Evidence-based Practices in Prevention and Treatment for Children and Adolescents:

A Report to the
Early Intervention Planning Council

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The Center for Urban Policy and the Environment (Center) at Indiana University-Purdue University Indianapolis entered into a partnership with the City-County Council of the city of Indianapolis and of Marion County, Indiana, to assist in the establishment and implementation of an Early Intervention Planning Council (EIPC). As described in City-County General Ordinance No. 70, 2005, the EIPC is charged with developing a comprehensive plan for early intervention that will provide services tailored to the individual needs of children who have been either adjudicated as or alleged to be delinquent children and referred to the Marion County Department of Child Services (DCS).

This report is part of a series of reports prepared by the Center to inform the EIPC. It begins with a discussion of prevention in general and systems of care as a model, and then presents evidence-based practices for mentoring, family support, school based mental health, psychiatric services for children and adolescents, child welfare and interventions in juvenile justice. An evidence-based practice has been or is being evaluated; has some quantitative and qualitative data showing positive outcomes; and has been subject to expert/peer review that has determined that a particular approach or strategy has a significant level of evidence of effectiveness. Each chapter includes a table with specific information outlining examples, citations, and contact information for the relevant evidence-based practices.

Faculty and graduate student advisors from Indiana University-Purdue University Indianapolis contributed material, which was compiled by Eric Wright, Laura Littlepage, and the EIPC support team.

Principles of Prevention: An Introduction

Research indicates that our best hope of creating public programs that deter child abuse, neglect, and delinquency is to create a comprehensive system of care that focuses not only on intervention, but on prevention (Weissberg, et al., 1997; Information, 2003). Such systems are both coordinated and integrated, and involve both the interests and input of the children and families involved. Efforts to address the needs of vulnerable children and families *before* they are deemed at-risk or in need of services have been proven effective in multiple studies (Stroul, 1996; Greenberg, et al., 2000). Prevention research in a variety of fields has also concluded that isolated services are less effective than coordinated systems of care in addressing the needs of vulnerable children (Stroul, 1993). Comprehensive and coordinated systems also show improvement over the continuum of care model (Stroul & Friedman, 1988). While the systems of care model provides a wide range of services over the lifespan of individuals, thus providing a "continuum of care," the system of care model takes the concept of comprehensive and coordinated care one step further and provides for intensive communication, cooperation and case management across individual service, departments and agencies (DePanfilis, & Salus, 1992; Dumka, Roosa, Michaels, & Suh, 1995). In some systems, teams of practitioners from a variety of fields come together to form teams that center around the needs of the vulnerable child and family (Burns and Goldman, 1999). Such services are termed wraparound services, and are a subset of system of care models (Clark, 1998). The involvement of the family as an important member of the system of care is also a shift from previous models (Adelman, et al., 1992; Combrinck-Graham 1995; Worthington, Hernandez, Friedman, & Uzzell, 2001).

Evidence supports the improvement of systems of care over the previous models, based on research conducted in a variety of settings by a wide range of researchers from diverse fields of study (Bickman, 1999; Ohl, 2003). The breadth of the research literature supporting systems of care models have generated a variety of descriptors for such systems of care, with each field coining its own enthusiastic and hopeful set of vocabulary to inspire effective action from communities and public programs (Kinney, 1994). These qualitative descriptors are useful for those in the process of developing a system of care model, providing normative guideposts for policymakers (Hanson, Deere, Lee, Lewin, & Seval, 2001). Table 1 provides characteristics for a sampling of vocabulary used to describe the values and goals of systems of care that have been proven effective in communities across the United States.

Table 1: Characteristics of Successful Programs and Systems of Care

Prevention-oriented:
• Focus on young children before problems get worse
• Systematically use screening and early detection procedures
• Direct preventive interventions at at-risk and protective factors rather than at categorical problem behaviors
• Move beyond crisis management and early intervention and focus on prevention and development
• Promote the recognition of mental health as an essential part of child health
Multifaceted:
• Offer wide arrays of direct services or serve as entry to those comprehensive services
• Aim interventions at multiple domains, changing institutions and environments as well as individuals
• Provide a package of coordinated, collaborative strategies and programs
• Have services that are flexible and provide nontraditional supports
• Cross professional and bureaucratic boundaries
• Promote interventions at multiple levels
• Expand intermediate services
• Use multidisciplinary teams and interagency teams

Table 1: Characteristics of Successful Programs and Systems of Care (continued)

Coordinated:
• Offer coordination, development, and leadership related to programs, services, resources, and systems
• Have interagency coordinating mechanisms in place
• Avoid duplication and gaps in service provision
• Integrate family- and child-centered mental health services into all systems that serve children and families
• Develop a public-private health infrastructure
Child-centered:
• Incorporate perspectives of children, youth, and families in development of mental healthcare planning
Family-focused:
• Enable personal relationships to exist between families and staff
• Utilize child-centered and family-centered approaches
• Involve parents and teachers in communications
• Fully engage families in services
• Have services that address the needs of the entire family
• Design services on the basis of the families' identified strengths and needs
• Deal with the child as part of a family, and the family as part of the community
• Have services that promote and strengthen the connection between family and community
• Have services that provide opportunities for family empowerment
• Recognize that all families need support
Community-based:
• Integrate systems of treatment with other community care systems
• Be responsive to local needs
• Have a staff member from the local community to serve as a facilitator
• Offer enhanced connections with community resources
• Build programs with community initiatives and participation
• Build social capital through collective action either by creating programs or empowering neighborhoods to create their own programs
• Create economic hope and opportunity by asking communities to identify their own needs and be prepared to listen and act on their responses
Effective:
• Maintain multi-year programs to foster enduring benefits
• Operate throughout childhood
• Offer direct services and instruction
• Target developmentally appropriate risk and protective factors
• Develop interventions based on theoretical frameworks and methodological rigor
• Individualize care
Accessible:
• Make intervention programs accessible to urban children and families
• Improve community outreach efforts
• Determine points of entry in existing systems and improve accessibility
• Provide creative care and education options that target individuals in their homes
• Decrease bureaucratic barriers
• Include access points to care from schools, medical offices, dental offices, and other providers
Sensitive to the child's environment:
• Consider the social context when evaluating children's needs and developing interventions
• Address issues of resilience in individuals, families, and communities as protective factors that determine youth behavior
• Simultaneously educate the child and instill positive changes across both the school and home environments
• Consider developmental changes among children in urban settings
• Examine alternate pathways and linking mechanisms in the association between context and the well-being of children
• Combine cultural and developmental sensitivity into intervention programs

Table 1: Characteristics of Successful Programs and Systems of Care (continued)

Well-staffed:
• Use carefully selected child associates as the program's prime, direct help-agents
• Modify professional roles to feature systematic early screening to identify children at risk
• Provide staff with time, training, and skills needed to build relationships of trust and respect
• Have providers who are persistent in meeting families' needs and are fully accessible
• Train young professionals to work in urban settings
• Train providers to listen to families' priorities and address the highest priorities first
• Train teachers, parents and providers to identify students who need intervention
• Train providers to take part in the collaborative process
• Encourage teachers to view themselves as part of a team effort to address the academic, social, and health development of students
Accountable:
• Provide accountability with creative and meaningful measures
• Prepare for policy recommendations by incorporating accountability and cost into intervention programs
• Adopt standardized assessment methods and instruments for early detection and evaluation
• Have clear values and goals that can be evaluated at regular intervals
• Recognize that prevention is more cost-effective than correction or remediation
Capacity-building:
• Develop a compelling vision and role for the coordinating body
• Mobilize the community at the grassroots level
• Involve the corporate world
• Commit to work together intensively for as long as needed

Two principles associated with the preventative system of care model are key to a system's success in implementing these values and goals: *integration* of systems and focus on *prevention* (Hoagwood, 1996). As a system, all problems and potential problems are approached by the system as a whole, including institutions that have traditionally had more solitary roles in treating and preventing certain kinds of child need (Dosser, et al., 2001). In a system of care model, the education, juvenile justice, mental health, and child protection subsystems work together with families and other community agencies through a unified approach to deal with the problems of child abuse, neglect, and delinquency—and their precursors—*together* (Center for the Study of Social Policy, 1996). Communication, teamwork, and shared goals and philosophies are vital for the system to work effectively. At the center of such a system are the child and his/her family—often with appropriate representatives from each of the other subsystems working in a team to help the child and family to conquer the challenges that put them at risk. The family and child are key participants in the system of care model; they are not subjects to be acted upon; rather, they are partners and participants in creating and executing individualized plans of action (Heflinger, 1996; Koroloff, 1996; Friesen, 1998). The prevention focus of such a system works to avert even the earliest risk factors and signs of vulnerability. Prevention and intervention are approached in three stages.

Three Levels of Prevention/Intervention

Part of the paradigm shift involved in a system of care approach is the recognition that problems once seen as independent issues are actually intricately related and are often risk factors for subsequent social problems. Children who are at risk of failing school, for example, are more likely to become delinquent in future years. Children who face abuse or neglect at home are at greater risk of both academic failure and delinquency (Loeber, Farrington, & Petechuck, 2003). The challenges faced by vulnerable children and families are interrelated and systemic; the response must also be interrelated and systemic. In a traditional care model, issues such as neglect, drug use, academic failure, poverty, chemical imbalance, and

delinquency might be treated by separate agencies; in a system of care model, appropriate elements of each subsystem are brought together to treat each problem currently or potentially faced by a vulnerable child and family.

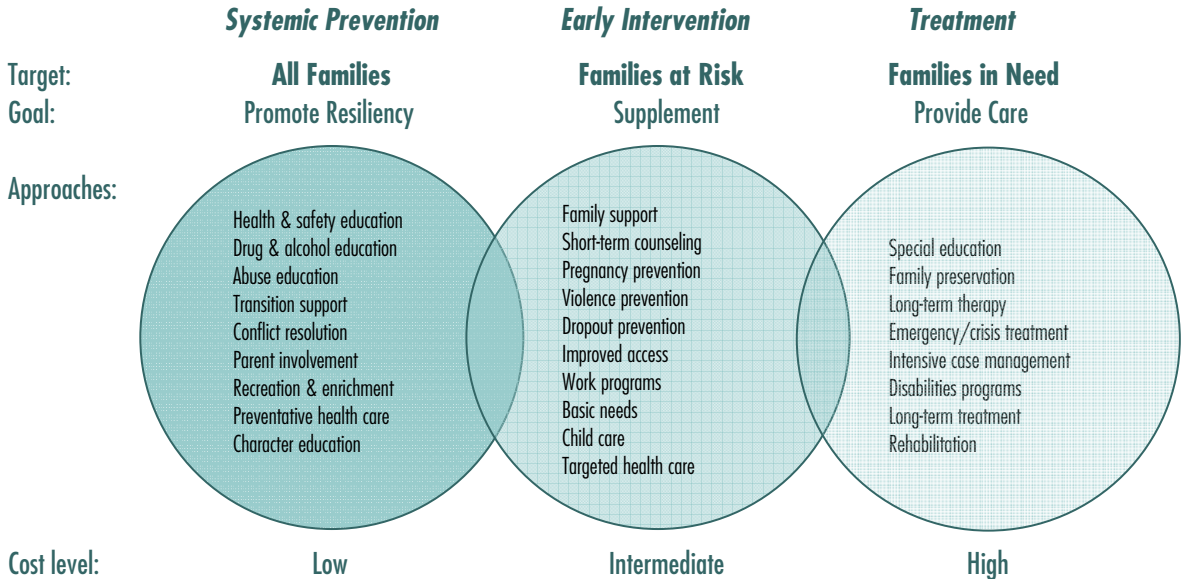
A preventative system of care also focuses on the treatment of problems before they begin. Some issues faced by a child or family are recognized not solely as isolated problems, but also as risk factors for related issues (Office of the Surgeon General, 2000). Common root problems including poverty, family history, mental, emotional and physical illness, and lack of social support are treated at the earliest recognizable onset, but also—by recognizing related vulnerabilities that may be precursors of these problems—before they occur (Weissberg, et al., 1997; Krishnakumar & Black, 1998). Risk factors for any kind of social problem are addressed and early intervention measures taken to keep risk factors from blossoming into actual problems.

Numerous studies and analyses have shown that prevention and early intervention are more effective (Buckner, 1985; Guralnick, 1997) and less expensive than treatment of more progressive social problems (Bernal, Estroff, Murphy, Jellinek, & Keller, 1998; Karoly, Kilburn, Bigelow, Caulkins, & Cannon, 2001). Early intervention for families and children displaying risk factors is good, but not good enough; a true preventative system of care is also focused on enhancing the strength and resiliency of children and families, giving them a greater advantage in overcoming risk factors they may face. Just as risk factors exist that make a child and family more vulnerable to future problems, protective factors exist that can help strengthen the resilience of child and family to those ills (Oddone, 2002).

An effective system of care works cohesively to engage children and families in no fewer than three levels of care (see Figure 1):

- *Systemic prevention:* Programs to enhance strength and resiliency for *all* children and families by helping to develop protective factors.
- *Early intervention*: Programs to help vulnerable children and families—children and families showing risk factors or early signs of trouble—to overcome risks and enhance resiliency.
- *Progressive intervention/treatment*: Programs for children and families that display heightened need for assistance in overcoming risk factors or problematic behaviors.

Figure 1: Prevention and Intervention at Three Levels of Care



Adapted from *Integrating Mental Health in Schools: Schools, School-Based Centers, and Community Programs Working Together. A Center Brief.* 2000, Health Resources and Services Administration: Washington, D.C.

This preventative approach is based on the belief that all children and families have needs which must be met in order for them to be successful. These needs comprise the conditions for success. Risk factors generally compromise or eliminate the fulfillment of these needs, making children and families more susceptible to problems. Conversely, by instituting programs that promote and support the conditions of child and family success, children and families can be more resilient to the stresses and challenges they face and are better equipped to overcome those challenges in a healthy and productive way.

Researchers at the Center for the Study of Social Policy identified nine conditions for child success—conditions that must be met for all children if they are to be successful. These conditions must be met regardless of a child or family's race, socioeconomic status, educational background, or other factors (see Table 2) (Center for the Study of Social Policy, 1996). A wide range of additional research has identified additional protective factors that contribute to child and family resiliency. Most current social services that are termed "prevention programs" are generally more early intervention oriented. Such programs identify and evaluate risk factors already present in children and families, and work to intervene in the progression of these risk factors into more advanced stages of dysfunction or problematic behavior. At the onset of serious problems or problem behaviors, treatment programs are engaged to help mitigate the effects of these problems and work toward recovery of children and families. A system of care approach enhances the cooperation and communication between agencies and individual engaged in all three levels of care, prevention, early intervention, and treatment.

Table 2: Conditions for Child Success

- Economic and physical security
- Environmental and public safety
- A nurturing, stable family environment
- Adult mentors and role models in the community
- Positive peer activities
- Opportunities to exert effort and achieve success
- Health care for medical needs
- Positive educational experiences and acquisition of useful skills
- Access to professional services to treat conditions or needs that may require professional care

Source: *The Case for Kids. Community Strategies for Children and Families: Promoting Positive Outcomes*. 1996, Center for the Study of Social Policy: Washington, D.C.

System Integration

Research shows that service models that involve integration of services offered by education, social services, mental health, and juvenile justice at the individual case level are most effective in preventing delinquency, abuse, and neglect than those which coordinate only at the departmental or agency levels or do not coordinate at all (Kahn, 1992). Children and families that are served by integrated systems of care fare better than those who receive individual services separately. Various system of care models exist—and development of a system of care depends on several factors including the community context, the background and history of the current system model, the philosophy and goals of the various organizations involved, and the strengths and weaknesses of the system's current infrastructure (see Table 3) (Stroul, et al., 1992). System integration often occurs through implementation of innovative approaches including on-site service delivery, intensive case management, wraparound services, and other service delivery models that involve case-level integration and coordination of services. Various agencies or departments may alternately take the lead, provide services, or perform an advisory role during interactions with children and families (DePanfilis & Salus, 1992). Many such models are school-based (Abdal-Haqq & ERIC Clearinghouse on Teacher Education Washington, D.C., 1993), with mental health (Health Resources and Services Administration, 2000) and social services professionals, law enforcement officers, parents, and teachers working in case teams to address and prevent a wide range of issues (Ascher, 1990). Schools are the predominant source of programs implemented as preventative measures, where children and families can learn methods of effective social interaction, conflict resolution, and problem solving (Cowen, 1997).

APA Task Force

The American Psychological Association created a task force on innovative models of mental health services for children, adolescents, and their families. The task force identified three key areas in which innovative approaches could improve the wellbeing of children: Education, social services, and juvenile justice (Hengeller, 1994). These findings have implications for the member agencies of the EIPC.

Education

The APA task force on innovative models of mental health services for children, adolescents, and their families identified several ways in which behavioral approaches in early education could be enhanced to improve outcomes. For example, parents should be invited to participate in rewarding the positive behavior of their children. Children should be taught effective behavioral strategies in addition to being corrected for inappropriate behavior. Parents should be taught how to positively encourage effective and appropriate behavior and social interaction. Schools are also a potential location for on-site, multi-agency

wraparound care models wherein integrated services center around the child and his or her individual needs. This type of model is effective when school-based but also flexible enough to include home-based visits or care when needed.

Table 3: Elements to consider in developing a system of care

• The community context
• Background and history of the current system model
• Philosophy and goals
• Target population
• System organization
• System care components
• System-level coordination mechanisms
• Client-level coordination mechanisms
• System of care activities
• System financing
• Evaluation
• Major strengths and challenges
• Technical assistance resources

Source: Stroul, B. A., et al., (1992). *Profiles of Local Systems of Care for Children and Adolescents with Severe Emotional Disturbances*, National Institute of Mental Health (DHHS), Rockville, MD.

Social Services

The APA task force on innovative models of mental health services for children, adolescents, and their families determined that a wide array of interventions and intensive family preservation strategies are the healthiest methods for preventing exacerbation of social problems. Crisis intervention should be employed when necessary; however, a family preservation approach involving intensive family services has been found effective in preserving the family unit and improving its function. This is accomplished through behavioral, cognitive, and environmental interventions focused on the whole family. Effective programs include parent training, coping skills, skills training, and concrete services and the availability of flexible discretionary funds (for furniture, clothing, rent, etc.).

Juvenile Justice

For children and families involved with the juvenile justice system, the APA task force on innovative models of mental health services for children, adolescents and their families determined that individualized wraparound care and intensive case management were the most effective strategies for helping prevent further issues of delinquency. The wraparound model involves a commitment to developing care based on the needs of the individual child/youth, surrounding the child and family with workers from a variety of community agencies. Consensus about treatment and case management is maintained among the key decision makers for a cohesive and child/family centered plan of intervention. Intensive case management includes a commitment to low worker caseloads and 24/7 case coverage for families. Effective intervention plans generally involve multisystemic therapy focusing on multiple inputs and environments.

Mental Health

The clear consensus of the APA task force on innovative models of mental health services for children, adolescents, and their families was that child- and family-centered systems of care including assistance from education, juvenile justice, social services, and mental health were the most effective way to assure the positive mental and emotional development of children and families. The task force recommended that

mental health organizations reduce the use of restrictive services and increase availability of home- and community-based services and partnerships with other agencies and stakeholders.

APA Task Force Conclusions

In addition to the recommendations for education, juvenile justice, social services, and mental health, the APA task force on innovative models of mental health services for children, adolescents and their families recommended innovations to whole systems of care for children and their families. These recommendations included an increase in provider accountability, more service integration, reform in mechanisms for financing of services, and training of direct service providers in the delivery of cost-effective services. The services themselves should be comprehensive, empower families, and be flexible and individualized to the needs of the individual children or families.

Conclusion: A Successful System

The goal of the Early Intervention Planning Council is to create a successful system of prevention, intervention, and treatment measures that will improve the wellbeing of children and families in Marion County. Research suggests that a successful system focuses not only on areas in which problems exist but also where strengths can be enhanced and problems prevented. A successful system is multifaceted but coordinated, creating a system of care that is responsive to the individual needs of the child and family, being flexible and sensitive to their needs and environments (DePanfilis & Salus, 1992). Such a system functions effectively, being well-staffed, accountable, and capacity-building while being accountable to its clients and public (Christner, 1998), and providing resilience-enhancing programs to all families, with additional support for vulnerable families and children and excellent care for families and children with special needs. To achieve this multi-tiered goal, a successful system provides support at no fewer than three levels of prevention and intervention: Systemic prevention for all children and families, early intervention for children and families at risk, and progressive intervention/treatment for children and families facing difficulty. These three levels of support should be available at every key developmental stage experienced by children, youth, and young adults.

Evidence-based Practices and Promising Approaches in Mentoring and Community-Based Civic Organizations

Introduction

There are different definitions for mentoring, but for the purposes of this discussion, we will use the following definition: Mentoring is a supportive relationship between a youth and an adult that offers guidance and concrete assistance as the individual goes through a difficult period, enters a new area of experience, takes on important tasks, or corrects an earlier problem. Most of the evidence described here is from programs working with youths aged 10-18. A mentor acts as a role model and a resource for a youth or young adult in developing his/her strengths, talents and problem solving skills. Mentors are caring, ordinary, responsible adults who are good listeners and demonstrate pro-social behavior. Mentoring appears to be an effective approach for all young people. More recently, there is evidence that mentoring is a best practice for delinquents. Mentoring programs for system-involved youth (SIY) can inspire and guide youth to pursue successful and productive futures, reaching their potential through positive relationships and utilization of community resources (Rhodes, 2005). Mentoring programs can be truly transformative in the lives of SIY if they incorporate evidence-based characteristics and are well implemented (DuBois, Holloway, Valentine, & Cooper, 2002b). On the other hand, mentoring programs that *do not* meet these criteria may actually do harm (Rhodes, Grossman, & Roffman, 2002).

Principles and Themes of Effective Intervention

There is a great deal of literature that points to the evidence-based practices of effective mentoring programs. For instance, mentoring programs should be guided by theory and research that emphasize a focus on positive youth development, youth-driven activities, and the development of core competencies and skills (e.g., decision-making, problem-solving, and accessing community resources) (DuBois, Neville, Parra, & Pugh-Lilly, 2002a). The success of a mentoring program depends largely on the program's ability to foster a trusting relationship between a mentor and a mentee. From a number of publications by Public/Private Ventures, it becomes clear that this can be accomplished through recruiting adult mentors who are mature, empathetic, excellent listeners, passionately committed, and able to serve as positive role models, thus engendering trust. Mentors must be offered training to develop a clear understanding of the needs of the youths they will work with and the expectations of the role of the mentor. Mentor training should prepare mentors to set realistic expectations for the relationship and to manage mentee resistance.

Evidence suggests that one-on-one mentoring leads to better outcomes than group mentoring approaches. Success also appears to depend upon regular, scheduled contact, lasting not less than one year, with weekly in-person contact, supplemented with regular phone contact. Match is critical: same sex, same race mentoring relationships tend to be more successful. Gender, race, and ethnicity are especially important since African American and Hispanic youth make up a disproportionate number of SIY (Sanchez & Colon, 2005) and a growing number of girls are involved in juvenile justice systems (Bogat & Liang, 2005). Research underscores that structured activities for mentors and mentees can be beneficial (DuBois, et al., 2002a). Such activities ideally expand the worldview of the youths, are low cost, and integrate the mentor and mentee into the larger program, all of which increase the rate of retention of the youth and the mentor in the program.

Mentoring programs must be able to effectively recruit, screen, train, and supervise staff and mentors (Sipe,

1996; Furano, Roaf, Styles, & Branch, 1993). Sufficient infrastructure means lower staff-to-mentor ratios; systems to monitor the mentor/mentee relationship and progress; group support systems; and performance evaluations and supervision. It is critical that mentoring programs set boundaries on the scope of the mentoring relationships, so that mentors understand the appropriate limitations of their role. Such systems can help to prevent mentor frustration and drop-out and ensure successful mentee outcomes (Tierney & Grossman, 1995).

Model Programs

The largest mentoring organization in the United States is Big Brothers/Big Sisters. A national evaluation of this program (Grossman & Garry, 1997) has been held up as evidence that mentoring is a best practice. Using a randomized experimental design to evaluate the program in many sites across the United States, Grossman and Garry found that the youths who were mentored were less likely to start using drugs and alcohol, less likely to use violence against others, less likely to be truant from school, more likely to feel better about school and academic work, and more likely to report stronger relationships with parents and peers. Formal mentoring has been used as an intervention to address risk factors as diverse as: early and persistent antisocial behavior, alienation, family management problems, and lack of commitment to school. The prototypical one-on-one mentoring approach is geared at enhancing such protective factors as healthy beliefs, opportunities for involvement, and shaping appropriate behavior (see the OJJDP website on Model Programs for more detail related to risk and protective factors addressed by formal mentoring programs).

