



Selected Validated Mental Health Programmes for Young People



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Selected Examples of Validated Parenting & Family Education Programmes

Copied from: http://www.dsgonline.com/mpg2.5/parent_training_prevention.htm

Adolescent Transitions Program

Intervention:

The Adolescent Transitions Program (ATP) is a multilevel, family-centered intervention targeting children who are at risk for problem behavior or substance use. Designed to address the family dynamics of adolescent problem behavior, it is delivered in the middle school setting to parents and their children. The parent-focused curriculum concentrates on developing family management skills such as making requests, using rewards, monitoring, making rules, providing reasonable consequences for rule violations, problem-solving, and active listening. Strategies targeting parents are based on evidence about the role of coercive parenting strategies in the development of problem behaviors in youth. The curriculum for teens takes a social learning approach to behavior change and concentrates on setting realistic goals for behavior change, defining reasonable steps toward goal achievement, developing and providing peer support for prosocial and abstinent behavior, setting limits, and learning problem-solving.

The long-term goals of the program are to arrest the development of teen antisocial behaviors and drug experimentation. Intermediate goals are to improve parents' family management and communication skills. To accomplish these goals, the intervention uses a "tiered" strategy with each level (universal, selective, and indicated) building on the previous level. The universal level is directed to the parents of all students in a school. Program goals at this level include engaging parents, establishing norms for parenting practices, and disseminating information about risks for problem behavior and substance use. At the selective level of intervention, the Family Check-Up, assessment, and support are provided to identify those families at risk for problem behavior and substance use. At the indicated level, direct professional support is provided to parents based on the results of the Family Check-Up through services including behavioral family therapy, parenting groups, or case management services.

Program activities are led by group leaders and include parent group meetings, individual family meetings, and teen group sessions, as well as monthly booster sessions for at least 3 months following completion of the group. Meetings and sessions may include discussion and practice of a targeted skill, group exercises (either oral or written, depending on group needs), role-plays, and setting up home practice activities. Many of the skill-building exercises include activities that parents and children do together. Each curriculum also has six accompanying videotapes that demonstrate the program's targeted skills and behaviors.

Evaluation Methodology:

Researchers conducted a 2-year randomized clinical trial to assess the effectiveness of the parent and teen interventions, both as individual interventions and together. Group leaders were mental health professionals. Participating families were self-referred through recruitment advertisements and screened for risk factors (closeness to parents, emotional adjustment, academic engagement, involvement in positive activities, experience seeking, problem behaviors, stressful life events, and child, peer, and family substance use). Those with four or more risk factors were eligible and randomly assigned to one of four groups: parent focus only, teen focus only, both parent and teen focus, and self-directed change (using program videos only). Random assignment was accomplished using cluster sampling to preestablish the order of assignment. After assignment, the sample included four cohorts of about 30 families each. Boys and girls were assigned separately to ensure equal gender distribution. The sample was composed of 158 families, including 83 boys and 75 girls. The children ranged in age from 10 to 14 and were in grades 6, 7, and 8. The sample was 95 percent European-American. A group of 39 families (22 girls, 17 boys) was also recruited as the control group.

Assessments of family interaction, family conflict, behavior problems, and substance use were done at baseline, program termination, and 1 year following termination. Family interaction was assessed using videotapes of parent-child interaction during problem-solving tasks. The interactions were coded and analyzed using the Family Process Code. Internal family conflict and external family stressors were measured using the Family Events Checklist. For behavior problems, the Child Behavior Checklist was used to assess changes in youth behavior through the intervention. Finally, all youths were asked to report on the frequency of their tobacco or other drug use in the past 3 months. In addition, expired-air carbon monoxide levels were assessed to corroborate self-reported smoking behavior.

The most recent evaluation was a 4-year randomized trial of the parent-focused ATP component with eight small community samples in Oregon. In contrast to the prior evaluation, the group leaders in this trial were not professional mental health workers. Subjects were students referred by schools or service agencies based on teacher or social service agency staff assessments, using the Teacher Risk Screening Instrument. The parents of students whose assessments revealed three or more risk factors were contacted and invited to participate in the parenting program. Interested families were randomly assigned to the immediate treatment intervention group or a waitlist control that would receive classes 3 months after the immediate treatment group finished the program. The sample consisted of 303 families, with 151 in the immediate treatment group and 152 assigned to control. The target children were 61 percent male and 39 percent female. The average age of the target children was 12.2 years, and 87.5 percent of the subjects were white. There were no significant differences in demographic characteristics of the immediate treatment and waitlist groups.

