offer family-focused interventions.

served primarily as volunteers. In a less formal manner, New York also used volunteer parent leaders to implement its model.

B. FAMILY-STRENGTHENING STRATEGIES

All the projects tailored their family-strengthening components. Three projects--Colorado, Puerto Rico, and Kentucky--introduced individualized, intensive methods for serving higher-risk families. Colorado also expanded families' period of involvement with Head Start by engaging families of children in the pre- and post-Head Start age groups. New York's approach relied solely on education and peer support groups. Table IV.2 provides an overview of Free to Grow family-strengthening strategies, organized as one-on-one versus group-based interventions.

1. One-on-One Services

Family-to-Family Peer Mentoring. Puerto Rico developed a family-to-family peer-mentoring strategy modeled after the traditional "compay" or "compadre" relationship--which, in Spanish, refers to an individual's godparent, mentor, and/or good friend. Family-to-family peer mentoring was expected to help high-risk families develop health-enhancing behaviors by linking them with other families that could serve as positive role models, advocates, and sources of support. Moreover, mentoring constituted a dual intervention in that it helped the mentor families--or compays--to develop new skills and gain self-confidence and experience. The compays were supervised by a Head Start social worker, and services and support were guided by an individualized intervention plan that was reviewed every three months. More traditional case management services complemented the support high-risk families received from their peer mentors.

TABLE IV.2

FREE TO GROW FAMILY-STRENGTHENING STRATEGIES

Colorado	Kentucky	New York	Puerto Rico
ONE-ON-ONE SERVICES			
Information and referral services - Focused on the needs of pre- and post-Head Start children	**Case Management** - While enrolled in Head Start (1 or 2 years) - Low to moderate intensity for most families - High intensity (weekly) for high-risk families		**Family-to-Family peer mentoring and case management** - Minimum of 4 hours per week, for as long as necessary (1-2 years)
Substance abuse treatment - Contract with local health department - On average, 3 hours per week of individual and group therapy, typically for 3 months	**Referrals to substance abuse treatment**		**Referrals to substance abuse treatment** **Individual and family therapy** - 1 hour per week for as long as needed, for family members not usually served by Head Start
CLASSES AND SUPPORT GROUPS			
Parent education - 10 weekly 2-3 hour sessions **ESL classes** - Weekly 2-hour sessions during school year **CPR and first aid** - 6-8 sessions; 8 to 13 hours **Enhanced transition support** - For transition from Head Start to kindergarten - 3 one-hour sessions	**Parent education** Periodic parent training and family enrichment activities	**Oral and cultural history program** - Twice-weekly 2-hour workshops, for 6 months **Women's education and support group** - Weekly 2-hour sessions, for 6 months	**Peer support group** - To ease transition from one-on-one peer mentoring - Twice a month, for as long as needed (1-2 years)

Community Voices: Free to Grow Family-to-Family Peer Mentoring

Sometimes it is more effective to work with families through their peers. (Family peer mentors)--"compays"--are not meant to replace (Head Start social workers). Rather, compays are an additional tool to enhance their effectiveness. Working with compays enables the program to work more intensely with families.
-- Free to Grow staff in Puerto Rico

Both the high-risk families and the compays were carefully screened for the project using structured assessment tools. The compays, well-respected families from the community, were often nominated by Head Start and other local service organizations. Compays were then individually matched with high-risk families. The average duration of peer mentoring was 18 months.

Intensive Case Management. The Kentucky project set into motion an agencywide redesign that introduced more structured case management services for all current Head Start families. Under the new approach, Head Start family advocates were assigned caseloads of about 60 to 65 families, including 3 to 5 high-risk families. Advocates typically met with the high-risk families once each week, often through a home visit. To identify families for intensive services, the project developed and continually refined an instrument and procedures for assessing each family's level of risk.

Substance Abuse Treatment Counseling. In Colorado, the project contracted with the local health department for a substance abuse counseling position dedicated to families in Free to Grow communities. Individual and group outpatient therapy was provided, generally over a period of three to four months. To identify families who might benefit from treatment, the Free to Grow counselor trained community providers, including Free to Grow staff, on how to recognize the signs that an individual might need help and to make referrals and access program services for clients. In Puerto Rico and Kentucky, case management staff referred family members to partner organizations for substance abuse treatment services.

Continuum of Care. The Colorado project used Free to Grow to enhance the continuum of care for Head Start families. Building on case management services, which it already provided to most current Head Start families, the project focused on helping families of children in the pre-Head Start (ages 0 to 3) and post-Head Start (ages 5 to 8) age groups. Most of the families identified had children enrolled in Head Start, in addition to children in the younger and/or older age groups.

2. Education and Support Groups

In New York, education and support groups were the primary vehicle for strengthening families while, in other sites, these activities supplemented individualized services. Through its innovative ***Oral and Cultural History Program***, New York addressed the special acculturation-related issues and needs of its immigrant Hispanic population--aiming to build parents' self-esteem, reduce their isolation, and increase their understanding of and pride in cultural traditions. The program was targeted to all interested Head Start parents. It was developed and implemented by a series of consultants and offered through twice-weekly group sessions throughout the program year. New York's ***Women's Education and Support Group*** gave parents an opportunity to provide each other with emotional support and encouragement and educated them about how to make prevention-oriented changes to improve their lives. Discussions and presentations covered a variety of parenting, family communication, and health-related topics. Complementing these programs, New York also offered a 16-hour program of substance abuse prevention training.

Toward the end of Phase II, the Puerto Rico project formed a peer support group to help parents transition from the intensive peer-mentoring intervention. Families were encouraged to join the compay support group after they met their goals of self-reliance. Colorado's parent classes were designed to fill gaps in existing Head Start and grantee agency services for parents in Free to Grow communities, and Kentucky's parent education activities filled a similar need.

All Head Start programs are required to offer participating children and their families some support to ease the transition from Head Start to kindergarten. As in other programs, the Colorado Head Start transition coordinator is responsible for hundreds of families. Through Free to Grow, staff held two to three special enhanced transition support sessions with parents in Free to Grow communities to provide information about how to advocate for their children during the elementary school years. Staff also provided information on school- and community-based programs.

3. Family-Strengthening Participation Levels

The experience of the pilot projects provides some sense of the number of individuals and families other projects could expect to reach under similar resource and programmatic conditions. Table IV.3 provides data on the number of people or families that participated in different Free to Grow interventions during a year when the interventions were fully operational. In large part, the Free to Grow projects reached or came close to their implementation targets. As one would expect, projects reached fewer people through the more intensive interventions such as case management and peer mentoring than through classes and support groups.

Puerto Rico reached about seven percent of its current Head Start families--all considered high risk--through its peer-mentoring component. This project involved an additional four percent of its families as peer mentors. Although the Puerto Rico project served a total of 69 at-risk families during the five-year pilot period, fewer than its initial goal of 100, the project experienced significant turnover among its Head Start social workers and had to contend with the effects of two major hurricanes. In addition, participation figures were lower than anticipated during the initial project years when screening and assessment procedures were being refined.

TABLE IV.3

ANNUAL FREE TO GROW PARTICIPATION LEVELS
FAMILY-STRENGTHENING STRATEGIES, BY SITE

Colorado	Kentucky	New York	Puerto Rico
TYPES OF FAMILIES TARGETED			
Pre-Head Start Post-Head Start Elementary School	Head Start	Head Start	Head Start Other families
APPROXIMATE ANNUAL PARTICIPATION LEVELS			
Substance abuse treatment 60 individuals (including 15 parents of young children) **Information and referrals** 400 referrals **Parent education** 49 parents **Transition support** 51 parents	**Case management** 41 high-risk (intensive) 588 other (less intensive) **Parent education** 300 parents	**Parent education and support groups** 125 parents	**Peer mentoring and case management** 31 high-risk families and 47 mentor families **Professional counseling** 13 families **Peer support group** 4 families
PERCENT OF CURRENT HEAD START FAMILIES[2]			
Not applicable	100 percent 6-7 percent high-risk	20 to 25 percent	11 percent

Kentucky's ambitious effort to expand case management services agencywide--with intensive services to high-risk families--reached a smaller proportion of high-risk families than expected (between six and seven percent of families, compared to their target of 10 to 15 percent). A major factor contributing to the lower numbers was that the family assessment tool did not work properly, missing many high-risk families. Moreover, Kentucky started using the risk assessment tool

[2]Includes individuals who participated in at least one project strategy.

throughout the agency's 16-county service network (not just the three Free to Grow target areas) prior to working out all the kinks. The expansion put increased demands on Head Start and agency leaders, and problems took longer to fix. On the other hand, Kentucky used Free to Grow to expand case management services to all families enrolled in Head Start, a much more ambitious accomplishment than the project forecast initially.

New York was successful in reaching its expected participation levels. Unlike Puerto Rico and Kentucky, New York did not explicitly target high-risk Head Start families. However, this project successfully involved a broad range of Head Start parents in its education and support groups, involving 20 to 25 percent of its parents each year. The Colorado project fell somewhat short of its implementation targets. Frequent turnover among Free to Grow staff, and the shift to a less intensive information and referral approach, contributed to lower-than-expected participation among families in the pre- and post-Head Start age groups. Colorado encountered the most difficulty engaging pre-Head Start families, in part because families in this group had little time available and/or were engaged in other programs. A substantial number of people (268) from Free to Grow neighborhoods participated in Colorado's enhanced substance abuse treatment component, but only 25 percent of them were parents with young children.

C. COMMUNITY-STRENGTHENING STRATEGIES

Although all the grantees had experience collaborating with parents and with other community service providers, Free to Grow community-strengthening work put Head Start on new terrain. Free to Grow's neighborhood groups brought together a broad range of community members in addition to Head Start parents, including agency/provider officials. Another new dimension was the emphasis on empowering community members to "take ownership" of the group and its agenda. Free to Grow community groups also took on new types of issues, such as safety and crime, drug trafficking, and

improving public spaces. While, in many ways, this work complemented Head Start program priorities (discussed more in Chapter VI), doing it well required a new set of skills.

1. Neighborhood Groups

The five Free to Grow projects each built their community-strengthening strategies around one or more neighborhood or community groups. To varying degrees, the groups provided Head Start parents and other residents the opportunity to develop leadership skills, work collaboratively with community agencies and service providers, and--most important--take actions that would make the community a safer and more protective environment for children. These efforts were intended to set in motion long-lasting and large-scale changes. Common goals included building stronger social networks, helping residents develop leadership and advocacy skills, making public spaces cleaner, reducing crime and violence, reducing the availability of alcohol and drugs, and making community programs and services more responsive to resident needs. Major components of Free to Grow community-strengthening efforts are summarized in Table IV.4 and described below.

Community Voices: Free to Grow Community-Strengthening Work

The community work that Free to Grow entails is very different from what Head Start programs typically do. The objective is no longer to do "for" the community, but rather to build capacity within the community so that residents change their lives and their community themselves, with Head Start as a partner.... Through Free to Grow we have learned that (Head Start's) objective should be to get residents to pool their own resources--their skills and volunteer labor--and complement these with resources available through local organizations.... We are no longer limited by what (Head Start) alone can do. Now, our limits are set by the dreams of local residents.-- FTG administrator in Puerto Rico

Most projects developed three or more neighborhood groups. Some of the groups--most notably in California, New York, and Colorado--were based in elementary schools or Head Start centers. These focused on school- or center-related needs of parents and families. The other groups--in all

TABLE IV.4

FREE TO GROW COMMUNITY-STRENGTHENING WORK

California	Colorado	Kentucky	New York	Puerto Rico
NUMBER AND TYPES OF GROUPS				
1 community association - 35 members on average - parents, other residents, provider and agency reps **5 school- and Head Start-based groups** - 10 members per group on average - Head Start and elementary school parents **1 youth advocate group** - 10 members on average - Youth ages 12 to 22	**2 neighborhood groups** - 25 members per group on average - parents, other residents, provider and agency reps **1 school-based group** - 25 members on average - elementary school parents	**3 neighborhood groups** - 15 members per group on average - Parents, other residents, provider and agency reps	**2 Head Start parent committees** - 25 members per group on average - Head Start parents	**1 community association** - 20 members **1 leaders group** - 35 members **6 neighborhood groups** - 15 members per group on average
OUTREACH AND RECRUITMENT METHODS				
Flyers/newsletters Presentations One-on-one Structured applications	Flyers/newsletters One-on-one	One-on-one Structured assessments	Flyers/newsletters Presentations	Flyers/newsletters Presentations One-on-one Structured assessments
LEADERSHIP TRAINING				
40+ hours structured curricula includes substance abuse prevention training	4 hours varied curricula	30 hours structured curricula; includes substance abuse prevention training	7 hours structured curricula 16 hours of separate training in substance abuse prevention	6 hours structured curricula; includes substance abuse prevention training

sites but New York--involved a broad range of community residents in addition to Head Start and elementary school parents. The neighborhood groups ranged in size, but at any given time they included between 12 and 30 members who attended the meetings regularly. Meetings varied in frequency, but usually were held weekly or every other week. In most of the sites, many group members were active participants over two or more years. The groups were supported by Free to Grow staff and were assisted at times and to varying degrees by consultants and others with more specialized expertise.

a. Outreach and Recruitment

Recruiting parents and other residents for the Free to Grow groups was an ongoing process. Projects used various approaches--including flyers and newsletters, group presentations, one-on-one discussions, and structured applications and assessments--to identify and select prospective leaders. Most projects relied on word-of-mouth as the primary means of "growing" group membership, with current members finding/inviting other interested residents. California, Kentucky, and Puerto Rico all acted selectively in identifying residents with strong leadership skills to help *lead* their groups. Kentucky, however, was the only site that restricted core group *membership* to residents who were identified by program staff as having leadership skills or potential.

The message of strengthening the families and communities of young, vulnerable children seemed to resonate with residents and help draw them together. The slogan of the California project --*Every Child Deserves a Safe Space Somewhere on This Planet*--was particularly effective in engaging residents. Projects found it best to avoid promotional messages that made explicit reference to substance abuse, instead emphasizing children and community improvement. Rather than make the link to substance abuse issues up front, projects discovered that it was best to work in those concepts slowly as residents became familiar with Free to Grow ideas.

b. Leadership Skills Development

Leadership training, typically provided by Free to Grow staff and partners as part of the neighborhood groups, was a crucial building block in preparing parents and other residents to work toward community change. While specifics varied across the projects, the goals of such training were to give parents and other residents the skills they would need to sustain the community work on their own. Training was also used to help group members understand and stay focused on Free to Grow's underlying substance abuse prevention goals. The training varied in structure and intensity, ranging from 4 hours of informal training in Colorado to 30 hours of structured training in Kentucky. Puerto Rico provided ongoing training and technical assistance to resident leaders through a monthly leaders' group. California developed a structured training program to prepare paraprofessional parent advocates to work closely with Free to Grow staff in supporting neighborhood groups. Similarly, in New York, parent leaders received additional training.