The bulk of the evidence on the effectiveness of formal mentoring comes from evaluations of either school-based or community-based mentoring programs (Herrera, Sipe, & McClanahan, 2000). In general, school-based mentoring has been shown to be effective in enhancing academic performance, but is typically a less expensive approach that provides lower levels of contact between the mentor and mentee. The community-based programs contribute more to influencing behaviors and can be used to reach youths who are not effectively engaged in the school setting.

Mentoring is often incorporated as a strategy within programs with many components. For instance, CASA START (Striving Together to Achieve Rewarding Tomorrows), has been shown to have strong evidence of reducing future drug use, violent crime, and drug dealing. This is a program that has been implemented and evaluated in cities across the country (Austin, TX; Bridgeport, CT; Memphis, TN; Savannah, GA; and Seattle, WA, were part of the largest evaluation of the program). Yet, in addition to mentoring, the program also provided (for all participants): case management, family services, afterschool and summer activities, and education services, making it difficult to identify the specific effects of mentoring (Harrell, Cavanaugh, & Sridharan, 1998).

Another example of a multi-dimensional program that included mentoring as a key component is the Movimiento Ascendencia (Upward Movement) program in Colorado. This program targets girls at risk for substance use and gang involvement. All girls were assigned to a female mentor that was expected to spend 2 hours each week together for 9 months. Results showed the program to be effective in reducing involvement in delinquency, but again it was not clear how much of a role the mentoring played in the positive outcomes (Williams, Curry, & Cohen, 1999). One more example is the Supporting Adolescents with Guidance and Employment (SAGE) program from North Carolina. This program has three key components: a cultural pride and ethnic identity component geared at African American youths and delivered by mentors, a job training and placement program, and an entrepreneurial experience (Flewelling, Paschal, Lissy, Burrus, Ringwalt, Graham, Lamar, Kuo, & Browne, 1999). Evidence from the evaluation provided preliminary evidence that this program can reduce the likelihood of violence and other problem behaviors for African American males, but again, it is not clear how important mentoring was to the outcomes.

One program where there was experimental evidence isolating the effects of mentoring within a multi-dimensional strategy, is the Across Ages program. This program used intergenerational mentoring (older adults with preteens) and found that mentoring was important for the success of the program. Those youths who received mentoring (in addition to life skills instruction in the school, community service projects, and parent workshops) were most likely to deal effectively with peer pressure to use drugs or alcohol, to have more positive attitudes about school and their future, to have stronger feelings of self-worth, and to have reduced reports of depression and to be less likely to use drugs and alcohol (LoSciuto, Rajala, Townsend, & Taylor, 1996). The evidence from the evaluation would at least put this program in the category of "adequate evidence."

Mentoring has been shown to make a difference in influencing educational outcomes. In the program Career Beginnings, the focus was on providing career-shaping mentoring for disadvantaged high school students (Cave & Quint, 1990). Mentors focused on exploring college and career options. The evidence of effectiveness is adequate for this program. Participants in the program (that involved mentoring and a service package that was built from a partnership between the high school, the community, and the university) reported higher aspirations after the program and were more likely to go to college.

For the year 1997, all youths leaving the Plainfield Juvenile Correctional Facility and returning to the Indianapolis metropolitan area were randomly assigned to one of three conditions: (1) those who received pre-release preparation through AIM and were assigned a mentor to work with them after their release; (2) those who received pre-release preparation through AIM, but were not assigned a mentor to work with them after their release; and (3) those who did not participate in any way with AIM. We have been following these youths for almost seven years now since their release. For the first four years after their release we can report the following results related to reincarceration:

Table 4: Reincarceration of Youth Leaving Plainfield Juvenile Correctional Facility

	Percent Reincarcerated	
	after 12 months	after 48 months
In AIM, with mentor	25%	44%
In AIM, no mentor	29%	50%
Not in AIM	39%	62%
Assigned to mentor–mentor and youth worked closely together	13%	28%

The results demonstrate that when the program is implemented effectively—note the final line of the table that looks specifically at the subgroup of youths in the first group where the mentor lived up to his or her commitment and the youth actively participated in the program—it can make a significant difference in the offending behavior of the youths involved and in the strain on criminal justice resources. These results also demonstrate that mentoring is critical for the long-term success of the youths.

Similarly, mentoring was shown to be effective in an effort targeted at delinquents. The National Faith-Based Initiative for High-Risk Youth Mentoring Program was implemented and evaluated in Baton Rouge, LA, Brooklyn, NY, Denver, CO, Philadelphia, PA, and Seattle, WA. Collaboration between faith-based organizations, juvenile justice agencies, and social service providers, this program offered services designed to increase skill development in the areas of education and employment and positive adult relationships (mentoring). Results found that mentoring led to increased adult support and decreased depression in the youths, which in turn contributed to a reduction in problem behaviors, such as responding to conflict negatively, handling anger in unproductive ways, using drugs and alcohol, and

delinquent activity (Bauldry, 2006).

In terms of positive youth development, there have historically been a number of community-based civic youth programs for youths to get involved in. The best known programs include Boy Scouts, Girl Scouts, the YMCA, the Boys and Girls Clubs, Girls, Inc., and 4-H. These programs have been important in the development of healthy attitudes and values, the learning of life skills, and leadership development. More recently, with evidence that significant numbers of adolescents are unsupervised for hours each day after school, and that the involvement of these youths in delinquency and other high-risk and problems is most likely to occur in the afterschool hours when adult supervision is lacking.

Relative Effectiveness of Interventions

Many of these programs have not yet been subject to quality evaluations. We can infer some conclusions about the potential of these programs to have an impact with youths from related activities in other community-based programs. As summarized in the Model Programs section of the OJJDP website, we can point to the following key lessons we have learned to date:

- Quality programs will involve mentoring, and life prep kinds of activities: college awareness and preparation, employment preparation/training, volunteer and community service opportunities, and youth leadership activities.
- Quality programs will also provide access to cultural enrichment and supervised recreation.
- The most effective programs have clear goals, are staffed effectively, pay attention to safety, draw on the diverse resources of the community, create learning experiences for the youths, and encourage the involvement of the family.

In general, these programs address a number of protective factors related to the involvement in positive activities with other peers, and several targeting the individual youth, such as social competencies and problem-solving skills, healthy positive beliefs, the perception of social support from adults and peers, positive expectations for the future, and a positive temperament. These programs are appropriate to address risk factors from several domains: the community in which they live, their experiences in school, the context of the family, the influence of negative peers, and their own individual characteristics.

Adequate evidence exists that the SMART Leaders program of the Boys and Girls Clubs of America is an effective strategy (Kaltreider & St. Pierre, 1995). This program is geared at the prevention of drug use and sexual activity among adolescents aged 13-15. The actual content of the program included a curriculum that focused on teaching social and personal competence skills geared at resisting peer and social pressure to engage in problem behaviors. The program also encouraged the youths to take on roles to help other youths benefit from the program. An evaluation of the implementation of the program in 14 different clubs in cities across the country found that the program was effective in changing attitudes about drug and alcohol use and to reduce the likelihood of eventual involvement in substance use. Preliminary evidence is available for another program of the Boys and Girls Clubs of America: Gang Prevention through Targeted Outreach. This program targets youths from 6-18 and was evaluated drawing a sample from 24 clubs across the country (Arbreton & McClanahan, 2002). This program uses the interest-based programming at the Boys and Girls Clubs to facilitate positive youth development and engagement in positive youth activities. The evaluation results showed that the strategy was successful at delaying the onset of some gang-related behaviors, and contributed to lower levels of involvement in delinquency and the juvenile justice system. There were also benefits in terms of school outcomes and engagement of the youths in positive activities.

There have been few evaluations of the programming provided in 4-H. One example is the Living Interactive Family Education (LIFE) Program that was established in 1999 at the Potosi Correctional

Center, a maximum security prison in Missouri. This program seeks to increase the amount of visitation between incarcerated fathers and their children, while involving the youths in 4-H activities. At the 4-H meetings, children and their fathers work together on curricula-based activities focused on the development of life skills, such as conflict resolution, substance abuse resistance, teamwork, and character development. Preliminary evidence is available at this point from the evaluation (Dunn, 2003). The results of the evaluation indicate that LIFE does increase the life skills of the youths participating in the program, although there was less improvement in the communication skills. The sample size was small and in one geographic location.

Another national civic organization providing youth development programming is the Boy Scouts. Boy Scouts are provided with opportunities to build character, explore the differences between right and wrong, take part in service projects to help others, set goals and then go about achieving them, be exposed to positive role models, be encouraged to spend more time with family, learn new skills, and use time constructively. A National Assessment of programming was organized according to six "critical elements of healthy youth development": strong personal values and character, a positive sense of self-worth and usefulness, caring and nurturing relationships with parents and peers, desire to learn, productive use of time, and social adeptness. Results found positive outcomes in each of these areas (Louis Harris and Associates, 1998). As the results of this study come from a survey of scouts and their parents across the country, they offer preliminary evidence at best of the impact of these programs.

Similarly, there has been a national evaluation of programming by the Girl Scouts of America. Traditional troop activities within Girl Scouts took place after school and in the early evening, involving organized play and learning activities supervised by positive adult role models and involving interaction between the girl and her parents. The organization has proposed the following outcomes for girls: self-reliance, self-competence, social skills (ability to make friends), respect for others, feelings of belonging, values and decision-making, helpfulness/concern for the community, teamwork, and leadership. Results of the evaluation found that regardless of age, compared to other school activities, troop activities gave them more opportunities to experience all nine outcomes. It appears that troop activities also enhanced the relationships the girls had with their parents. As with the results from the assessment of Boys Scouts programming, these results come from a survey of girls involved in the program, their parents, adult leaders, and others outside of Girl Scouts. As such, they offer at best preliminary evidence of the effectiveness of programming (Hwalek & Minnick, 1997).

There is also preliminary evidence from other initiatives not being provided by national civic organizations described so far. One program, described above in the section on mentoring, Movimiento Ascendencia (Upward Movement), targets girls at risk for substance use and gang involvement. Girls were exposed to organized sports and recreational activities, cultural activities, and case management. Results showed the program to be effective in reducing involvement in delinquency (Williams, Curry, & Cohen, 1999). Another program, BUILD (Broader Urban Involvement and Leadership Development), from Chicago, is also a gang prevention program that incorporates a number of elements from quality programs: afterschool sports programs, recreational activities, career training, and college counseling. This program also drew upon the participation of corporate sponsors, community leaders, and parents. A recent evaluation of the program focus on an implementation of the program with youths released from a detention center in Chicago. The results showed that the youths who actually participated in BUILD were less criminally involved thereafter (Lurigio, Bensiger, & Thompson, 2000). These results offer preliminary evidence to the effectiveness of the program.

Challenges

Community Programs

One challenge noted is that the programs are often trying to accomplish too many disparate goals, and not doing any thing real well (Raley, Grossman, & Walker, 2005). Another concern is that often these programs receive funding through competitive opportunities but then the staff of the programs has not bought into the logic models laid out in the grant proposal (Hipps, Ormsby, Diaz, & Heredia, n.d.). Staffing of these programs is also a challenge in that turnover is often high, the pay for these positions is relatively low and so the best staff will move on to other opportunities. Finding ways to retain the highly-skilled staff members is also a function of how likely the program will retain the youths, as they have trouble building relationships with staff members when turnover is high (Raley, et al., 2005). Retention of the youth for a significant length of time is a challenge and is important as the evidence shows that the longer the involvement of the youths in the programming, the more positive the results. For youths to get the most out of the programming, it is also critical for them to attend the activities several times each week. Programs need to work to encourage participation at this level. Many of the youths that are interested in the services being offered are not the youths who need the services most. In contrast, a critical challenge is that the demand for services is too high, overwhelming the programs and lowering the effective adult-youth interactions (Bunnell & Pate, 2006). Programs need to specifically target the high-risk youths who do not have effective adult supervision and support in place. Partners may also create challenges in that they may not make referrals as expected, meaning the programs are undersubscribed by the youths who most need the services—low utilization may also challenge the ability of the programs to sustain themselves or to attract additional funding (Hipps, et al., n.d.).

Mentoring Programs

Sherk (2000) catalogues the issues that programs have to be wary of in implementing mentoring programs that work (see also DuBois, et al., 2002b). First, programs must have enough resources and sufficient staffing. The staff must understand their role in recruiting and nurturing volunteers. It is critical, as well, that the program managers are passionate and committed about mentoring and good role models for the volunteers. Many ineffective programs suffer from not having a clearly defined mission and goals. It is also problematic when the programs have not developed partnerships and relationships with schools, faith-based organizations, social clubs, corporations, and universities. Problems have also been found when programs do not provide ongoing monitoring and support of the mentoring relationships. Initial training and ongoing training must also be in place to avoid some of the problems that many mentoring programs face. It is also critical that effective practices are in place to recruit, screen, and train volunteers.

From our experiences at AIM, I would also note the following challenges that mentoring programs often face: Too often, mentoring programs are somewhat passive in their preparation of staff and volunteers for the work of mentoring, training mentors and then sending them out to "do good." Most programs do not critically assess their own capacities to facilitate effective mentoring. This is critical for a number of reasons. First, the way that volunteers are treated by an organization is typically the way they will in turn treat the youths—therefore, it is critical that the organization models maintaining regular contact with the mentors and focuses on providing resources targeted at the needs of the mentors. Second, mentors will often make the mistake of doing most of the talking—they have things they want the mentee to know about, they are trying to convince the mentee that they are qualified to be their mentor—when in fact, the best way to sell oneself as a good mentor is to listen and ask questions that are directed at the youth's interests, needs, and future plans—staff must be developed to be good coaches for the mentors, so that mentors develop and hone these skills. Third, SIY will likely be interested, and even motivated, to make changes in their lives that will take them out of delinquent and self-destructive patterns of behavior. Yet, they are unlikely to know how to go about making such a change. Many mentors are not going to know how to help the

youths make real change. It is up to the program staff to provide training and ongoing coaching that equips the mentors to be able to teach the mentees effective decision making skills, effective problem solving skills, structures for gaining insight into their own behaviors, and to provide enough practice to integrate the new behavior patterns that replace the existing habits. And fourth, the majority of volunteers and staff are going to be better at focusing on the details than they are at seeing the big picture—it is critical that program administrators, program staff, and program volunteers all are able to keep their focus on the ultimate goals ("the big picture") of the program. That will help them understand how to handle situations that arise and will keep them engaged in the process of documenting their efforts. This will serve the program well in its efforts to monitor the effectiveness of its approach.

Table 5: Evidence-based Intervention Programs—Mentoring and Community Programs

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Big Brothers/Big Sisters programs in eight cities: Phoenix; Wichita; Minneapolis; Rochester, New York; Columbus, Ohio; Philadelphia; Houston; and San Antonio	Traditional one-on-one mentoring between a youth and an adult, carefully matched after a thoughtful screening process of both the youth and the mentor. Relationships were designed to last more than one year and for many, the length of adolescence for the youth involved.	Very Strong. The study involved random assignment in 8 sites and a reasonably large sample. The follow-up period was over 18 months, allowing for a significant amount of time to allow for the effects of the mentoring to be observed.	959 10- to 16-year-olds. Half of these youths were randomly assigned to a treatment group for which mentor matches were made and the other half were assigned to waiting lists. After 18 months the two groups were compared.	Risk Factors: ***Individual*** • Delinquency • Early initiation of violent behavior • Involvement in personal crimes • Involvement in property crimes • Substance use/abuse • Drug dealing • Contact with police • Violent behavior • Weapon use • Crime recidivism ***Family*** • Poor family management practices • Low levels of parental involvement • Poor family bonding and family conflict ***School*** • Academic failure • Truancy and dropping out of school • Early and persistent antisocial behavior at school Protective Factors: ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management	Morrow, K.V., and Styles, M.B. (1995). *Building Relationships with Youth in Program Settings: A Study of Big Brothers/Big Sisters.* Philadelphia: Public/Private Ventures. Tierney, J.; Grossman, J.; and Resch, N. (1995). *Making a Difference: An Impact Study of Big Brothers/Big Sisters.* Philadelphia: Public/Private Ventures.

Table 5: Evidence-based Intervention Programs—Mentoring and Community Programs (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Meta analysis of mentoring programs	59 studies of mentoring programs involving one-on-one mentoring, the use of pre-post comparisons or the use of a comparison group, and the mean age of youths served was 18 or younger.	Strong—there was consistent positive effects of mentoring across the different evaluations, providing a variety of settings, locations, and co-occurring programmatic features. Stronger effects were found for community-based versus school-based mentoring. Stronger effects were also found where there was monitoring of program implementation. Stronger effects were also found when the mentors had backgrounds in helping professions or in teaching and where there was ongoing training of the mentor after the initial training. Stronger effects were found in programs where there were clear expectations about the amount of contact between the mentor and the mentee.	Youths under the age of 19, and typically involving teens or adolescents.	Risk Factors: ***Individual*** • Delinquency • Early initiation of violent behavior • Involvement in personal crimes • Involvement in property crimes • Substance use/abuse • Drug dealing • Contact with police • Violent behavior • Weapon use • Crime recidivism ***Family*** • Poor family management practices • Low levels of parental involvement • Poor family bonding and family conflict ***School*** • Academic failure • Truancy and dropping out of school • Early and persistent antisocial behavior at school Protective Factors: ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management	DuBois, D. L., Holloway, B. E., Valentine, J. C., & Cooper, H. (2002). Effectiveness of mentoring programs for youth: A meta-analytic review. *American Journal of Community Psychology* 30: 157(41).

Table 5: Evidence-based Intervention Programs—Mentoring and Community Programs (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
National Faith-Based Initiative for High-Risk Youth Mentoring Program, implemented and evaluated in Baton Rouge, LA; Brooklyn, NY; Denver, CO, Philadelphia, PA; and Seattle, WA. Contact Information: Shawn Bauldry, Public/Private Ventures.	A collaboration between faith-based organizations, juvenile justice agencies, and social service providers. Services were designed to increase skill development in the areas of education and employment and positive adult relationships (mentoring).	Adequate. The evaluation involved five sites, but with only a total of 160 youths across the five sites. Did involve a comparison group that did not receive mentoring.	High-risk youths that had already been involved in the juvenile justice system—ages 8-22, with most in the age range 12-19. Boys and girls were served in this program.	Risk Factors: ***Individual*** • Delinquency • Early initiation of violent behavior • Involvement in personal crimes • Involvement in property crimes • Substance use/abuse • Drug dealing • Contact with police • Victimization and exposure to violence • Weapon use • Crime recidivism ***Family*** • Poor family management practices • Low levels of parental involvement • Poor family bonding and family conflict ***School*** • Academic failure • Truancy and dropping out of school • Early and persistent antisocial behavior ***Community*** • Low-income neighborhood • Violence in the neighborhood Protective Factors: ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management	Bauldry, S. (2006). *Positive Support: Mentoring and Depression among High-Risk Youth.* Philadelphia: Public/Private Ventures. Bauldry, S. & Hartmann, T.A.. (2004). *The Promise and Challenge of Mentoring High-Risk Youth: Findings from the National Faith-Based Initiative.* Philadelphia: Public/Private Ventures.

Table 5: Evidence-based Intervention Programs—Mentoring and Community Programs (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Aftercare for Indiana through Mentoring (AIM), based in Indianapolis, with sites also in eight other regions throughout the state. Contact information: G. Roger Jarjoura, Executive Director of AIM, (317) 920-6843, rjarjour@iupui.edu	This program provides mentoring support and prerelease planning to incarcerated juvenile offenders making the transition back to the community.	Adequate—a randomized experiment was conducted demonstrating significant differences in the likelihood of reincarceration for those participating in AIM and those not taking part in the program. While the program has been replicated in other sites, none have been the subject of independent evaluations. The design of the program is consistent with the published best practices for organizations serving highly at-risk youth.	Incarcerated juvenile offenders, aged 12-21, with most under 19, boys and girls, from throughout the state of Indiana.	Risk Factors: ***Individual*** • Delinquency • Early initiation of violent behavior • Involvement in personal crimes • Involvement in property crimes • Substance use/abuse • Drug dealing • Contact with police • Violent behavior • Weapon use • Crime recidivism ***Family*** • Poor family management practices • Low levels of parental involvement • Poor family bonding and family conflict ***School*** • Academic failure • Truancy and dropping out of school • Early and persistent antisocial behavior at school Protective Factors: ***Individual*** • Self-discipline • Readiness for work • Educational engagement • Good health • Basic needs satisfied ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management	Unpublished evaluation research available on the AIM website: http://aim.spea.iupui.edu *Best Practices Guide for Organizations Serving Highly At-Risk Youth* published by the Mentoring Center. Oakland, CA. Available at www.mentor.org.

Table 5: Evidence-based Intervention Programs—Mentoring and Community Programs (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
The Living Interactive Family Education (LIFE) Program was established in 1999 at the Potosi Correctional Center, a maximum security prison in Missouri. Contact Information: Elizabeth Dunn at DunnE@missouri.edu with questions about the evaluation and Lynna Lawson at LawsonL@missouri.edu with questions about the LIFE program.	This program seeks to increase the amount of visitation between incarcerated fathers and their children, while involving the youths in 4-H activities. At the 4-H meetings, children and their fathers work together on curricula-based activities focused on the development of life skills, such as conflict resolution, substance abuse resistance, teamwork, and character development.	Preliminary—the results of the evaluation indicate that LIFE does increase the life skills of the youths participating in the program, although there was less improvement in the communication skills. The sample size was small and in one geographic location.	The LIFE Program is designed to help children and youth whose fathers, or other significant male role models, are incarcerated.	Risk Factors ***Family*** • Poor family bonding and family conflict Protective Factors: ***Individual*** • Positive beliefs and standards • Highly developed personal and pro-social skills • Parental bonding ***Family*** • Supportive parent-child relations • Proactive family management ***School*** • Positive attitude toward school	Dunn, E. (2003). Life skills in children of incarcerated fathers. University of Missouri-Columbia. Available on line at: http://extension.missouri.edu/fcrp/evaluation/LifeSkillsReport6-03.doc
A synthesis of research on the programs (primarily afterschool) offered by the Boys and Girls Clubs of America.	Prevention classes geared toward all Club members, targeted outreach that involves recruiting youth with specific risk characteristics to engage in broader Club activities, educational programs designed to integrate learning activities throughout the Club and to offer homework help, technology centers in Clubs to increase youth access to computers and the Internet, and career-oriented initiatives.	Preliminary—rigor of research is not strong; design of study is not based on experimental models, involving site visits, surveys, reports of staff. Numbers of kids involved is not small, though.	School-aged youths are served by the Boys and Girls Clubs.	Risk Factors: ***Individual*** • Beliefs and attitudes favorable to deviant or antisocial behavior Protective Factors: ***Individual*** • Support academic achievement • Promote job readiness	Arbreton, A.J.A., Sheldon,J., & Herrera, C. (2005). *Beyond Safe Havens: A Synthesis of 20 Years of Research on the Boys & Girls Clubs.* Philadelphia: Public/Private Ventures.

Table 5: Evidence-based Intervention Programs—Mentoring and Community Programs (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
National evaluation of Boy Scouts and Venturing. Contact information: Boy Scouts of America, 1218 West Adams, Chicago, IL 60607 www.chicagobsa.org	Boy Scouts are provided with opportunities to build character, explore the differences between right and wrong, take part in service projects to help others, set goals and then go about achieving them, be exposed to positive role models, be encouraged to spend more time with family, learn new skills, and use time constructively.	Preliminary—the results of this study come from a survey of scouts and their parents across the country. Beyond reports from parents, there are no behavioral indicators of the outcomes.	Boys in first through fifth grades (or ages 7, 8, 9, or 10) may join Cub Scouts. Boy Scouting is available to boys who have completed the fifth grade or who are 11-17 years old. Venturing is a program for young men and women ages 14 (who have completed the eighth grade) through 20.	Protective Factors: ***Individual*** • High self constructs • Positive beliefs and standards ***Family*** • Supportive parent-child relations ***School*** • Desire to learn • Proactive use of time • Social adeptness	Louis Harris and Associates. (1998). Strengthening Youth, Families and Neighborhoods. A National Program-Outcomes Study. Available online at: www.scouting.org/nav/enter.jsp?s=mc&c=rr.
National evaluation of programming by Girl Scouts of America	Traditional troop activities within Girl Scouts that took place after school and in the early evening, involving organized play and learning activities supervised by positive adult role models and involving interaction between the girl and her parents.	Preliminary—results come from a survey of girls involved in the program, their parents, adult leaders and others outside of Girl Scouts. Sample size of almost 8000.	Girls aged 8-17.	Protective Factors: ***Individual*** • High self constructs • Respect for others • Highly developed personal and pro-social skills • Feelings of belonging • Values and decision-making ***Peer-group*** • Helpfulness/concern for the community • Teamwork • Leadership	Hwalek, M. and Minnick, M.E. (1997). Girls, Families, and Communities Grow Through Girl Scouting: The 1997 Girl Scouts of the U.S.A. National Outcomes Study. New York, N.Y.: GSUSA, 1997.

