

LifeSkills Training

Public Health & Prevention: School-based

Benefit-cost estimates updated December 2019. Literature review updated June 2014.

Current estimates replace old estimates. Numbers will change over time as a result of model inputs and monetization methods.

The WSIPP benefit-cost analysis examines, on an apples-to-apples basis, the monetary value of programs or policies to determine whether the benefits from the program exceed its costs. WSIPP's research approach to identifying evidence-based programs and policies has three main steps. First, we determine "what works" (and what does not work) to improve outcomes using a statistical technique called meta-analysis. Second, we calculate whether the benefits of a program exceed its costs. Third, we estimate the risk of investing in a program by testing the sensitivity of our results. For more detail on our methods, see our [Technical Documentation](#).

Program Description: LifeSkills Training (LST) is a school-based classroom intervention to reduce the risks of alcohol, tobacco, drug abuse, and violence by targeting social and psychological factors associated with initiation of risky behaviors. Teachers deliver the program to middle/junior high school students in 24 to 30 sessions over three years. Students in the program are taught general self-management and social skills and skills related to avoiding substance use.

Benefit-Cost Summary Statistics Per Participant

Benefits to:

Taxpayers	\$420	Benefit to cost ratio	\$13.49
Participants	\$954	Benefits minus costs	\$1,295
Others	\$45	Chance the program will produce benefits greater than the costs	62 %
Indirect	(\$20)		
Total benefits	\$1,399		
Net program cost	(\$104)		
Benefits minus cost	\$1,295		

The estimates shown are present value, life cycle benefits and costs. All dollars are expressed in the base year chosen for this analysis (2018). The chance the benefits exceed the costs are derived from a Monte Carlo risk analysis. The details on this, as well as the economic discount rates and other relevant parameters are described in our [Technical Documentation](#).

Detailed Monetary Benefit Estimates Per Participant

Benefits from changes to: ¹	Benefits to:				
	Participants	Taxpayers	Others ²	Indirect ³	Total
Crime	\$0	\$0	\$39	\$0	\$39
K-12 grade repetition	\$0	\$0	\$0	\$0	\$1
Labor market earnings associated with problem alcohol use	\$943	\$401	\$0	\$0	\$1,344
Property loss associated with problem alcohol use	\$3	\$0	\$5	\$0	\$8
Health care associated with problem alcohol use	\$6	\$31	\$35	\$16	\$87
Mortality associated with problem alcohol	\$3	\$1	\$0	\$23	\$27
Adjustment for deadweight cost of program	\$0	(\$14)	(\$35)	(\$59)	(\$108)
Totals	\$954	\$420	\$45	(\$20)	\$1,399

¹In addition to the outcomes measured in the meta-analysis table, WSIPP measures benefits and costs estimated from other outcomes associated with those reported in the evaluation literature. For example, empirical research demonstrates that high school graduation leads to reduced crime. These associated measures provide a more complete picture of the detailed costs and benefits of the program.

²“Others” includes benefits to people other than taxpayers and participants. Depending on the program, it could include reductions in crime victimization, the economic benefits from a more educated workforce, and the benefits from employer-paid health insurance.

³“Indirect benefits” includes estimates of the net changes in the value of a statistical life and net changes in the deadweight costs of taxation.

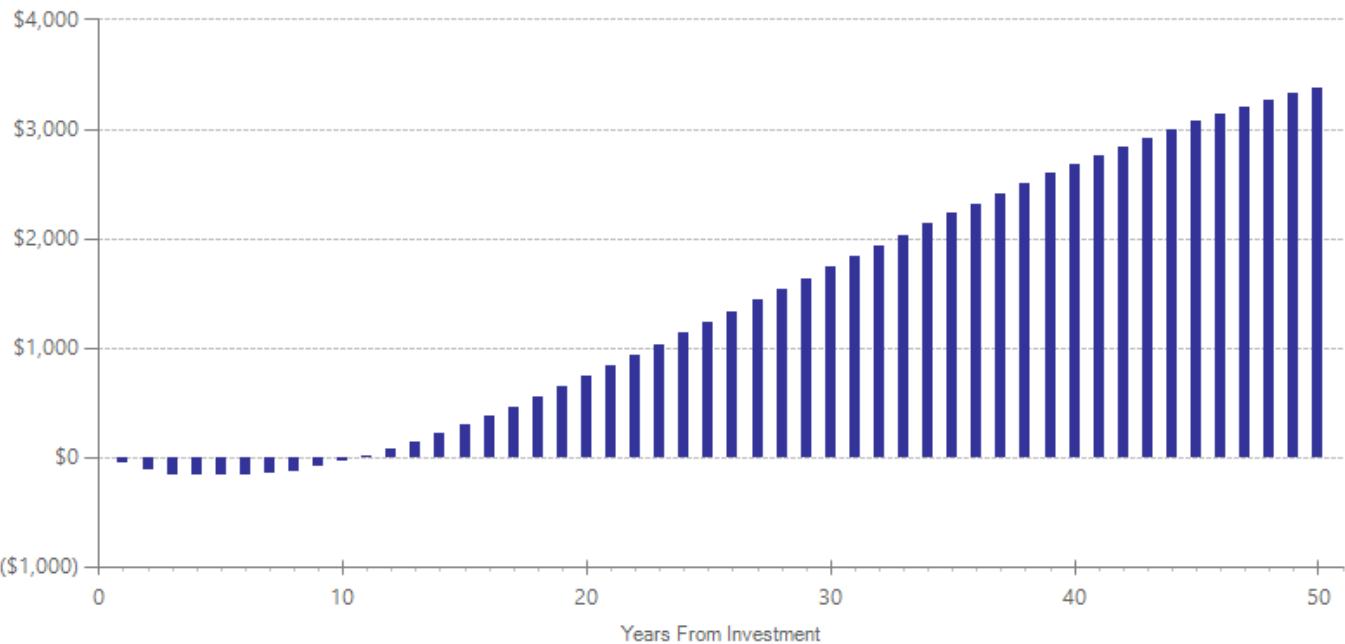
Detailed Annual Cost Estimates Per Participant