Range of Free to Grow Leadership Training Topics

Substance Abuse Prevention
Visioning Community Change
Community Mapping
Relationship Building
Learning About Ourselves and Our Communities
Communication and Leadership Skills
Effective Meetings
Group Facilitation
Designing Issues for Action
Moving Issues to Action

The projects provided training in substance abuse prevention theory in various ways. California, Kentucky, and Puerto Rico incorporated these topics into leadership training for neighborhood group members. Colorado took an indirect approach, training Free to Grow staff with the idea that they would, in turn, help the community groups focus on appropriate risk and protective factors. New York offered a separate 16-hour substance abuse prevention training program but did not offer the training in connection with the work of its groups.

c. Community Assessments

All the projects went through a process to assess community needs and assets. Issues identified through these assessments helped neighborhood group members reach consensus about priorities and develop action plans. In some cases, a "visioning" approach was used, which involved having residents reflect on the current state of the community, describe how they wanted it to be in the future, and then work together to formulate a plan designed to translate that vision into action. All the projects used informal group discussions to identify community needs and shared concerns, and most conducted some type of outreach to gather additional input from residents about their concerns. When possible, the projects consulted existing data sources, for example, statistics on crime and substance abuse. Several projects also participated in a more formal assessment--a survey of local residents known as the "community engagement process"--which they found especially valuable because it involved local residents in all aspects of the data collection and analysis and helped build capacity and support for Free to Grow.

d. Interagency Coordination

While all the projects relied on partners and collaborators to support their community efforts (discussed later), they varied in the extent to which they involved organizations in interagency councils and neighborhood groups. Interagency coordination took several forms, including the use of councils to provide guidance and technical assistance to Free to Grow staff and participants, direct participation by partners and collaborators in the Free to Grow neighborhood groups, and support and assistance in implementing particular initiatives. In Kentucky and Puerto Rico, interagency councils comprising Free to Grow and Head Start staff and other organization representatives met regularly to coordinate service delivery efforts and develop strategies to address community needs. In California, agency representatives participated in the communitywide Free to Grow association.

Although an interagency council was not established in Colorado, partners and collaborators in this site participated more actively in the neighborhood groups, relative to the other sites. The New York project was unable to involve community agencies as it had hoped, which limited its use of collaborative interagency efforts to advance its community work. As the Free to Grow work progressed, Kentucky, Puerto Rico, and Colorado each tried to minimize the direct involvement of partner and collaborator representatives in the neighborhood groups, choosing instead to engage partners and collaborators more as resources to the groups rather than as regular participants.

e. Community Action

Community action, broadly defined here, represents the implementation of activities, initiatives, and campaigns to make communities and families more protective, risk-free environments for children. Efforts at community action targeted various groups, involved a broad set of community actors, and required different levels of program effort. Short-term activities like neighborhood block parties, resource fairs, and clean-up drives helped expose residents to Free to Grow, recruit new group members, and build support for larger-scale advocacy initiatives and community infrastructure improvements. In the order of their intensity, Free to Grow community action efforts are highlighted below.

Stronger Enforcement of Laws and Local Ordinances. Efforts in this area aimed to reduce exposure to drug dealing and the advertising of alcohol and tobacco. In Kentucky, residents focused on advocating for stronger enforcement of laws prohibiting alcohol sales to minors and changes in probation and parole guidelines for convicted drug dealers. In California, the youth advocate group gathered data to make a case for stronger enforcement of a local ordinance governing storefront advertising of alcohol and tobacco products. In New York, parents advocated for stronger enforcement of laws restricting alcohol and tobacco sales to minors.

Community Policing, and Safety and Surveillance. All the projects recognized crime and violence---particularly related to alcohol sales, drug trafficking, and substance abuse--as key resident concerns. Hence, they all worked collaboratively with the police and other law enforcement officials to promote community surveillance and safety improvements and to help restore a sense of order in their communities. Kentucky residents mobilized grassroots support and worked with an influential community foundation to institute a community-policing program. Free to Grow task force members in California worked with the police and city officials to have two elementary schools declared drug-free school zones. In Puerto Rico, the groups worked with the police to establish a Neighborhood Safety Council, which formalized communication lines between residents and the police and actively engaged the police in a variety of neighborhood safety and surveillance initiatives.

Infrastructure Improvements, Neighborhood Cleanups, and Beautification. Most neighborhood groups worked on such improvements as developing playgrounds and safe play spaces, installing street lights in poorly lit areas, adding crosswalks and speed bumps to reduce high-speed traffic in school areas, maintaining or repairing school facilities, and/or controlling sewage and waste. To enhance resident pride in the community, most projects implemented neighborhood cleanup and beautification efforts such as clean-up drives and community sweeps, graffiti removal, and the planting of flowers and trees.

Academic and Recreational Activities. Though not as central as some other project components, all the projects focused to some extent on meeting the needs of local children and youth. Activities in this area promoted awareness of substance abuse prevention, providing after school or summer camp programs and/or organizing tutoring and related academic supports. Through its youth advocate program, California formalized this work by training teens and young adults about substance abuse prevention concepts and asking them to plan and implement social activities and prevention-oriented projects.

Service Enhancements. All the projects worked to enhance available services or improve access to existing services. Several developed resource guides to help connect families with service providers and other community resources. In addition, New York sponsored activities to help immigrants learn more about the naturalization process and other citizenship issues, Puerto Rico sponsored an immunization clinic, and Colorado sponsored clothing and school supply drives. In Puerto Rico, Free to Grow parents and other residents successfully lobbied the Department of Education to reverse a decision that would have closed the local elementary school.

Educational and Social Activities. All the projects sponsored educational and social events to bring residents together and promote a sense of community spirit and pride. These events were especially useful early on in getting residents involved and exposing them to Free to Grow. Common activities included festivals, block parties, health and substance abuse prevention resource fairs, family recognition days, and educational workshops.

2. Community-Strengthening Participation

As intended, the projects engaged an active group of Head Start parents and other residents in neighborhood groups, and leveraged support for their initiatives from other community agencies. At any given time, a project engaged 50 to 90 residents in neighborhood groups. Over the course of the pilot, each project trained between 90 and 130 participants in core leadership. In addition, they involved a substantial segment of the population in their target areas. For example, an estimated 1,400 to 2,900 residents in each site (up to 20 percent of residents) participated in at least one Free to Grow community effort. Relative to the size of its target community, the Puerto Rico project actively involved the most parents and community residents in its neighborhood groups, and it reached more residents than most of the other projects.

The level of participation tells only a small part of the story of the Free to Grow community-strengthening experience. Creating change at the community level does not require participation of large numbers of people, although involving more people may make it more likely that these efforts will be substained. More important than the size of the groups or the number of people attending community activities is the extent to which community efforts produce changes in community-level risk and protective factors (discussed further in Chapters 5 and 6).

D. COMMUNITY PARTNERSHIPS

The design of Free to Grow assumes that no one agency or organization can do this work alone. In all the projects, a variety of community entities served as partners and collaborators to provide important services and support Free to Grow. In particular, they supported efforts to deliver intensive services to families, help educate staff and parents about substance abuse and related issues, improve police patrolling and surveillance in the target areas, and in general provide "top-down" support to facilitate the implementation of "bottom-up" community action efforts.

Table IV.5 summarizes the types of organizations with which each Free to Grow project maintained partnerships and collaborations. Although the projects leveraged support from a broad range of organizations with different areas of expertise, four types of organizations were most important to Free to Grow's prevention efforts:

1. ***Police Departments.*** These agencies offered drug and gang awareness training to staff and participants, enforced drug-free school zones, assisted with implementing neighborhood watch programs, and provided community policing in the target areas.

TABLE IV.5

KEY FREE TO GROW PARTNERS AND COLLABORATORS, BY SITE

Type of Partner/Collaborator	California	Colorado	Kentucky	New York	Puerto Rico
Substance Abuse Organizations	T	T	T	T	T
Police	T	T	T	T	T
Elementary and Other Schools	T	T	T	[a]	T
Family Service Providers and Coalitions		T	T	T	T
Community Center and/or Recreational Organizations		T	T		T
Specialized Consultants	T			T	T
Others	Community College		Community Foundation Churches Housing Authority	District Attorney's Office Immigrant Rights Coalition	Mayor's Office

[a] Early in the Free to Grow project, the elementary school-based SOAR program (Schools Organized to Actively Resist substance abuse) was an important New York partner. However, the relationship weakened over time and by the end of Phase II the local elementary schools and SOAR were no longer considered Free to Grow partners.

2. ***Substance Abuse Organizations.*** These organizations, agencies, and, in some cases, paid consultants conducted training on substance abuse issues for staff and participants and accepted referrals for substance abuse treatment and counseling.

3. ***Elementary Schools.*** As dominant and stable community institution, schools were an important medium through which the projects recruited new members and leveraged support for Free to Grow. Schools provided space for activities, enrichment activities for children and families, and continuity in service provision as children made the transition from Head Start to elementary school.

4. ***Family Service Providers.*** These organizations played an active role in providing services to children, youth, and families as part of Free to Grow efforts.

While the projects built on a culture of cross-agency collaboration that already existed within their Head Start programs and communities, they also needed to develop new partnerships to achieve

Free to Grow's objectives, particularly its community-strengthening objectives. Although most projects were accustomed to working with schools and family service providers, all of them developed new partnerships with local police departments, and most developed new relationships with substance abuse organizations. The focus of even traditional partnerships was also new, as Free to Grow work considered a broader range of family needs and addressed a broader set of issues at the community level. Finally, Free to Grow introduced new ways of working with parents and other community residents, involving them as partners more than simply as people to be served. At times, this new way of "doing business" put Free to Grow grantees and Head Start programs in the position of advocating on behalf of parents and other residents, which required some adjustment in their traditional role.

Partners and collaborators were involved with Free to Grow strategies in a variety of ways and at different levels of effort. By the time the pilot had ended, three major types of roles had emerged:

1. ***Operators*** were active in the ongoing operation of such project components as community policing, substance abuse treatment services, peer mentoring, and parent education. Given their extensive involvement, operating partners (other than the police) often were paid as contractors or consultants for their services.

2. ***Advisers*** guided and supported Free to Grow project staff in one or more of the following ways: providing technical assistance, consultation, or strategic planning assistance; acting as an advocate for the project in the local policy arena; and/or marshaling resources within the community.

3. ***Supporters and contributors*** performed tasks such as training staff and participants around particular topics, accepting referrals for services or programs, providing activities for children and youth, recruiting residents to the neighborhood groups, and donating space for project activities. Supporters did this on a regular basis, with contributors helping out as needed.

These roles evolved as the projects progressed through different stages of the pilot program. During Phase I, partners often played a strategic role, helping shape the model and refine the interventions. As implementation progressed and Head Start staff became more involved, partner roles focused

more on support and or helping implement specific interventions. By the end of the pilot period, partners often assumed a role in sustaining one or more Free to Grow components.

E. CAPACITY-BUILDING VIA TRAINING AND TECHNICAL ASSISTANCE

The Free to Grow grantees needed both up-front and ongoing training and technical assistance to help their staff develop and implement Free to Grow strategies successfully. Over the course of the project, the grantees tapped diverse sources for training and technical assistance, including the initiative's National Program Office (NPO), their own Head Start family services staff, project partners, and contracted consultants. In general, the intensive, ongoing technical assistance offered by the NPO and outside consultants complemented project-led, capacity-building efforts. The extent to which the sites received training and technical assistance varied, depending, in part, on their ability to recognize the need for assistance and their initiative in seeking it out. Overall, projects provided two to three weeks of initial Free to Grow-related training for key staff in the early part of the demonstration; they received an average of 4 to 10 days of technical assistance per year during each of three implementation years (with the level of assistance higher in the first year).

The NPO, housed at the Joseph H. Mailman School of Public Health of Columbia University, along with its corps of expert consultants, worked directly with project and grantee staff at each Free to Grow site. Project monitoring and technical assistance were performed via telephone contacts, periodic site visits, and grantee conferences. Additional site-specific, technical assistance was provided through on-site consultations, as needed and requested. Also, key Free to Grow and Head Start staff participated in semiannual and annual grantee conferences sponsored by the NPO. Typically lasting two to three days, these conferences included workshops on substance abuse prevention, model development, family services, partnership and collaboration, community action, and various other relevant topics. The conferences helped the project staff think strategically about

refinements that could make more effective their Free to Grow model and its implementation. In addition, the conferences offered project staff the opportunity to share their experiences with a national advisory panel and other grantees, to gain insight and learn to from their experiences.

At times, projects found it confusing to sort out the NPO's combined roles of monitoring and technical assistance. For example, it was important for Free to Grow project staff to be clear about implementation problems and challenges in order to benefit from technical assistance; at the same time, however, being candid about problems exposed them to possible monitoring sanctions. Over the course of the pilot period, projects that experienced greater difficulties became somewhat more cautious in seeking technical assistance from the NPO.

Because Free to Grow's family-strengthening strategies were logical extensions of Head Start's ongoing work with families, on the whole, projects were able to draw on expertise inherent in their Head Start programs and grantee agencies. In contrast, the task of building capacity for community-strengthening work among Head Start and Free to Grow staff proved challenging. Developing a Head Start and community infrastructure to support community action required specialized community-organizing and development skills, which were generally lacking in Head Start. Most projects obtained assistance on substance

Key Community-Focused Training and Technical Assistance Topics

Using substance abuse prevention theory to guide program strategies

Cultivating leadership skills among Head Start parents and other residents

Moderating meetings of neighborhood and community groups

Recruiting new leaders and developing wide support for Free to Grow within the community

Assessing community needs (risk and protective factors)

Developing strategic action plans to address needs

Conducting program self-assessments

Cultivating enduring partnerships and collaborations with a variety of organizations, including the police

abuse prevention concepts, leadership development, community organizing, and developing strong partnerships.

F. EXPANSION TO NEW NEIGHBORHOODS AND COMMUNITIES

The Free to Grow projects were expected to expand their model within the pilot area and extend it into additional neighborhoods and communities if feasible. By so doing, important insights were learned about the implications of replicating the Free to Grow models on a wider scale in other Head Start communities. All but one of the projects--New York--expanded its model to serve additional families and develop neighborhood groups in new target areas (see table below).

Full Service Delivery Area. Kentucky implemented the most ambitious expansion plan by offering intensive case management services agencywide across its 16-county service network. Expanding the case management component was part of an agencywide change in family service delivery, designed to develop the capacity of all Head Start family advocates to serve high-risk families. The rapid expansion of case management services, however, made it difficult to focus on improving the new family assessment tools and procedures and to connect the family- and

NATURE OF FREE TO GROW EXPANSION

California	Colorado	Kentucky	New York	Puerto Rico
Neighborhood groups established at two elementary schools and three Head Start centers within the same community	Full expansion to two neighborhoods within same community	Intensive case management services expanded to 15 counties (agencywide) Community groups established in two additional counties	None	Peer mentoring expanded to seven neighborhood sectors Community groups developed and implemented in 13 neighborhood sectors

community-strengthening work in ways that would support the recruitment of Head Start parents into neighborhood groups.

New Communities. Kentucky, California, and Colorado replicated their Free to Grow models in additional communities. Establishing resident-focused neighborhood groups in two Kentucky expansion communities proved more challenging than in the pilot community, primarily because community resources and collaborative service networks were not as strong in these areas. In addition, the lack of interagency councils in the expansion sites and difficulties cultivating strong partnerships with police and family service providers limited the intensity of community action efforts. Nevertheless, neighborhood groups in the expansion areas achieved notable community-based victories, though not at the same overall level of strength as that of the pilot community. California and Colorado expanded Free to Grow to additional, separate neighborhoods within the same overall community. Both sites used schools and Head Start centers as the focal point of their groups, and they leveraged support from existing partner and collaborative relationships. Still, new relationships in both expansion sites needed to be developed with the school and Head Start staff who sponsored or supported the groups.