Evidence-based Practices and Promising Approaches in Family Support for Juvenile Delinquency Prevention and Intervention

Introduction

A critical question for early intervention is how can we support families so that they can rear children to "thrive in safe, caring, supportive families and communities?" That is to say:

- prevent and protect children from abuse, neglect, and abandonment
- provide safe, nurturing, and stable homes
- preserve the family (i.e., nuclear, extended, foster, or adoptive)
- prevent out of home placement
- provide permanent, safe, and stable family environments
- provide safe and stable community environments (Indianapolis Partnership for Child Well-Being, 2005)

This chapter will identify evidence-based practices and promising approaches in family support (i.e., family centered practice models/services). A family is a close relationship among people who are related to one another by blood, marriage, formal adoption, informal adoption (i.e., fictive kin or "taking in"), or a decision to relate to each other as family (Billingsley, 1992). Supportive families are families that function effectively.

Principles and Theories of Effective Intervention

All families are expected to fulfill the following functions: Produce children, establish legal responsibility for them, teach them (i.e., socialize) the knowledge, skills, attitudes, and values they need to live successfully within the culture, establish kinship lines for mutual aid and inheritance, provide economic and emotional security for their members, provide consistent sexual partners for adult members, and control sexual behavior according to social norms and values (e.g., incest taboo). In addition to their expected functions, the literature is clear that there is a small set of factors (i.e., strengths) that protect family systems from dysfunction and facilitate resilience in the face of disequilibrium (Hill, 1999, 1972). When these factors are absent, family systems are at risk of dysfunction (e.g., poverty, unemployment, violence, divorce, out-of-wedlock births, single female headed households, behavior problems in children and adolescents, delinquency, addictions, truancy, and dropping out of school) (Moore, Chalk, Scarpa, & Vandivere, 2002).

First, they demonstrate strong kinship bonds. That is to say, they incorporate relatives and fictive kin, both children and elders into their households. They do not rely on extra-familial systems to provide materially or emotionally for their members.

Strong kinship bonds encompass committed and stable relationships between parents through the institution of marriage. For both males and females, second only to companionship, the primary benefit of marriage is to provide the context for childrearing (Billingsley, 1992; Bowman, & Forman, 1997; Keith, 1997; Neighbors, 1997; Waite, 1995). This is true across socio-economic groups, but more so for those who were currently or had been married, and most true for men. The enormous responsibilities of

childrearing can be overwhelming for single parents, particularly when combined with responsibilities for providing for the family's economic security. Potentially, responsibilities such as supervising and nurturing children or assisting them with educational homework, is easier when two parents are present. Therefore, women, who are solely responsible for childbearing, and primarily responsible for child supervision and nurturing, benefit from the social support provided by a nurturing husband. In addition, for married couples, there is the expectation of additional support from the extended kinship networks of spouses, their friends, and others in their natural helping network. If the marriage functions well and draws both kinship networks together, then the chronic role strain among single mothers, especially among the poor is the polar opposite of married mothers. The research reviewed does, however, acknowledge that married men and women still specialize in family-related labor with child rearing and nurturing still being predominantly within the female domain, even for mothers in the full-time labor force. The result is "that mothers were consistently higher than fathers in marital-family stress, parent-child stress, and [responsibility for] religious socialization" (Bowman & Forman, 1997, p. 241). The solution to these high levels of stress among married women is greater flexibility in traditional family roles. A more equitable distribution of labor in child rearing could translate into lower levels of marital conflict and higher levels of marital stability and satisfaction (Blackman, 2005).

Second, they demonstrate a strong work orientation. This means that collectively they place a strong personal and/or family emphasis on hard work and ambition. However, both family size and family resources, particularly income, are crucial to family protectiveness and resilience.

Third, protective and resilient families demonstrate flexible family roles. Family members do what needs to be done regardless of sex or age and decision making power is distributed fairly among adults regardless of sex.

Fourth, they demonstrate a strong achievement orientation. They are determined and hope to realize the American Dream, but only if they perceive realistic opportunities to succeed. Ideally, the American Dream (Blackman, 1996) includes post-secondary education in a skill, craft, or profession; well-paying and respected occupations (e.g., computing, accounting, government service, professional sports or entertainment), business ownership, personal and financial independence during the retirement years, acquisition and consumption of valued material symbols of success, home ownership, acquisition of luxury clothing items and automobiles, and prestigious social recognition. However, minimally, the Dream is characterized by the ability to pay their bills, reside in a safe and affordable apartment, provide modest clothing, modest cars for themselves and their family members, as well as being happy with oneself and one's lifestyle, particularly if one has overcome major obstacles.

"Success" also has a moral component: (a) producing children only when one is able to provide and care for them; (b) ensuring that children are "directed in the right way;" (c) "Not robbing or stealing or doing things to hurt other people;" (d) avoiding incarceration and negative peer influences; (e) sobriety (i.e., no alcohol or drug abuse); (f) self-respect; (g) courtesy; (h) intimacy with God; (i) accomplishing the purpose for which one was created; and (j) loving all people non-judgmentally, including those considered to be unsuccessful as well.

A crucial feature of protective and resilient families is that they socialize, not only a strong achievement orientation into their members, but more specifically, they teach them a love of learning. Parents and other adults say and model that education is important, that educational failure is unacceptable, and that they can succeed in spite of despite barriers such as poverty, racism, and sexism (Scanzoni, 1971). Parents, guardians, and other adult community members must insist on the following: regular school attendance, completion of homework assignments, a "don't quit," "can't give up" attitude, and advocate for positive school experiences for their children.

Furthermore, African American students must receive race socialization (Thornton, 1997) that involves being taught explicitly the significance of racism and discrimination, what it means to be an African American in America, what to expect in social interactions with people who think they are superior to them. Adult family members serve as buffers between children and the social environment, becoming "a filter of societal information and a primary interpreter of the social structure for their children" (Thornton, 1997). Similarly, female children and adolescents must receive gender socialization, learning explicitly the significance of sexism, how to interact with males as well as females to develop positive self-concepts and self-esteem crucial to success. Protective and resilient families continuously reinforce for children and adults their self-esteem and hope enabling them to succeed in the outside community.

Finally, protective and resilient families have a strong religious orientation (Hill, 1999, 1972). They demonstrate strongly held morals (i.e., beliefs about what is right and wrong), a reverence for life that makes murder unacceptable, a belief in life and power beyond the physical realm. They also have a love for and strong commitment to children and their well-being. They provide strict authoritative discipline of children with the goal of teaching them respect for self, others, and authority, a strong work and achievement orientation, how to be happy despite external stressors, and gratitude for whatever one has. In addition, they demonstrate a belief in service to others, self-denial and sacrifice, mutual aid, cooperation with other people to achieve economic, political, and social goals, civic participation and activism(e.g., governmental electoral process and community self-help programs). They retain pride in their ethnic identity and community, promoting its well-being. They understand the norms, values, and resources of "American" life (i.e., competition, individuality, privacy), but balance these against values that are vital to the stability and quality of family and community life.

Model Programs

What kinds of family centered services are included? Table 6 includes a small sample of program models for which reliable outcome data are available.

Challenges

"If you want to be an engineer, doctor, accountant, etc., there are schools for that; but if you want to be a mother, father, husband, or wife there are few, if any schools. The importance of child rearing and marriage is left to guesswork, trial and error, and whatever you picked from your parents" (Kunjufu, 1984). Therefore, significant improvements in childrearing outcomes, including juvenile delinquency, child abuse, neglect, and abandonment, will come only as individuals, couples, and families acquire the knowledge, skills, attitudes, values, material resources, and supportive social relationships needed for adequate family functioning.

Table 6: Evidence-based Intervention Programs — Family Support

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Early Childhood Education and Assistance Program (ECEAP) Contact information: Managing Director. Early Childhood Education and Assistance Program, 906 Columbia Street, SW, PO Box 48350. Olympia, WA 98504-8350. Phone: (360) 725-2830. Fax: 360-586-0489. E-mail: ECEAP_Admin@CTED.wa.gov	ECEAP is a community-based, family-focused, comprehensive, pre-kindergarten program designed to help children and their families who are in poverty. The program focuses on helping three- and four-year-olds prepare for and succeed in school while helping their parents progress toward self-sufficiency	Preliminary. Rating based on the fact that there is only one study that has evaluated the program so far and the methodology used exhibits some weaknesses.	3-4 year olds and their families	Risk factors: ***Family*** • Low socio-economic status Protective factors: ***Individual*** • Preparedness for school ***Family*** • Economic self-suffiency	(http://www.promisingpractices.net/program.asp?programid=96

Table 6: Evidence-based Intervention Programs — Family Support (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Multisystemic Therapy Contact information: Marshall E. Swenson MST Services 710 J. Dodds Boulevard Mount Pleasant, SC 29464 Phone: 843.856.8226 Fax: 843.856.8227 Email: marshall.swenson@mstservices.com	Multisystemic Therapy (MST) typically uses a home-based model of service delivery to reduce barriers that keep families from accessing services. Therapists have small caseloads of four to six families; work as a team; are available 24 hours a day, 7 days a week; and provide services at times convenient to the family. The average treatment involves about 60 hours of contact during a 4-month period. MST therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g., extended family, neighbors, friends, church members) and removing barriers (e.g., parental substance abuse, high stress, poor relationships between partners). Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including behavioral, cognitive-behavioral, and the pragmatic family therapies. This family–therapist collaboration allows the family to take the lead in setting treatment goals as the therapist helps them to accomplish their goals.	Very Strong	Ages: 12 to 17 Special Populations: Serious/Chronic Offenders Less Serious Offenders Problem Behaviors: Family Functioning ATOD Aggression/Violence	Risk Factors: ***Family*** • Poor family management practices • Parental criminality • Poor family bonding ***Individual*** • Involvement in anti-social behavior • Involvement in delinquent behavior • Beliefs and attitudes favorable to deviant or antisocial behavior • Drug dealing • Substance use/abuse • Early initiation of violent behavior • Presence of psychological condition • Conduct disorder ***School*** • Low academic achievement Protective Factors: ***Family*** • Proactive family management • Good relationships with parents/Bonding or attachment to family ***Individual*** • Perception of social support from adults and peers ***School*** • Student/school bonding ***Peer*** • Involvement with positive peer group activities • Good relationships with peers	Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology, 63*(4), 569–578. Henggeler, S. W., Rodick, J. D., Borduin, C. M., Hanson, C. L., Watson, S. M., & Urey, J. R. (1986). Multisystemic treatment of juvenile offenders: Effects on adolescent behavior and family interactions. *Development Psychology, 22*(1), 132–41.

Table 6: Evidence-based Intervention Programs — Family Support (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
The Nurse Family Partnership Program Contact information: Nurse-Family Partnership, National Office, 1900 Grant Street, Suite 400, Denver, CO 80203-4307. 866.864.5226 (Toll free). 303.327.4240 (Main). 303.327.4260 (fax). info@nursefamilypartnership.org (E-mail). www.nursefamilypartnership.org (Website).	The Nurse Family Partnership program (previously named the Prenatal and Infancy Nurse Home Visitation Program) provides home visits by registered nurses to first-time mothers, beginning during pregnancy and continuing through the child's second birthday. The program has three primary goals: (1) to improve pregnancy outcomes by promoting health-related behaviors; (2) to improve child health, development and safety by promoting competent care-giving; and (3) to enhance parent life-course development by promoting pregnancy planning, educational achievement, and employment.	Very strong. The program has undergone three randomized studies using large sample sizes (ranging from 400 to 1,189 women) and up to 15 years of longitudinal follow-up for the initial study.	First-time mothers	Risk factors: ***Family*** • Low socioeconomic status • Single-parent family/divorce • Teenage mother Protective factors: ***Individual*** • Prenatal and perinatal care ***Family*** • Supportive relationships among family and friends • Educational achievement and employment for parents	(http://www.promisingpractices.net/program.asp?programid=16

Table 6: Evidence-based Intervention Programs — Family Support (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
The Parents Fair Share (PFS) Demonstration Program Contact information: Sharon Rowser. Manpower Research Demonstration Corporation. 88 Kearney St., Suite 1800, San Francisco, CA 94108. Phone: (510) 663-6373. Fax: (510) 844-0288.E-mail: srowser@mdrcsf.org	The initial goals of the program included helping unemployed, non-custodial parents (primarily fathers) to secure employment, pay child support, and participate more fully and responsibly as parents.	Very Strong. Random assignment, large numbers (5,000) multi-site	Non-custodial parents (usually fathers)	Risk factors: ***Family*** • Parental criminality • Low parental education • Parental unemployment • Parent-child relations Protective factors: **Individual** • Economic self-sufficiency • Supportive parent-child relations	The Responsible Fatherhood Curriculum used in the peer support groups is available online at: www.mdrc.org/InPractice (http://www.promisingpractices.net/program.asp?programid=43).
Individual Development Accounts Contact information: IN Department of Commerce IDA Program. Assets for Independence. IN Community Development Division. One N. Capitol Ave, Ste 600. Indianapolis, IN 46204. (317) 233-0541.	IDAs are matched savings for low-income individuals, to be used for home ownership, education, or small business capitalization. IDA programs also include financial education and staff support to encourage saving	Strong. Multi-year evaluations conducted in 13 sites	Low-income adults	Risk factors: ***Family*** • Low socioeconomic status Protective factors: ***Family*** • Economic self-sufficiency	http://gwbweb.wustl.edu/csd/Publications/2002/SherradenResearchReport2002.pdf#search='ida%20accounts%20research

Table 6: Evidence-based Intervention Programs — Family Support (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Becoming Parents Program Contact information: Becoming Parents Program, Inc. 206.291.8313 877.586.2778 toll free	This approach targets married or committed couples who are becoming parents for the first time through birth, adoption, or foster parenting and consists of a series of classes designed to help them learn skills and knowledge to strengthen their relationships. The program involves 27 hours of classroom time, mostly during the weeks preceding birth, with one 3-hour "booster" session held when the infant is 6 to 8 weeks old and another when the child is 6 months old.	Preliminary. Previous program had evaluation	New parents	Protective factors: ***Family*** • Stable home environment	Jordan, P.L., Stanley, S.M., & Markman, H.J. (2001) Becoming Parents: How to Strengthen Your Marriage as Your Family Grows. San Francisco: Josse-Bass.
Guiding Good Choices African-American Marriage Enrichment Program©: How to Make Your Good Thing Better Contact information: Lorraine Blackman School of Social Work lblackma@iupui.edu (317) 274-6713	Research-based curriculum to develop a social work practice model to prevent marital disillusionment and divorce and, secondarily, to build professional capacity in Indiana to provide ethnic and gender sensitive family life education.	Preliminary. Quantitative and qualitative research suggest(s) positive effects on relationship stability, perceived relationship quality, decreased conflicts over childrearing, and high levels of consumer satisfaction, especially among males. Only research based curriculum for African Americans recommended by the Administration for Children and Families, U.S. Department of Health and Human Services.	African-American married couples	Risk factors: ***Family*** • Single-parent family/divorce Protective factors: ***Family*** • Stable home environment	www.aafle.org Blackman, L. C. (1998). Marriage enrichment programs for African-Americans. In R. R. Greene & M. Watkins (Eds.), *Serving diverse constituencies: Applying the ecological perspective* (pp. 241-262). New York, NY: Aldine de Gruyter.

Table 6: Evidence-based Intervention Programs — Family Support (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Reducing the Risk	The school-based curriculum helps teens understand the personal responsibilities and consequences of sexual activity, (and) develop and practice the decision-making, negotiating, and refusal skills needed to resist negative social pressures regarding sexual contact. In addition, the program aims to strengthen parent-child communication about issues related to sexual activity. The Reducing the Risk curriculum is intended to supplement pre-existing sexual education programming.	Preliminary: Despite a large sample size and quasi-experimental design, and the existence of a second evaluative study, and some positive outcomes, it produced somewhat mixed results and failed to significantly positively affect its primary goal of reducing the frequency of unprotected sex. The program was shown to significantly increase the level of knowledge regarding appropriate and correct use of contraceptives. The program was also found to increase parent-child communication on contraceptives and related issues.	Under 18	Risk factors: ***Individual*** • Risky/early sexual behavior Protective factors: ***Family*** • Supportive parent-child relations	http://www.promisingpractices.net/program.asp?programid=37

Evidence-based Practices and Promising Approaches in School-Based Mental Health Programs

Introduction

While school based mental health (SBMH) allows for easier access to treatment, the current structure of treatment programs can vary significantly and can be fragmented (Adelman & Taylor, 2003). Some programs are reactive, treating mental illness only when it manifests itself as behavioral problems in the classroom; however, reactive programs focus solely on those children experiencing severe social-emotional difficulties, missing the opportunity to begin identifying and treating problems before they escalate. Other programs take a more preventive tack and promote healthy social-emotional development by using collaborative efforts such as wraparound treatment teams. Moreover, by addressing problems earlier (e.g., elementary years), schools are able to respond, identify, and provide social and emotional supports that may prevent escalation in behaviors.

Principles and Themes of Effective Intervention

To address problems earlier, schools need assessment tools to identify students who may be in need of early intervention. Better assessment tools can help identify students in need of intervention and help ensure placement in the least restrictive environment (Paz & Graham, 1995). For example, one such instrument was developed just because behavioral disorders are more difficult to identify than academic disabilities, called the Systematic Screening for Behavioral Disorders. The SSBD relies on three steps. First, teachers rank order students based on a set of criteria. Second observations about those three students who ranked highest are quantified. Third, school-based mental health staff then make observations of these students and referrals for further evaluation as appropriate. This process can help identify those students in need of behavioral intervention more accurately. Another assessment tool is the use of *pre-referral process* interventions. Developed to reduce the referrals to special education and mandated by federal special education laws, this process requires schools to make and document changes to the general education classroom before a referral can be made. Data on effectiveness of changes as well as all interventions that are tried need to be collected and analyzed and it should be clear that the student is indeed in need of an actual referral. It is legally and ethically important for a school to be thorough in its attempt to help the student succeed in school prior to making a formal referral for special education.

The theoretical frameworks underlying SBMH should support its practical applications. Interventions can begin at any point, can be reactive or preventive, and should focus on using the best practices based on evidence available. Gresham (2004) argues that interventions should be modeled after the severity of the presenting problem. He advocates using a three-tiered model throughout the school, focused on maintaining children in the least restrictive environment. By focusing on the entire school population, the first tier, called universal interventions, is aimed at preventing challenges among all students. These are the day-to-day instruction and supports provided to all students, including differentiation, proactive classroom management, and data study teams, which all generally ensure that learning is meaningful and interesting and that students are ready to engage in learning (e.g., breakfast and lunch programs). Prevention also includes fully involving families in schools.

In the second tier, targeted or selective interventions are aimed at working with children with one or more mental health needs, including the special education population (American Academy of Pediatrics, 2004).

Schools may screen students to identify those with suspected disabilities or unmet mental health (or academic) challenges. A referral system, gleaned from parents, teachers, or other school personnel (Paz & Graham, 1995) also can be implemented in which referrals are encouraged. In the second tier, schools provide "targeted" strategies and supports for students who are having behavioral (or academic) challenges. This level can involve positive behavior supports, mentoring, instruction in social skills and conflict resolution, school-based mental health services, and many others. Unlike prevention, the concentration is more on what to do *after* problems occur or needs are detected; however, the continued goal is to use this information to build and to improve the school's preventative practices.

Finally, in the third tier those with more severe social and emotional disturbances benefit best from an intensive intervention. This may be placement in special education, for example. Regardless, the top tier includes more intensive forms of supports for students who are demonstrating significant challenges in behavior (or learning). At this level, a variety of intensive interventions may be implemented for individual students such as individual behavior plans, one-on-one mentoring, and/or academic remediation. Gresham (2004) argues implementing the best model must be based on Response to Intervention (RTI), making behavior change the defining factor that drives the intensity of the intervention. However, RTI does present some issues regarding treatment integrity and treatment intensity. Indeed, the treatment must be implemented as intended (i.e., with fidelity) or it cannot be assumed to be effective; thus, implementation must be evaluated and monitored (Gresham, 2004). Some programs take this model further, including interventions for maintaining and sustaining over time appropriate functioning that is attained in the second and/or third tiers. For example, the *Tripartite Model*, based on the three tiers, focuses on the underlying reason for the intervention, and includes the creation of individual treatment plans for each child (Pfeiffer & Reddy, 1998), also emphasizing intensive case management (Heathfield & Clark, 2004).

Model Programs

In recent years, the importance of using e*vidence-based interventions* for youth has emerged across the spectrum of children's social services. Again, such approaches often are predicated on an initial preventative effort. General education (i.e., non-special education) classroom teachers effectively instructing children on broad skills within the typical classroom setting is part of a universal preventive intervention (Schaeffer, Bruns, Weist, Stephan, Goldstein, & Simpson, 2005). Similar to the first tier, this effort focuses with the entire classroom to manage behaviors and to institute a set of rules and expectations for behavior. Schaeffer et al. (2005) states that this requires school-wide buy-in because it relies heavily on teachers.

A growing trend in SBMH is the concept of linking schools with community service providers, agencies, and resources. This creates a *continuum of care* that can provide more comprehensive treatment of mental health issues and can be targeted to the general population and/or specifically to students with serious or specific needs (e.g., students in special education or students labeled with emotional disturbance). This approach is also used in *Positive Behavioral Interventions and Supports* (PBIS; see pbis.org), which has been implemented in many schools (Eber, Sugui, Smith, & Scott, 2002). This method works well for keeping students with serious emotional and behavioral problems in school (Atkins, Graczyk, Frazier, & Abdul-Adil, 2003). Robinson and Rapport (2002) conclude that this treatment can be applied to various disruptive behaviors and continue to be effective. In some programs, the collaboration between school personnel, mental health professionals, and family members is used to provide a *wraparound treatment team* for each child (e.g., see VanDenBerg & Grealish, 1996). The team approach has the added benefit of avoiding or "filling in" gaps in treatment often found with more fragmented services particularly because of the collaboration that results from bringing together professional from different child-serving systems and families (Weist, Lever, & Stephan, 2004).

The continuum created by these approaches, sometimes referred to as an ecological model, also acts a method to conceptualize treatment around the individual and family unit in terms of a broader social environment (Anderson & Mohr, 2003; Motes, Pumariega, Simpson, & Sanderson, 1998). A challenge to this model exists when the partners of different agencies lack a shared vision. True collaboration is difficult to achieve because it is both product and process, requiring partners to share responsibilities and to commit to overcome the inevitable conflicts that accompany collaboration. True collaboration also requires participants to commit to a common mission and goal. For example, a common goal is difficult to pursue with high turnover in staff, who comprise these teams, among the agencies involved in treatment. This can be addressed through weekly or regular meetings among all partners to keep lines of communication open (Jennings, Pearson, & Harris, 2000).

There are few established practices for direct treatment interventions for youth with mental health challenges in the school setting. The manuals that do exist generally are based on both behavioral and cognitive principles, and the interventions themselves often focus on more remedial skills for targeted interventions of those with behavior disorders. Nationwide, there have been program reviews for violent youths, such as the study done by the Center for the Study and Prevention of Violence (CSPV), or the model programs identified by the Center for Substance Abuse Prevention (CSAP). However, no reviews have been done to identify key programs to be implemented by mental health professionals in schools. Thus, Schaeffer et al. (2005) suggest the use of standard intervention protocols in clinical practice and ensuring buy-in by all stakeholders as key components to an effective evidence-based intervention.

Walker (2004) addresses the issue of evidence-based practice for school intervention, describing a successful program focused on aggression in young children, entitled *The First Step to Success*. First Steps focuses on early intervention for antisocial children. Another practice with literature supporting its success is *Positive Behavioral Supports* (PBS). Similar to PBIS, Walker (2004) describes this as a comprehensive method of discipline and behavior support in schools and cites a successful effort in a program entitled *Effective Behavioral Support* (EBS), which has been implemented nationally. Walker (2004) further emphasizes that these programs' success is grounded in their ability to address barriers to comprehensive responses to challenging needs that are easily integrated into school environments and are culturally relevant. Walker (2004) further calls for evaluation of implementation and integrity, followed by a scaling up of sustainable intervention efforts in schools nationwide, as well implementation of programs that show efficacy and effectiveness within actual classroom settings.

