

Kids Don't Float

Adapting the public health approach to develop, test, and evaluate potential recreational boating safety interventions.

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On a June day in 1998, 12-year-old Pamela Smith was playing along the water's edge in Kotzebue, Alaska, with some friends when she suddenly slipped into deep water. While she knew how to swim, she was having difficulty doing so in the current and with such cold water. As she struggled to keep her head above the water, she yelled out for help. Fortunately, 10-year-old George "Radar" Lambert was also there that day, and he saw her go under the water while being taken out by the current.

Radar—a non-swimmer—quickly donned a nearby "Kids Don't Float" loaner life jacket and dog-paddled out to Pamela, who by then had gone under a second time and was too cold and out of breath to speak. He grabbed her around her neck and started back to land, later recalling, "I used every muscle in my body to get to shore."

When asked what he was thinking as he went out to Pamela, Radar shrugged his shoulders and said, "She's my friend. I have to help her." His was the first of at least 28 "Kids Don't Float" program saves in Alaska.



Radar Lambert shortly after the event in Kotzebue. Photo by Tom Fazzini. Photo courtesy of the Alaska Office of Boating Safety.

Kids Don't Float began in 1996 in the coastal town of Homer, Alaska, in response to the high incidence of childhood drowning in Alaska. A local fire chief came up with the idea after attending an injury prevention conference where he learned about the "Children Can't Fly" campaign, a highly successful injury prevention program created in response to deaths from window falls in New York City.

The Kids Don't Float program started with a handful of life jacket loaner stations in communities around Kachemak Bay. It quickly expanded and is now in action thanks to communities, organizations, and individuals statewide. It has been embraced in other parts of the nation more recently.

With 624 life jacket loaner stations in place in Alaska, it has been hailed as one of the best examples of what a successful injury prevention program looks like.

First-Hand Experience

Like many involved in boating safety, my career began in the field. I was on the "response" side of boating accident and drowning cases as a park ranger responsible for law enforcement and emergency medical care. In Alaska, the emergency medical services unit is tied to the "prevention" side of the Department of Health, and I was first introduced to the concept of the public health approach to injury prevention as an emergency medical technician.

Public Health Approach to Injury Prevention

The public health approach to injury prevention is a proven model that could greatly benefit recreational boating safety programs for many reasons:

- It uses a wide range of proven sciences and disciplines.
- It is already widely understood and used by many federal agencies, state agencies, and injury prevention organizations.
- In some disciplines (e.g., modern social marketing's application to injury prevention-related behavioral issues), it has already been integrated into professional "best practices."¹
- It targets resources on the highest priorities.
- It focuses on preventive interventions that have been tested with the target population before implementation.

- It is highly accountable. Performance measurements are meaningful because they are tied to objectives and carefully built in at the front end during the design phase—not after the fact.
- It is collaborative. Proven effectiveness encourages and secures high levels of voluntary engagement at the grass-roots level.
- It is transformative, encouraging continuous improvement.
- It is nimble—highly responsive to evidence, evaluation, and any changes in environment or culture over time.

Endnote:

¹ Hong Cheng, Philip Kotler, and Nancy R. Lee, "Social Marketing for Public Health," Jones and Bartlett, 2011.

Later, as we worked to get legislation passed and to establish a boating safety program in Alaska, some members of Alaska's professional injury prevention community participated as part of our first citizens' advisory council. We followed what some other states had put forth, including some early public education projects such as a boater's handbook, some TV and radio spots, posters, and print ads.

As I reported on these and other early accomplishments to the council, members would often ask, "Those look great, but how do you know if you're accomplishing anything?"

At first I was defensive, but over time I came to understand and appreciate the question. The truth was that we really didn't know the answer.

Public Health

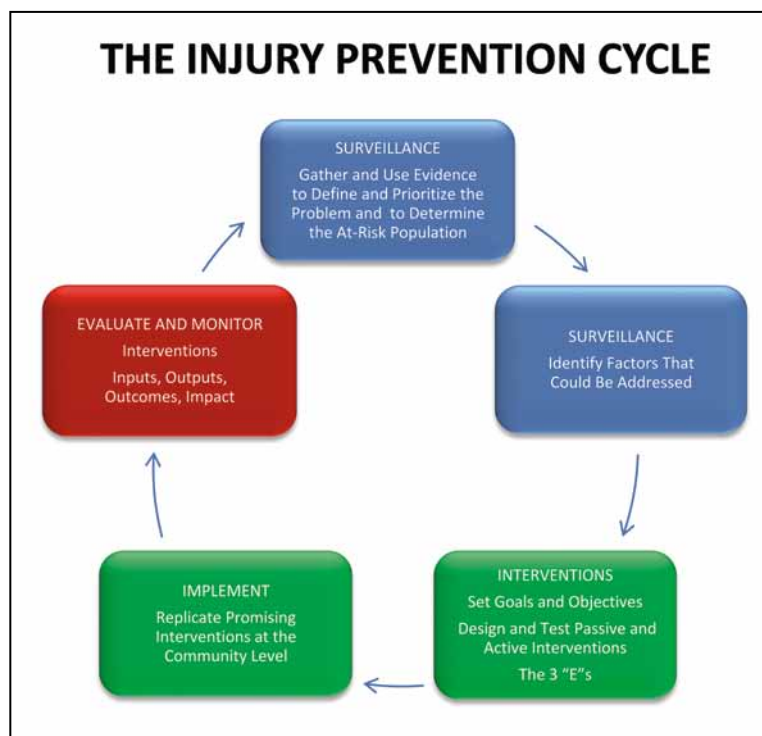
The term "public health" generally refers to organized societal measures to prevent disease, promote health, and prolong life. For more than a century, the scientifically proven public health approach has achieved tremendous successes in preventing or reducing infectious disease worldwide and, more recently, preventable illnesses and injury.¹