Intervention group participants were assessed using measures of parent behavior, parental feelings about the child, parental depression, and children's behavior at baseline, both after the completion of the final session and 6 months following the final session. The *Parent Report of Problematic Interactions* was used to assess coercive elements in parent-child interactions. Parents' reports of their reactions to their child were assessed using the Parenting Scale—Adolescent Version. In addition, the Taped Situations Test was used to measure parents' ability to handle common parenting situations in positive, effective ways. Parents' feelings about their children were measured using the Inventory of Family Feelings. The instrument used to assess parental depression was the Beck Depression Inventory. Finally, the extent to which the child exhibited problematic behavior

was assessed through the Parental Daily Reports and the Child Behavior Checklist.

Evaluation Outcome:

Analysis of the data from the 2-year study found significant improvements in family interactions. Parents and children in the intervention groups showed reductions in negative engagement in family interactions. This effect was the same for the combined parent-teen intervention as it was for either intervention condition alone. In addition, the results of latent growth curve modeling analyses indicated that children's externalizing behavior was significantly reduced after their parents participated in ATP. The researchers conducted additional analyses on a subset of "high attending" families and found that for parents who received four or more sessions of ATP there was a clear and moderate-sized effect of treatment on parent-reported externalizing behavior.

Researchers in the 4-year study used growth curve modeling to identify intervention effects, compare treatment and control groups, and track changes in these groups over time. This analysis revealed several promising effects of the intervention. For example, parents in both treatment and waitlist groups showed significant improvements in positive problem-solving with their teens attributable to treatment and maintained this at future assessment points. In addition, parents in both groups had improved feelings toward their children and were less likely to react negatively to their children's behavior and less likely to take a "lax" approach to their children after participating in the program. Both groups also showed improvements in the skill areas of tracking and reinforcing behavior, setting expectations and defining problems, and remaining calm in stressful situations. Child behavior also showed improvement as a result of participation in the program. Antisocial behaviors decreased significantly, measures of child adjustment showed improvement, and total problem behavior decreased.

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Strengthening Families Program

Intervention:

The Strengthening Families Program (SFP) is a parenting and family skills training program that consists of 14 consecutive weekly skill-building sessions. Parents and children work separately in training sessions and then participate together in a session practicing the skills they learned earlier. Two booster sessions are used at 6 months to 1 year after the primary course. Children's skills training sessions concentrate on setting goals, dealing with stress and emotions, communication skills, responsible behavior, and how to deal with peer pressure. Topics in the parental section include setting rules, nurturing, monitoring compliance, and applying appropriate discipline.

SFP was developed and tested in 1983 with 6- to 12-year-old children of parents in substance abuse treatment. Since then, culturally modified versions and age-adapted versions (for 3- to 5-, 10- to 14-, and 13- to 17-year-olds) with new manuals have been evaluated and found effective for families with diverse backgrounds: African-American, Asian/Pacific Islander, Hispanic, American Indian, Australian, and Canadian.

Evaluation Methodology:

SFP has been evaluated at least 18 times on Federal grants and at least 150 times on State grants by independent evaluators. The original National Institute on Drug Abuse (NIDA) study involved a true pretest, posttest, and follow-up experimental design with random assignment of families to one of four experimental groups: 1) parent training only, 2) parent training plus children's skills training, 3) the complete SFP including the family component, and 4) no treatment besides substance abuse treatment for parents. SFP was then culturally adapted and evaluated with five Center for Substance Abuse Prevention High-Risk Youth Program grants by independent evaluators using statistical control group designs that involved quasi-experimental, pretest, posttest, and 6-, 12-, 18-, and 24-month follow-ups. Recently, SFP was compared with a popular school-based aggression prevention program (I Can Problem Solve) and found highly effective (effect sizes = .45 to 1.38), employing a true experimental pretest–posttest, 12-month, and 24-month follow-up design in two Utah school districts. A NIDA four-group randomized clinical trial with about 800 primarily African-American families in the Washington, DC, area also found good results.