	Annual cost	Year	dollars	Summary
Program costs	\$34	2013		Present value of net program costs (in 2018 dollars)
Comparison costs	\$0	2013		(\$104) Cost range (+ or -) 10 %

The cost estimate assumes teachers deliver 7.5 hours of the intervention over ten sessions per year (the program is typically implemented for three years) to approximately 26 students per class. The estimate includes cost for training and student materials based on data from Blueprints for Healthy Youth Development and the developer’s website (<http://www.blueprintsprograms.com/program-costs/lifeskills-training-1st>; <https://www.lifeskillstraining.com/2016-PHP-Price-List.pdf>).

The figures shown are estimates of the costs to implement programs in Washington. The comparison group costs reflect either no treatment or treatment as usual, depending on how effect sizes were calculated in the meta-analysis. The cost range reported above reflects potential variation or uncertainty in the cost estimate; more detail can be found in our [Technical Documentation](#).

Detailed Annual Cost Estimates Per Participant



The graph above illustrates the estimated cumulative net benefits per-participant for the first fifty years beyond the initial investment in the program. We present these cash flows in non-discounted dollars to simplify the “break-even” point from a budgeting perspective. If the dollars are negative (bars below \$0 line), the cumulative benefits do not outweigh the cost of the program up to that point in time. The program breaks even when the dollars reach \$0. At this point, the total benefits to participants, taxpayers, and others, are equal to the cost of the program. If the dollars are above \$0, the benefits of the program exceed the initial investment.

Meta-Analysis of Program Effects

Outcomes measured	Treatment age	No. of effect sizes	Treatment N	Adjusted effect sizes and standard errors used in the benefit-cost analysis						Unadjusted effect size (random effects model)	
				First time ES is estimated			Second time ES is estimated				
				ES	SE	Age	ES	SE	Age	ES	p-value
Alcohol use before end of high school	13	3	280	0.034	0.074	18	0.034	0.074	18	0.028	0.702
Alcohol use before end of middle school	13	5	3150	-0.026	0.033	14	-0.026	0.033	14	-0.080	0.017
Cannabis use before end of high school	13	3	280	0.000	0.077	18	0.000	0.077	18	-0.007	0.398
Cannabis use before end of middle school	13	4	3056	-0.014	0.033	14	-0.014	0.033	14	-0.041	0.217
Internalizing symptoms	13	4	3092	-0.018	0.091	14	-0.018	0.091	16	-0.054	0.549
Problem alcohol use	13	2	1947	-0.059	0.116	15	-0.059	0.116	25	-0.241	0.421
Smoking before end of high school	13	4	359	-0.076	0.073	18	-0.076	0.073	18	-0.128	0.129
Smoking before end of middle school	13	8	3617	-0.028	0.033	14	-0.028	0.033	14	-0.083	0.012

Meta-analysis is a statistical method to combine the results from separate studies on a program, policy, or topic in order to estimate its effect on an outcome. WSIPP systematically evaluates all credible evaluations we can locate on each topic. The outcomes measured are the types of program impacts that were measured in the research literature (for example, crime or educational attainment). Treatment N represents the total number of individuals or units in the treatment group across the included studies.

An effect size (ES) is a standard metric that summarizes the degree to which a program or policy affects a measured outcome. If the effect size is positive, the outcome increases. If the effect size is negative, the outcome decreases.