Injury prevention, an increasingly important field within public health, is an adaptation of the public health approach the World Health Organization, federal agencies (such as the Centers for Disease Control and Prevention), nonprofits (such as the Safe States Alliance), state health departments, and many others utilize. The injury prevention field uses evidence to identify and define a public health problem, the population at risk, and causal factors that might be influenced. We develop and test potential interventions to find out what might work, then replicate promising interventions (ideally at the grass-roots level) and carefully evaluate and monitor results throughout the process.

We gather quantitative and qualitative evidence to define a problem as well as when, where, how, and to whom it occurs. We then prioritize the problem against other identified problems, considering frequency, severity, and/or cost to society. We then identify factors that may respond to intervention.

The Three Es

Interventions are designed specifically for a target population in at least one



of (but ideally, a mix of) the classic “three Es” of injury prevention:

- education,
- engineering/environment, and
- enforcement.

Education helps us to persuade and alter attitudes, which in turn alters behaviors. Engineering/environment is another strong area of intervention. Boating safety examples include passive interventions, such as built-in supplemental flotation and powerboat engine cut-off devices, and active interventions like carriage requirements. Finally, public policy enactment and enforcement are strong agents in achieving rapid social change. Examples of enactment and enforcement strategies include boating while intoxicated laws and mandatory life jacket wear.

Implementation

We test potential interventions on the target population and evaluate them to find out what works. We implement interventions that have first been tested with the target population, then we use their experience to identify and address the barriers and benefits to change (as perceived by the target population).

Promising interventions are implemented and widely replicated, ideally at the community level, where injury prevention programs are most effective. The best injury prevention programs have high levels of engagement from partners and stakeholders at the local level; they can clearly see the benefit of participating and want to be a part of it.

Evaluate and Monitor

Evaluation is a key step throughout the process. We assess interventions beginning with the design phase, during implementation, and then we evaluate the outcome following the intervention. This includes short-term, mid-term, and long-term outcomes and, to a lesser extent, any impact to public health. If interventions are successful, they continue to be replicated and monitored over time. If not, we adjust or terminate them, and the cycle begins again.

Where the Keel Meets the Water

While recreational boating safety has seen some vast improvements over the years, challenges remain. We must be willing to know whether our program activities are effective, need to be improved, or are not effective. The only real failure would be to continue to commit resources to (or

expand) the implementation of measures we’re not really sure are working or not. In other words, we risk doing the wrong thing “righter,” making it even “wonger.” Instead, we must discover what is and *isn’t* working, committing our resources and efforts to only the interventions that have the greatest potential effect.

In Alaska, we have found it easiest to apply the approach first to discretionary programs (those not required by public policy or formal agreement), such as social marketing. Over the years, we have applied this approach to build several of our programs. Along the journey, we have identified some successes, as well as initiatives that required revision or replacement. Overall, Alaska’s boating safety program has been better for it.

To replicate this in your area, start small. Learn about it and give it a try. Following the process does not necessarily have to be expensive or time-consuming. In some cases, it may be possible to go back and incorporate missing pieces of the model into existing programs. In other cases, it might be better to start at the beginning.

In the end, if done right, programs can become even more successful, and more lives will be saved—just ask Radar and Pamela.

About the author:

Mr. Jeff Johnson has served as Alaska’s boating law administrator since 1998. He has experience as a former president of the National Association of State Boating Law Administrators, president of the Western States Boating Administrators Association, and chair of the National Boating Education Standards Panel. He currently serves on the National Boating Safety Advisory Council.

Endnote:

¹ Tom Christoffel and Susan Scavo Gallagher, “Injury Prevention and Public Health,” Aspen Publishers, 1999.

For more information:

Narrative and statistics courtesy of the Alaska Office of Boating Safety. For more information, visit the website: <http://dnr.alaska.gov/parks/boating/index>.