New Sectors Within a Neighborhood. Puerto Rico intensified the work it was doing within a single neighborhood by expanding its peer-mentoring intervention to seven additional "sectors"of the same target neighborhood. Its expansion effort also involved developing a structure for ongoing grassroots community action throughout the 13 sectors of the target neighborhood. Puerto Rico found it more difficult to develop neighborhood groups in the sectors where the peer-mentoring intervention did not already exist. Many of the resident leaders of the community action work were the peer mentors themselves, who were eager for continued community involvement and leadership

opportunities. Overall, the development of leadership skills among the peer mentors supported the process of ongoing civic leadership development and community action in Puerto Rico.

G. HEAD START INTEGRATION AND SUSTAINABILITY

The Free to Grow models were to be integrated into Head Start during Phase II, with the expectation that integration would support the sustainability of the projects into the future. Only three projects--Kentucky, New York, and Puerto Rico--were successful in integrating Free to Grow into Head Start. Kentucky restructured its Head Start program by creating the Family and Community Team and giving "ownership" of Free to Grow to Head Start staff. Both New York and Puerto Rico integrated their family strategies into the existing Head Start family service structure by redefining job responsibilities of existing staff. These projects also integrated the community work into the existing Head Start parent involvement structure. Kentucky and Puerto Rico developed the capacity of traditional Head Start staff to implement the family-strengthening work and incorporated their new Free to Grow community-strengthening staff into their Head Start structure. Puerto Rico took the extra step of creating a new Head Start position, family/community partnership coordinators, which expanded the responsibilities of parent involvement coordinators to include community strengthening work. The New York project prepared Head Start staff to lead most of the Free to Grow work but, at the same time, relied on specialized consultants to continue leading its innovative Oral and Cultural History program.

INTEGRATION OF FREE TO GROW INTO HEAD START

	California	Colorado	Kentucky	New York	Puerto Rico
Level of Integration	None	Low	Full	Moderate	Full
Roles Redefined for Head Start Staff					
Family-Strengthening Roles	--	Yes	Yes	Yes	Yes
Community-Strengthening Roles	--	Yes	Yes	Yes	Yes
New Free to Grow Staff Added Into Head Start?	--	--	--	--	--
Family-Strengthening Staff	--	--	Yes	--	Yes
Community-Strengthening Staff					

Colorado planned to integrate some aspects of Free to Grow by having Head Start family advocates assume responsibility for some family-focused activities and by having one or two family advocates serve as liaison to the neighborhood groups. Although California thought it might be able to incorporate some aspects of Free to Grow's leadership and community development training into Head Start, at the end of Phase II, plans were still on hold. Having Free to Grow operate separately from Head Start in some cases made it more difficult to build support among Head Start staff for developing the skills and taking on new responsibilities for Free to Grow work. Because Free to Grow's community components were new for Head Start, their integration was inherently more challenging than it was for the family components.

Over time, the integration of Free to Grow into Head Start helped some projects sustain Free to Grow. With integration, Free to Grow work could be sustained, using regular Head Start operating funds after an initial investment of funds to restructure Head Start and create new staff responsibilities and positions. In addition, partner organizations played a significant role in sustaining Free to Grow components in some projects.

PROSPECTS FOR SUSTAINING FREE TO GROW

	California	Colorado	Kentucky	New York	Puerto Rico
Assessment of Prospects Overall	Low	Low/ Moderate	High	Moderate	High
Components integrated and sustained by Head Start	None	Some	Most	Most	All
Components integrated and sustained by partner(s)	Some	Most	Some	None	None

Both Kentucky and Puerto Rico planned to sustain the family- and community-strengthening components--including continuation of the new community specialist staff positions (one in Puerto Rico and two in Kentucky). In New York, all the Free to Grow components, except for the Oral and Cultural History Program, were being sustained by Head Start, although there was still some uncertainty about procedures and funding for training new staff over time. The New York project was operated by a small Head Start delegate agency that lacked direct control over resource and program restructuring decisions. To a much greater extent, Colorado relied on its partners to sustain Free to Grow. Each neighborhood group was, to some degree, sustained by a partner organization. As originally planned, the local health department committed to continue its support for the substance abuse counselor position and institutionalized Free to Grow's enhanced outreach efforts. Lacking support from Head Start and from its partners, most components of the California project were not sustained beyond the end of Phase II, although it appeared likely that the project's most successful community group--an elementary school parent task force--would continue without Head Start support.

V. PERCEIVED CHANGES IN FAMILIES AND COMMUNITIES

An important goal of the process evaluation was to specify the outcomes expected from Free to Grow interventions, thus laying the foundation for future efforts to measure the impacts of Free to Grow during a full-scale demonstration. The final outcome--reductions in substance abuse problems--can be measured only after the young children in families and communities targeted by Free to Grow reach adolescence and young adulthood. In the near term, however, it is possible to begin to observe changes in risk and resilience factors and to make clear the theoretical link between Free to Grow interventions and these risk and protective factors. This chapter describes the process that projects went through to specify these linkages and outcomes and reports the types of changes Free to Grow projects appear to have influenced during the pilot program.

A. SPECIFYING FAMILY- AND COMMUNITY-LEVEL OUTCOMES

The NPO and the MPR evaluation team worked with project staff during Phase II to specify the hypothesized link between Free to Grow interventions and expected outcomes. We focused on three types of outcomes (as we show in the logic model presented in Chapter I):

1. ***Near-Term Implementation Benchmarks.*** Process measures that indicate whether, to what extent, and how well interventions are implemented

2. ***Intermediate Outcomes.*** Primarily changes in risk and protective factors associated with substance abuse

3. ***Long-Term Outcomes.*** Reduction in substance abuse problems among children in families and communities targeted by Free to Grow

Ultimately, the process resulted in a flowchart for each project that outlined the theory of change governing Free to Grow strategies: how specific interventions would bring about changes in families

and communities that would make the environment for children more supportive of healthier, substance-free lifestyles. Appendix A contains the resulting flowcharts for each project.

Developing and refining the logic models took considerable time and effort but had great value. The process of linking interventions with near-term implementation benchmarks enabled projects to think hard about the types of outcomes the interventions, as implemented, could realistically be expected to influence and to develop work plans that organized and focused their efforts around measurable objectives. Linking these near-term benchmarks to specific risk or protective factors clarified the relationships between Free to Grow interventions and substance abuse prevention theory. During the process, project staff became more articulate about substance abuse prevention theory, which helped them to communicate Free to Grow messages more clearly to families, partner organizations, and potential funders. The process also helped project staff become more strategic about where to focus their energies, and provided reinforcement in some cases for redirecting energy away from less intensive interventions, toward those more likely to have a benefit.

As we saw in Chapter I, the Free to Grow pilot projects aimed to influence a large number of outcomes at the family and community levels. Table V.1 provides an overview of these outcomes by project. Family-level outcomes targeted by all the projects included:[1]

- Improved parenting skills, family management practices, and family bonding
- Stronger, positive norms and attitudes about drug and alcohol use
- Increased knowledge of resources and services available in the community

[1]Although the California project had no explicit family-focused interventions, its community-strengthening work had important family-strengthening benefits. Thus, we include family-strengthening outcomes among those targeted by this project. This spillover effect was true of community-strengthening efforts in all of the Free to Grow sites.

TABLE V.1

OVERVIEW OF OUTCOMES TARGETED BY FREE TO GROW PROJECTS

	Outcomes	California	Colorado	Kentucky	New York	Puerto Rico
FAMILY LEVEL						
1	Improved parenting skills, family management practices, and family bonding		X	X	X	X
2	More positive family norms and attitudes about drug and alcohol use	X	X	X	X	X
3	Increased parental knowledge and use of available community services/resources	X	X	X	X	X
4	Reduced drug and alcohol problems among parents, siblings, other family members		X	X		X
5	Reduced parental/family isolation, lack of support			X	X	X
6	Fewer unmet basic needs for shelter, food, clothing		X	X		X
7	Increased parental skills in advocating for family needs	X		X	X	X
8	Reduced family conflict			X		X
9	Reduced problems associated with dislocation/immigration/cultural conflict				X	
COMMUNITY LEVEL						
10	Reduced social isolation; increased interaction and connectedness among residents	X	X	X	X	X
11	Reduced neighborhood disorganization (crime, violence, physical deterioration)	X	X	X	X	X
12	Increased knowledge and understanding of substance abuse risk/protective factors and prevention resources	X	X	X	X	X
13	Increased advocacy skills among community residents	X	X	X	X	X
14	Increased parent involvement in school and community activities	X	X	X	X	X
15	Stronger enforcement of laws and norms that discourage alcohol and drug use	X		X	X	X
16	Reduced availability of alcohol and other drugs	X		X	X	X
17	Reduced association with drug-using peers	X	X	X		X
18	Improved academic success; stronger commitment to school	X		X		

The first two outcomes are demonstrated risk/protective factors, while the third would most likely influence substance abuse indirectly and to a lesser extent. Other known family-level risk/protective factors that some of the projects targeted are:

- Reduced drug and alcohol problems among parents, siblings, and other family members (Colorado, Kentucky, and Puerto Rico)
- Reduced family conflict (Kentucky and Puerto Rico)

The remaining family-level outcomes projects identified are related to such factors as isolation, immigration or cultural conflicts, access and use of resources, and advocacy skills--factors that have not yet been shown to have a direct influence on substance abuse patterns, though they may do so indirectly.

At the community level, all five projects aimed to reduce the level of disorganization in the neighborhood and community, a factor known to influence substance abuse patterns. The term "disorganization" encompasses the dimensions of crime and violence and the physical condition of buildings, streets, parks, and other public spaces. All projects also aimed to reduce isolation and increase interaction and social connectedness among local residents. Most projects targeted two other community-level outcomes with a demonstrated link to substance abuse:

- Improved enforcement of laws and norms that discourage drug and alcohol use
- Reduction of the availability of drugs and alcohol

Several other known risk and protective factors are included under community-level outcomes, although these factors focus on children or youth. Four projects incorporated interventions to give children and youth more positive after-school options to limit exposure to drug-using peers, and two implemented tutoring and reading programs to promote success in and commitment to school.

Included are other outcomes at the community level that may influence substance abuse indirectly or to a lesser extent:

- Increasing knowledge and awareness of substance abuse prevention ideas and resources
- Increasing the skills of community residents to advocate for community-level change
- Increasing parent involvement in school and community activities
- Improving the availability and coordination of services and programs in the community

B. PERCEIVED CHANGES IN FAMILIES AND COMMUNITIES

The pilot program evaluation did not formally measure the impact of Free to Grow on outcomes specified by the projects. During the final round of site visits, however, we obtained perceptions of the changes Free to Grow had brought about during the five-year pilot period. To do this, we focused on a subset of more common Free to Grow outcomes and asked respondents to specify on a five-point scale, "based on what you have seen or heard," the degree of change made by Free to Grow in each area. Respondents included Free to Grow, Head Start, and partner organization staff, parents, and other community residents. Their responses are summarized in Table V.2; project-specific findings are contained in Appendix B.[2] This overview gives a general sense for the types of family and community outcomes the Free to Grow programs may have influenced.

At the family level, respondents reported seeing some level of change in most areas. Larger changes were perceived in parenting skills and bonding between children and their parents and in meeting the basic needs of housing, food, and clothing. Smaller levels of change were observed in

[2]When interpreting these findings, it is important to keep in mind that Free to Grow projects varied in the extent to which they set out to influence outcomes in these areas. The Compton Free to Grow model, for example, did not include an explicit family-strengthening component, and only some of the projects included interventions to directly address more serious problems, such as substance abuse or domestic violence.

TABLE V.2

MAGNITUDE OF CHANGES PERCEIVED IN FREE TO GROW FAMILIES AND COMMUNITIES

Items in Evaluation Form	Corresponding Outcome in Table V.1	Average Magnitude of Change Perceived**		
		High (>4)	Moderate (3.1-4.0)	Low (≤3.0)
FAMILY LEVEL				
Building stronger parenting skills; stronger bonds between children and their parents	1	NY, PR	CA, CO, KY	
Getting parents to have clear rules about drugs/alcohol	2	NY	CA, KY, PR	CO
Getting people to stop using drugs and alcohol	4		KY, NY	CA, CO, PR
Helping families with shelter, food, clothing needs	6	CO, PR	KY, NY	CA
Helping people to get their GED or to get a job	6	NY	CA, PR	CO, KY
Stopping domestic abuse/family violence	8		KY, NY, PR	CA, CO
COMMUNITY LEVEL				
Cutting down on crime and violence in the community	10		CO, KY, NY, PR	CA
Making the community cleaner and less run-down	10	PR	CA, CO, KY, NY	
Helping people feel safe in their neighborhood/community	10		CA, CO, KY, NY, PR	
Getting people to want to stay in the community	10		CO, KY, NY, PR	CA
Getting residents to solve community problems	12	CO, PR	CA, KY, NY	
Getting agencies/providers to listen and respond to resident concerns	12	CO, KY, PR	CA, NY	

TABLE V.2 (continued)

Items in Evaluation Form	Corresponding Outcome in Table V.1	Average Magnitude of Change Perceived**		
		High (>4)	Moderate (3.1-4.0)	Low (≤3.0)
Getting people involved in the community; getting parents involved in schools	13	CO, KY, NY, PR	CA	
Getting community members together more often	13	CO, KY, PR	CA, NY	
Stopping the sale of drugs and alcohol to minors	14, 15		KY, NY, PR	CA, CO
Stopping drug use and drug trafficking	14. 15		KY, NY, PR	CA, CO
Giving children better things to do in their free time	16	NY	CA, CO, PR	KY

NOTES:

**For each item, respondents circled a number from 1 to 5, with 1 defined as “no change,” 3 as “some change,” and 5 as “big change.”

The total number of respondents for each project is summarized below:

	NUMBER OF RESPONDENTS		
PROJECT	Total	Free to Grow, Head Start and Partner Organization Staff	Parents or Residents
California	20	10	10
Colorado	11	11	0
Kentucky	14	7	7
New York	16	9	7
Puerto Rico	33	8	25
TOTAL	94	45	49

such areas as the use of drugs and alcohol and domestic violence. But we might expect change in these areas to take time; because these problems are also more private, change may not be as readily observed by others in the community.

At the community level, Free to Grow usually was perceived as having brought about a moderate level of change. Areas perceived as having changed to a large extent were resident involvement in the community and the schools, and the levels of interaction among residents. In Puerto Rico, respondents also perceived large improvements in the physical appearance of the community. Problems such as drug and alcohol sales to minors and drug trafficking were perceived as having changed to a lesser extent, although it is encouraging that respondents felt that some improvements had been made in the level of crime and violence and in the extent to which community residents felt safe and wanted to stay in the community.

The magnitude of change observed in the Free to Grow pilot communities may differ from the level of change other communities might experience. First, the models were fully developed and tested for a relatively short time period--at most, three years. Communities implementing Free to Grow models today would be able to get started more quickly. Future programs will also have the benefit of lessons learned from the pilot sites to help focus efforts most productively during planning and implementation. On the other hand, the pilot sites were, in some respects, further along than many other Head Start programs in their capacity to implement a complex intervention such as Free to Grow. The success of future Free to Grow efforts will depend in part on the capacity of the implementing programs to make good use of the lessons learned in the pilot program.