Relative Effectiveness of Interventions

Indeed, prevention and intervention should target the cultural environment of children and schools (Heathfield & Clark, 2004). Services, supports, and interventions must be fully sensitive to a child's background. Heathfield and Clark (2004) state that the overrepresentation of students from minority backgrounds in special education is often because cultural variables are being ignored and behaviors misinterpreted. There is also dire need for further early preventative services that are culturally sensitive and relevant. Within this framework, the involvement of the family is critical in ensuring the most effective treatment for children. Parents should be included as partners in their child's care so that environmental and developmental issues can be fully addressed by intervention (Anderson & Mohr, 2003). Often parents have been relegated to the "backseat" on the treatment team; however by building the treatment team around the family, intervention can be more narrowly focused on the individual student and her or his family (Robertson, Anderson, & Meyer, 2004). Vanderbleek (2004) also points out that parental involvement is also beneficial to academic performance among students with various behavioral problems (Vanderbleek, 2004). Indeed, parents know their children best and consequently are most familiar with their child's challenges. School personnel and mental health professionals can learn about the child's environment, strengths, and challenges from parents and can work with the family to appropriate

interventions. Also, by emphasizing parental involvement, treatment teams can encourage families to be or become the primary decision-makers in the child's life; thus, empowering families to become more self-sufficient (Anderson, Wright, Kooreman, Mohr, & Russell, 2003).

Challenges

An obvious challenge to this wraparound model occurs when communication among partners break down (Wright et al., 2006). The model also fails if collaboration is not fostered (Robertson, et al., 2004). Collaboration must be comprehensive, including social service agencies, community partners, and students and families. Collaboration must extend from the team to the system level and back, influencing policy and procedural changes (Anderson, Meyer, Sullivan, & Wright, 2005; Hernandez & Hodges, 2003). All stakeholders must also assume responsibility for continuing efforts to stay connected and keep the team functioning. The concept of resistance among stakeholders arises from cultural, socioeconomic, historical and political differences in perspective must be anticipated addressed, and overcome (Anderson, et al., 2005; Anderson & Mohr, 2003).

Casat argues that there are drawbacks in SBMH programs (Casat, et al., 1999). For example, if there are not adequate supports or buy-in from the community or the family, children can be unnecessarily placed in more restrictive settings such as self-contained special education classes. Another problem is high burnout and turnover among therapists, making retraining a constant necessity. Also, teachers in school systems may be resistant to the idea of mental health services in schools. It is important to recognize that the traditional educational system was not designed to prevent or even respond to the wide range of health, mental health, social, and psychological difficulties associated with emotional and behavioral challenges in children. Therefore, as might be expected, educators generally have not viewed themselves as responsible for providing these kinds of services and supports (Epstein & Walker, 2002; Robertson, Anderson, & Meyer, 2004; Woodruff, Osher, Hoffman, Gruner, King, Snow, & McIntire, 1999). Yet, in spite of this historical lack of preparation or attention, schools have in fact become the de facto service system for mental health and related service provision (Farmer, Burns, Phillips, Angold, & Costello, 2003). Most importantly, there is an emerging body of research suggesting that when implemented comprehensively and with fidelity to the underlying model and theory, children can be maintained in school and often supported in or returned to less restrictive classroom settings through SBMH services and supports.

Table 7: Evidence-based Intervention Programs--School Mental Health Programs

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
The First Step to Success Developed by the University of Oregon	Addresses needs of kindergarten students at risk for developing or having antisocial or aggressive behaviors. Uses trained consultant to work with school and students for 3 months to work on screening, curriculum, and family involvement.	Very Strong. Lasting effects three years out, across schools, settings, teachers and peer groups. High teacher satisfaction rate.	Kindergarten students	Risk Factors: ***Individual*** • Involvement in antisocial behavior • Displays of aggression	Center for Effective Collaboration and Practice http://cecp.air.org/resources/success/firststep.asp
Effective Behavioral Support Program (EBS) Developed by the University of Oregon Used by Lane County, OR, schools	Approach to Positive Behavioral Support (PBS), being implemented in approximately 500 schools nationally; team of school staff assesses needs and implements program.	Very Strong. Well-researched and highly effective	Universal—designed to prevent disruptive behaviors in all students, even those with behavior problems	Risk Factors: ***Individual*** • Involvement in antisocial behavior • Displays of aggression Protective Factors: ***Individual*** • Positive beliefs and standards • Highly developed personal and pro-social skills	Center for Effective Collaboration and Practice http://cecp.air.org/resources/success/ebs.asp
Second Step Violence Prevention Program	Early intervention program to address aggression; provide children with the skills they need to create safe environments and become successful adults.	Very Strong. Well-researched and highly effective	Grades Pre-K-9	Risk Factors: ***Individual*** • Displays of aggression Protective Factors: ***Community*** • Safe environments	http://www.cfchildren.org/cfc/ssf/ssf/ssindex/
Positive Behavioral Support (PBS)	Approach to teach values and competencies (i.e., be safe and responsible).	Very Strong. Clear and consistent evidence of effectiveness across sites and studies in reducing behavior problems and disciplinary referrals	Universal-used in classroom, lunchroom, hallways and any other area where problems can occur.	Protective Factors: ***Individual*** • Positive beliefs and standards • Highly developed personal and pro-social skills	http://www.pbis.org/main.htm

Table 7: Evidence-based Intervention Programs--School Mental Health Programs (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Bluegrass IMPACT (Interagency Mobilization for Progress in Adolescent and Child Treatment)	Works to establish a responsive, collaborative, and community-based approach to helping children with emotional or behavioral problems. Case manager works to facilitate services. 17 Counties in Kentucky	Strong/Very Strong. Studies show significant success rates and satisfaction rates among families.	Those with behavior disorders in elementary and secondary schools.	Risk Factors: ***Individual*** • Presence of psychological condition • Exhibits internalizing disorders • Exhibits externalizing disorders • Involvement in antisocial behavior • Lack of emotional support	Center for Effective Collaboration and Practice http://cecp.air.org/resources/success/kentucky_impact.asp
Constructive Discipline Model Los Angeles County, CA	Multifaceted approach to intervention to reduce violence and vandalism, with the implementation of a school-wide behavioral improvement plan	Strong. Has been demonstrated and one controlled study of several schools showed a decrease in violence of 78.5%.	Grades 4-8	Risk Factors: ***Individual*** • Early initiation of violent behavior • Involvement in personal/property crimes Protective Factors ***Individual*** • Implementation of school-wide behavioral improvement plan	Hamilton Fish National Institute on School and Community Violence http://hamfish.org/pub/vio_strat.pdf
The Comer Process: The School Development Program (SDP)	A process to deal with obstacles to parent and community participation, to encourage collaboration and communication among all adult stakeholders around school management, and to implement instruction informed by child development principles and curriculum alignment. 650 schools nationwide	Very Strong. First implemented in 1968, now spread nationwide.	Elementary and secondary schools	Risk Factors: ***Individual*** • Exhibits externalizing disorders • Presence of psychobiological factors • Lack of emotional support • Presence of psychological conditions • Conduct disorder • Exhibits internalizing disorder • Problematic social information processing • Suicide attempts Protective Factors: ***Individual*** • Positive beliefs and standards • Highly developed personal and pro-social skills • High self constructs • Social support	Center for Effective Collaboration and Practice http://cecp.air.org/resources/success/school_development_program.asp

Evidence-based Practices and Promising Approaches in Mental Health and Psychiatric Treatment

Introduction:

In community surveys, the prevalence of one or more psychiatric disorders amongst children and adolescents ranges from 17.6 to 22.2 percent. If serious functional impairment is considered, the rate drops to 11 percent. The estimated number of affected children with Serious Emotional Disturbance in the United States is 6 to 9 million children (9 to 13 percent of the population); however, 70 percent of all children needing mental health services do not receive those services. The most common diagnoses seen in order of prevalence are disruptive behavioral disorders (including attention deficit/hyperactivity disorder, oppositional defiant disorder, and conduct disorder), substance use disorders, anxiety disorders (including generalized anxiety disorder, social anxiety disorder, specific phobia, post-traumatic stress disorder, and obsessive-compulsive disorder), mood disorders (such as major depressive disorder and less commonly bipolar disorder), and learning disorders of various types.

Children with mental health problems do not self-identify, as many adults do. Rather, they must be suspected of having a mental health issue by those who live with, educate, or otherwise care for them. Many times, emotional and behavioral problems will be severe before parents will acknowledge that their child's problems are beyond the scope of normal development and seek professional consultation. School settings may be the first to initiate an investigation into the cognitive, behavioral, emotional, and/or adaptive functioning of a child who is not succeeding either academically or socially at school. If first contact about a mental health problem is undertaken by a parent, it is usually pursued in the office of the familiar family doctor rather than the foreign terrain of a community mental health center or child psychiatrist's office. Sometimes, a child will receive no formal mental health evaluation until s/he has been brought into either the Juvenile Justice system due to conduct disturbances or the Department of Children's Services due to parental neglect and/or abuse. All of these points of entry—parents, school, family physician, mental health center, child and adolescent psychiatrist, juvenile justice, and child welfare—have significant roles to play in maintaining the well-being of our future generations. If the identification process were functioning optimally, then our children might receive services earlier to prevent greater impairments in all domains, which have much greater and costlier consequences as children grow up (e.g., school failure, truancy, substance abuse, conduct disturbances, unwanted pregnancies, etc.)

Before establishment of the Child and Adolescent Service System Program initiative (CASSP) in the late 1980s, child mental health resources were fragmented into various factions: the remnants of the child guidance clinics which emphasized individual and family-driven therapy versus the modern medical model which placed children in institutions and emphasized pharmacotherapy without community supports. As government funding shifted away from talk therapies and towards medical treatments, fewer resources were available to help children succeed in their home environments. Since the early 1990s, the systems of care model (an outgrowth of the CASSP) has been adopted as the standard philosophy for treating children and adolescents, which maintains that the best place for a child to be treated is in his/her community, preferably at home, with decisions driven by the culture, resources, and guidance of the child's family, coordinated by some central agent, and funded by some nonspecific and flexible funding source. Although these principles are meant to be applied to every child, by no means have adequate systems of care been created to meet the needs of most children. Funding sources, staffing issues, training, oversight,

infrastructure, leadership, coordination, and effective communication all remain significant obstacles to successful establishment of systems of care in Indiana.

"Systems of care" encompasses multiple components, each of which has a degree of evidence for efficacy when scrutinized individually. These include but are not limited to psychopharmacology directed by a child and adolescent psychiatrist, psychosocial interventions such as cognitive behavioral therapy and interpersonal therapy, family-focused therapies such as family and parenting interventions, integrated community-based treatment which includes multisystemic therapy, case management, therapeutic foster care, respite care, and home-based services; and school-based interventions. The concept of "wraparound" services led by parent/child teams has also been studied as a therapeutic entity with positive outcomes, and may contain several of the elements listed above plus other more informal interventions such as mentoring and community activities such as Boys' Club participation. (Pumariega, Winters, & Huffine, 2003)

While the systems-of-care concept intends to avoid the utilization of intensive services such as hospitalization, there are times when this level of care is indicated. An instrument such as the one developed by the American Academy of Child and Adolescent Psychiatry's Work Group on Community Systems of Care called the CASII (Child and Adolescent Service Intensity Instrument) has been designed to quantify and standardize the intensity of a youth's need for services, on a dimensional continuum of symptoms and functioning. A recommendation can be made, whether the problem is psychiatric, substance abuse, developmental, or some combination, and might include anything along the spectrum from outpatient services, day hospital, partial hospitalization, acute hospitalization, residential treatment, or longer-stay hospitalization. (*AACAP Practice Information*) In Indiana, an application process for state hospitalization depends upon significant scores on the Achenbach Child Behavior Checklist completed by a mental health professional plus other evidence that the youth has failed attempts at community-based treatment and remains impaired in at least two areas of functioning. This is much the same determination used for eligibility for the Seriously Emotionally Disturbed (SED) Waiver, which is funded partly through federal monies matched in lesser part by state funds. These waivers are intended to keep at-risk youth with high need for services in the community rather than placing them in an institution. Of course, if the particular youth has demonstrated the failed attempts in the community mentioned above, then there may be no alternative to placement at a state-operated facility for a period of time. At the current time, there is no other standardized risk or needs assessment for youth that is utilized to determine if a different (say, less intensive) level of services is warranted.

Principles and Themes of Effective Intervention

The American Academy of Child and Adolescent Psychiatry (AACAP) routinely establishes and publishes practice parameters for its members through the work of expert panels who utilize evidence-based studies and expert consensus in delineating minimal standards, clinical guidelines and options for a particular area of child and adolescent psychiatry. One such "Practice Parameter" is on "Child and Adolescent Mental Health Care in Community Systems of Care," currently available to Academy members and soon to be in print.

When comparing several of the recommendations for minimal standards and clinical guidelines for practice as advanced by the AACAP in this document with the current status locally, there are several areas where improvement could result in benefits. These benefits are supported by the most recent research data. These will be delineated below:

AACAP Recommendation 3

> "Mental Health interventions should be actively coordinated with services by other providers, including primary care providers, and whenever possible, integrated with interventions provided by other social agencies. This can occur at the case, program and larger system level." [Minimal Standard]

Due to constraints of HIPAA (Health Insurance Portability and Accountability Act) and the various physical and logistical boundaries that separate agencies, communication across providers is a difficult accomplishment. This is essential, however, for youth who require multiple services in the community.

Traditionally, there has been a demarcation between "turfs," meaning that school is school, home is home, and juvenile detention is juvenile detention. Each system has its own "treatment" philosophy, financial base, and priorities. If systems-of-care is truly going to work, then these boundaries need to become more integrated, with mental health permeating all of them. In particular, there is a growing body of evidence that mental health services delivered in school settings in various forms—school consultations by psychiatrists, preventative interventions, as well as psychoeducation and skills-building groups for identified youth—have shown efficacy for a number of different mental health problems across the age spectrum. (Pumariega, et al., 2003) The same should be inferred for the juvenile justice system, where as many as 75 percent of juvenile offenders have one or more diagnosable psychiatric conditions. Most receive no mental health care while detained, however (American Academy of Child and Adolescent Psychiatry, 2005).

The primary care physician is crucial to this equation but is often left out of the picture until the child or adolescent runs into major problems at home, school or in the community. Helpful in ruling out disease processes that may be causing or contributing to the youth's mental or behavioral symptoms, the primary care physician is an important and trusted point of contact for many families. Linking primary care physicians more broadly to local mental health centers for referrals or mental health information might facilitate entry into mental health treatment and/or systems of care at a more appropriate time.

Active coordination requires that someone actually attends to the coordination of the unique set of services provided by the various agencies which may involve child welfare, juvenile justice, education, community mental health, and private providers for each individual patient. This is further complicated by wraparound services from the community such as volunteers for transportation, instructors of leisure activities, mentors, after-school programs, etc. Active coordination implies accessibility, so that providers know whom to contact for initial referral and ongoing problems. Although not specified in this standard, active coordination would also mean coordinating the stream of funds that would enable the youth to benefit from services integrated across agencies without duplication of effort and expense. The political and logistical aspects of such coordination are daunting. The benefits of this "case management," if one were to reframe it as such, since the position entails managing resources both human and financial in the most efficient manner, are well-documented in terms of reduced hospitalizations, fewer foster placement changes, decreased numbers of runaway episodes, and increased adjustment of youth, among other positive outcomes. (Hoagwood, Burnsk, Kiser, Ringeisen, & Schoenwald, 2001)

AACAP Recommendation 11

> "Services should be delivered in the most normative and least restrictive setting that is clinically appropriate. Children should have access to a continuum of care with assignment of level or intensity of care determined by clinically informed decision-making." [Minimal Standard]

At the present time, access to a continuum of care seems to hinge upon whether or not a child has a source of funding and/or is affiliated with a mental health center which actually has developed an operational system of care. Currently, Medicaid will pay for certain services but not others, and community mental health centers find themselves short on human resources, thereby having to choose which cases they serve

with home-based services and case management. While all counties in Indiana must endorse having a system of care, certain counties in Indiana have so little funding for children's mental health that their system is a skeleton at best. When pressed, a case manager can give a vague description of services. One system I encountered hinged on the downtown barber. Some cases which should qualify as severe enough to engage systems of care, therefore, do not, simply because the resources aren't there.

Counties do exist which have services, but finding a funding source becomes the issue. As mentioned above, Medicaid does not cover all services suggested by systems of care, but will pay for many important ones such as case management. If the child has the option of the SED Waiver but deteriorates, she/he may be admitted to a hospital acutely but must forfeit the waiver if placement at a residential treatment facility or state-operated facility is needed. The waiver must be applied for again at the time of discharge, which can delay services for weeks. Of course, this point will be moot if the state does away with the SED Waiver after the start of a new year, as has been suggested by its administrator.

Recently, Medicaid has agreed to pay certain qualified private hospitals and other facilities as residential treatment facilities (PRTFs) as an alternative to more expensive state hospitalization. The payment is for a maximum 90-day period only, approved in 30-day blocks, after which the youth is meant to return to the community. Traditionally, a child could not be placed at a residential treatment facility unless paid for by his/her county's DCS or Probation Department. This might occur after a series of acute hospitalizations or other failed intensive treatment experiences or else as a step-down placement after state hospitalization when that level of care was no longer required but the child was not yet ready for the transition home. It is not yet clear whether residential treatment as an alternative to state hospitalization for some children is cost-effective since the state hospital is receiving applications for children who have reached their limit of 90 days in a PRTF but continue to need intensive services. This is where a systematic approach to needs assessment would be helpful.

AACAP Recommendation 12

> "Significant attention should be paid to transitions between levels of care, services, agencies, or systems to ensure that care is appropriate, emphasizing continuity of care." [Clinical Guideline]

As mentioned in previous sections, early identification by those most closely in contact with troubled children should be the standard, primary care physicians and teachers being good choices. A seamless process of referral to a mental health provider for evaluation should follow, who would designate the intensity of services needed. A "seamless process" implies that primary care physicians need better connections to community mental health centers and community mental health centers need to have a presence in our schools and juvenile detention centers.

Depending upon the assessment of need, a child may require simple outpatient services, hospital-based services acutely, and/or entry into a system of care, the benefits of and some barriers to which have been described above.

When the needs of the youth are complex and multiple agencies are involved, then it is essential that case management be the central organizing element that coordinates services, connects providers, assesses family/patient needs, and utilizes available funding wisely. As mentioned previously, there are many transitions at the present time which are troublesome—from state-operated facility to home, from no SED Waiver to Waiver status—and others, such as the juvenile who turns 18 while receiving youth services and must be "admitted" to the adult side of the mental health center (and is sometimes lost in the system).

Relative Effectiveness of Intervention Types

Different program elements will be presented with supporting information and rated according to their relative effectiveness. There is no clear-cut way to evaluate and compare these different elements because they have been studied in different ways and they are, in and of themselves, so diverse. When studying youth with behavioral disturbances within the context of family systems and communities, it is difficult to determine the appropriate outcomes measures e.g., clinical improvement vs. quality of life vs. cost/benefit ratio. The strongest evidence naturally comes from the arena where research can be conducted in a standardized and reproducible manner (pharmacotherapy, followed by psychosocial therapies), but even these have "translational" problems, meaning good studies do not always translate into good real-world practices. There have been few review studies of wraparound services or case management, for example, and therefore these program elements may seem to have low relative effectiveness; however, when the studies are examined together, their therapeutic value appears more promising.

Model programs

From reviewing the studies about mental health care for youth, no true comprehensive model programs currently exist. There are elements, however, that stand out as essential for the success of community-based care. This list would include school-based mental health services of a wide array, day treatment as an alternative to acute hospitalization, case management of "brokered" services especially if provided in the home, therapeutic foster care when the home is not an option, wraparound services funded by a flexible funding source, psychosocial interventions offered at school, in the home, and in community mental health centers to include parent training, multisystemic therapy, and cognitive behavioral therapy, and assessment and treatment by a qualified child and adolescent psychiatrist who is an integrated member of the treatment team.

Although "more" does not always mean "better," we have learned from the MTA and TADS studies that when it comes to the treatment of children and adolescents, combinations of therapies are often optimal. Certainly for youth who have serious emotional disturbances, all functional domains must be considered in the treatment plan.

Challenges

Children and adolescents across the state are being underserved when it comes to their mental health needs; Marion County is not immune to this deficiency. Community Mental Health Centers do not get reimbursement commensurate with the services they could or should provide and some are therefore very limited in scope. Children who need services are not always identified early enough or when identified are not able to negotiate through the system to get their needs met due to the still-fragmented state of inter-agency communication and coordination. Systems of care are either understaffed or underfinanced, and in any case underutilized in this county, due to a combination of financing and frustrations with the waiver system. Coordinated case management and invested cooperation of stakeholders, namely, Juvenile Justice, Department of Children's Services, Department of Education, Community Mental Health Centers, and Division of Mental Health and Addictions, are essential for successful growth of systems of care in Marion County. Better and expanded reimbursement by Medicaid would also go a long way to improve access to services for children.

The efforts to access funds for the SED Waivers in Indiana have proven so onerous to many community mental health centers that the system is on the verge of collapse. Providers are not interested in providing services due to delay in payment, and case managers are overwhelmed by the amount of documentation involved in each application and transaction. Although the original plan was to expand the waiver to all counties from a pilot of nine, which began in 2003, it never did so. The state is currently considering the

legitimacy of this program, which appears to be reaching so few children, the maximum being 44 at any given time (200 slots were anticipated to be available). The flexible funding available via the waivers allowed for the very services intended by home and community-based care that cannot otherwise be conventionally billed and is usually unaffordable by most households. If the proposal to ask counties to match the federal money by shifting payment away from residential treatment to a waiver system is imposed, it may not be any more successful than past programs. If counties don't have money to pay for placements at the present time, it accomplishes nothing. Perhaps the actual administration process of the waivers could be revisited instead, as this would be a loss of resources for our children if the waiver program disappears.

As for acute services, there is a definite need for child and adolescent inpatient psychiatric beds in Marion County. Many times physicians are unable to get a patient admitted to a hospital within this county due to various barriers. Unfortunately, due to the inability to deliver the required intensity of community-based care, patients are admitted to residential treatment facilities and state hospitals with longer stays than are probably necessary for most youth.

Indiana is in the midst of an anticipated shortage of psychiatrists, and a very real-time shortage of child and adolescent psychiatrists. If the number of trainees in these fields does not increase in the next ten years, there will be a real crisis in meeting the psychiatric needs of the state, particularly of children. At the same time, the training stipends for psychology interns continually decline, leading to fewer professionals who can evaluate children and adolescents and fewer who have the requisite skills to provide expert psychosocial therapies such as cognitive behavioral therapy.

Availability and coordination of funding seem to be two of the biggest hurdles to the implementation of programs to identify and evaluate children, to administrate and pay for systems of care services, and to pay for needed services such as residential treatment and therapeutic foster care which are not currently available to many deserving youth.

When discharging adolescent patients from a state-operated facility "placement" sometimes becomes the most difficult accomplishment of a hospitalization. Oftentimes the adolescent's psychosocial circumstances are part of the reason for his/her admission, and returning directly home is not a reasonable option. Unless the Department of Education will sponsor the individual to a residential facility due to his/her overwhelming developmental/educational needs, the youth's local Probation Department (meaning the youth is on probation) is willing to pay for therapeutic foster care, residential treatment, or a group home, or the Department of Children's Services (meaning the child is a ward) is willing to do likewise, there is no funding for these types of placements. In addition, there is a shortage of group homes and therapeutic foster care in general.

There are additional concerns for which there are no easy answers associated with added expense to the community, those being children and adolescents who have parents with serious psychiatric disturbances, those who have suffered severe abuse of multiple forms and have been perpetrators themselves, those who have two or more serious psychiatric disorders, and those who have substance abuse problems in addition to a psychiatric disorder. These youth are likely to need an intensity of services much higher than anticipated based on usual community expectations. They often require inpatient stabilization at a state-operated facility before consideration of maintenance in the community, and may require step-down placement in a residential treatment facility as mentioned above. These youth may not have the option of community-based care, no matter how intensive, in the active phases of their illnesses.

Furthermore, there are those on probation whose behavior cannot be controlled safely in the state hospital but who will not receive adequate treatment in the Department of Corrections due to inadequate

formularies and lack of therapeutic programming. Sometimes a hard decision must be made in the interest of safety (of staff and other patients) to return them to Probation. There are youth who have no family due to the ravages of parental psychiatric disturbance, substance abuse, and/or abuse/neglect and no facilities to receive them due to the youths' past behaviors in those less restrictive settings. (Some have been in the "system" for as long as 10-11 years). There are youth who have serious mental illness and nowhere to go for lack of the kinds of facilities available to adults with similar mental illnesses (i.e., group homes for patients with bipolar disorder or schizophrenia). These youth often remain "institutionalized" for lack of a better alternative. Many challenges remain if we are to adequately serve our children.