Adjusted effect sizes are used to calculate the benefits from our benefit cost model. WSIPP may adjust effect sizes based on methodological characteristics of the study. For example, we may adjust effect sizes when a study has a weak research design or when the program developer is involved in the research. The magnitude of these adjustments varies depending on the topic area.

WSIPP may also adjust the second ES measurement. Research shows the magnitude of some effect sizes decrease over time. For those effect sizes, we estimate outcome-based adjustments which we apply between the first time ES is estimated and the second time ES is estimated. We also report the unadjusted effect size to show the effect sizes before any adjustments have been made. More details about these adjustments can be found in our [Technical Documentation](#).

Citations Used in the Meta-Analysis

Botvin, G.J., Baker, E., Botvin, E.M., Filazzola, A.D., & Millman, R.B. (1984). Prevention of alcohol misuse through the development of personal and social competence: A pilot study. *Journal Studies on Alcohol*, 45(6), 550-552.

Botvin, G.J., Baker, E., Dusenbury, L., Botvin, E. M., & Diaz, T. (1995). Long-term follow-up results of a randomized drug abuse prevention trial in a white middle-class population. *Journal of the American Medical Association*, 273(14), 1106-1112.

Botvin, G.J., Baker, E., Dusenbury, L., Tortu, S., & Botvin, E.M. (1990). Preventing adolescent drug abuse through a multimodal cognitive-behavioral approach: Results of a 3-year study. *Journal of Consulting and Clinical Psychology*, 58(4), 437-446.

Botvin, G.J., Batson, H.W., Witts-Vitale, S., Bess, V., Baker, E., Dusenbury, L. (1989). A psychosocial approach to smoking prevention for urban Black youth. *Public Health Reports*, 104(6), 573-583.

Botvin, G.J., Baker, E., Filazzola, A.D., & Botvin, E.M. (1990). A cognitive-behavioral approach to substance abuse prevention: One-year follow-up. *Addictive Behaviors*, 15(1), 47-63

Botvin, G.J., Dusenbury, L., Baker, E., James-Ortiz, S., Botvin, E.M., & Kerner, J. (1992). Smoking prevention among urban minority youth: Assessing effects on outcomes and mediating variables. *Health Psychology*, 11(5), 290-299.

Botvin, G.J., Dusenbury, L., Baker, E., James-Ortiz, S., & Kerner, J. (1989). A skills training approach to smoking prevention among Hispanic youth. *Journal of Behavioral Medicine*, 12(3), 279-296.

Botvin, G.J., & Eng, A. (1982). The efficacy of a multicomponent approach to the prevention of cigarette smoking. *Preventive Medicine*, 11(2), 199-211.

Botvin, G.J., Eng, A., & Williams, C.L. (1980). Preventing the onset of cigarette smoking through life skills training. *Preventive Medicine*, 9(1), 135-143.

Botvin, G.J., Epstein, J.A., Baker, E., Diaz, T., Ifill-Williams, M. (1997). School-based drug abuse prevention with inner-city minority youth. *Journal of Child and Adolescent Substance Abuse*, 6(1), 5-19.

Botvin, G.J., Griffin, K.W., Diaz, T., & Ifill-Williams, M. (2001). Drug abuse prevention among minority adolescents: Posttest and one- year follow-up of a school-based preventive intervention. *Prevention Science*, 2(1), 1-13.

Botvin, G.J., Griffin, K.W., Diaz, T., & Ifill-Williams, M. (2001). Preventing binge drinking during early adolescence: One- and two-year follow-up of a school-based preventive intervention. *Psychology of Addictive Behaviors*, 15, 360-365.

Botvin, G.J., Renick, N.L., & Baker, E. (1983). The effects of scheduling format and booster sessions on a broad spectrum psychosocial approach to smoking prevention. *Journal of Behavioural Medicine*, 6(4), 359-379.

Botvin, G.J., Schinke, S.P., Epstein, J.A., Diaz, T., & Botvin, E.M. (1995). Effectiveness of culturally focused and generic skills training approaches to alcohol and drug abuse prevention among minority adolescents: Two-year follow-up results. *Psychology of Addictive Behaviors*, 9(3), 183-194.

Spoth, R.L., Randall, G.K., Trudeau, L., Shin, C., & Redmond, C. (2008). Substance use outcomes 5 1/2 years past baseline for partnership-based, family-school preventive interventions. *Drug and Alcohol Dependence*, 96(1), 57-68.

Vicary, J., Smith, E., Swisher, J., Hopkins, A., Elek, E., Bechtel, L., & Henry, K. (2006). Results of a 3-year study of two methods of delivery of life skills training. *Health Education & Behavior*, 33(3), 325-339.