C. COMMUNITY VOICES

Focus group discussions with parents and provider/agency representatives furnished additional insights into Free to Grow's influence on families and communities. Focus group participants

perceived Free to Grow as having helped parents become more skilled and confident in their approach to parenting. Many noted that Free to Grow gave parents a better sense for how to gauge the structure and disciplining children need and expect, as well as the skills to recognize and address unhealthy attitudes, behaviors, and communication styles among family members.

In addition to addressing parenting skills directly, Free to Grow helped parents feel better about themselves, which in turn helps them be better parents. Projects strengthened self-esteem in a variety of ways--by providing opportunities for parents to meet other parents and interact socially, reinforcing the value of cultural traditions, using peer-mentoring approaches to model healthy behaviors and attitudes, and giving parents opportunities to become more involved in community activities.

The program has helped me a lot with my children, in my family. What I have learned has helped me handle them better, and have more patience.--Parent, New York

Parents who participate in [Free to Grow] become more energetic, more self-confident. They pursue more opportunities on their own. Also, they have a more positive, 'can-do' outlook...they look for solutions and are better equipped to solve problems in their families and their personal lives.--Parent, New York

The training I've received and my experiences as a compay have helped me a lot. Now, I have many more strategies to cope with stressful situations. I think that I have become a better mother and wife. Before we became involved in the project, my husband and I were very distant with each other. Our communication has improved a lot. We are a much closer family now. We feel blessed and recognize how fortunate we are to have each other.--Parent/Peer Mentor, Puerto Rico

Prior to participating [in the Oral and Cultural History Program], many parents feel alone and unempowered. The program helps to connect them with other parents.--Provider, New York

In some communities, Free to Grow helped parents with substance abuse problems get into treatment programs.

[The treatment program] gave me my life back. I had lost my mind on speed. I was in a psychiatric ward....They connected me with my counselor and she showed me how to live again. If I didn't have [the program] and my counselor to show me these baby steps I would have been lost.--Parent, Colorado

Free to Grow also helped empower parents to advocate both for themselves and for their children. They built stronger connections between parents and community providers and agencies, made parents more aware of services and programs, and helped parents communicate more effectively with school and other community providers.

Free to Grow makes you comfortable to stand up and speak in public in a professional way. . .with the police, mayor, and community officials.--Community Resident, Kentucky

Parents are the ones who live in the community, who know and care more about what's going on and what's needed. Free to Grow provided more opportunities for parents to get involved. . .and it was more than just meetings or field trips. Free to Grow helped them develop skills, like writing letters. Parents who participated were more likely to follow a process to get a problem resolved, instead of just complaining--School Principal, California

Our community used to have little unity. Little by little...we have realized that we need to become united, to help one another. The voice of one person is not heard, but the voices of [many] are. We need to be united because when we are united we become strong--porque en la union es que esta la fuerza--Parent, New York

As parents, we now know better what our role is in the school, in the community.--Parent, California

Involving parents with young children in community-strengthening work had a dual effect. Parents became more engaged in and attached to the community, and the agendas of community action groups became more focused on the needs of families with young children. The emphasis on parents as agents of change within communities, not just within families, set Free to Grow apart from other programs.

We became empowered both as parents and as community activists--Parent, California

Instead of sitting back and complaining, now we mobilize to solve problems. We've tackled lighting, street signs, and the need for sewers. Two [residents] were very concerned about the lack of after-school opportunities for our children. They met with the mayor and helped make our dream of a community library a reality.--Community Leader, Puerto Rico]

By having Free to Grow family- and community-strengthening strategies together, Head Start gets real value added. --Community Provider, Kentucky

[Free to Grow] has helped Head Start reach parents on a different level. It has helped parents focus on the drawbacks of substance use and abuse and has given them a language to use to talk to their children about substance abuse issues. It has helped them focus more attention on themselves and on what they can accomplish. It has helped to empower parents.--Free to Grow Staff, New York

Respondents also noted the value of listening to and working with people living in the community. Free to Grow was also seen as building the capacity of local residents to serve as agents of change in their communities.

The difference with Free to Grow is that it is community-based, neighborhood-based. It is local family and neighborhood advocating and there are dedicated resources for this. If you don't bring it down to a neighborhood level, nothing gets done in a really tangible sense.--Provider, Colorado

The objective is no longer to do 'for' the community, but rather to build capacity 'within' the community so that residents change their lives and their community themselves. Residents need to be both leaders and active participants in this process.-- Community Provider, Puerto Rico

In addition to strengthening parents and families (that is, the "human capital" of communities), Free to Grow community-focused efforts also helped to make neighborhoods safer and less run-down. Free to Grow was seen as having influenced the underlying causes of community decline.

There is more security, more control [at the school]. The physical plant conditions have improved a lot too. You may ask "But what does having a clean school have to do with substance abuse prevention or with school success?" But, you see, if children have a clean, comfortable, safe building in which to study they are going to learn more in their classes and think: 'No, no...I'm an educated, worthwhile person. I'm going to say no to drugs.--Parent, California

Before Free to Grow came in, it was real bad. Since Free to Grow came in, it's really straightened up a lot. It's peaceful over there now. The police are walking through, and they didn't do that 'til Free to Grow moved in and got involved with them. It's calmed down a whole lot.--Community Resident, Kentucky

Before [Free to Grow] one never saw police [in our community] unless there was a shootout. Then, they would enter with their riot gear, ready for a confrontation....We now have a very different relationship. The police recognize and publicize the change. There's noticeably more patrolling. You see officers around regularly. They set up seat-belt checkpoints on the main access road and stop every vehicle. This discourages drug buyers from coming in.--Community Resident, Puerto Rico

More shopowners are posting signs that indicate they do not sell alcohol and tobacco to minors...Police are trying to crack down--that's why they are sending minors into the stores to see if they are sold beer or cigarettes...Now that they can get caught, Bodega owners have a stronger incentive to obey the laws about not selling to minors.--Parent, New York

Free to Grow is trying to get to the underlying issues...not just clean-up drives and providing services. Free to Grow doesn't just fix the surface problem, we try to find out what is causing it.--Community Resident, Kentucky

VI. CONCLUSIONS: SUCCESS OF MODEL IMPLEMENTATION AND PROSPECTS FOR FUTURE REPLICATION

In its early phases, Free to Grow was a pilot program designed to develop and test new substance abuse prevention models focused on the period of early childhood. Each of the Free to Grow grantees sought to break new ground within their Head Start programs and target communities. Through a dual approach of working simultaneously with families and the community, they focused on helping parents and other residents improve family functioning, cultivate skills, and work together to achieve long-lasting, large-scale preventive changes in their communities. Success in implementing and sustaining Free to Grow would demonstrate the value and feasibility of incorporating into Head Start a substance abuse prevention framework and preventive strategies.

In this chapter, we apply structured criteria to assess the success of the five Phase II Free to Grow projects in meeting the initiative's ambitious objectives. We also identify factors contributing to success in implementing Free to Grow overall and, more specifically, practices contributing to success in implementing family- and community-strengthening strategies. We then provide suggestions for selecting the next generation of Free to Grow programs and structuring and supporting their work. We conclude with a summary of Free to Grow's family- and community-strengthening successes and their value to Head Start.

A. DIMENSIONS OF IMPLEMENTATION SUCCESS

The Foundation and the Free to Grow NPO expected that, "by the end of Phase I, grantees should demonstrate evidence of a well-defined, promising model with preliminary evidence of feasibility and effectiveness."[1] Ten "criteria of success"--including such factors as the models'

[1]Free to Grow National Program Office. "Application for a Three-Year Project Implementation Grant: Free to Grow, Head Start Partnerships to Promote Substance-Free Communities." New York, (continued...)

definition, significance, innovativeness, and cultural sensitivity--were used to assess the degree to which each Phase I project succeeded in meeting this objective and should be awarded Phase II funding.[2] During Phase II, in addition to meeting these criteria, Free to Grow grantees were expected "to further implement and document the model(s) so that, by the end of Phase II, [they] can be institutionalized and sustained as an ongoing feature of the Head Start programs." Success would, therefore, be reflected in (1) the overall strength of each project's family- and community-strengthening efforts; and (2) grantees' ability to develop Head Start's organizational capacity to implement fully, and sustain, Free to Grow efforts over time.

To determine whether the Phase II grantees met these important objectives, we ranked their Free to Grow efforts using the Foundation's criteria of success (see Table VI.1). We focused on four dimensions of success: (1) clarity and strength in articulating the Free to Grow models, (2) extent of implementing the interventions, (3) sustainability, and (4) preliminary evidence of effectiveness.

As Table VI.1 shows, two sites--Puerto Rico and Kentucky--achieved much success by developing sound Free to Grow prevention models and fully implementing their proposed interventions. In addition, these grantees integrated their projects securely into their Head Start structures and developed viable plans for sustaining Free to Grow strategies over the long term. Through the strong connection of their model strategies to prevention science and the changes reported by staff, parents, and other project participants, these projects also demonstrated preliminary evidence of effectiveness. Noteworthy features of their models and implementation experiences are highlighted next.

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[1](...continued)
NY: NPO, National Center for Children in Poverty, Columbia University School of Public Health, August 1, 1995.

[2]Appendix C includes the Foundation's "Criteria of Success for Phase I."

TABLE VI.1

DIMENSIONS OF IMPLEMENTATION SUCCESS

CRITERIA FOR SUCCESS	PRESENCE OF SUCCESS FACTORS AT EACH PROJECT				
	CA	CO	KY	NY	PR
Overall Assessment of Implementation Success[a]	**M**	**M**	**H**	**M**	**H**
1. Clarity and Strength of the Free to Grow Model	**5**	**5**	**5**	**4**	**5**
- Model is innovative for Head Start	**T**	**T**	**T**	**T**	**T**
- Model addresses needs of high-risk families and communities	**T**	**T**	**T**	**T**	**T**
- Model is clear, well-defined, and sufficiently well-articulated	**T**	**T**	**T**	**T**	**T**
- Model has strong foundation in prevention theory and research	**T**	**T**	**T**		**T**
- Model is generalizable or adaptable to other Head Start settings	**T**	**T**	**T**	**T**	**T**
2. Implementation of the Free to Grow Interventions	**3**	**5**	**8**	**5**	**8**
- Approach was feasible as shown through the full implementation and ongoing operation of model interventions			**T**	**T**	**T**
- Reasonable levels of participation achieved over the intended period of time and for well-suited families and residents			**T**	**T**	**T**
- Interventions were multi-faceted and of appropriate frequency, intensity, and duration			**T**		**T**
- Interventions were well-connected and mutually reinforcing					**T**
- Strong, productive, ongoing partnerships formed with key community organizations		**T**	**T**		**T**
- Families linked to community resources and/or service gaps filled	**T**	**T**	**T**	**T**	**T**
- Approach was culturally sensitive, and staff reflected the composition of and/or were responsive to target population	**T**	**T**	**T**	**T**	**T**
- Interventions valued by families, other residents, and partners	**T**	**T**	**T**	**T**	**T**
- Interventions fully replicated in expansion sites[b]		**T**	**T**		
3. Sustainability of Free to Grow Interventions	**0**	**1**	**2**	**1**	**3**
- Broad community involvement in and ownership of FTG by resident leaders					**T**
- Model interventions integrated and institutionalized within Head Start			**T**	**T**	**T**
- Resources leveraged from collaborating service providers and other local resources		**T**	**T**		**T**
4. Preliminary Evidence of Effectiveness	**0**	**1**	**1**	**1**	**2**
- Large changes reported in family risk/protective factors		**T**		**T**	**T**
- Large changes reported in community risk/protective factors			**T**		**T**

[a]To determine the overall assessment for each project, the numeric values for each category were summed and the ratio of the total score to the maximum possible score was calculated for each project. Using this ratio, projects were ranked as follows: low=0 to 33 percent of maximum possible score; medium=34 to 66 percent; and high=67 to 100 percent.

[b]The New York project never intended to expand its Free to Grow model to other sites. The Puerto Rico project did expand its model but not to new neighborhoods or communities (rather, to new sectors of the target community).

Puerto Rico. Aspira's compay model constituted a powerful dual intervention. The project linked at-risk Head Start families to exemplary Head Start parents and other families from their same community; working in concert with Head Start social workers, the compay mentors greatly enhanced the individualized support and attention the program offered to these high-risk families. While more intensive and structured family assessment procedures were needed to identify both at-risk and exemplary families, the use of peer mentors and the development of new advocacy and leadership skills among these parents provided an effective springboard for building an infrastructure for sustained grassroots community action. Cultivating a spirit of shared responsibility among local residents and service providers required building relationships of mutual trust and cooperation; Free to Grow community-strengthening work therefore required much emphasis on relationship building, which took time and required much effort on the part of staff. With effective guidance and support from individuals experienced in community development work, however, Aspira's compay project was able to establish the largest number of community action groups among all Phase II grantees. By the end of Phase II, Aspira's groups also achieved clear ownership by local residents.

Kentucky. By introducing new family assessment tools and reformulating Head Start's family social service structure, Audubon helped its staff become more effective at identifying at-risk Head Start families. This, in turn, enabled the program to provide more families with the increased individualized attention and support they needed. Through its support for community action groups, Audubon's Free to Grow project also enhanced Head Start's capacity to identify prospective community leaders, link them to opportunities to further cultivate their leadership potential, and support grassroots efforts to improve the local community environment. Still, two types of challenges limited this project's accomplishments. First, the early versions of tools developed to identify both at-risk and highly functioning Head Start families did not adequately assess family

strengths and needs, which hindered staff efforts to target high-risk families for more intensive case management and to link strong families to Free to Grow community groups. Second, while Free to Grow's family- and community-strengthening components were linked in the model, in practice these linkages did not work as well as intended. This limited their leadership development and community-strengthening accomplishments.

The three other Phase II projects--New York, Colorado, and California--achieved important victories and implemented promising and innovative program strategies. Overall, however, they were less successful in implementing and sustaining their projects.

New York. Through its Free to Grow groups and parent committees, Fort George greatly expanded the involvement opportunities for Head Start parents. It also made services more responsive to family needs and expanded the range of concerns addressed to include community issues. This grantee developed a highly innovative Oral and Cultural History Program to address the special acculturation- and dislocation-related needs of recently arrived immigrants. However, because this component was implemented primarily through consultants (who were reluctant to develop formal curricula for their modules and train grantee staff on how to deliver the sessions), the distinctive program appeared unlikely to be sustained beyond the pilot project. Moreover, despite the abundance of civic involvement opportunities locally, Fort George was largely unable to link Free to Grow community-strengthening efforts to those of other local grassroots organizations or to formalize procedures to help Free to Grow participants take on leadership roles outside of Head Start.