Table 8: Evidence-based Intervention Programs—Child and Adolescent Mental Health

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Psychopharmacology	Children and adolescents with serious psychiatric disorders are assessed by a qualified child and adolescent psychiatrist for appropriate diagnosis and possible prescribing of medications.	Strong. Although there are still significant gaps in our working knowledge about pharmacologic agents in children and adolescents, these interventions have shown increasing efficacy for childhood mental health disorders. These agents should be made available to the Severely Emotionally Disturbed (SED) population when appropriate, because, if left untreated, those disorders are likely to cause significant symptoms, functional impairment, and hence more time in restrictive environments. (Pumariega, Del Mundo, & Vance, 2002; U.S. Department of Health and Human Services, 1999)	Children and adolescents with serious psychiatric disorders	Risk Factors: ***Individual*** • Presence of psychobiological and genetic factors • Presence of psychiatric condition • Exhibits internalizing disorders • Exhibits externalizing disorders Protective Factors: ***Individual*** • Self-discipline ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management	Pumariega, A.J., Del Mundo, A.S., & Vance, B. (2002). Psychopharmacology in the context of systems of care. In B.J. Burns & K. Hoagwood (Eds.), *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders* (pp.277-300). New York: Oxford University Press. U.S. Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Winters, N., & Terrell, E. (2003). Case Management: The Linchpin of Community-Based Systems of Care. In A.J. Pumariega & N.C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry* (p. 186). John Wiley & Sons, Inc., San Francisco.

Table 8: Evidence-based Intervention Programs — Child and Adolescent Mental Health (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Multimodal Treatment Study of ADHD MTA Cooperative Group,1999a, 1999b	A comparative study of pharmacological, behavioral treatment, combination, and usual community treatment for children diagnosed with attention deficit hyperactivity disorder (ADHD).	Very Strong. Largest (579 participants) and longest (14 months) study of randomized participants to medication alone, behavioral therapy alone, combination treatment, and usual community treatment. Medication and combination treatment were found to be more effective than behavioral therapy alone or the usual community treatment. Children with co-morbid anxiety seemed to benefit more from behavioral therapy than their counterparts without anxiety.	Children with ADHD	Risk Factors: ***Individual*** • Presence of psychiatric disorders, especially multiple • Chaotic home environments • Exhibits externalizing disorder • Exhibits conduct disorder Protective Factors: ***Individual*** Social support	Multi-site Treatment of ADHD Cooperative Group, (1999), *Archives of General Psychiatry*, 56, 1073-1096. Pumariega, A., and Fallon, T. (2003).Pharmacotherapy in Systems of Care for Children's Mental Health. In A.J. Pumariega & N.C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry* (p. 121). San Francisco: John Wiley & Sons, Inc..

Table 8: Evidence-based Intervention Programs—Child and Adolescent Mental Health (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Multisystemic therapy (MST)	Perhaps the best-studied family and community-based treatment model, MST is an intensive short-term home-based treatment for youth with serious emotional disturbances. Its central focus is to determine the factors that are contributing to or maintaining identified youth problems across the youth's and family's social ecology (Schoenwald, Brown, & Henggeler, 2000).	Strong. The efficacy of MST has been demonstrated in three randomized controlled trials for youth in the juvenile justice system. MST programs were compared to usual community treatment interventions in Memphis, Tennessee, and Simpsonville, South Carolina. These studies found that MST was superior to usual community treatment in decreasing adolescent behavioral problems and improving family relations (Henggeler et al., 1986). In other studies, MST has been associated with lower rates of re-arrest and self-reported delinquent behaviors (Henggler, Pickrel, Brondino, & Crouch, 1996). More recently, psychiatrically-affected youth without juvenile justice involvement and youth with substance abuse problems were exposed to MST with success (Rowland, et al. 2000; Henggler, Pickrel, Brondino, & Crouch, 1996). Although the efficacy of MST has been demonstrated in multiple settings, including juvenile justice, substance abuse, child welfare, and mental health, the findings have been demonstrated by only one group and need to be replicated by others.	Youth with serious emotional behavioral disturbances	Risk Factors: ***Individual*** • Involvement in delinquency • Early initiation of violent behavior • Involvement in personal or property crimes • Substance use/abuse • Drug dealing • Contact with police • Violent behavior • Weapon use • Crime recidivism ***Family*** • Poor family management practices • Low levels of parental involvement • Poor family bonding • Family conflict • Poor parent-child relations • Anti-social parents Protective Factors: ***Individual*** • Self-discipline ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management	Schoenwald, S.K., et al. (2000). Inside Multisystemic therapy: Therapist, supervisory, and program practices. *Journal of Emotional and Behavioral Disorders*, 8, 113-127. Henggeler, S.W., Rodrick, J.D., Borduin, C.M., Hanson, C.F., Watson, S.M., & Vrey, J.R. (1986). Multisystemic treatment of juvenile offenders: Effects on adolescent behavior and family interaction. *Developmental Psychology*, 22, 132-141. Henggler, S.W., et al. (1996). Eliminating (almost) treatment dropout of substance abusing or dependent delinquents through home-based multisystemic therapy. *American Journal of Psychiatry*, 153, 427-428. Rowland, M.D., et al. (2000). Adapting Multisystemic therapy to serve youth presenting psychiatric emergencies: Two case studies. *Child Psychology and Psychiatry Review*, 5, 30-43. Rogers, K. (2003). Evidence-Based Community-Based Interventions. In A.J. Pumariega & N.C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry* (pp. 155-156). John Wiley & Sons, Inc., San Francisco.

Table 8: Evidence-based Intervention Programs—Child and Adolescent Mental Health (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Behavior training	A commonly used outpatient intervention used in conjunction with other treatments, covering issues of discipline, behavior-shaping strategies, and training in child development.	Adequate. Although core symptoms of ADHD were not affected, some improvement in behavior has been reported, usually in the presence of parents but not in other settings such as school. In comparison to wait-list controls, parent training has been found to improve some ADHD symptoms, reduce behavioral problems, and increase grades in school-age children (Sonuga, et al., 2001; Stein, 1999). Other studies, however, have demonstrated no impact on behavior problems in youth, although there was an increased sense of competency among parents (Weinberg, 1999). Cited as a "well-established" therapy for ADHD according to Brestan and Eyberg, 1998.	Children and adolescents with ADHD	Risk Factors: ***Individual*** • Beliefs and attitudes favorable to deviant or antisocial behavior • Exhibits externalizing disorder • Exhibits conduct disorders ***Family*** • Poor family management practices • Child's countercontrol Protective Factors: ***Individual*** • Self-discipline ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management	Sonuga, B., et al. (2001). Parent-based therapies for preschool attention-deficit/hyperactivity disorder: A randomized, controlled trial with a community sample. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40, 402-408. Weinberg, H.A. (1999). Parent training for attention-deficit hyperactivity disorder: Parental and child outcome. *Journal of Clinical Psychology,* 55, 907-913. Brestan, E.V., & Eyberg, S.M. (1998). Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and 5,272 kids. *Journal of Clinical Child Psychology*, 27, 179-188. Rogers, K. (2003). Evidence-Based Community-Based Interventions. In A.J. Pumariega & N.C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry* (p. 159). John Wiley & Sons, Inc., San Francisco. Ollendick, T.H., et al. (2006). Empirically Supported Treatments for Children and Adolescents. In P.C. Kendall (Ed.), *Child and Adolescent Therapy: Cognitive-Behavioral Procedures* (p.499). The Guilford Press, New York.

Table 8: Evidence-based Intervention Programs—Child and Adolescent Mental Health (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Parent training	Parent training is one of the most commonly used outpatient interventions for conduct and oppositional-defiant disorders. The treatments that work consist of specific components which are taught to the parents. The work is most effective when the interventions are performed early in the child's development.	Strong. Brestan and Eyberg (1998) conducted a review of psychosocial interventions for child and adolescent conduct problems, including oppositional defiant disorder and conduct disorder. Of the 82 studies they reviewed, they identified two treatments as well established and several others as probably efficacious. Well-established treatments, which include a series of videotapes modeling parent training (Spaccarelli, Cotler, & Penman, 1992) and a parent training manual (Bernal, Klinnert, & Schultz, 1980), follow Patterson and Gullion's Living with Children (1971), which is based on operant conditioning and teaches parents to reward desirable behaviors and punish deviant behaviors. Other treatments that are probably efficacious include some that focus on intervening early with youth and include parent training and MST.	Children and adolescents with disruptive behavior disorders (conduct or oppositional-defiant disorder)	Risk Factors: ***Family*** • Poor family management practices • Child's countercontrol Protective factors ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management	Brestan, E.V., & Eyberg, S.M. (1998). Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and 5,272 kids. *Journal of Clinical Child Psychology*, 27, 179-188. Spaccarelli, S., Cotler, S., & Penman, D. (1992). Problem-solving skills training as a supplement to behavioral parent training. *Cognitive Therapy and Research*, 16, 1-17. Bernal, M.E., Klinnert, M.D., & Schultz, L.A. (1980). Outcome evaluation of behavioral parent training and client-centered parent counseling for children with conduct problems. *Journal of Applied Behavior Analysis*, 13, 677-691. Patterson, G., & Gullion, E. (1971). *Living with children*. Champaign, IL: Research Press. Rogers, K. (2003). Evidence-Based Community-Based Interventions. In A.J. Pumariega & N.C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry* (pp. 158-159). John Wiley & Sons, Inc., San Francisco.

Table 8: Evidence-based Intervention Programs—Child and Adolescent Mental Health (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Cognitive behavior therapy (CBT)	The primary psychosocial treatments for major depressive disorders have been various forms of psychotherapy, including play therapy, cognitive behavior therapy (CBT), interpersonal therapies, and family therapy. Using the American Psychological Association criteria, there are no well-established treatments for major depressive disorder in children and adolescents but some which are probably efficacious such as CBT.	Strong. In a comprehensive review article, Kaslow and Thompson (1998) found only one form of CBT to be probably effective. Youth receiving this treatment reported lower rates of depression, less self-reported depression, improved cognition, and increased activity levels compared to wait-list controls (Lewinsohn et al., 1996). CBT has also been used as a prevention intervention; it has recently been demonstrated to have a substantial positive effect on adolescents at risk for developing depressive disorders (Beardslee, Versage, Wright, & Salt, 1997; Clark, et al., 2001). More recent data from the Treatment of Adolescents with Depression Study (TADS) by March, Silva, Petrycki, & Curry, 2004, showed a positive response for CBT plus fluoxetine treatment of 71% compared to 60.6% for fluoxetine alone and 34.8% for placebo alone. Although CBT alone was not statistically different from placebo, it did reduce suicidal ideation in combination with fluoxetine. This was conducted at 13 clinics and involved 439 adolescents during 2000-2003.	Children and adolescents with depression or at risk for developing depression	Risk Factors: ***Individual*** • Presence of psychiatric condition • Suicide attempts • Problematic social information processing • Early onset of antisocial behavior • Late stage of antisocial behavior ***Family*** • Low levels of parental involvement • Poor family bonding • Family conflict • Parent-child relations • Parental depression Proactive Factors: ***Individual*** • Positive beliefs and standards • Highly developed personal and pro-social skills • High self constructs • Social support ***Family*** • Supportive parent-child relations	Kaslow, N.J., & Thompson, M.P. (1998). Applying the criteria for empirically supported treatments to studies of psychosocial interventions for child and adolescent depression. *Journal of Clinical Child Psychology*, 27, 146-155. Beardslee, W.R., Versage, E.M., Wright, E.J., & Salt, P. (1997). Examination of preventive interventions for families with depression: Evidence of change. *Development and Psychopathology*, 9, 109-137. March, J., Silva, S., Petrycki, S., Curry, J., et al. (2004). Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for adolescents with depression study (TADS) randomized controlled trial. *Journal of the American Medical Association*, 292 (7), 807-820. Rogers, K. (2003). Evidence-based community-based interventions. In A.J. Pumariega & N.C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry* (p. 158). John Wiley & Sons, Inc., San Francisco.

Table 8: Evidence-based Intervention Programs—Child and Adolescent Mental Health (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Cognitive behavior therapy (CBT)	The group of disorders comprising the category of anxiety disorders is prevalent and wide ranging among children and adolescents and is composed of separation anxiety disorder, generalized anxiety disorder, social phobia, obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD). Multiple components of CBT are appropriate for application to anxiety disorders in individual and group therapy settings.	Strong. For treating phobias, behavioral techniques of CBT were granted "probably efficacious" or "well-established" status based on empirical evidence (Kazdin & Weisz, 1998; Ollendick & King, 1998). The results are less conclusive for other anxiety disorders; however, at least three randomized trials have been performed by two different research groups with children who have anxiety disorder diagnoses (other than phobia). This would give CBT at least a "probably efficacious" status, using the American Psychological Association standards. In addition, a small randomized controlled trial was conducted in a school setting with African-American adolescents presenting with anxiety disorders. Clinician ratings and self-report measures were significantly improved, and three out of four of the CBT group no longer met their anxiety disorder criteria. (Ginsburg & Drake, 2002). In a larger study (N=71), children with generalized anxiety, social anxiety or separation anxiety were randomized to family group CBT or wait list control. At the completion of the treatment, 69% of the FGCBT children were diagnosis-free compared to 6% of the wait-list children. This percentage held at 12-month follow-up. (Shortt, Barrett, & Fox, 2001)	Children and adolescents with anxiety	Risk Factors: ***Individual*** • Exhibits internalizing disorders • Lack of emotional support Protective Factors: ***Individual*** • Positive beliefs and standards • Highly developed personal and pro-social skills	Kazdin, A., & Weisz, J. (1998). Identifying and developing empirically supported child and adolescent treatments. *Journal of Consulting and Clinical Psychology*, 66, 100-110. Ollendick, T.H., & King, N.J. (1998). Empirically supported treatments for children with phobic and anxiety disorders: Current status. *Journal of Clinical Child Psychology*, 27, 156-167. Ginsburg, G., & Drake, K. (2002). School-based treatment for anxious African-American adolescents: A controlled pilot study. *Journal of the American Academy of Child & Adolescent Psychiatry*. 41(7): 768-75. Shortt, A.L., Barrett, P.M., & Fox, T.L. (2001). Evaluating the FRIENDS program: a cognitive-behavioral group treatment for anxious children and their parents. *Journal of Clinical Child Psychology*. 30(4): 525-35. Kendall, P.C., & Suveg, C. (2006). Treating anxiety disorders in youth. In P.C. Kendall (Ed.), *Child and Adolescent Therapy: Cognitive-Behavioral Procedures* (p.279). The Guilford Press, New York.

Table 8: Evidence-based Intervention Programs — Child and Adolescent Mental Health (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
School-based mental health services	Provision of mental health services including medication management, psychosocial interventions, or a combination of both is accomplished in the school environment.	Strong. Anecdotal reports, studies, and surveys attest to the effectiveness of school-based mental health services in improving clinical outcomes and behavioral functioning (Hoagwood, 2000; Atkins, et al., 1998). Treatment interventions can be effective, whether they are applied to mood disorders or attention deficit and disruptive behavior disorders (Clarke, et al., 1995). The use of psychotropic medications or psychosocial interventions or both, has proven effective in treating these disorders in school-based settings. Cognitive-behavioral therapy has proven particularly effective in school-based settings with the major clinical disorders, especially depression and oppositional-defiant and conduct disorders (Hoagwood & Erwin, 1997).	Youth with various clinical diagnoses	Risk Factors: ***Individual*** • Exhibits externalizing disorders • Presence of psychobiological and genetic factors • Lack of emotional support • Presence of psychiatric conditions • Conduct disorder • Exhibits internalizing disorder • Problematic social information processing • Suicide attempts Protective Factors: ***Individual*** • Positive beliefs and standards • Highly developed personal and pro-social skills • High self constructs • Social support	Hoagwood, K. (2000, Winter). State of the evidence on school-based mental health services – NIMH perspectives. *Report on Emotional and Behavioral Disorders in Youth*, 13-17. Atkins, M.S., et al. (1998). An ecological model for school-based mental health services for urban, low-income, aggressive children. *Journal of Behavioral Health Research*, 5, 64-75. Clarke, G., et al. (1995). Targeted prevention of unipolar depression in an at-risk sample of high school adolescents: A randomized trial of a group cognitive intervention. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34, 312-321. Hoagwood, K., & Erwin, H.D. (1997). Effectiveness of school-based mental health services for children: A ten year research review. *Journal of Child and Family Studies*, 6, 435-451. Porter, G.K., et.al. (2003).School-Based Mental Health Services: A Necessity, Not a Luxury. In A.J. Pumariega & N.C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry* (p. 258). John Wiley & Sons, Inc., San Francisco.

Table 8: Evidence-based Intervention Programs—Child and Adolescent Mental Health (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Therapeutic foster care	Therapeutic foster care differs from regular foster care in that the foster parents are trained to deal with youth with severe emotional and behavioral problems. Care is delivered in a home setting using a family-based model to provide youth with a nurturing home environment.	Very strong. Four randomized controlled studies of therapeutic foster care programs demonstrated that therapeutic foster care improved behavior, decreased the use of institutional care, and lowered costs compared to other settings for previously hospitalized youth (Chamberlain & Reid, 1991). Emotional and behavioral adjustments were greater for youth in therapeutic foster care than in regular foster care (Clark, et al., 1994). Reincarceration and residential care decreased for youth receiving therapeutic foster care who had a history of delinquency compared to delinquent youth in residential placements (Chamberlain & Moore, 1998). Kutash and Rivera (1995), in a review of eighteen reports of uncontrolled trials found that 60 to 90 percent of youth treated in a therapeutic foster home were discharged to less restrictive settings. Most were able to remain in these less restrictive settings for substantial periods of time.	Youth with serious emotional disturbances	Risk Factors: ***Individual*** • Involvement in delinquency • Early initiation of violent behavior • Involvement in personal or property crimes • Substance use/abuse • Drug dealing • Contact with police • Violent behavior • Weapon use • Crime recidivism Protective Factors: ***Family*** • Stable home environment	Chamberlain, P., & Reid, J.B. (1991). Using a specialized foster care community treatment model for children and adolescents leaving the state mental hospital. *Journal of Community Psychology*, 19, 266-276. Clark, H.B., et al. (1994). Improving adjustment outcomes for foster children with emotional and behavioral disorders: Early findings from a controlled study on individualized services. *Journal of Emotional and Behavioral Disorders*, 2, 207-218. Chamberlain, P., & Moore, K. (1998). A clinical model for parenting juvenile offenders: A comparison of group care versus family care. *Clinical Child Psychology and Psychiatry*, 3, 375-386. Kutash, K., & Rivera, V.R. (1995). Effectiveness of children's mental health services: A review of the literature. *Education and Treatment of Children*, 18, 443-477. Rogers, K. (2003). Evidence-Based Community-Based Interventions. In A.J. Pumariega & N.C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry* (pp. 156-157). John Wiley & Sons, Inc., San Francisco.

Table 8: Evidence-based Intervention Programs—Child and Adolescent Mental Health (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Partial hospitalization and day treatment	Day treatment programs are interventions designed to be more intensive than traditional outpatient services such as individual group or family therapy, but they are less restrictive than inpatient care. The programs may be located in schools, hospitals, clinics, or community settings. Most programs offer a range of services, including individual, family, and group therapy, and educational interventions.	Adequate. Most of the research done on day treatment programs shows positive results; however, most of these studies are uncontrolled. These studies show an improvement in family functioning and improvement in the youth behavioral symptoms (Kutash & Rivera, 1995). Most studies found improvement in the youth's academic functioning, though some found no improvement. Day treatment services were also found to reduce the use of more costly and restrictive services such as hospitalization and residential treatment. Controlled studies examining day treatment services demonstrated decreased behavioral problems and improved family functioning (Grizenko, Papineau, & Sayegh, 1993; Grizenko, 1997).	Youth with various clinical diagnoses	Risk Factors: ***Individual*** • Delinquency • Early initiation of violent behavior • Involvement in personal crimes • Involvement in property crimes • Substance use/abuse • Drug dealing • Contact with police • Violent behavior • Weapon use • Crime recidivism ***Family*** • Poor family management practices • Low levels of parental involvement • Poor family bonding and family conflict ***School*** • Academic failure • Truancy and dropping out of school • Early and persistent antisocial behavior at school Protective Factors: ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management	Kutash, K., & Rivera, V.R. (1995). Effectiveness of children's mental health services: A review of the literature. *Education and Treatment of Children*, 18, 443-477. Grizenko, N., Papineau, D., Sayegh, L. (1993). Effectiveness of a multimodal day treatment program for children with disruptive behavior problems. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32, 127-134. Rogers, K. (2003). Evidence-Based Community-Based Interventions. In A.J. Pumariega & N.C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry* (p. 155). John Wiley & Sons, Inc., San Francisco.

Table 8: Evidence-based Intervention Programs—Child and Adolescent Mental Health (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Wraparound services; Alaska, Florida, Illinois, Indiana, Kentucky, Maryland, New York, Vermont, Wisconsin	Community-based, individualized, culturally-competent services guided by a team approach spearheaded by the child and family with interagency collaboration and flexible funding, coordinated by a case manager.	Strong. Burns and Goldman (1998) examined the evidence base for wraparound services and reviewed fourteen studies representing programs in nine states. The studies were most often pre-post studies comparing baseline and follow-up without a control group (ten studies) followed by randomized clinical trials (two studies), and case study design (two studies). The studies generally showed that the programs were moderately successful at producing behavioral adjustment, family adjustment, and school adjustments. Some programs appeared very successful, while others appeared only minimally successful.	Youth for risk of out-of-home placements and youth returning from residential placements.	Risk Factors: ***Individual*** • Delinquency • Early initiation of violent behavior • Involvement in personal & property crimes • Substance use/abuse • Drug dealing • Contact with police • Violent behavior • Weapon use • Crime recidivism ***Family*** • Poor family management practices • Low levels of parental involvement • Poor family bonding • Family conflict • Family receipt of welfare • Parent-child relations • Parental depression • Domestic violence • Child's counter control • Delinquent siblings ***School*** • Academic failure • Truancy & dropping out of school • Early and persistent antisocial behavior at school • Involvement in bullying • Behavior disorder • Poor attitude/performance/low academic achievement Protective Factors: ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management	Burns, B.J., & Goldman, S.K. (1998). Promising practices in wraparound for children with severe emotional disturbance and their families. In Center for Mental Health Services, *Systems of care: Promising practices in children's mental health*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental health Administration, U.S. Department of Health and Human Services. Rogers, K. (2003). Evidence-Based Community-Based Interventions. In A.J. Pumariega & N.C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry* (p. 153). John Wiley & Sons, Inc., San Francisco.

Table 8: Evidence-based Intervention Programs — Child and Adolescent Mental Health (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Case manager as part of an interdisciplinary team — North Carolina	Several studies examine case management services where the case manager serves as part of the interdisciplinary team.	Very strong. A randomized trial found that youth served by an interdisciplinary team headed by a case manager were more likely to receive community-based services, spend fewer days in psychiatric hospitals, and receive more comprehensive services than youth served by treatment teams headed by their primary clinician. Using the case manager approach with youth in foster care placements has been found to keep youth in placements longer, increase social skills, decrease absenteeism from school, and decrease delinquency compared to youth in traditional foster care without a case manager. Youth receiving team-based services were found to have fewer behavioral symptoms and significantly better overall functioning than youth receiving multiple services without the benefit of a case manager. Overall, case management appears to be an effective approach to treating youth with emotional and behavioral problems. Although studies report positive outcomes in multiple areas of functioning and the ability to access and remain in services, further outcomes are difficult to assess and compare because of the wide variation in programs using case management services.	Youth with serious emotional disturbances	Risk Factors: ***Individual*** • Involvement in delinquency • Early initiation of violent behavior • Involvement in personal or property crimes • Substance use/abuse • Drug dealing • Contact with police • Violent behavior • Crime recidivism ***School*** • Academic failure • Truancy and dropping out of school • Early and persistent antisocial behavior at school • Involvement in bullying Protective Factors: ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management	Burns, B., eet al. (1996). A randomized trial of case management for youth with serious emotional disturbance. *Journal of Clinical Child Psychology*, 25, 476-486. Clark, H.B., et al. (1998). An individualized wraparound process for children in foster care with emotional/behavioral disturbances: Follow-up findings and implications from a controlled study. In M. H. Epstein, K. Kutash, & A.J. Duchnowski (Eds.), *Outcomes for Children and Youth with Emotional and Behavioral Disorders and Their Families: Programs and Evaluation Best Practices* (pp. 686-707). Austin, TX: Pro-Ed. Evans, M., et al. (1996). Child, family, and systems outcomes of intensive case management in New York State. *Psychiatric Quarterly*, 67, 273-287. Rogers, K. (2003). Evidence-Based Community-Based Interventions. In A.J. Pumariega & N.C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry* (pp. 154-155). John Wiley & Sons, Inc., San Francisco.