Colorado. The Community Partnership for Child Development (CPCD) developed a strong Free to Grow model focused on (1) building a continuum of care for families with young children; (2) improving access to substance abuse treatment and family counseling services; and (3) bringing

parents, other residents, and agency representatives together to address high-priority community concerns. The Free to Grow, neighborhood-based family advocates were truly the centerpiece of CPCD's model. By cultivating long-lasting relationships with families with young children from the target communities--beginning in the pre-Head Start years and extending well beyond their children's involvement in the program--staff were expected to strengthen referrals for specialized services (including Free to Grow's family counseling and substance abuse treatment) and to make efforts to involve parents in the neighborhood councils more fruitful. However, because of staff's difficulty engaging pre-Head Start families, general reluctance to discuss substance abuse issues, and high turnover--among other reasons--CPCD's vision for the Free to Grow family advocates never materialized. Over time, the work of these staff evolved to focus primarily on supporting the neighborhood councils. This change weakened the link between Free to Grow's family- and community-strengthening components which, in turn, affected the agendas of the neighborhood councils and, ultimately, buy-in from CPCD.

California. Drew Head Start was most successful in its grassroots organizing efforts. In a community highly divided along racial and ethnic lines, Free to Grow staff managed to motivate local black and Hispanic residents to come together in the citywide council and made them feel that their concerns were being taken seriously. However, limitations in staff capacity and skills, as well as the backdrop of contentious racial/ethnic politics at the institutional level, made achieving Free to Grow's community-strengthening objectives difficult. While civic-organizing principles provided a strong framework for organizing, and though effective materials were developed to support the implementation of Free to Grow community-strengthening components, project staff had difficulty moving beyond training aspects to bring about sustained community action. The project also had trouble building relationships at the institutional level and developing leadership within Free to

Grow's community groups. This undermined the long-term viability of their community interventions. As originally formulated, Drew's parent advocate component would have been the catalyst for strong Head Start parent involvement in the community council; implementation of this component was nevertheless hindered by welfare reform and poor definition of the advocates' role. When the parent advocate component failed, the school/Head Start-based "safe space" task forces became the principal mechanism for involving parents in Free to Grow community-strengthening efforts. The task forces, however, were never connected in a meaningful way to the citywide council. Head Start performance problems and grantee administrative issues magnified the challenges this project faced, with Head Start and grantee leaders frequently failing to take corrective actions to address the limitations of Free to Grow staff and components.

In general, Free to Grow family-strengthening strategies proved to be a natural extension of Head Start's ongoing work with families. However, all sites faced challenges implementing community-strengthening strategies, reflecting Head Start's relative inexperience in this area. Significant levels of program commitment, staff effort, partner organization support, and training and technical assistance were necessary to develop Head Start's ability to perform this type of work. In the next section, we turn to factors that contributed to Free to Grow's implementation success.

B. FACTORS CONTRIBUTING TO OVERALL SUCCESS

Many factors made Free to Grow challenging to implement, while others facilitated implementation and/or contributed to success. In Table VI.2, we summarize the factors that appeared to be most important in the successful implementation of Free to Grow.[3] As the table

[3]While, in their design, the Free to Grow models may have had features intended to achieve these outcomes, we judged the projects on the extent to which these factors were actually present or achieved during implementation.

TABLE VI.2

FACTORS CONTRIBUTING TO FREE TO GROW SUCCESS

	Presence of Success Factors at Each Project[a]				
SUCCESS FACTORS	CA	CO	KY	NY	PR
Overall Level of Success	M	M	H	M	H
Contextual Factors					
1. Organizational Capacity for Substance Abuse Prevention	4	6	7	2	7
- Sponsoring agency and Head Start grantee have strong reputation in target community and among local service providers	**T**	**T**	**T**	**T**	**T**
- Sponsoring agency is structurally, financially stable		**T**	**T**		**T**
- Head Start grantee has extensive collaborative experience and well-established relationships	**T**	**T**	**T**	**T**	**T**
- Sponsoring agency has broad programmatic and service agenda	**T**		**T**		**T**
- Head Start grantee has demonstrated strong strategic planning skills and commitment to continuous quality improvement		**T**	**T**		**T**
- Head Start grantee has authority to allocate resources to support FTG	**T**	**T**	**T**		**T**
- Community views FTG sponsoring agency as a "can-do" organization that is responsive to their priorities and needs		**T**	**T**		**T**
2. Community Receptivity to Substance Abuse Prevention	2	1	1	2	2
- Substance abuse-related problems are widely recognized and acknowledged	**T**			**T**	**T**
- Community residents and other constituents have expressed dissatisfaction with local conditions and a desire for improvements	**T**	**T**	**T**	**T**	**T**
3. Contextual Stability	1	1	2	1	1
- Low residential mobility and stable resident base in target community			**T**		**T**
- Relatively low turnover among Head Start and FTG staff	**T**		**T**	**T**	
Program Practices					
4. Strong Commitment to Free to Grow Implementation	1	1	4	2	5
- Sponsoring agency/Head Start leadership are highly involved in ongoing project oversight and guidance			**T**	**T**	**T**
- Head Start leadership provide a clear, strong vision for FTG and continuously reinforce it to staff, participants, and partners			**T**		**T**
- Sponsoring agency involved a wide range of collaborators in FTG	**T**	**T**	**T**	**T**	**T**
- Staff with relevant expertise--including community development expertise--play leading roles in FTG					**T**
- FTG leadership provide strong strategic planning and project management skills			**T**		**T**

TABLE VI.2 *(continued)*

SUCCESS FACTORS	Presence of Success Factors at Each Project[a]				
	CA	CO	KY	NY	PR
5. Adequate Training and Technical Assistance	0	0	2	1	2
- Head Start provides ongoing staff training and assistance and develops tools/procedures to institutionalize its capacity for FTG work			**T**	**T**	**T**
- Head Start staff have well-defined tools and procedures to identify and recruit families, assess their strengths and needs, and link them to appropriate FTG interventions and involvement opportunities			**T**		**T**
6. Strong Substance Abuse Prevention Focus	1	2	2	1	2
- Risk/protective factor framework guides the design of FTG components	**T**	**T**	**T**	**T**	**T**
- Prevention principles guide community group efforts to assess local needs and resources, set reasonable goals, and develop FTG activities		**T**	**T**		**T**
7. Leverages Existing Community Resources	4	5	5	4	6
- FTG components and strategies build on and enhance Head Start services and activities	**T**	**T**	**T**	**T**	**T**
- Parents and/or other local residents are used in paraprofessional capacity to extend staff support for Head Start families	**T**			**T**	**T**
- Community improvement efforts involve a broad cross-section of community members	**T**	**T**	**T**		**T**
- Local residents assume responsibility for FTG community groups, including an active role in the implementation of community-strengthening activities and initiatives		**T**	**T**	**T**	**T**
- FTG partners and collaborators provide resources and ongoing support to implement FTG activities and initiatives	**T**	**T**	**T**		**T**
- Sponsoring agency/Head Start leadership marshals resources and/or makes structural changes to sustain FTG efforts		**T**	**T**	**T**	**T**
8. Synergy of FTG Strategies and Activities	1	2	3	1	4
- FTG components allow parents, residents to progressively develop higher-level advocacy, activism skills to promote prolonged involvement	**T**	**T**	**T**		**T**
- FTG family and community components are implemented in a well-connected and mutually reinforcing manner					**T**
- FTG community strengthening activities and initiatives build on and reinforce each other			**T**	**T**	**T**
- FTG community improvement efforts are well connected to other local efforts		**T**	**T**		**T**

[a]To determine the overall assessment for each project, the numeric values for each category were summed and the ratio of the total score to the maximum possible score was calculated for each project. Using this ratio, projects were ranked as follows: low=0 to 33 percent of maximum possible score; medium=34 to 66 percent; and high=67 to 100 percent.

shows, success factors can be grouped into eight categories: (1) the grantee's capacity for substance abuse prevention; (2) the target community's receptivity to substance abuse prevention efforts; (3) Free to Grow's contextual stability; (4) a strong commitment to Free to Grow implementation; (5) adequate training and technical assistance; (6) strong substance abuse prevention focus; (7) active use of existing community resources; and (8) structuring project work to achieve synergy among Free to Grow strategies and activities. The checks indicate the factors that were present in each project. The first three categories represent contextual factors contributing to success; the rest we view as program practices. We discuss these factors below.

1. Contextual Factors

Characteristics of the organizations sponsoring the Free to Grow projects and the communities in which their models were being implemented either contributed to or impeded the success of Free to Grow efforts. In examining the experiences of Phase II grantees, we found the following contextual factors to be important:

- ***Organizational Capacity for Substance Abuse Prevention.*** Well-established, financially stable, and respected grantee agencies and Head Start programs provided a solid foundation for Free to Grow and lent it an air of legitimacy. Grantees with a broad service agenda were especially well equipped to implement Free to Grow strategies.

- ***Community Receptivity to Substance Abuse Prevention.*** The severity and persistence of problems related to drugs and alcohol, poverty, and crime in all Free to Grow target communities motivated residents and providers to join together in project efforts.

- ***Contextual Stability.*** The grantees targeting communities with established provider networks and low residential mobility found it easier to recruit members to the Free to Grow neighborhood groups and generate broad support for their community strengthening initiatives. Not surprisingly, the retention of key Free to Grow staff was an important ingredient in the success of the most successful projects.

2. Program Practices Contributing to Overall Success

Program practices were another important determinant of the overall success of the Phase II Free to Grow projects. Some of the practices contributed to *overall* success implementing Free to Grow strategies, while others were related more closely to family- or community-strengthening work. In examining the experiences of Phase II grantees, we found that the following practices more often facilitated Free to Grow implementation and/or contributed to *overall* success:

- ***Strong Commitment to Free to Grow Implementation.*** Successful implementation of Free to Grow required additional effort from Head Start staff in the short run; in the longer term, it required fundamental changes in the ways in which staff interacted with parents and community residents. Ongoing involvement by the Head Start grantee leadership was instrumental in developing a strategic vision for Free to Grow, communicating this vision clearly to all parties involved in the project, and reinforcing continuously the intrinsic value of the new Free to Grow approaches. Commitment was also evident when the program designated a responsible team that collectively possessed expertise in program development, project management, substance abuse prevention, and community development, along with knowledge and understanding of the target communities.

- ***Adequate Training and Technical Assistance.*** Successful grantees provided and received ongoing support as Head Start staff mastered important prevention concepts. Program staff needed extensive and ongoing support to learn important prevention principles and make these operational in their day-to-day activities with families. The development of structured family assessment tools and procedures (1) helped ensure that Free to Grow components complemented preexisting Head Start services, (2) facilitated coping with normal staff turnover; and (3) supported the ongoing monitoring of Free to Grow work and the formulation of model adjustments or improvements, as needed.

- ***Strong Substance Abuse Prevention Focus.*** Integrating needs and resource assessments into community-strengthening procedures enhanced awareness of important community issues, built consensus around these, and defined the priorities for community action work. Incorporating a risk and protective factor framework into the groups' needs/resource assessment and community action planning activities help ensure that Free to Grow efforts remained focused on the projects' principal community-strengthening objectives: reducing risks for and enhancing resiliency against substance abuse.

- ***Leveraging Existing Community Resources.*** The stronger Free to Grow projects marshaled diverse resources and continually engaged a broad cross-section of constituent groups and community stakeholders in their community-strengthening

efforts. Key groups included Head Start parents, other parents and local residents, local service providers, and representatives of what was believed to be the community's "power elite." The active involvement of service providers facilitated the community-strengthening activities, but the more successful grantees learned to define boundaries for involving provider representatives and local officials so as to maintain residents' ownership of the groups.

C ***Linking Free to Grow Strategies and Activities.*** The most successful Free to Grow projects implemented a variety of family-strengthening strategies designed to respond to the needs of a wide range of families and had clear procedures for linking activities and individuals participating in them to the ongoing work of their community action groups. Structuring more intensive interventions, such as case management and peer mentoring, to accommodate different intensities of need and adjust as family needs changed over time facilitated staff work and helped keep families engaged. Additional successes came through:

- Linking family- and community-strengthening strategies, to extend families' participation in Free to Grow beyond their children's participation in Head Start

- Incorporating community action groups into Head Start's parent involvement opportunities, to identify and recruit more parents

- Creating ongoing leadership training and technical assistance, to guide and advance work of neighborhood groups and support higher-level advocacy and civic activism skills

- Implementing community education and general involvement activities, to foster a supportive community environment and build a base of support for subsequent efforts

- Building momentum from current community-strengthening projects, to allow residents to reclaim their communities and begin addressing more challenging issues related to drug dealing, violence, and substance abuse

C. REPLICATING FREE TO GROW IN HEAD START

Phase II evaluation findings provide a strong basis for testing Free to Grow approaches on a larger scale. Across all the projects, participating parents, community residents, and organizations valued Free to Grow for empowering them to become more effective agents of change within their families and communities. Although certain program features need further refinement, the evaluation identified more and less promising approaches (as well as the conditions under which they

succeeded). The evaluation also identified the types of outcomes these approaches could help bring about. Thus, the stage is set for a more rigorous test of Free to Grow strategies on a larger scale, and the Foundation will be supporting a larger-scale demonstration in many Head Start communities around the country. Several considerations came into play in guiding the selection of a new generation of grantees, the structure of future Free to Grow programs, and the support new grantees will need.

1. Selecting the Next Generation of Free to Grow Grantees

The experiences of Free to Grow grantees to date suggest that not all Head Start grantees and delegate agencies are equally well suited to take on the challenges of implementing family- and community-strengthening strategies. As we saw in Phases I and II, certain grantee characteristics and attributes can facilitate Free to Grow implementation. New grantees should:

- ***Be well-established, respected organizations.*** Strong reputations provide legitimacy to Free to Grow efforts and inspire confidence in their eventual success. Less well-established organizations may find it difficult to develop the basic family and community relationships and the confidence to build the capacity needed for success.

- ***Have an established record of successful collaboration.*** This will facilitate efforts to expand alliances to include nontraditional Head Start partners--such as substance abuse prevention agencies, the police, community development resources, recreational organizations, and faith-based organizations--as well as challenge other providers to adopt a new vision of collaboration aimed at effecting community-level changes in support of resident-defined priorities and concerns.

- ***Show a strong commitment to continuous quality improvement.*** Head Start's leadership must be committed to and closely involved in the paradigm shift that requires a great deal of capacity building, learning, and adjustment. The Head Start director and other high-level management staff fulfill important roles in forming community relationships, fostering collaboration with other service organizations, developing family- and community-strengthening strategies, evaluating implementation progress, and enlisting staff support.

2. Structuring Free to Grow Work

Replication will require many choices on the part of new grantees about how to structure their projects and manage their implementation. Based on the Phase I and II evaluation findings, we recommend the following as key considerations for this structuring:

- ***Strategies should be customized.*** Rather than replicating current models intact, future Free to Grow models and strategies should be tailored to the community circumstances of the new grantees. The program models must also reflect each grantee's strengths, resources, and needs.

- ***Strategies selected should build on and complement existing Head Start procedures.*** Free to Grow implementation is facilitated when programs are able to build on well-established, proven procedures for family recruitment, assessment, service planning, intervention, and referral for specialized services when appropriate.

- ***Community partners are an important element.*** Successful Free to Grow grantees recognized that no single organization can fight substane abuse problems alone. Police departments, substance abuse agencies, schools, and other family service providers offer important assets when implementing specific interventions (such as specialized counseling for high-risk families) or strategies (such as community policing). Partners may also help sustain Free to Grow efforts.

- ***Grantees should implement both family- and community-strengthening strategies.*** The experiences of the more successful Phase II grantees suggest that synergy is achieved by implementing both family- and community-strengthening strategies. Benefits of implementing both types of strategies are greatest when Free to Grow components articulate a progression of activities that extend parents' participation beyond their children's enrollment in Head Start and help participants continuously develop higher-level advocacy and civic activism skills.

- ***Free to Grow efforts should target relatively high-risk communities.*** Free to Grow can be effective in many communities through its strong message of community partnership--with Head Start parents, residents, and service providers working together to improve local conditions. This message has particular resonance and urgency when drug-related problems in the targeted communities are severe and persistent.

- ***Free to Grow outreach and recruitment should emphasize building strengths.*** Promoting Free to Grow as an initiative to improve children's healthy development, rather than refer to it as a substance abuse initiative, increases overall receptivity to project efforts and minimizes possible resident hesitation to associate with a substance abuse prevention initiative. Having a clear, science-based framework to assess family and community needs as these relate to substance abuse is essential as well.

- ***Free to Grow strategies should be integrated into Head Start work from the outset.*** To promote Free to Grow's sustainability, the family- and community-strengthening strategies selected should be integrated from the beginning into Head Start's program structure and operations. Attention should be paid throughout to instituting procedures and developing tools that help institutionalize Free to Grow strategies and facilitate staff training to guard against excessive staff turnover.

- ***Responsibility for Free to Grow implementation should be in the hands of experienced, highly-skilled staff.*** As a team, the Free to Grow staff should possess strong strategic-planning skills, experience implementing special projects, community-organizing or neighborhood development expertise, and knowledge of the risk and protective factor framework and science-based prevention strategies. Because of the increased susceptibility of pilot projects to staff turnover, special attention should be paid to strategies for retaining key staff throughout the Free to Grow implementation period.

3. Support for New Grantees

As we have noted, Phase II grantees faced numerous challenges, which we expect new grantees to face as well. Often, implementation may compete with practical, high-priority concerns of the local programs, such as increasing the number of families served, expanding hours of service, increasing staff salaries, and improving facilities. Free to Grow family-strengthening strategies also require new procedures, new staff skills, and changes in how staff interact with Head Start families. Similarly, implementing Free to Grow community-strengthening strategies requires specialized community-development skills, the development of new partnerships, and changes in the aims of Head Start collaborations. These and other challenges mean that the next generation of Free to Grow grantees will need extensive support when they begin implementing their projects. Three types of support stand out as crucial: (1) financial support, (2) training and building capacity, and (3) technical assistance.

Financial Support. Because of the close alignment of Free to Grow work with dimensions of the revised Head Start Program Performance Standards, most Phase II grantees felt confident that they and other Head Start programs could sustain Free to Grow work within their existing budgets

and program structures. However, grantee administrators also believed that future grantees would need start-up funds to cover essential capacity-building investments, such as training staff and enlisting the help of consultants (or hiring new staff) to help develop new procedures that can later be used for ongoing staff training and operation of the Free to Grow strategies. Importantly, integrating community-strengthening efforts required additional Head Start staff. By using parents and local residents in a paraprofessional or volunteer capacity, some grantees were able to minimize the costs of such additions. Leveraging resources from Free to Grow partners and collaborators to support Free to Grow implementation was also essential--because of the many high-priority demands on Head Start program resources.

Training and Capacity Building. Head Start programs and their staff will need to take on new roles and responsibilities that will likely extend beyond their current expertise. Although circumstances will be different with each grantee, training and capacity-building efforts should include, at a minimum, the following:

- Direct training and technical assistance in (1) substance abuse prevention (including the risk and protective factor framework), (2) intervention with at-risk families, and (3) civic leadership and community action
- Support for learning hard-to-grasp substance abuse prevention principles and ongoing reinforcement of these principles, especially when turnover occurs among key staff and participants
- Ongoing, capacity-building efforts to give Head Start staff the time needed to assimilate important new concepts and procedures
- Access to ready-to-use Free to Grow implementation materials--including manuals and other resources--since Head Start programs are unlikely to have the time or resources to develop their own and hiring consultants to develop such materials can be costly
- Assistance in identifying consultants and other resources for training and capacity-building efforts

Technical Assistance. Free to Grow projects are likely to benefit from periodic contacts with an experienced provider of training and technical assistance. The primary function of technical assistance will be to facilitate meeting the training and capacity-building needs identified above. In addition, ongoing contact between the technical assistance provider and the new grantees will trigger periodic reviews of Free to Grow implementation progress, ongoing evaluation of what is going well (and what difficulties are encountered), and opportunities to guide the formulation of refinements to the replication process. In providing such support and guidance, it will be important to cultivate a climate of excellence while fostering honest dialogue about implementation strengths and weaknesses and supporting Free to Grow ownership by the sponsoring organizations. Achieving this will require the delicate balancing of monitoring and technical assistance functions.

D. FREE TO GROW'S VALUE TO HEAD START

The models developed by the Free to Grow grantees in Phase I, and grantees' experiences in refining, fully implementing, and integrating their model strategies into Head Start's program structure in Phase II, demonstrate the feasibility and value of conducting substance abuse prevention efforts within Head Start. Through their eager and continued participation, Head Start parents and staff, community residents, and collaborating service providers communicated their strong endorsement of Free to Grow's approach to prevention. Moreover, their perception that Free to Grow efforts brought about important family and community changes suggests that Free to Grow approaches may be appealing and appropriate to other communities facing similar challenges. Free to Grow provides a comprehensive framework--grounded in the scientific evidence on risk and protective factors for substance abuse--that allows Head Start programs to evaluate the strengths and needs of their families and communities as these relate to substance abuse. Using this framework, Head Start programs will be able to assess identified needs against their current activities, determine

what strategies are working and which services can be improved, and identify family and community needs that remain unaddressed. This framework also provides a structure for addressing important gaps in service delivery and enhancing the important high-quality work that Head Start programs already do with young children, their families, and the communities in which they live.

Although Head Start has been a family-strengthening program for 35 years, Free to Grow offers a new service paradigm that specifically focuses on protecting children from the risks associated with later substance abuse. These risks include both family and community factors, so Free to Grow models include strategies that provide intensive support to at-risk families, develop higher-level advocacy skills in strong families, cultivate civic leadership skills in parents of young children and other local residents, support grassroots efforts to achieve fundamental preventive changes at the community level, and collaborate with a wide range of community service providers in support of Head Start's program mission. Free to Grow's family supports and new types of community partnerships have the potential to make neighborhoods and families more protective environments for children through their implementation in Head Start. These Free to Grow strategies can:

- ***Facilitate family partnership agreements.*** The Free to Grow grantees were particularly strong in developing these agreements now required by the Revised Head Start Program Performance Standards that became effective in January 1998. For example, in identifying at-risk families, several Phase II grantees developed and instituted more-detailed family assessment procedures. Head Start programs can use these to help identify both at-risk Head Start families needing specialized, intensive support and strong, healthy families that could assume leadership roles within their programs.

- ***Increase parental involvement.*** All Phase II Free to Grow grantees expanded parent involvement opportunities to include ongoing support and education groups, paraprofessional activities (such as peer mentoring or parent advocacy), and community action groups. Staff and administrators see the progression of involvement opportunities as extending the period of parent involvement with Head Start beyond children's enrollment in the program.

- ***Expand parent education and staff training.*** Parents find the information on substance abuse prevention provided by Free to Grow programs useful. In addition, prevention

training helps staff become more aware of the symptoms of substance abuse and more knowledgeable about appropriate strategies and resources for helping families.

- ***Strengthen interventions for at-risk families.*** Strategies such as family-to-family mentoring, specialized case management, and family therapy or counseling build on existing case management and counseling services and enhance Head Start's work with families that are at risk for substance abuse or are currently affected by moderately complex to severe substance abuse problems.

- ***Employ parents as resources.*** Employing Head Start parents as resources for other families constitutes a dual intervention. Using parents as volunteers or paraprofessional staff offers a relatively economical, practical alternative to hiring new staff or expanding the responsibilities of current staff. Peer mentoring and parent advocacy provide stronger Head Start parents with opportunities to mentor and support other Head Start families, while also creating new role models. These parents can develop new skills, build competencies, and gain self-confidence and experience that may help them attain personal goals and embark in new roles.

- ***Strengthen Head Start's leadership in the community.*** True to the spirit of the Revised Program Performance Standards, Free to Grow offers strategies for Head Start grantees to cultivate civic leadership skills in Head Start parents and other local residents, extend grantees' collaborative efforts to nontraditional Head Start partners, and support grassroots efforts for community improvement. Assuming a leadership role in the empowerment and organization of local communities makes it possible for Head Start to achieve more fundamental community-level changes.

- ***Develop parent advocacy skills.*** Implementing Free to Grow strategies provides Head Start parents with opportunities to cultivate progressively higher-level advocacy and leadership skills. This strengthens Head Start's efforts to support parental advocacy and civic activism by articulating a clearer progression of leadership opportunities for parents, both during and beyond their participation in the program.

- ***Create new types of collaborative relationships.*** Strong partnerships with local government, schools, substance abuse prevention organizations, churches, recreational organizations, and other community resources help create and sustain concerted action toward the improvement of the Free to Grow target communities. The collaborative relationships reach beyond traditional service coordination and enhancement to focus on supporting resident-led efforts to address community needs and concerns extending beyond the purview of any one provider organization. The police and other law enforcement organizations are essential partners in Free to Grow community strengthening efforts, especially in communities with severe illicit drug dealing and community violence problems.

Finally, although Free to Grow family- and community-strengthening strategies will aid Head Start programs in meeting the Revised Head Start Program Performance Standards, they also create new challenges. For example, community advocacy work can strain established collaborative relationships when Head Start grantees challenge traditional agency loyalties and encourage their partners to let resident-defined community needs and priorities inform their work. In addition, Free to Grow community-strengthening strategies require specialized community development skills that Head Start programs may need to cultivate. To focus more on substance abuse prevention, Head Start programs may also need to adopt new procedures, help staff develop new skills, and adapt their ways of interacting with families. When successful, however, future Free to Grow Head Start efforts can facilitate and support the work of community groups, helping residents progress toward their goals without undermining residents' sense of ownership in their community.

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APPENDIX A

LOGIC MODELS

FIGURE A.1

A LOGIC MODEL FOR CALIFORNIA'S FREE TO GROW PROJECT

Goal: prevent substance abuse problems by reducing risks and enhancing protective factors at the family and community levels

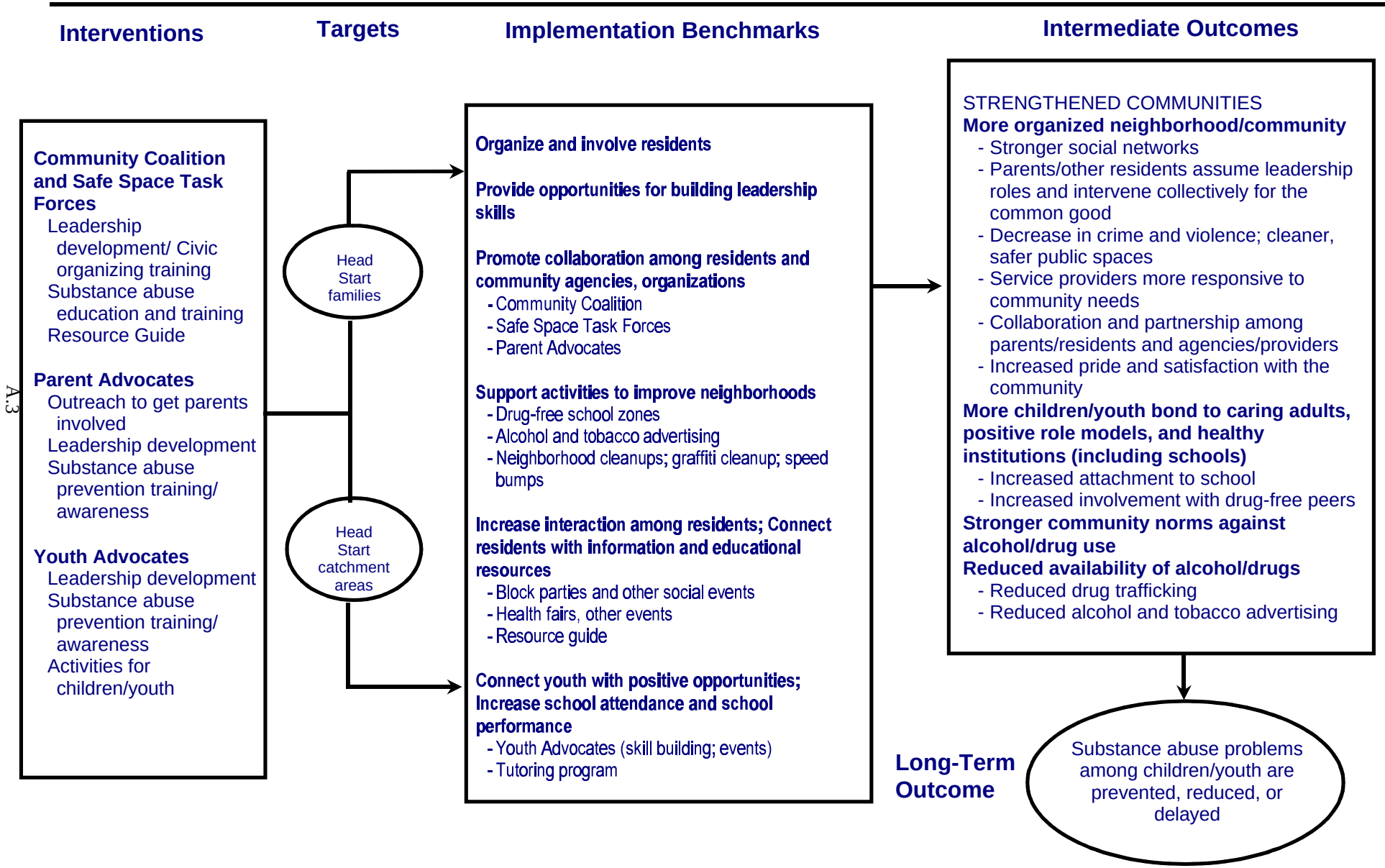


FIGURE A.2

A LOGIC MODEL FOR COLORADO'S FREE TO GROW PROJECT

Goal: Prevent Substance Abuse Problems by Reducing Risks and Enhancing Protective Factors at the Family and Community Levels