Table 8: Evidence-based Intervention Programs—Child and Adolescent Mental Health (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Case management functions	A randomized trial of case management in which a dedicated case manager (experimental condition) was compared with case management functions assigned to the primary therapist.	Strong. It was found that designating primary clinicians as case managers did not increase the time they spent doing case management. Youth in the experimental condition reported less alcohol use than in the control condition. In addition, youth in the experimental condition had a richer array of services, used fewer hospital days, remained in treatment longer, and reported greater satisfaction than in the control condition. (Burns, Farmer, Angold, Costello, & Behar, 1996).	Youth with serious emotional disturbances	Risk Factors: ***Individual*** • Involvement in delinquency • Early initiation of violent behavior • Involvement in personal or property crimes • Substance use/abuse • Drug dealing • Contact with police • Violent behavior • Crime recidivism ***School*** • Academic failure • Truancy and dropping out of school • Early and persistent antisocial behavior at school • Involvement in bullying Protective Factors: ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management	Burns, B.J., Farmer, Angold, A., Costello, E., Behar, L. (1996). A randomized trial of case management for youths with serious emotional disturbance. *Journal of Clinical Child Psychology*, 25, 476-486. Winters, N., & Terrell, E. (2003). Case Management: The linchpin of community-based systems of care. In A.J. Pumariega & N.C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry* (p. 182). John Wiley & Sons, Inc., San Francisco.

Table 8: Evidence-based Intervention Programs—Child and Adolescent Mental Health (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Intensive case management models; The Children and Youth Intensive Case Management Model (CYICM) in New York	The CYICM in New York State was an intensive broker model in which case managers with caseloads of ten were assigned to high-risk youth populations as long as necessary. Their activities, based primarily in the community, included advocacy and direct support, in addition to service coordination. They were available to the clients at all times and had access to flexible funds.	Strong. When compared with a matched comparison group, CYICM led to a decrease in inpatient utilization and decreased high-risk behaviors (Evans, Banks, Huz, & McNulty, 1994)	Youth with serious emotional disturbances	Risk Factors: ***Individual*** • Delinquency • Early initiation of violent behavior • Involvement in personal or property crimes • Substance use/abuse • Drug dealing • Contact with police • Violent behavior • Crime recidivism ***School*** • Academic failure • Truancy and dropping out of school • Early and persistent antisocial behavior at school • Involvement in bullying Protective Factors: ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management	Evans, M.E., Banks, S.M., Huz, S., & McNulty, T.L. (1994). Initial hospitalization and community tenure outcomes of intensive case management for children and youth with serious emotional and behavioral disabilities. *Journal of Child and Family Studies*, 3, 225-234. Winters, N., & Terrell, E., (2003). Case management: The linchpin of community-based systems of care. In A.J. Pumariega & N.C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry* (p. 180). John Wiley & Sons, Inc., San Francisco.

Table 8: Evidence-based Intervention Programs—Child and Adolescent Mental Health (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
The Broker Model: Oregon Partners Project (1990-1995)	This style includes: • access to flexible funding from a pooled fund • multi-agency service planning teams • family participation at all levels • caseloads of 17 • case manager fiscal authority to authorize all services except for foster care and school placements • close supervision of case managers by child and adolescent psychiatrists. This was a Robert Wood Johnson Mental Health Services for Youth system of care demonstration project.	Adequate. The Oregon Mental Health Division and Portland State University did an evaluation of the Oregon Partners Project (OPP) using a quasi-experimental design comparing case management and flexible funding (OPP) with case managers lacking access to flexible funds or fiscal authority (Gratton, Paulsen, Stuntzner-Gibson, & Summers, 1995). At the 12-month period, the OPP children were more socially competent; children and caregivers were more satisfied with services and more empowered as families; the service system was more coordinated, comprehensive, and individualized; and less restrictive, community-based alternative services had been developed. The groups did not show differences in clinical outcomes.	Youth with serious emotional disturbances	Risk Factors: ***Individual*** • Delinquency • Early initiation of violent behavior • Involvement in personal or property crimes • Substance use/abuse • Drug dealing • Contact with police • Violent behavior • Crime recidivism ***School*** • Academic failure • Truancy and dropping out of school • Early and persistent antisocial behavior at school • Involvement in bullying ***Family*** • Poor family management practices • Low levels of parental involvement • Poor family bonding • Family conflict • Poor parent-child relations Protective Factors: ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management	Gratton, J., Paulsen, R., Stuntzner-Gibson, D., & Summers, R. (1995). Oregon Partners Project: Progress and outcomes report. Paper presented at Building on Family Strengths Conference, Portland, OR. Winters, N., & Terrell, E. (2003). Case management: The linchpin of community-based systems of care. In A.J. Pumariega & N.C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry* (p. 181). John Wiley & Sons, Inc., San Francisco.

Table 8: Evidence-based Intervention Programs—Child and Adolescent Mental Health (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
The family-centered intensive case management (FCICM) model	This is a team case management approach that uses parent advocates and flexible service funds to purchase economic and social supports, along with in-home respite care. In the study, children were randomly assigned to two conditions. The first was FCICM, which used a team of case manager and family advocate to provide all care in the home; the family-centered case manager's aim was to support the skills of family members in functioning as the natural case manager for the child. The second was family-based treatment (FBT), a treatment foster program, which treated the child out of the home.	Adequate. The children in the FCICM were shown to have better clinical and functional outcomes at significantly lower cost than the FBT group. Neither group showed improvement in family functioning at eighteen months (Evans & Armstrong, 2002).	Youth with serious emotional disturbances	Risk Factors: ***Individual*** • Delinquency • Early initiation of violent behavior • Involvement in personal & property crimes • Substance use/abuse • Drug dealing • Contact with police • Violent behavior • Weapon use • Crime recidivism ***Family*** • Poor family management practices • Low levels of parental involvement • Poor family bonding • Family conflict • Family receipt of welfare • Parent-child relations • Parental depression • Domestic violence • Child's countercontrol • Delinquent siblings ***School*** • Academic failure • Truancy & dropping out of school • Early and persistent antisocial behavior at school • Involvement in bullying • Behavior disorder • Low performance/achievement Protective Factors: ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management	Winters, N., & Terrell, E. (2003). Case management: The linchpin of community-based systems of care. In A.J. Pumariega & N.C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry* (p. 180). John Wiley & Sons, Inc., San Francisco.

Table 8: Evidence-based Intervention Programs—Child and Adolescent Mental Health (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT); Home-Based Therapy (HBT); Philadelphia, PA	Wraparound models: EPSDT: a modular model with a separate evaluator, behavioral specialist, therapeutic support staff and mobile therapist. HBT: consisted of a team of two experienced mental health clinicians who did anything and everything needed, including evaluation and therapy. Interestingly, many of the same staff members were involved in both programs, and they shared the same psychiatric consultant.	Adequate. Outcomes at six, twelve, and eighteen months were compared. The two programs had similar overall costs, but youth enrolled in the HBT model showed greater clinical improvement at all measurement points. There was also a significant dropout rate in the EPSDT program. These results suggest that in children with SED, as in adults with SPMI, the clinical case management model may be more effective than the broker model. The less effective EPSDT model, which delivered more hours of service by more people, recalls Bickman's comment about the Fort Bragg continuum of care project: "More is not always better."	Youth with serious emotional disturbances	Risk Factors: ***Individual*** • Delinquency • Early initiation of violent behavior • Involvement in personal & property crimes • Substance use/abuse • Drug dealing • Contact with police • Violent behavior • Weapon use • Crime recidivism ***Family*** • Poor family management practices • Low levels of parental involvement • Poor family bonding • Family conflict • Family receipt of welfare • Parent-child relations • Parental depression • Domestic violence • Child's countercontrol • Delinquent siblings ***School*** • Academic failure • Truancy & dropping out of school • Early and persistent antisocial behavior at school • Involvement in bullying • Behavior disorder • Low performance/achievement Protective Factors: ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management	Winters, N., & Terrell, E. (2003). Case management: The linchpin of community-based systems of care. In A.J. Pumariega & N.C. Winters (Eds.), *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry* (p. 180). John Wiley & Sons, Inc., San Francisco.

Evidence-based Practices and Promising Approaches in Child Welfare Reform

Introduction

Historically, care for needy children has been a shared responsibility. During much of the 19th century, charitable organizations provided the majority of social services for indigent children. These services continued well into the 20th century. However, changing social dynamics, massive immigration, and growing public scrutiny illuminated many of the inadequacies of care provided by these organizations. In response to these revelations, anti-cruelty societies were formed to investigate allegations of abuse and neglect and aid in the prosecution of the offenders. In this regard, the anti-cruelty societies of the early 20th century were the precursors to modern child protective agencies (Schene, 1998).

The goals of child protective services remain closely aligned to its watchdog roots. Traditionally, Child Protective Services (CPS) agencies have continued to center their efforts primarily on the screening and investigation of child maltreatment and neglect cases. These agencies often bear the major responsibilities for desired welfare outcomes. In its historic function, CPS is an intrusive agency. Welfare officials primarily use information gathered from investigations, rather than family assessments, to guide placement decisions and subsequent treatment plans. These decisions are typically concluded without the input of the family. CPS services, in conjunction with law enforcement intervention, have been utilized for all families in need of services, without sensitivity to the varying levels of severity (English, Wingard, Marshall, Orme, & Orme, 2000). Further, many of CPS agencies function with little engagement between government agencies and community organizations.

Several key problems have been identified with the traditional functioning of CPS. Some of these concerns include; over and under estimation of need, the ineffectiveness of an authoritarian service approach, repeat maltreatment and overdependence on out of home care, and a lack of flexibility in responding to the individual needs of families. Because of these concerns, several states have implemented changes to overhaul their child welfare systems. This chapter will outline the structure and objectives of child welfare reform models across the United States by compare promising state programs, program models, and systems of care. The chapter will also evaluate the relative effectiveness of these reforms.

Principles of Effective Intervention

The past 25 years have seen rising numbers of children in foster care, public criticism, and increasing expenditures that have prompted new trends of child welfare reform. Unlike the reporting laws of the 1970s, the 1980s and early 1990s saw an increase in early intervention legislation.

In 1980 Adoption Assistance and Child Welfare Act required that states make a "reasonable effort" first to establish permanency within the family unit. Some of the other major goals of the act were to; to shift federal support to permanency strategies, decrease the number and lengths of stay for youth in foster care, and to improve the quality of social services. These reform themes are expanded in later legislation. Both the 1993 Family Preservation and Support Initiative and the 1997 Adoption and Safe Families Act, mandate the creation of early intervention supports and an increased urgency on rapid permanency placements (Schene, 1998). These reform efforts have been expedited by the availability of Title IV-E demonstration waivers, which has been utilized by several states to experiment with innovative welfare programming (Pecora, Whittakar, Mulaccio, Barth, & Plotnick, 2000).

The legislative themes reflect the principles of identified best practices outlined in major research efforts. Some of the most common themes are listed in Table 9.

Table 9: Identified Best Practices of Child Welfare Reform

Increased emphasis on kinship care and family reunification
Government/community partnerships
Child and family centered services
Home/community based supports
Family and group decision making
Differential response
Cultural sensitivity
Data driven practice

Source: Child Welfare System Improvements in California, 2003-2005: Early Implementation of Key Reforms.

Model Programs

These themes compose the structure of some of the most successful and noted reforms. Two of the most recognizable are the Alabama and Utah systems of care. A system of care, as defined by Substance Abuse and Mental Health Services Administration (SAMHSA), is a coordinated network of community-based services and supports organized to meet the challenges of children and youth.

The Alabama System of Care is an ongoing reform initiated by the 1991 lawsuit, *R.C. v. Hornsby*, in which Alabama Disabilities Advocacy program alleged the state system failed to provide adequate services for children with emotional/behavioral disorders in the foster care system. The case was settled and a consent decree was approved. The consent degree included, among other provisions, that the state of Alabama overhaul its child welfare system to address the needs of child and families involved with child protective services. Currently, Alabama is one of three states undergoing radical reform in response to civil litigation (Green & Tumlin, 1999). This new, system of care is outlined in detail. Many of the major goals outlined in the *R.C.* case are echoed in the Utah system of care. Both models employ themes that facilitate three major goals: early prevention of placement, early intervention, and family preservation. These systems of care share several main principals.

Both systems of care emphasize the use of individually tailored home and community based treatment to increase the caregiver's ability to provide a stable home environment. Under the Adoption and Safe Families Act, the state of Alabama offers performance based funding to social service organizations across the state that meet the varying intensity levels of client need. These services include: family counseling, domestic abuse support groups, literacy classes, and substance abuse treatment. The Department of Resource Management created an online database used to keep social workers apprised of available services (ADHS Progress Report, 2005). While the state of Utah primarily focuses on home-based treatments, the state has also implemented the FACT (Families, Agencies, Communities, Together) initiative as an attempt to improve collaboration and service delivery. The initiative brings together state agency representatives onto local interagency councils which provide individualized case management to children and families whose needs cannot be met by a single agency (U.S. Department of Health and Human Services, Annual Report, 2003).

In the case that the child's primary residence is deemed unsafe, both systems of care adhere closely to the permanence principal, making next of kin placement a top priority in all placements. Alabama is currently working to increase the number of children placed within the family by requiring guardians to disclose the

names of absentee family members early in the case file. In addition, the state is planning to include family visits as a part of the Individualized Service Plan to increase the likelihood of reunification. The state of Utah utilizes a strengths based assessment process called the Functional Assessment to identify strengths and protective factors of the family system. Caseworkers then use this information to prevent out of home placement. The state of Utah also offers a wide variety of home-based services to address the important risk-factors involved in the case, both for the parents or caregivers and the child (Utah Department of Human Services Children and Family Services, 2003).

The two systems also place substantial emphasis on the utilization of continual professional development in addition to comprehensive data collection and evaluation. Utah employs a Practice Model Training required for all professional staff in the areas of engaging, teaming, assessing, planning, and intervening. Caseworkers are required to complete 160 total training hours a year. Supervisors also receive training on data management and data evaluation. Training in Alabama is coordinated through the Office of Child Welfare Training and offers its own state training models; ACTI, and ACTII which focus on advanced training issues. The state also employs nine full-time trainers who write curricula, provide trainings to 67 counties, and develop partnerships with outside agencies to meet the imminent needs of the agency.

Data-driven reform is another key component of effective reform. In 1993, federal funds for child welfare information systems (SACWIS) became available through Title XIII, Section 13713, the Enhanced Match for Automated Data Systems, of the Omnibus Budget Reconciliation Act (OBRA). This legislation qualified states to receive funding from the Title IV-E program of the Social Security Act to design and implement their own information systems. Currently, 48 states are in phases of SACWIS incorporation. The state of Utah initiated its own compliance program (U.S. Department of Health and Human Services Administration for Children and Families, 2006).

In 1997, Utah's compliance information systems model, the SAFE system was launched statewide. The creation of the system was prompted by David C. Lawsuit Settlement Agreement. The system provides workers with immediate access to information relating to services delivered, services needed, and general management information. SAFE is used in conjunction with Utah's Unified Social Services Delivery System which provides government reports, processes payments for provider services, and interfaces with other state systems (National Association for State Information Systems, 1998). These systems are both touted to significantly lower caseworker documentation loads.

In the state of Alabama, the Office of Quality Assurance was specifically designed to monitor progress in three critical areas—safety, permanency, and child well-being. This approach to assessment includes a self-assessment and quarterly/annual reports from each county, as well as an onsite evaluation conducted by QA staff. The OQA also provides technical assistance and quarterly trainings for QA county coordinators. Much of this assistance focuses on technical assistance for quarterly reports and staff preparation for onsite reviews.

Both systems of care replicate principals of the Annie E. Casey Foundation Family to Family child welfare approach. Starting in 1992, the Annie E. Casey Foundation received funding to provide six states with start up grants for the Family to Family initiative. Family to Family is a model of child welfare reform aimed at reforming the foster care system to increase permanency. The Family to Family initiative provides states with start up financial resources and technical assistance to implement the necessary changes. The major principals of Family to Family are Recruitment, Training, and Support of Resource Families (Foster and Relative):

- Building Community Partnerships
- Family Team Decision-Making

- Self-Evaluation

Family to Family has been field tested in Alabama, New Mexico, Ohio, and Maryland. New York City is also in the process of adopting some of the major components of Family to Family and new testing sites are underway in San Francisco, Oregon, Kentucky, Michigan, North Carolina, and Colorado (Annie E. Casey Foundation, 2006). Family to Family, as well as its key objectives and components, have been identified as an effective reform approach with proven success in many of the country's most demoralized agencies (Bong & Omang, 1999).

One of the shared components is the recruit and support of foster families. Currently, Utah and Alabama are making concentrated efforts to increase cultural sensitivity in placements. For example, the state of Alabama is conducting research on effective marketing strategies in efforts to increase the number of Hispanic foster families. So far the state has translated all informational materials to Spanish and is currently researching community organizations that are suited to meet the needs of Hispanic foster families. There are similar recruitment plans focused on locating foster homes for teenagers and physically frail children. Utah is undertaking similar measures. The Utah Foster Care Foundation has partnered with the Utah Native American Children's Coalition to recruit Native American foster families at major cultural events.

Alabama is the only state to create a separate resource program to specifically address the needs of foster families. The Alabama Post Adoptions Connections program provides information and referral service to local therapists and mental health agencies, adoption family support groups, and educational training opportunities. The program operates statewide (Alabama Post Adoptions Connections, 2006). Utah utilizes funding from the federal Safe and Stable Act in conjunction with other grants to provide regions around the state with preventative services that are tailored to the needs of each community. In 2003, the state of Utah joined with the Utah Association of Family Support Centers to create the position of Utah Community Network Community to provide community organizations with technical support, fund seeking, and community needs assessments (U.S. Department of Health and Human Services Annual Report, 2003).

As described in the previous section both systems of care and Family to Family emphasize the importance of using continual data tracking to readjust welfare practice. The self-evaluation component of Family to Family requires that grantees: create a database designed to track children receiving out of home care, collect data from community providers on the type and scope of services; to create self-evaluation teams to consistently analyze the data, and utilize the data to improve child welfare practice. As a grantee of the Family to Family project, the state of Alabama incorporated these reforms by combining the self-evaluation component with the already existent Quality Assurance program. The state of Utah utilizes information from data from the SAFE system to create annual statewide assessments, which assess progress in key reform objectives.

Another element of the Family to Family model, Family Group Decision Making (CFGDM), has been recognized as a research-based effective practice in child welfare (American Public Human Services Association Guidelines, 1999.) The roots of FGDM can be traced to New Zealand's Family Group Conferencing model and Oregon's Family Unity meeting. The FGDM approach allows the families of children at-risk for removal to work directly with caseworkers to create a plan for safety, reunification, or placement of a child. This approach has been embraced by the Utah Department of Human Services. Child and Family Teams work in collaboration with families to create written service plans within 45 days of removal or referral to children's services. The service plans include parental expectations, time frames, and permanency goals (U.S. Department of Health and Human Services Annual Report, 2003).

State programs model closely the principles of evidence-based reform. One of the most emphasized principles is the availability of family support systems designed to address recognized risk factors to prevent occurrences of child maltreatment prior to removal or CPS referral. Some of the common parental and socialization risk factors linked to child maltreatment are summarized in Table 10.

Table 10: Risk Factors of Child Maltreatment and Neglect

Parental factors	Socialization factors
• Teenaged and single parent	• Lack of social services
• Poor coping skills	• High unemployment rate
• History of substance abuse	• Low income
• Domestic violence	• Inaccessibility to health care
• Lack of social supports	
• Lack of parenting skills	
• Large families	
• History of mental illness	

Source: Primary Prevention of Child Abuse, University of South Carolina School of Medicine

Research has shown that substance abuse is one of the most influential risk factors in child maltreatment and neglect. One major reason is that substance abuse is often accompanied by other problems, such as mental health illness, domestic violence, economic instability, and insecurity due to community volatility (Gruber & Fleetwood, 2004). Parent substance abuse has been found to substantially hinder a parent's ability to be attentive, responsive to their children's needs, and to provide effective discipline (Gruber & Fleetwood, 2004). This has been the rationale behind a major paradigm shift from an individual focus to a multi-front family centered approach. This is the philosophy of treatment modeled by Project Connect.

Project Connect was established in 1992 by the Children's Friend & Service Network and is based in Providence, Rhode Island. The program, which contracts with the Rhode Island Department of Children, Youth and Families, provides wraparound services designed to address the needs of families who are at risk of a removal due to substance abuse. Clients are referred to the program through state welfare agency workers. One of the major components unique to Project Connect is the use of Risk Inventory for Substance Abuse Affected Families, which was developed by Project Care staff and pilot tested for effectiveness. The assessment is used to evaluate risk levels and core areas of child well-being: parental affection, approval, expectations, and discipline.

Project Connect staff utilize the data to design wraparound services. In addition to home-based substance abuse treatment, Project Connect offers relapse prevention, parenting groups, domestic violence and sobriety support groups, and service linkage to transportation, housing resources, outpatient treatment facilities, and adequate healthcare and legal services, (Chile Welfare League of America, *Research Roundup*, 2002). Families stay with the program 9.5 months on average. At the end of the term, families are revaluated using a Termination Summary and a recommendation for permanent placement is determined based on measured progress.

Another closely related program is Massachusetts Society for the Prevention of Cruelty to Children (MSPCC) Project Connect program. MSPCC program utilizes strengths-based and family centered planning to increase permanency by providing parents with the social, economic, and psychological supports needed to effectively provide in-home care for children with severe emotional disturbance. This is

major contrast to traditional approaches to SED behaviors which been characterized as largely crisis-oriented, exclusive, uncoordinated, and repetitive (Malysiak, 1997).

Clients are referred to Project Connect through welfare workers. At original intake, basic demographic information is collected and children are administered the Children's Global Assessment Scale (CGAS) to identify risk factors and strengths of the family unit. Families begin collaborating with interagency teams which are comprised of professionals from the Department of Mental Health, the Department of Mental Retardation, Juvenile Justice, and Special Education in addition to the child's family's home support network, including parents, grandparents, and other guardians. The teams meet bi-weekly and create individualized service plans for each family, building on strengths and addressing key risk factors. The plan addresses issues related to mental health, social supports, access to health insurance, as well as supports to help carry out the plan, including transportation. After three months in the program, the CGAS is re administered to evaluate proper placement (Child Welfare League of America Child Voice, 2002).

The Family Assessment and Stabilization Team (FAST) based in Washington State is another program that adheres closely to the permanency principal. FAST is collaboration between the Washington Department of Children and Family Services, Catholic Community Services (CCS), and Pierce County Mental Health. The program focuses on securing safety and permanency for displaced youth who are homeless or at risk at being placed in institutionalized care. Children, ages 9-17 are referred to the program by regional welfare and mental health professionals. Most children who are referred do not have immediate family contacts. FAST utilizes a team approach including care coordinators, therapists, and family support specialists.

Upon referral, CCS workers try to stabilize the situation by making immediate contact with family members to locate potential suitable placements for the child. FAST caseworkers make a particular effort to explore the father's side of the family. Children are can be placed in the intermediate time period in FAST homes. Because of the nature of this service, it is provided 24 hours a day. After initial contact is made, intensive background checks are completed. Most children are able to relocate to relative care. CCS adheres to the wraparound, family group decision making, and Family to Family principals. Teams meet with the child and family support system to identify key strengths and weaknesses and devise a plan of treatment. The FAST program is focused on developing self-sufficiency but provides emergency assistance in the transitional period (Catholic Community Services of Western Washington Program Overview, 2003).

Project SafeCare, a model program originated in the state of Illinois, also utilizes the principals of permanency and family and children centered support. Project SafeCare provides early intervention in the form of social supports and education for families reported or at-risk for child maltreatment or neglect. Children are referred to the program by three sources: DCFS workers and local hospitals. Only children births to five years of age are accepted for the program. Project SafeCare was designed to be a short term and in-home intervention, lasting approximately 24 weeks.

The intervention focuses on improving parental skills in three key areas; child health care, parent-child interactions, home safety/accident prevention, three areas where parents involved in maltreatment cases often demonstrate sever deficiencies. This model is based on research that illustrates when a parent lacks knowledge on issues related to child development, unrealistic expectations are developed. These misconceptions can lead to abusive forms of punishment (Goldman, et al., 2003). Pre-assessments for each subject were administered prior to the lessons and assessed based on observation and role-playing exercises. Only families who completed all three sessions were included in the comparison data.

Relative Effectiveness of Interventions

The state of Alabama approach to child welfare continues to be recognized as a national model (Eckhold, 2005). In 2003, the Department of Health and Human Services administered a performance assessment to measure key child welfare objectives. According to the review, the state of Alabama made significant progress in the area of increased placement stability. In 2003, 92.6 percent of the children in foster care for less than 12 months experienced fewer than two placement settings. Also, Alabama also illustrated progress in the reduction of placements for young children in institutionalized care. In 2003, only 6.5 percent of the children entering foster care in Alabama who were age 12 or younger were placed in group homes, less than the national median of 8.3 percent, and representing a change of -39.8 percent points from the previous federal review in 2000. Because of data the federal review could not establish whether or not there was a reduction in repeat child maltreatment. However, the victim abuse rate 2003 was 8.4 per 1,000 children. That number is lower than the nationwide median of 10.6 per 1,000 children (U.S. Department of Health and Human Services, 2003). These numbers stand in contrast to earlier outcome statistics. From 1989-1992, between 84 and 87 percent of children experienced no fewer than two placements. For children in foster care for more than one year but less than two, more than 50 percent of children experienced three or more placement settings (Research Triangle Institute, et al., 1997).