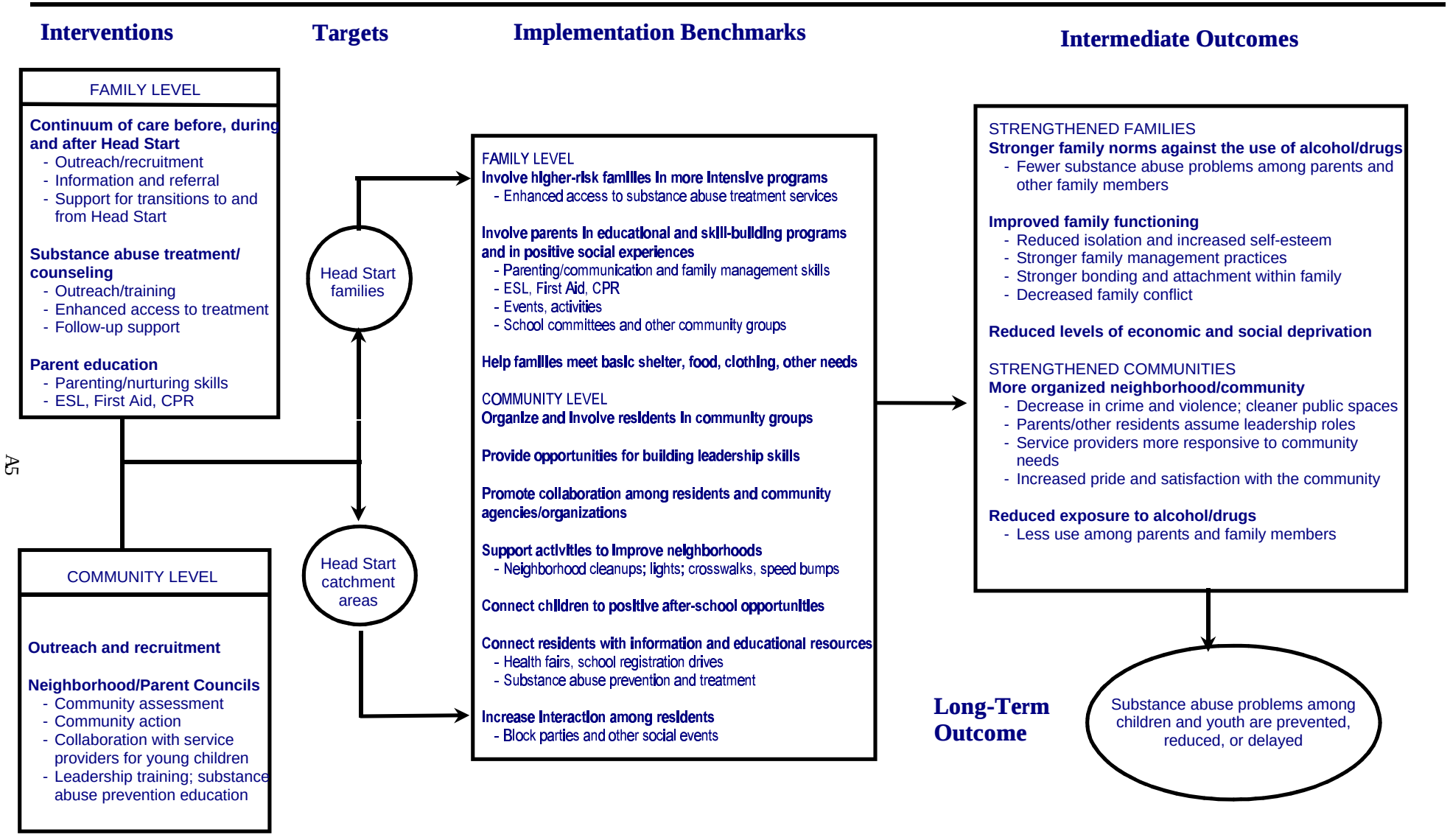


FIGURE A.3

A LOGIC MODEL FOR KENTUCKY'S FREE TO GROW PROJECT

Goal: Prevent Substance Abuse Problems by Reducing Risks and Enhancing Protective Factors at the Family and Community Levels

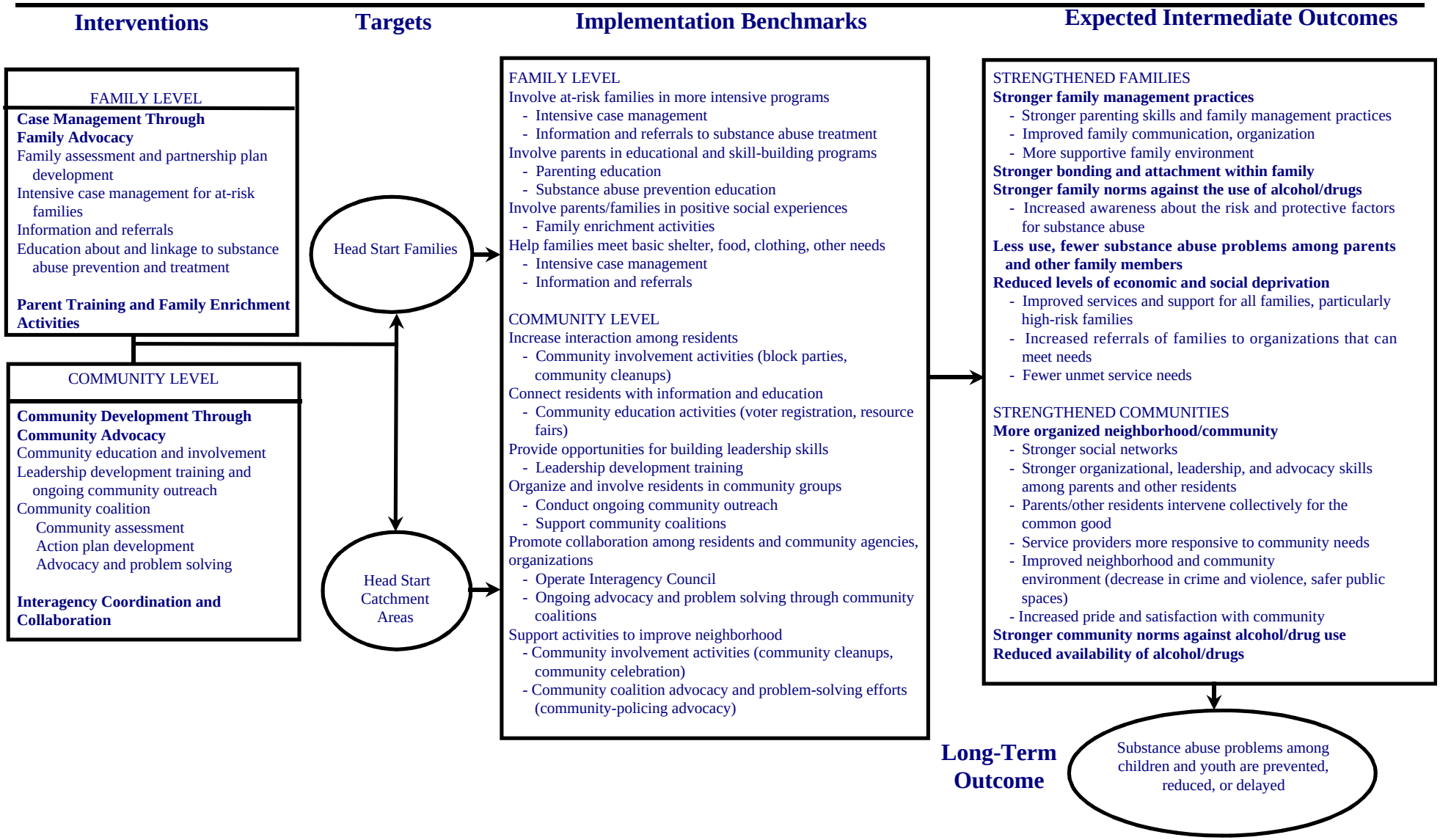


FIGURE A.4
A LOGIC MODEL FOR PUERTO RICO'S FREE TO GROW PROJECT
Goal: to prevent substance abuse problems by reducing risks and enhancing protective factors at the family and community levels

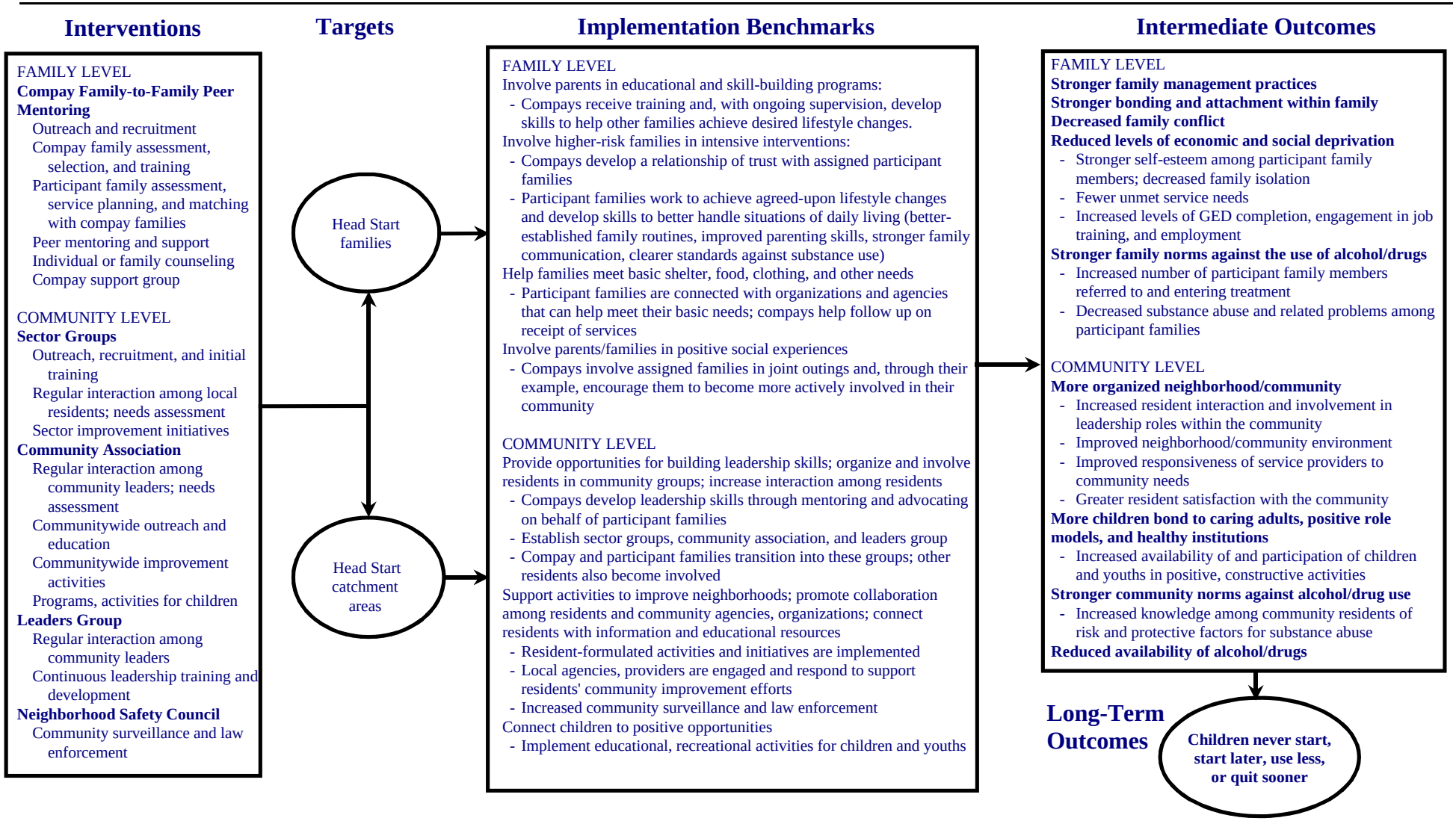
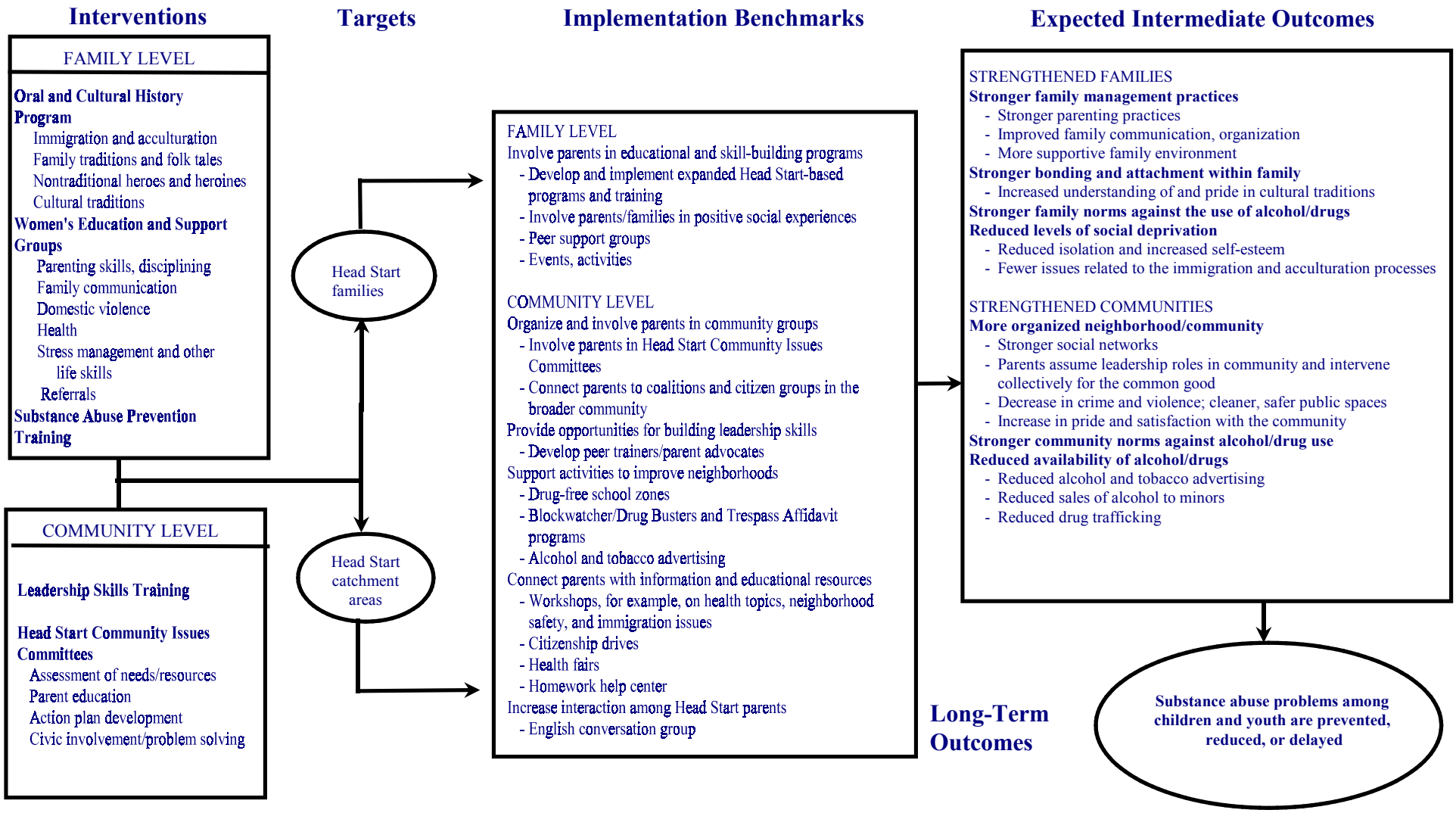


FIGURE A.5

A LOGIC MODEL FOR NEW YORK'S FREE TO GROW PROJECT

Goal: Prevent Substance Abuse Problems by Reducing Risks and Enhancing Protective Factors at the Family and Community Levels



APPENDIX B

TALLY OF RESPONSES FOR PROJECT OUTCOMES

TABLE B.1

EVALUATION CHECKLIST

TALLY OF RESPONSES
Compton, California Free to Grow Project

(Number of Responses)	Respondent Category			
	FTG, Head Start, Grantee Staff 8	Other Provider 2	Parents 10	Overall 20
Items in Evaluation Form	Average Scores			
a. Getting parents involved in schools	3.5	4.0	3.5	3.6
b. Building stronger parenting skills; stronger bonds between children and their parents	3.9	4.0	3.7	3.8
c. Getting parents to have clear rules about drugs/alcohol	3.1	4.0	3.6	3.4
d. Getting people to stop using drugs and alcohol	2.9	3.5	2.9	3.0
e. Stopping domestic abuse/family violence	2.5	*2.5*	2.3	2.4
f. Helping families with shelter, food, clothing needs	3.0	3.0	2.7	2.9
g. Helping people to get their GED or to get a job	3.4	3.5	2.7	3.1
h. Getting agencies/providers to listen and respond to resident concerns	3.8	4.0	3.5	3.7
i. Getting people involved in the community	3.9	4.0	3.9	3.9
j. Getting community members together more often	3.8	4.0	3.6	3.7
k. Getting residents to solve community problems	3.6	4.0	2.9	3.3
l. Giving children better things to do in their free time	3.4	4.0	3.7	3.6
m. Stopping the sale of drugs and alcohol to minors	2.8	3.5	2.2	2.6
n. Stopping drug use and drug trafficking	2.7	3.5	2.2	2.5

TABLE B.1 (*continued*)

(Number of Responses)	Respondent Category			
	FTG, Head Start, Grantee Staff 8	Other Provider 2	Parents 10	Overall 20
Items in Evaluation Form	Average Scores			
o. Cutting down on crime and violence in the community	2.9	3.0	3.1	3.0
p. Making the community cleaner and less run-down	3.5	3.5	3.8	3.7
q. Making it easier for residents to get the services they need	3.3	4.5	3.5	3.5
r. Helping people feel safe in their neighborhood/ community	3.3	4.5	3.1	3.3
s. Getting people to want to stay in the community	3.0	4.5	2.7	3.0
t. Other changes we haven't mentioned: - Civic practices: getting more people to work across ethnic and institutional lines (score: 5) - Empower parents, lift their self-esteem (score: 5)				

TABLE B.2

EVALUATION CHECKLIST

TALLY OF RESPONSES
Colorado Springs, Colorado Free To Grow Project

	Respondent Category			
(Number of Responses)	FTG Staff 2	Head Start or Grantee Staff 2	Other Community Provider 7	Overall 11
Items in Evaluation Form	Average Scores			
a. Getting parents involved in schools	3.5	5	4	4.1
b. Building stronger parenting skills; stronger bonds between children and their parents	4	4	3	3.4
c. Getting parents to have clear rules about drugs/alcohol	2.5	3	3	2.9
d. Getting people to stop using drugs and alcohol	3	2.5	3	3
e. Stopping domestic abuse/family violence	2.5	1	2.5	2.5
f. Helping families with shelter, food, clothing needs	5	5	3.7	4.2
g. Helping people to get their GED or to get a job	2	3	1.8	2.4
h. Getting agencies/providers to listen and respond to resident concerns	4	5	4.3	4.4
i. Getting people involved in the community	4.5	4	4.1	4.2
j. Getting community members together more often	4	5	4	4.2
k. Getting residents to solve community problems	4	4	4.5	4.3
l. Giving children better things to do in their free time	4	3	3.6	3.6
m. Stopping the sale of drugs and alcohol to minors	1.5	1.5	1.8	1.7
n. Stopping drug use and drug trafficking	1.5	1.5	2.3	2
o. Cutting down on crime and violence in the community	3.5	3	3.3	3.3

TABLE B.2 (*continued*)

(Number of Responses)	Respondent Category			
	FTG Staff 2	Head Start or Grantee Staff 2	Other Community Provider 7	Overall 11
Items in Evaluation Form	Average Scores			
p. Making the community cleaner and less run-down	4	4	3.7	3.8
q. Making it easier for residents to get the services they need	4	4	3.8	3.9
r. Helping people feel safe in their neighborhood/ community	4	4	3.5	3.7
s. Getting people to want to stay in the community	4	4	3.5	3.5
t. Other changes we haven't mentioned:				

TABLE B.3

EVALUATION CHECKLIST

TALLY OF RESPONSES
Owensboro, Kentucky Free to Grow Project

(Number of Responses)	Respondent Category			
	Staff 4	Partners 3	Parents/ Residents 7	Overall 14
Items in Evaluation Form	Average Scores			
a. Getting parents involved in schools	3.3	2	3	2.9
b. Building stronger parenting skills; stronger bonds between children and their parents	3.5	3	4.3	3.8
c. Getting parents to have clear rules about drugs/alcohol	3.3	2.7	4.5	3.8
d. Getting people to stop using drugs and alcohol	2.8	2	4.3	3.4
e. Stopping domestic abuse/family violence	2.8	2	4	3.2
f. Helping families with shelter, food, clothing needs	3.7	2.5	3.6	3.4
g. Helping people to get their GED or to get a job	3.5	3	2.3	2.8
h. Getting agencies/providers to listen and respond to resident concerns	4.5	4	4.8	4.5
i. Getting people involved in the community	4.7	3	4.4	4.2
j. Getting community members together more often	4.3	3	4.6	4.2
k. Getting residents to solve community problems	4.3	3.3	4.0	3.9
l. Giving children better things to do in their free time	3.5	3.7	4.0	2.9
m. Stopping the sale of drugs and alcohol to minors	3.8	2	4.8	3.9
n. Stopping drug use and drug trafficking	3.3	3	4.2	3.7
o. Cutting down on crime and violence in the community	3.5	3	4.3	3.8
p. Making the community cleaner and less run-down	3.5	3.3	4.3	3.9

TABLE B.3 (*continued*)

	Respondent Category			
(Number of Responses)	Staff 4	Partners 3	Parents/ Residents 7	Overall 14
Items in Evaluation Form	Average Scores			
q. Making it easier for residents to get the services they need	4	3.5	3.8	3.8
r. Helping people feel safe in their neighborhood/ community	3.8	3.3	4.4	4.0
s. Getting people to want to stay in the community	3.0	3	4.0	3.5
t. Other changes we haven't mentioned:				

TABLE B.4

EVALUATION CHECKLIST

TALLY OF RESPONSES
New York City, New York Free to Grow Project

	Respondent Category		
(Number of Responses)	Staff (8) and Partners (1) 9	Parents/ Residents 7	Overall 16
Items in Evaluation Form	Average Scores		
a. Getting parents involved in schools	4.4	5	4.7
b. Building stronger parenting skills; stronger bonds between children and their parents	4.1	4.3	4.2
c. Getting parents to have clear rules about drugs/alcohol	4.2	4.8	4.5
d. Getting people to stop using drugs and alcohol	3.7	3.3	3.5
e. Stopping domestic abuse/family violence	3.4	4.0	3.7
f. Helping families with shelter, food, clothing needs	3.8	4.3	4.0
g. Helping people to get their GED or to get a job	4.2	4.0	4.1
h. Getting agencies/providers to listen and respond to resident concerns	3.7	4.4	4.0
i. Getting people involved in the community	4.7	4.1	4.4
j. Getting community members together more often	4.1	3.8	4.0
k. Getting residents to solve community problems	3.8	4.3	4.0
l. Giving children better things to do in their free time	4.3	4.5	4.4
m. Stopping the sale of drugs and alcohol to minors	3.8	3.8	3.8
n. Stopping drug use and drug trafficking	3.7	3.8	3.7
o. Cutting down on crime and violence in the community	3.8	4.0	3.9
p. Making the community cleaner and less run-down	3.8	3.7	3.8
q. Making it easier for residents to get the services they need	3.9	3.7	3.8
r. Helping people feel safe in their neighborhood/ community	3.7	3.2	3.5
s. Getting people to want to stay in the community	3.6	3.1	3.4
t. Other changes we haven't mentioned:			

TABLE B.5

EVALUATION CHECKLIST

TALLY OF RESPONSES
Puerto Rico Free To Grow Project

	Respondent Category				
(Number of Responses)	Staff and Partners 8	Participant Families 5	Compay Families 7	Leaders 13	Overall 33
Items in Evaluation Form	Average Scores				
a. Getting parents involved in schools	4.5	5	4	3.8	4.2
b. Building stronger parenting skills; stronger bonds between children and their parents	4.4	5	4.3	4.2	4.4
c. Getting parents to have clear rules about drugs/alcohol	4	4.6	4.4	3	3.8
d. Getting people to stop using drugs and alcohol	2.9	4.2	4.1	2.1	3.0
e. Stopping domestic abuse/family violence	4.1	3.2	3.8	2.6	3.3
f. Helping families with shelter, food, clothing needs	4.6	4.6	4.3	3.8	4.2
g. Helping people to get their GED or to get a job	4.6	4.2	4.1	3.5	4.0
h. Getting agencies/providers to listen and respond to resident concerns	4.6	5	4	4.3	4.4
i. Getting people involved in the community	4.8	4.6	4.3	4.4	4.5
j. Getting community members together more often	4.6	4.6	4.3	4.2	4.4
k. Getting residents to solve community problems	4.8	3.6	4.6	4.3	4.4
l. Giving children better things to do in their free time	4.3	4.8	3.4	3	3.7
m. Stopping the sale of drugs and alcohol to minors	3.3	4.4	2.8	3.2	3.3
n. Stopping drug use and drug trafficking	3.4	3.8	3.6	2.7	3.2
o. Cutting down on crime and violence in the community	4	3.8	3.4	2.5	3.3
p. Making the community cleaner and less run-down	4.6	4.4	3.8	4.5	4.4
q. Making it easier for residents to get the services they need	4.5	4.6	3.7	3.6	4.0

TABLE B.5 *(continued)*

(Number of Responses)	Respondent Category				
	Staff and Partners 8	Participant Families 5	Compay Families 7	Leaders 13	Overall 33
Items in Evaluation Form	Average Scores				
r. Helping people feel safe in their neighborhood/ community	4.6	4.2	3.8	3.4	3.9
s. Getting people to want to stay in the community	4.5	3.8	4.1	3.5	3.9
t. Other changes we haven't mentioned: - Support educational initiatives (1 person, score 4) - Meet needs of bilingual community (1 person, score 3)					

APPENDIX C

CRITERIA OF SUCCESS FOR PHASE I AND OBJECTIVES FOR PHASE II OF FREE TO GROW

APPENDIX C

CRITERIA OF SUCCESS FOR PHASE I AND OBJECTIVES FOR PHASE II OF FREE TO GROW

A. CRITERIA OF SUCCESS FOR PHASE I

By the end of Phase I, the grantees should demonstrate evidence of a well-defined, promising model with preliminary evidence of feasibility and effectiveness. Specifically:

1. Clear, Well-Defined Model

The strategy or overall approach, objectives, and methods of the model should be clear and well defined. This includes measurable objectives. The strategy and the objectives should have been relatively clear at the beginning of Phase I; it is the methods for accomplishing the objectives that probably will evolve and become clearer and more well developed by the end of Phase I. The model must have logical and conceptually clear underpinnings.

2. Significant Model

The intervention should address in a meaningful way an important part of the substance abuse problem among families served by the Head Start grantee. It should also incorporate the principles of increasing protective factors and decreasing the risk factors for preschool children through strategies that address family and community needs.

3. Innovative Model

The model offers the Head Start community new ways of addressing the issue of substance abuse prevention for Head Start families by carefully setting forth an intervention that will recast traditional ways of approaching this increasingly harmful societal phenomenon. A grantee may use

interventions that have been tried in other kinds of programs and/or settings but are rarely, if ever, found in Head Start; therefore, it does not have to be a "never tried before" intervention to be considered innovative in the Free to Grow initiative.

4. Appropriate Potency or Level of Intensity

The breadth and intensity of the intervention should fit the nature of the problem addressed. The intensity of the intervention refers to its frequency, duration, and number of hours. The breadth of the intervention refers to the number of components of the problem it addresses. Substance abuse in a family and/or neighborhood is a complex, multifaceted, determined, and typically entrenched problem. Therefore, to make a significant and lasting improvement in the environment for small children, a relatively intense intervention is likely to be needed. For example, a 10-session curriculum for parents, by itself, is not likely to reduce substance abuse in families.

5. Culturally Sensitive

The model is reflective of, and clearly addresses, the specific cultural needs of the parents and communities it seeks to serve. Staffing decisions are made consonant with the ethnic and the cultural diversity of the Head Start families. Any interventions proposed are respectful of the values and mores of the Head Start families and communities served.

6. Generalizability of the Model

The model seems applicable to a significant portion of other Head Start grantees. Because there are many Head Start programs nationwide, a model does not have to be applicable to all or even most of them. It should, however, be applicable to a significant portion (that is, at least 20 percent), for example, rural projects or projects serving migrant workers.

7. Feasibility of the Model

Based on pilot testing, the model can be readily implemented and does not overburden the Head Start grantees or their partners. Participation levels of parents, families, and Head Start staff meet the stated objectives. Staff, parents, and partner organizations are satisfied with the model and accept it.

8. Strong Partnerships

A strong partnership has been formed between the Head Start grantee and selected other community organization(s). The strength of the partnership could be defined by such tangible mechanisms as formal agreements, regularly scheduled meetings and written communications, and communications at both the administrative level and the "front line." The strength of a partnership could also be defined by the number and scope of functions shared by the organizations: information sharing, referrals, sharing resources, sharing accountability, joint decision making, and actual integration of services (for example, co-location).

9. Marshals or Utilizes Community Resources (In Addition to the Partners in the Grant)

The grantee fully identifies needed and available resources in the community that are pertinent to its objectives and model and demonstrates, on a pilot basis, the ability to link families to them. When needed resources are unavailable, the grantee might facilitate and stimulate gap reduction.

10. Preliminary Evidence of Potential Effectiveness

The model is logically and conceptually sound. There is a logical and conceptual basis for thinking that the strategies will produce the stated objectives. The proposed short-term outcomes for the family and/or neighborhood can be seen anecdotally, via systematic description (project

records and formal evaluation). For example, the objective of a model might be to get parents or other household members to enter and stay in treatment.

B. OBJECTIVES FOR PHASE II

The criteria of success for Phase I will continue to be applicable in Phase II. In addition, the purpose of Phase II is to further implement and document the model so that, by the end of Phase II, the model can be institutionalized and sustained as an ongoing feature of the Head Start program. This means that, during Phase II, grantees will be expected to:

1. Expand the model by greater penetration into the entire neighborhood of the pilot test as originally defined by the grantee. Those projects that are positioned to move beyond the original target neighborhood (that is, adding additional neighborhoods) are encouraged to do so.

2. Ensure that all components of the model are fully operational.

3. Assess the feasibility of the model when it is taken "to scale" (that is, expanded participation, retention, and available resources).

4. Further refine and document the model so it is replicable. This means that the final production of manuals, training guides, and so forth are to be made available to the national Head Start program and other Head Start grantees.

5. The Head Start grantee is to address issues (for example, cost) relevant to institutionalization and sustainability.

Source: Adapted from "Application for a Three-Year Project Implementation Grant: Free to Grow, Head Start Partnerships to Promote Substance-Free Communities." Free to Grow National Program Office, August 1, 1995.