Although the two states share many of the same reform principles, some of the measurements have declined from the 2002 federal assessment. For example, in 2002, the state of Utah placed 88.7 percent of children in permanent homes, well above the national median of 79.8 percent. This percentage dropped slightly in 2003 to 83.5 percent, which fell closer to the national median of 86.3. In 2002, the percentage of children who experienced two or less placement settings during their first 12 months in the foster care system was 74.9 percent, substantially below the national median of 84.1. This number declined further in 2003 to 72.5 percent with approximately the same national median. Similarly the numbers of children under the age of 12 placed in institutionalized care was 11.2 percent, greater than the national median of 8.3 percent. The pattern was also illustrated in the numbers of maltreatment and neglect case, from a 12.2 per 1,000 children ratio in 1999 to 16.6 child victims per 1,000 in 2003. The federal report notes, however, that these numbers may have been affected by legislation passed in 1999 that made the "witnessing or knowledge" of abuse (child and domestic) a misdemeanor offense. The report also notes that rising unemployment rates and increased frequency of poverty—which have been closely correlated to incidences of abuse—may have also have influenced the numbers (U.S. Department of Health and Human Services, Child welfare outcomes, 2003).

The Family to Family program implementation sites were evaluated in 1998 by the Triangle Research Division and the University of North Carolina Jordan Institute for Families. The evaluation summarized the progress of each grantee site, including Alabama, New Mexico, Ohio, Maryland and Pennsylvania. The evaluation used data comparisons before Family to Family was implemented and after. The evaluation concluded that one of the major changes experienced was an overall decrease in placement disruptions. For example, in Pennsylvania four out of five children (83 percent) of children experiencing care episodes of one year or less experienced only one placement, compared to 78 percent in 1990. This pattern was true for all but one of the grantee sites.

The evaluation also examined outcomes related to service availability. According to the evaluation the state of Alabama did not make much progress in this area due to inconsistency of leadership, making it difficult to maintain long-term relationships. Other sites showed more progress as formal collaborations with community organizations began to take shape. The evaluation also noted increased production, analysis, and interpretation of the data as one of the most significant benefits of the program in all grantee sites. Overall the evaluation emphasizes that more progress was made in states where states maintained a strong focus on the principles of Family to Family. Also, the report notes that needy communities are capable of

meeting the needs of children and families when interagency communication is present and when proper supports are available.

Project Connect collaborated with Lenore Olson of the Rhode Island School of Social Work to conduct a small scale evaluation in 2000. At the time 88 families were involved in the program. The study was designed as an informal control-group—comparing families with similar risk factors to those who completed the program. Hypothesis tests were conducted to compare pre- and post-tests for both groups in five categories. These categories included: parenting skills, substance abuse risk, abuse and neglect risk, caretaker risk, and child risk. Significant improvements were noted for those families participating in Conduct Connect in four of five subtopics within the parenting skills category. This was also the case for data related to family risk of abuse and neglect. Also, significant improvements were noted in all subtopics within the substance abuse risk category ($p>.05$). For the group who did not complete the program, data ranged from increased risk to increased improvement. Increased risk was found in 2 of 11 categories: emotional care under the age of 2 and physical needs of a child. The other nine areas ranged from increased risk to increased improvement. However, improvements were not statistically significant. No follow up data were reported on recidivism rates for each group. Project Connect has been identified as a model practice and is utilized as a teaching tool at local colleges (Child Welfare League of America *Research Roundup*, 2002).

In 2004 the MSPCC Project Connect conducted a self-evaluation in collaboration with Brandeis University. The evaluation compares the needs of SED identified children before and after involvement with Project Connect. According to the data, 85 percent of children prior to involvement with Project Connect had been placed in specialized institutional care. At case closure, however, only 8 percent of those same children required the same level of care. Also, using the Child Global Assessment Scale, the data showed improved functioning in 79 percent of all cases. MSPCC Project Connect has also been recognized by the Child Welfare League of America as a model program (MSPCC Evaluation Department, 2004).

Evaluation on Project SafeCare was conducted by researchers from University of Kansas, University of Judaism, and Behavioral Ecology Consulting in 2002. The evaluation compared members of Project SafeCare to families exhibiting similar behaviors and with children of approximately the same ages enrolled solely in Family Preservation services. Forty one families were chosen for each group. The study tracked the families involved in the study for a four year period. The data illustrated that families who participated in Project SafeCare were less likely to be reported for maltreatment than those involved only in family preservation services (Molko, et al., 2002).

The FAST program does not have available research data. However, its principles are closely aligned with strengths-based care/Wraparound approach, Family Group Decision Making, and Family to Family, all of which have been recognized as best practices in child welfare.

Challenges

Any major overhaul will provide challenges. Several themes arise throughout multiple programs and systems of care. One of the most pervasive trends of reform is the inclusion of community resources in the early prevention process. This requires effective inclusion, requires a sophisticated level of coordination, and communication between the appropriate supervisory agency and frontline welfare workers. Currently, it is a typical occurrence that social workers, often overburdened by large caseloads and corresponding documentation demands, do not have the time or resources to effectively direct their clients to existing services. This task will require not only collaboration, but also a clear system of accountability to ensure

quality of services, and a real-time database to keep frontline workers informed on what is available for their clients.

To be effective, these services must be reasonably accessible to families in their own communities. These collaborations must facilitate connections with other social supports, including healthcare, childhood and workforce development, and housing (Pecora, et al., 2000).

It is worthy to note, however, that while individualized treatment has been identified as a best practice for reform, too much of a differential response can also cause problems particularly when welfare local, county, and state each follow their own procedures for responding to abuse (McDonald, 2001).

Creating and enforcing a reporting system with intermediate interventions and appropriate procedures without comprising the safety and well-being of children poses another challenge. The themes of the wraparound process require many elements that are not present in most CPS agencies, including unconditional commitment from frontline workers and administrators to the approach and flexible funding for service providers (Research & Training Center, 2003). Caseworkers have also expressed frustrations over long waiting lists for essential mental health and substance abuse services due to changes in the Medicaid system. All of these challenges can be exacerbated by leadership and state policy, one of the largest hurdles to full implementation of the Family to Family program (Green & Tumlin, 1999).

Table 11: Evidence-based Intervention Programs—Child Welfare Reform

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk/Protective Factors	Key References
Project Connect, Rhode Island Contact information: Tina Laprade Family Preservation Program Manager (401) 729-0008	Project connect targets children and families who are at imminent risk of removal or who have already had children removed because of substance abuse. The goal of the program is to help parents become substance-free and to ensure safety for the children. The program utilizes home-based substance abuse and family counseling, support groups and linkage to community resources (i.e.. affordable housing, substance abuse treatment, legal services). The average length of treatment for Project Connect in a 2000 study was 9.5 months.	Strong. Controlled study, the program was evaluated in 2000 by Project Connect in conjunction with Lenore Olson of the Rhode Island School of Social Work.	Families that are at risk of losing a child based on substance abuse related issues.	Risk Factors: ***Family*** • Parental substance abuse • Poor parent-child relations • Poverty • Single-parent families • Parental depression • Poor family bonding • Family conflict Protective Factors: ***Family*** • Supportive parent-child relations • Stable home environment ***Community*** • Involvement of supportive adults • Pro-social opportunities for participation • Availability of neighborhood resources • Safe environment • Low neighborhood crime rate • Non-disadvantaged neighborhood • Rewards for pro-social community involvement • Clear social norms	Azzi-Lessing, L. & Olsen, L. (1996). Substance abuse-affected families in the child welfare system. *Social Work, 41,* 15-23. Child Welfare League of America. (2002, March). Research roundup, *Moving from Research to Practice, March 2002.* www.childrensfriendservice.org

Table 11: Evidence-based Intervention Programs—Child Welfare Reform (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk/Protective Factors	Key References
Project Connect, Massachusetts Massachusetts Society for the Prevention of Cruelty to Children Contact information: Massachusetts Society for the Prevention of Cruelty to Children 99 Summer Street Boston, MA 02110 Phone: (617) 587-1500	The goal of MSPCCs Project Connect is to improve the functioning of children with severe emotional disturbance and provide parents with the support and education to provide in-home care to their children. The program utilizes wraparound services provided by interagency teams. Working in collaboration with caregivers, the team develops, monitors, and offers support in the effective implementation of a comprehensive treatment plan based on the family's needs. Using flexible funding, Project Connect provides funding for necessary services that are unaffordable or for resources that do not exist in the community.	Adequate. MSPCC evaluates Project Connect in conjunction with Brandeis University.	Youth 9-17 and their families suffering from severe emotional disturbance	Risk Factors ***Individual*** • Presence of psychobiological factors • Presence of psychological conditions ***Family*** • Parental substance abuse • Poor parent-child relations • Poverty • Single-parent families • Parental depression • Poor family bonding • Family conflict Protective Factors ***Family*** • Supportive parent-child relations • Stable home environment ***Community*** • Involvement of supportive adults • Pro-social opportunities for participation • Availability of neighborhood resources • Safe environment • Low neighborhood crime rate • Non-disadvantaged neighborhood • Rewards for pro-social community involvement • Clear social norms	Massachusetts Society for the Prevention of Cruelty to Children. *Project Connect*. Retrieved September 6, 2006, from http://www.mspcc.org/index.cfm?fuseaction=Page.viewPage&pageId=131.

Table 11: Evidence-based Intervention Programs—Child Welfare Reform (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk/Protective Factors	Key References
The Family Preservation System: Family Assessment and Stabilization Team (FAST) Washington State Contact information: Mary Stone Smith Phone: (253) 225-0984 Vice-President Email: Maryss@ccsww.org Catholic Community Services 5210 North 44th St. Tacoma, Washington 98407	FAST is a collaboration between the Department of Children and Family Services, Catholic Community Services, and Pierce County Mental Health. The goal of FAST is to secure permanency for youth 9-17 who are homeless (due to family conflict/ejection from foster placement) or at imminent risk of admission into institutionalized care. Caregivers, CCS workers, and DCFS social workers coordinate to devise treatment plans with the goal of returning to the designated family (extended, foster, or immediate). These plans seek to address the "unmet" need of the child that may correspond to behaviors/mental health issues.	Adequate. Based on principles of Family to Family model, Family Group Decision Making and Tailored Care/Wraparound	Youth displaced by family conflict, family unwillingness to provide care, or who have been ejected from group/foster home placements.	Risk Factors: ***Individual*** • Involvement in antisocial behavior • Exhibits internalizing disorders • Delinquency • Ward of state/child welfare ***Family*** • Lack of emotional support • Low levels of parental involvement • Poor family bonding and family conflict ***Community*** • Lack of social ties. Protective Factors: ***Family*** • Stable home environment • Supportive parent-child relations ***Community*** • Placed in adoptive/extended family • Support from neighborhood institutions	Louisell, M. (2004). Model Programs for youth permanency. *California Permanency for Youth Project.* Retrieved September 2006. from http://www.cpyp.org/Files/ModelPrograms.pdf

Table 11: Evidence-based Intervention Programs—Child Welfare Reform (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk/Protective Factors	Key References
Casey Foundation Family to Family model Alabama, New Mexico, Pennsylvania, Ohio, and Maryland Contact information: The Annie E. Casey Foundation 701 St. Paul St. Baltimore, MD 21202 Phone number: 410-547-6600	The goal of the Family to Family model is aid to states in restructuring their child welfare systems to: increase family permanency, reduce the placement of children in institutional settings, develop a network of family-centered and community-based foster care, decrease the length of out-of home stays, and to provide community resources needed to preserve the family. Major outcomes include: • Recruitment, training, and support of resource families. • Building community partnerships in area of high need • Family-decision making • Self-evaluation based on solid data	Very Strong. Non-equivalent control group studies on various Family to Family grant sites.	Victims of abuse and their families.	<u>Risk factors</u> ***Family*** • Poor family management practices • Poor family bonding and family conflict • Parent-child separation • Child maltreatment • Parent-child relations • High turnover of placement • Low socioeconomic status ***Community*** • Community disorganization • High poverty level • Few public and social services • Limited youth programming <u>Protective Factors</u> ***Family*** • Stable home environment • Supportive parent-child relations • Proactive family management • Placed in adoptive family ***Community*** • Family advocacy • Effective social policies/programs • Support from neighborhood institutions	Health and Social Policy Division (Research Triangle Division) & Jordan Institute for Families (School of Social Work). (1998). Evaluation of Family to Family Executive Summary. Chapel Hill, NC. The Annie E. Casey Foundation. (2006). *Family to Family: Tools for rebuilding foster care.* Retrieved September 8, 2006, from http://www.aecf.org/initiatives/familytofamily/overview.htm.

Table 11: Evidence-based Intervention Programs—Child Welfare Reform (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk/Protective Factors	Key References
Utah System of Care Contact information: Child and Family Services Department of Human Services 120 North 200 West, #225 Salt Lake City, Utah 84103 Phone: (801) 538-4100 Fax: (801) 538-3993 E-mail: CAROLMILLER@utah.gov	The goal of the Utah Division of Children and Family Services System of Care is to prevent abuse, neglect, and dependency. The Utah practice model provides community support to families to create home environments that are safe, nurturing, and permanent. The Utah practice model follows a set of principals that include: • Protection for all children and adults • A focus on development in nurturing settings • Permanency for all children • Cultural sensitivity in the permanency approach • Partnership with community organizations • Organizational structure to effectively and compassionately address the needs of children and families. • Professional development and competence.	Very Strong. Federal and annual state review.	Children and families involved with the Division of Children and Family Services.	Risk Factors ***Family*** • Poor family management practices • Poor family bonding and family conflict • Parent-child separation • Child maltreatment • Parent-child relations • High turnover of placement • Low socioeconomic status ***Community*** • High poverty level • High mobility rates • Ineffective social policies • Few public and social services • Limited youth programming Protective Factors ***Family*** • Placed in adoptive family • Social support • High accountability • Proactive family management ***Community*** • Effective social policies/programs • Support from neighborhood institutions • Family advocacy	U.S. Department of Health and Human Services. (2003). *Executive Summary* Utah Child and Family Services Review. Utah Department of Human Services. *Practice Model Principals.* Retrieved September 3, 2006, from http://www.dcfs.utah.gov/practice_model.htm.

Table 11: Evidence-based Intervention Programs—Child Welfare Reform (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk/Protective Factors	Key References
Alabama System of Care Contact information: Alabama Department of Human Resources Child Protective Services Contact Information Phone Number: (334) 242-9500 Phone Number: (334) 242-9500 Email: fsd@dhr.state.al.us	The Alabama System of Care consists of a set of core principles mandated in the 1991 consent decree of the *R.C. vs. Walley*. The core principals include the following: • Strong focus on in-home care in all applicable CPS cases. • Access to comprehensive services for children and families • Individualized and strengths-based services. • Prompt response to allegations of sexual abuse. • Embrace service delivery in community and home-based settings. • Involvement of family and foster parents in the planning and delivery of services. • Provide highly trained and adequately burdened caseworkers.	Very Strong. Federal and annual state review.	Children and families involved with the Office of Child Protective Services.	Risk Factors ***Family*** • Poor family management practices • Poor family bonding and family conflict • Parent-child separation • Child maltreatment • Parent-child relations • High turnover of placement • Low socioeconomic status ***Community*** • High poverty level • High mobility rates • Ineffective social policies • Few public and social services • Limited youth programming Protective Factors ***Family*** • Placed in adoptive family • Social support • High accountability • Proactive family management ***Community*** • Effective social policies/programs • Support from neighborhood institutions • Family advocacy	Judge Bazelon Center for Mental Health Law. (1998). *Making Child Welfare Work: Forging New Partnerships to Protect and Sustain Families.* Available from http://www.bazelon.org/issues/children/publications/rc/index.htm *RC v. Walley* Consent Decree, 1-40P (Alabama 1988)

Table 11: Evidence-based Intervention Programs—Child Welfare Reform (continued)

Program Name Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk/Protective Factors	Key References
Project SafeCare, Illinois	Project SafeCare is a research based program aimed at lowering the presence of child maltreatment risk factors in the home to increase the likelihood of positive parent-child interactions. Clients are referred through both the Department of Children and Family Services or through local hospitals. Only children ages birth-5 years old are eligible for the program. Project SafeCare aims to improve skills in three areas: bonding/parent child interaction training, infant and child care, and home safety and cleanliness. Project SafeCare is based on Project 12 Ways. Once a client is referred, an initial home visit is scheduled. Project SafeCare staff implements a series of assessments and asks the parents to sign a waiver describing the conditions of the program. The program is designed to be a temporary, 24 week intervention.	Adequate. One time quasi-experimental study	Families with prior history of child maltreatment; families identified as at-risk for child maltreatment.	Risk Factors ***Family*** • Poor family management practices • Poor family bonding and family conflict • Low parental education • Low socioeconomic status • Single parent-family • Parent-child relations Protective Factors ***Individual*** • Self-discipline **Family** • Stable home environment • Supportive parent-child relations • Proactive family management	http://www.cachildwelfareclearinghouse.org/program/6/detailed Molko, R., Lutzker, J., Wesch, D. (2003) Project SafeCare: Improving Health, Safety, and Parenting Skills in Families Reported For and At-risk of Maltreatment, *Journal of Family Violence (18)*6, 337-386.

Evidence-based Practices and Promising Approaches in Juvenile Justice

This review summarizes the best practices literature regarding juvenile justice interventions. As such, it focuses on programs and strategies for dealing with youth who have come into contact with the juvenile justice system. There is also a wealth of literature, meriting a separate summary review, regarding promising and effective approaches to primary prevention of delinquent and other adolescent problem behaviors. The interventions discussed in the current summary are those that can be used by diversion, probation, juvenile correctional, parole, or aftercare programs.

Two major strands of literature inform this review:

1. Meta-analyses[1] that yield themes and principles of effective intervention (e.g., Andrews, Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990; Lipsey & Wilson (1998); Aos, Phipps, Barnoski, & Lieb, 2001).
2. Web-based compendia of program evaluation studies that organize programs by the quality and consistency of evaluation outcomes (to be discussed below; see appended list of web resources for references to such guides). These can provide local policymakers with descriptions of effective programs, references to the specific evaluation studies, and links to technical assistance resources.

A general consensus has emerged from these strands of the literature regarding what works, and equally importantly, what does not work in programs for delinquent youths. As will become apparent, specific programs that have been shown to be effective reflect the themes and principles from the meta-analyses, so these will be discussed first, followed by a listing of specific intervention models that can be considered evidence-based or promising.

Principles and Themes of Effective Intervention

In 1975, Lipton, Martinson, and Wilks published a narrative review of evaluation studies of correctional interventions that was interpreted to show little in the way of effective interventions. Despite other narrative reviews that countered this interpretation (Palmer, 1975; 1992; Gendreau & Ross, 1979; 1987), for more than a decade, the subsequent consensus was that "nothing works," and the emphasis of correctional policy, especially for adults but also for juveniles, moved away from treatment to punishment.

In 1990, however, a meta-analysis of 80 evaluations of juvenile and adult correctional programs, conducted by Canadian researchers Don Andrews, Paul Gendreau, and colleagues, challenged that consensus and provided evidence that certain kinds of interventions worked with certain kinds of offenders (Andrews, et al., 1990). Their interpretation of their findings led to a set of four "principles of effective correctional intervention" (Andrews, 1995; Andrews & Bonta, 1998) as summarized in Howell (2003, pp. 212-214):

1. Interventions should target the known predictors of crime and recidivism for change. Dynamic risk factors, that is, those that can be changed, include:
    a. Antisocial or procriminal attitudes, values, beliefs, and cognitive-emotional states;

[1] Meta-analyses apply quantitative techniques to statistically aggregate findings from several individual studies. They begin with selection criteria for studies to include, code aspects of the research designs, and compare "effect sizes" across studies, weighted for the sample size of each study. The "effect size" is the difference between the measures outcome (e.g., recidivism) of the intervention group versus a comparison or control group. For technical details concerning meta-analysis and examples of its use, see Cook, Cooper, Cordray, Hartman, Hedges, Light, et al., (1992).

   b. Procriminal associates and isolation from prosocial others;
   c. Antisocial personality factors, such as impulsiveness, risk taking, and low self-control.
2. The treatment services should be behavioral in nature … behavioral, social learning, and cognitive-behavioral strategies.
3. Treatment should be delivered in a style and mode that is consistent with, or matched to, the learning styles of the offender.
4. Treatment interventions should be delivered mainly to higher-risk (as opposed to lower risk) offenders. There is evidence that the same interventions that reduce recidivism for high risk offenders are either ineffective, thus wasting scarce resources (Schumacher & Kurz, 2000), or can actually increase future offending when applied to low risk offenders (Andrews & Bonta, 1998).

Subsequent meta-analyses have provided additional evidence that program effectiveness is related to the extent to which programs incorporate these principles (Antonowicz & Ross, 1994). These principles, as further developed and disseminated in the United States by Latessa and colleagues (e.g., Latessa, Cullen, & Gendreau, 2002), provide the foundation of the "What Works" practices, increasingly being adopted by state and local adult and juvenile correctional systems.

Relative Effectiveness of Intervention Types

Two meta-analytic studies provide complementary insights into the relative effectiveness of various types of interventions in reducing recidivism. While recidivism reduction is not the only measure of intervention effectiveness, and its definitions may vary, it is the primary one with which policymakers must be concerned. Lipsey and Wilson (1998) selected 200 programs for serious and violent juvenile offenders for inclusion in their study. They ordered their results by effect size and type of intervention setting (non-institutional or institutional), as shown in Table 12 below:

Table 12: Effectiveness of Interventions for Serious and Violent Juvenile Offenders

Type of Treatment Used With Non-institutionalized Offenders	Type of Treatment Used With Institutionalized Offenders
Positive effects, consistent evidence	
Individual counseling (.46)	Interpersonal skills (.39)
Interpersonal skills (.44)	Teaching family homes (.34)
Behavioral programs (.42)	
Positive effects, less consistent evidence	
Multiple services (.29)	Behavioral programs (.33)
Restitution with probation/parole (.15)	Community residential (.28)
	Multiple services (.20)
Mixed, but generally positive effects, inconsistent evidence	
Employment related (.22)	Individual counseling (.15)
Academic programs (.20)	Guided group counseling (.09)
Advocacy/casework (.19)	Group counseling (.05)
Family counseling (.19)	
Group counseling (.10)	
Weak or no effects, inconsistent evidence	
Reduced caseload, probation/parole (-.04)	Employment related (.15)
	Drug abstinence (.08)
	Wilderness/challenge (.07)
Weak or no effects, consistent evidence	
Wilderness/challenge (.12)	Milieu therapy (.08)
Early release, probation/parole (.03)	
Deterrence programs (-.06)	
Vocational programs (-.18)	

Source: Adapted from Lipsey & Wilson (1998, p.332) by Howell (2003, p. 204). The midpoints of estimated effect sizes are shown in parentheses; positive effect sizes indicate recidivism reduction.

Not only did the effectiveness of various treatment types differ in community or institutional settings, but other factors besides treatment type were stronger predictors of effectiveness. For non-institutionalized offenders, characteristics of the juveniles were more strongly related to outcomes. Echoing the "risk principle" of Andrews (1995), those with more serious offense histories and higher risk profiles were more likely to be successful. For institutionalized offenders, general program characteristics (e.g., program age, auspices, type of staff, etc.) and the amount of treatment provided were stronger predictors of outcomes than treatment type (Lipsey & Wilson, 1998).

The Washington State Institute for Public Policy conducted an ambitious cost-benefit study of early childhood programs, middle childhood and adolescent programs for nonoffenders, juvenile offender programs, and adult offender programs (Aos, Phipps, Barnoski, & Lieb, 2001). Only the results of the juvenile offender programs will be discussed here. Their sophisticated meta-analysis determined the average size of crime reduction for various types of programs, and then calculated the cost-benefit of the program types based on their cost per participant and the potential taxpayer and potential crime victim benefits from future crimes prevented. Table 13 summarizes their results.

Table 13: Comparative Costs and Benefits of Juvenile Offender Programs

	Net Direct Cost of the Program, Per Participant	Estimated Benefits[a] Per Dollar Spent
Specific "Off the Shelf" Programs		
Multisystemic Therapy (-0.31)	$4,743	$28.33
Functional Family Therapy (-0.25)	$2,161	$28.81
Aggression Replacement Training (-0.18)	$738	$45.91
Multidimensional Treatment Foster Care (-0.37)	$2,052	$43.70
Adolescent Diversion Project (-0.27)	$1,138	$24.91
General Types of Treatment Programs		
Diversion with services (vs. regular juvenile court processing) (-0.05)	-$127	na[b]
Intensive probation (vs. regular probation) (-0.05)	$2,234	$4.00
Intensive probation (as alternative to incarceration) (0.00)	-$18,478	na[b]
Intensive parole supervision (vs. regular parole) (-0.04)	$2,635	$3.32
Coordinated services (-0.14)	$603	$25.59
Scared Straight type programs (0.13)	$51	na[c]
Other family-based therapy approaches (-0.17)	$1,537	$21.13
Juvenile sex offender treatment (-0.12)	$9,920	$3.38
Juvenile boot camps (0.10)	-$15,424	na[b]

Source: Adapted from Aos, et al. (2001). Average crime reduction effect sizes are in parentheses; negative signs indicate crime reduction.

[a] Benefits per participant reflect the combined savings to taxpayers from reduced criminal justice processing costs (if any) and the value of crime victim benefits based on the program's estimated effect on preventing future crimes, net of program costs.

[b] Since these programs actually represent immediate cost savings, one cannot calculate a cost-benefit ratio. Aos, et al. estimate the total benefits per participant for Diversion with Services to be $5,579. Intensive Probation as an alternative to incarceration produces no differences in recidivism, but is substantially less expensive, with an estimated $18,000 to $19,000 in savings per participant. Juvenile Boot Camps, despite their lower up-front cost than regular juvenile correctional institutions, have been found to increase recidivism, and Aos, et al. estimate a negative bottom line of $3,587 per participant.

[c] Scared Straight type programs have been found to increase recidivism; Aos, et al. estimate their bottom line as a negative $24,531 per participant.

Several observations can be made from Table 13. First, it provides additional evidence that interventions of many kinds "work," both in terms of crime prevention and "bang for the buck." Important exceptions here are shock incarceration intervention programs such as Scared Straight, and boot camps that actually increase the probability of future offending. Second, many treatment-oriented programs, including Multisystemic Therapy, Functional Family Therapy, Aggression Replacement Therapy, Multidimensional Foster Care, coordinated services, and other family-based therapies, provide relatively greater benefits per dollar invested than do regular juvenile justice supervision programs such as probation, intensive probation or parole. A caveat here is that intensive probation, when used as an alternative to incarceration (that is, for youth who would otherwise be incarcerated), produces similar recidivism outcomes as incarceration, but at far less cost. Finally, diversion as an alternative to regular court processing also provides immediate cost savings with no increase in recidivism risk.

Model Programs

There are several listings of model programs that have been developed over the last few years by various organizations. Most relevant for juvenile justice programs are the lists from the Office of Juvenile Justice and Delinquency Prevention (OJJDP),[2] the Substance Abuse and Mental Health Services Agency

[2] [Online] available from http://www.dsgonline.com/mpg2.5/mpg_index.htm

(SAMHSA),[3] the University of Colorado's Center for the Study and Prevention of Violence (CSPV) Blueprints Project,[4] and a federal report produced by the University of Maryland (Sherman, et al., 1997).[5] Each of the above listings organizes programs into slightly different categories using somewhat different criteria. Therefore, while there is some overlap among the lists, they do not produce identical rankings. Nevertheless, there is a relative consensus regarding the highest rated programs (e.g., Multisystemic Therapy; Functional Family Therapy; Aggression Replacement Therapy; Treatment Foster Care), and regarding the least effective programs (e.g., shock incarceration, boot camps). For present purposes, the OJJDP list will be presented in detail, but readers are urged to consult the other sources as well.

OJJDP organizes its listing according to five levels of penetration into the juvenile justice system as follows:

1. Prevention—based on a public health model, targeting children, families and communities in general to reduce the risk of and increase resiliency against problem behaviors.
2. Immediate Sanctions—diversion mechanisms that hold youth accountable for their actions by sanctioning behavior and in some cases securing services, but at the same time generally avoiding formal court processing. They are appropriate for most first-time misdemeanor offenders, many minor repeat offenders, and some nonviolent felons. These are often based on restorative justice principles (see Bazemore & Terry, 1997).
3. Intermediate Sanctions—programs that hold youth accountable for their actions through more restrictive and intensive interventions (nonresidential or residential), short of secure care. Intermediate sanctions are appropriate for juveniles who continue to offend following immediate interventions, youth who have committed more serious felony offenses, and some violent offenders who need supervision, structure, and monitoring but not necessarily institutionalization.
4. Residential Programs—Juveniles whose offenses are serious or who fail to respond to intermediate sanctions are handled at a different level of the juvenile justice continuum. These youth may be committed to out-of-home placement in an institutional or camp-like setting, or they may be eligible for an alternative placement, such as community confinement.
5. Reentry—Reentry programs are defined as reintegrative services that prepare out-of-home placed juveniles for reentry into the community. A comprehensive reentry process typically begins after sentencing, continues through incarceration and into the period of release back to the community. (OJJDP, n.d.).

[3] [Online] available from http://modelprograms.samhsa.gov/template.cfm?page=default
[4] [Online] available from http://www.colorado.edu/cspv/index.html
[5] [Online] available from http://cjcentral.com/sherman/sherman.htm

For present purposes, prevention programs will not be discussed. Table 14 lists exemplary, effective, and promising programs from the OJJDP Guide.

Table 14: OJJDP Exemplary, Effective and Promising Programs

	Immediate Sanctions	Intermediate Sanctions	Residential Programs	Reentry
Exemplary Programs	Functional Family Therapy	Functional Family Therapy		
	Multisystemic Therapy	Multisystemic Therapy		
	SNAP	Under 12 Outreach		
Effective Programs	Academic Tutoring and Social Skills Training	The Families in Action (FIA)	Aggression Replacement Training® (ART®)	Aggression Replacement Training® (ART®)
	The Baton Rouge (LA) Partnership for the Prevention of Juvenile Gun Violence	The Baton Rouge (LA) Partnership for the Prevention of Juvenile Gun Violence	Mendota Juvenile Treatment Center (MJTC) - Wisconsin	Lifeskills '95
	The Bethlehem (PA) Police Family Group Conferencing Project	Career Academies	Phoenix House Academy	
	The Indianapolis Restorative Justice Conference Project	The Tri-Agency Resource Gang Enforcement Team (TARGET)	Residential Student Assistance Program (RSAP) – substance abuse TX program	
		The Sexual Abuse, Family Education, and Treatment (SAFE–T) Program	The Sexual Abuse, Family Education, and Treatment (SAFE–T) Program	
			VisionQuest	VisionQuest
Promising Programs	The Victim–Offender Mediation Program (VOMP), Albuquerque (NM)	Delaware Juvenile Drug Court Diversion Program	Father Flanagan's Girls and Boys Town (GBT)	
	Anchorage Youth Court (AYC)	Cuyahoga County (OH) Intensive Probation Supervision (IPS)		
	Reintegrative Shaming Experiment (RISE) - Canberra	Reintegrative Shaming Experiment (RISE) - Canberra		
	Independence Youth Court (IYC) – Independence (MO)	Intensive Supervision Juvenile Probation Program – Peoria (IL)		
	Michigan State Diversion Project	Jefferson County (AL) Juvenile Gun Court		
	Minneapolis Center for Victim–Offender Mediation	Maine Juvenile Drug Court		
	Multidisciplinary Team (MDT) Home Run Program – San Bernardino County (CA)	Orange County (CA) Juvenile Substance Abuse Treatment Court (JSATC)		
	Project Back-on-Track – Gainesville (FL)	Project Back-on-Track – Gainesville (FL)		
	Washington, DC, Restitution Program	Washington, DC, Restitution Program		
	California's Repeat Offender Prevention Program (ROPP)	Wayne County (MI) Intensive Probation Program		
	Wraparound Milwaukee	Wraparound Milwaukee		
	Oakland (CA) Victim–Offender Reconciliation Program			

Only three programs are listed as exemplary:

Functional Family Therapy. ***(Immediate and Intermediate Sanctions)***. Functional Family Therapy (FFT) is a family-based prevention and intervention program for dysfunctional youths ages 11 to 18 that has been applied successfully in a variety of multi-ethnic, multicultural contexts to treat a range of high-risk youths and their families. The model includes specific phases: engagement/motivation, behavior change, and generalization. Engagement and motivation are achieved through decreasing the intense negativity often characteristic of high-risk families. The behavior change phase aims to reduce and eliminate the problem behaviors and accompanying family relational patterns through individualized behavior change interventions (skill training in family communication, parenting, problem-solving, and conflict management). The goal of the generalization phase is to increase the family's capacity to adequately use multisystemic community resources and to engage in relapse prevention.

FFT ranges from an average of 8 to 12 one-hour sessions for mild cases and incorporates up to 30 sessions of direct service for families in more difficult situations. Sessions are generally spread over a 3-month period and can be conducted in clinical settings as an outpatient therapy and as a home-based model.

Several evaluation studies using matched or randomly assigned control/comparison group designs were conducted between 1973 and 1997. The studies have included follow-up periods of 1, 2, 3, and 5 years. The model has been applied to populations in urban and rural settings and among many racial and ethnic groups. In multiple evaluations of FFT, the findings show that when compared with standard juvenile probation services, residential treatment, and alternative therapeutic approaches, FFT is highly successful. The outcome findings of the research conducted during the past 30 years show that when compared with no treatment, other family therapy interventions, and traditional juvenile court services (e.g., probation), FFT can reduce adolescent re-arrests by up to 60 percent. Moreover, both randomized trials and comparison group studies show that FFT significantly reduces recidivism for a wide range of juvenile offense patterns.

Multisystemic Therapy. ***(Immediate and Intermediate Sanctions).*** Therapy (MST) typically uses a home-based model of service delivery to reduce barriers that keep families from accessing services. Therapists have small caseloads of four to six families; work as a team; are available 24 hours a day, 7 days a week; and provide services at times convenient to the family. The average treatment involves about 60 hours of contact during a 4-month period. MST therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g., extended family, neighbors, friends, church members) and removing barriers (e.g., parental substance abuse, high stress, poor relationships between partners). Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including behavioral, cognitive-behavioral, and the pragmatic family therapies. This family–therapist collaboration allows the family to take the lead in setting treatment goals as the therapist helps them to accomplish their goals.

The first controlled study of Multisystemic Therapy with juvenile offenders (Henggeler, et al., 1986) evaluated the effectiveness of MST compared with usual community treatment for inner-city juvenile offenders and their families. The study's success led to several randomized trials and quasi-experimental studies aimed at extending the effectiveness of MST to other populations of youths who presented serious clinical problems and their families. In the most comprehensive and extensive completed evaluation of MST to date (Borduin, et al., 1995), the effectiveness of MST was compared with individual therapy (IT). Participants (n=200) were 12- to 17-year-old juvenile offenders and their

families, referred from the local Department of Juvenile Justice office and randomly assigned to receive either MST (n=92) or IT (n=84). Families receiving MST reported and evidenced more positive changes in their dyadic family interactions than did IT families at post treatment. For example, MST families reported increased cohesion and adaptability and showed increased supportiveness and decreased conflict–hostility during family discussions, in comparison with IT families. Most important, results from a 4-year follow-up of recidivism showed that youths who received MST were significantly less likely to be re-arrested than youths who received individual therapy. MST completers (n=77) had lower recidivism rates (22.1 percent) than MST dropouts (46.6 percent; n=15), IT completers (71.4 percent; n=63), IT dropouts (71.4 percent; n=21), and treatment refusers (87.5 percent; n=24). Moreover, MST dropouts were at lower risk of re-arrest than IT completers, IT dropouts, and refusers. In addition, MST youths were less likely to be arrested for violent crimes (e.g., rape, attempted rape, sexual assault, aggravated assault, assault/battery) following treatment than were IT youths. Neither adolescent age, race, social class, gender, nor pretreatment arrest history moderated the effectiveness of MST.

SNAP™/Under 12 Outreach. ***(Intermediate Sanctions).*** The Under 12 Outreach Project (ORP) of the Child Development Institute in Canada was developed as an intervention for child delinquents. ORP serves boys ages 6–11 who have had police contact or are referred from other sources, and who also are clinically assessed as engaging in above-average levels of aggressive, destructive, or other antisocial behavior. The program's screening and assessment procedures involve two interviews at intake—one with the child, another with the parent—in addition to an objective risk assessment that uses the Early Assessment Risk List for Boys. EARL–20B (as it is known) is a validated, structured, clinical decision-enhancing risk assessment tool for use with aggressive and delinquent boys under 12. ORP employs a multisystemic approach, combining interventions that target the child, the family, and the child in the community. The program uses a variety of established interventions: skills training, training in cognitive problem solving, self-control strategies, cognitive self-instruction, family management skills training, and parent training. ORP is a 12-week outpatient program with five primary components:

- SNAP™ Children's Club—a structured group that teaches children a cognitive-behavioral self-control and problem-solving technique called SNAP™ (Stop Now and Plan).
- A concurrent SNAPP Parenting Group (Stop Now and Plan Parenting) that teaches parents effective child management strategies.
- One-on-one family counseling based on SNAPP.
- In-home academic tutoring for children who are not performing at their age-appropriate grade level.
- Individual befriending for children who are not connected with positive structured community-based activities and require additional support. Examples of specific therapeutic SNAP™ topics (that match presenting problems of children) include "Stop Stealing," "Peer Pressure," "Dealing With Angry Feelings," and "Avoiding Trouble."

The cornerstone of ORP and its parallel gender sensitive program for girls, Earlscourt Girls Connection (EGC), is SNAP™. ORP has been in operation and extensively researched for 20 years. EGC began in 1996 and has also proved effective. Both programs are fully manualized and are in various stages of replication. Thirty-nine full or modified replications of the SNAP™ model are currently in operation in Canada, the United States, Europe, and Scandinavia.

Studies of ORP and EGC, using rigorous scientific procedures and standardized measurement tools (including two evaluations of independent replications of ORP) have consistently demonstrated positive treatment effects. Overall, studies on the ORP and EGC show the following:

- Significant improvements after treatment with maintenance of treatment gains at 6, 12, and 18 months in terms of three standard outcome measures—internalizing (e.g., anxiety, depression), externalizing (e.g., aggression, delinquency), and social competency (e.g., peer relations, participation in activities).
- Seventy percent of the treated high-risk children do not have criminal records by age 18.
- Treated children improve significantly more than children receiving an attention only or delayed treatment; effect sizes are larger for boys (exceeding 1.1) and moderate (0.38) for girls.
- Parents experience less stress in their interactions with their children and increased confidence in managing their children's behavior.
- Children report a less positive attitude toward antisocial behavior, associate with fewer peers who their parents consider a "bad influence," and demonstrate more prosocial skills after treatment with teachers, peers and family members.

The average cost of providing ORP services for a low-risk child is about $1,000 (4-month program), $2,300 for a moderate-risk child (6-month program), and $4,300 for a high-risk child (12-month program).

Table 15 provides additional detail about the exemplary programs, including target population, problem behaviors addressed, and risk/protective factors addressed. More complete detail about effective and promising OJJDP model programs, including program descriptions, summaries of evaluations, and references can be found on the model program website (http://www.dsgonline.com/mpg2.5/mpg_index.htm).

Table 15: Evidence-based Intervention Programs—Juvenile Justice

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Functional Family Therapy Source: OJJDP Model Program Guide, [online] available from http://www.dsgonline.com/mpg2.5/TitleV_MPG_Table_Ind_Rec.asp?id=29 Contact information: James F. Alexander Department of Psychology 380 South 1350 East, #502 University of Utah Salt Lake City, UT 84112 Phone: 801.581.6538 Fax: 801.581.5841 Email: jfafft@psych.utah.edu	Functional Family Therapy (FFT) is a family-based prevention and intervention program for dysfunctional youths ages 11 to 18 that has been applied successfully in a variety of multi-ethnic, multicultural contexts to treat a range of high-risk youths and their families. It integrates several elements (established clinical theory, empirically supported principles, and extensive clinical experience) into a clear and comprehensive clinical model. The FFT model allows for successful intervention in complex and multidimensional problems through clinical practice that is flexibly structured and culturally sensitive. The model includes specific phases: engagement/motivation, behavior change, and generalization. FFT ranges from an average of 8 to 12 one-hour sessions for mild cases and incorporates up to 30 sessions of direct service for families in more difficult situations. Sessions are generally spread over a 3-month period and can be conducted in clinical settings as an outpatient therapy and as a home-based model.	Very Strong.	Ages: 11 to 18 Ethnicity: • African-American • American Indian/Alaskan • Asian/Pacific Islander • Hispanic • White Gender: Both Special Populations: • Serious/chronic offenders • Mentally ill offenders Problem Behaviors: • Family functioning • ATOD • Aggression/violence	Risk Factors: ***Family*** • Poor family management practices • Poor family bonding • Family conflict ***Individual*** • Involvement in antisocial behavior • Beliefs and attitudes favorable to deviant or antisocial behavior • Delinquent beliefs • Involvement in delinquency • Drug dealing Protective Factors: ***Family*** • Proactive family management	Alexander, J. F., Pugh, C., Parsons, B. V., & Sexton, T. L. (2000). Functional Family Therapy. In D. S. Elliott (ed.), *Blueprints for violence prevention (Book 3), 2nd ed.* Boulder, CO: Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado. Barton, C., Alexander, J. F., Waldron, H., Turner, C. W., & Warburton, J. (1985). Generalizing treatment effects of Functional Family Therapy: Three replications. *American Journal of Family Therapy, 13*(3), 16–26. Gordon, D.A., Graves, K. & Arbuthnot, J. (1995). The effect of Functional Family Therapy for delinquents on adult criminal behavior. *Criminal Justice and Behavior, 22*(1), 60–73.

Table 15: Evidence-based Intervention Programs—Juvenile Justice (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Multisystemic Therapy Source: OJJDP Model Program Guide, [online] available from http://www.dsgonline.com/mpg2.5/TitleV_MPG_Table_Ind_Rec.asp?id=363 Contact information: Marshall E. Swenson MST Services 710 J. Dodds Boulevard Mount Pleasant, SC 29464 Phone: 843.856.8226 Fax: 843.856.8227 Email: marshall.swenson@mstservices.com	Multisystemic Therapy (MST) typically uses a home-based model of service delivery to reduce barriers that keep families from accessing services. Therapists have small caseloads of four to six families; work as a team; are available 24 hours a day, 7 days a week; and provide services at times convenient to the family. The average treatment involves about 60 hours of contact during a 4-month period. MST therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g., extended family, neighbors, friends, church members) and removing barriers (e.g., parental substance abuse, high stress, poor relationships between partners). Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including behavioral, cognitive-behavioral, and the pragmatic family therapies. This family–therapist collaboration allows the family to take the lead in setting treatment goals as the therapist helps them to accomplish their goals.	Very Strong.	Ages: 12 to 17 Ethnicity: • African-American • American Indian/Alaskan • Asian/Pacific Islander • Hispanic • White Gender: Both Special Populations: • Serious/chronic offenders • Mentally ill offenders Problem Behaviors: • Family functioning • ATOD • Aggression/ violence	Risk Factors: ***Family*** • Poor family management practices • Family history of the problem behavior • Parental criminality • Poor family bonding • Family conflict ***Individual*** • Involvement in antisocial behavior • Delinquent beliefs • Involvement in delinquency • Drug dealing • Substance use/abuse • Early onset of aggression • Violent behavior • Presence of psychological condition • Conduct disorder ***School*** • Low academic achievement Protective Factors: ***Family*** • Proactive family management • Supportive parent-child relation ***Individual*** • Perception of social support from adults and peers ***School*** • Positive attitude toward school • Support from teachers/bonds with school ***Peer*** • Involvement with positive peer group activities • Good relationships with peers	Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology, 63*(4), 569–578. Henggeler, S. W., Rodick, J. D., Borduin, C. M., Hanson, C. L., Watson, S. M., & Urey, J. R. (1986). Multisystemic treatment of juvenile offenders: Effects on adolescent behavior and family interactions. *Development Psychology, 22*(1), 132–41.

Table 15: Evidence-based Intervention Programs—Juvenile Justice (continued)

Program Name, Original Location	Brief Program Description	Strength of Evidence	Target Population	Target Risk and Protective Factors	Key References
Under 12 Outreach Project,Toronto Source: OJJDP Model Program Guide, [online] available from http://www.dsgonline.com/mpg2.5/TitleV_MPG_Table_Ind_Rec.asp?id=699 Contact information: Dr. Leena K. Augimeri Child Development Institute 46 St. Clair Gardens Toronto, ON M6E 3V4 Phone: 416.603.1827 Fax: 416.654.8996 Email: augimeri@childdevelop.ca	The Under 12 Outreach Project (ORP) of the Child Development Institute in Canada was developed as an intervention for child delinquents. ORP serves boys ages 6–11 who have had police contact or are referred from other sources, and who also are clinically assessed as engaging in above-average levels of aggressive, destructive, or other antisocial behavior. The program's screening and assessment procedures involve two interviews at intake—one with the child, another with the parent—in addition to an objective risk assessment that uses the Early Assessment Risk List for Boys. EARL–20B (as it is known) is a validated, structured, clinical decision-enhancing risk assessment tool for use with aggressive and delinquent boys under 12. ORP employs a multisystemic approach, combining interventions that target the child, the family, and the child in the community. The program uses a variety of established interventions: skills training, training in cognitive problem solving, self-control strategies, cognitive self-instruction, family management skills training, and	Very Strong.	Ages: 6 to 12 Ethnicity: • African-American • American Indian/Alaskan • Asian/Pacific Islander • Hispanic • White Gender: Both Special Populations: Young offenders Problem Behaviors: • Delinquency • Aggression/violence	Risk Factors: ***Family*** • Poor family management practices • Parental criminality • Poor family bonding • Family conflict • Child maltreatment • Domestic violence • Single-parent family/divorce • Sibling antisocial behavior • Family transitions • Low parental; education level • Parental depression ***Individual*** • Beliefs and attitudes favorable to deviant or antisocial behavior • Delinquent beliefs • Involvement in delinquency • Substance use/abuse • Drug dealing • Early onset of aggression and/or violence • Cognitive and neurological deficits/low intelligence quotient/hyperactivity • Victimization and exposure to violence • Lack of guilt and empathy • Poor refusal skills • Life stressors • Presence of psychological condition • Conduct disorder ***School*** • Low academic achievement	Augimeri, L. K., Farrington, D. P., Koegl, C. J., & Day, D. M. (2006). *The Under 12 Outreach Project: Effects of a community-based program for children with conduct problems.* Toronto, Ontario: Centre for Children Committing Offences, Child Development Institute. Augimeri, L. K., Jiang, D., Koegl, C. J., & Carey, J. (2006). *Differential effects of the Under 12 Outreach Project (ORP) associated with client risk and treatment integrity.* Toronto, Ontario: Centre for Children Committing Offences, Child Development Institute.

	parent training. ORP is a 12-week outpatient program with five primary components: 1. SNAP™ Children's Club—a structured group that teaches children a cognitive-behavioral self-control and problem-solving technique called SNAP™ (Stop Now and Plan). 2. A concurrent SNAPP Parenting Group (Stop Now and Plan Parenting) that teaches parents effective child management strategies. 3. One-on-one family counseling based on SNAPP. 4. In-home academic tutoring for children who are not performing at their age-appropriate grade level. 5. Individual befriending for children who are not connected with positive structured community-based activities and require additional support. Examples of specific therapeutic SNAP™ topics (that match presenting problems of children) include "Stop Stealing," "Peer Pressure," "Dealing With Angry Feelings," and "Avoiding Trouble." The cornerstone of ORP and its parallel gender sensitive program for girls, Earlscourt Girls Connection (EGC), is SNAP™. ORP has been in operation and extensively researched for 20 years. EGC			• Negative attitude toward school/Low bonding/Low school attachment/Commitment to school • Inadequate school climate/Poorly organized and functioning schools/Negative labeling by teachers • Dropping out of school • School suspensions • Truancy/Frequent absences • Low academic aspirations • Frequent school transitions ***Peer*** • Gang involvement/Gang membership • Peer alcohol, tobacco, and/or other drug use • Association with delinquent and/or aggressive peers • Peer rejection ***Community*** • Availability of alcohol and other drugs • Availability of firearms • Community crime/High crime neighborhood • Social and physical disorder/Disorganized neighborhood • Community instability • Low community attachment • Economic deprivation/Poverty/Residence in a disadvantaged neighborhood <u>Protective Factors</u>: ***Family*** • Proactive family management • Supportive parent-child relations • Opportunities/rewards for pro-social family involvement • Stable home environment	

	began in 1996 and has also proved effective. Both programs are fully manualized and are in various stages of replication.			***Individual*** • Perception of social • Highly developed personal and pro-social skills • Resilient temperament • High self constructs • Positive beliefs and standards ***School*** • Support from teachers/faculty • Opportunities for pro-social school involvement • Strong school motivation • Positive attitude toward school • School bonding • Above average academic achievement /Reading and math skills ***Peer*** • Involvement with positive peer group activities • Good relationships with peers • Parental approval of friends ***Community*** • Involvement of supportive adults • Pro-social opportunities for participation • Availability of neighborhood resources • Safe environment • Low neighborhood crime • Non-disadvantaged neighborhood • Rewards for pro-social community involvement • Clear social norms	

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