Evaluation Outcome:

Research, using randomized experimental designs and pretest and posttest data collection, has found consistent positive results for diverse families, and up to 5-year follow-up measures:

- Parent Training improves parenting skills and children's behaviors and decreases conduct disorders.
- Children's Skills Training improves children's social competencies (e.g.,

communication, problem solving, peer resistance, and anger control).

- Family Skills Training improves family attachment, harmony, communication, and organization.
- The full SFP improves more risk and protective factors predictive of later problem behaviors than other studied interventions.

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Say It Straight

Intervention:

Say It Straight (SIS) is a communication skills program developed to prevent destructive behaviors and promote wellness in young people, parents, and other adults. The program targets destructive behaviors such as violence, risky sexual behaviors, and use of alcohol, tobacco, and other drugs. Promotion of wellness concentrates on increasing self-awareness, personal and social responsibility, good communication skills, positive self-esteem, and positive relationships.

SIS creates opportunities for people to discover their internal resources, connect to their deepest wishes, and develop the skills needed to express and implement them in appropriate ways. Trainings are action-oriented and use visual, auditory, and kinesthetic modalities to involve people with different learning styles. The use of role-plays such as body sculpting (that is, placing one's body into certain physical postures) as a facilitative strategy helps participants understand empowering (e.g., supporting, caring) and disempowering (e.g., placating, people-pleasing) communications. Students and adults create films that help them explore significant situations in their lives. Exploring different communications and coping behaviors by acting a role is theorized to help contribute to prohealth behaviors and facilitate the change process.

Because the training is co-created by participants, it gives them a sense of ownership and transcends culture, age, and gender. Addressing individual, family, and community risk and protective factors, SIS aims for the development of self-sustaining prevention communities.

The distinctive features of the Say It Straight program include the following:

- Flexibility to be applied across settings (e.g., schools, support groups, prisons, treatment agencies, community-based organizations, churches) and across age groups (8 to adult) and roles (e.g., students, parents, teachers, healthcare providers).
- Training entire classrooms or schools, rather than selected students who have been labeled in negative ways. This gives the message that everyone can improve their communication skills, creating bonds rather than separations among people.
- Concentrating on solutions, on improving coping skills, and on one's strengths and resources. At no time during the training is factual information about alcohol or drugs given.
- Giving ownership and responsibility for the training to participants by letting them choose the content of the films—that is, letting them co-create their training. This not only ensures cultural, ethnic, developmental, and gender relevancy, but it also respects the participants' freedom.

Evaluation Methodology:

The effectiveness of Say It Straight in the prevention of violence, delinquency, alcohol and drug abuse, and HIV/AIDS has been studied since 1982.

Study No. 1

One of the more rigorous studies of the effectiveness of SIS on preventing or reducing alcohol and drug abuse among 11- to 13-year-olds used a quasi-experimental design with random assignment to condition. Three middle schools were randomly assigned to treatment or control.

The treatment school was compared with two control schools that implemented their own information-oriented drug-prevention program. A total of 509 students participated in the SIS program. Of these, 202 were sixth graders, 215 were seventh graders, and 92 were eighth graders.

In the control schools, 1,539 students were measured on alcohol- and drug-related suspensions. Along with the suspensions, in the second control school, a subset (of the total 714 students) was measured on variables related to positive communication (specifically, communication using “leveling and assertive attitudes”) before and after their usual drug prevention program. The subset sample consisted of 21 sixth graders, 35 seventh graders, and 28 eighth graders.

Pretest and posttest measurements of the effectiveness of SIS included a questionnaire designed to measure attitudes toward communication that included “assertiveness and leveling,” an open-ended measure asking what was learned after the program, and rates of alcohol and drug school suspensions. A 1-year follow-up looked at the program’s lasting effects on alcohol- and drug-related suspensions in the eighth grade.

Study No. 2

This study was a continuation of Study No. 1 from the previous academic year. Because of the success of SIS in the treatment school, SIS was requested in one of the previous year’s control schools. Further, the original treatment school asked the program developer to do SIS with all the incoming sixth graders and do SIS reinforcement with seventh and eighth graders who had been trained as sixth and seventh graders the year before. Finally, one elementary school asked that their fifth graders also be offered SIS. Alcohol-/drug-related school suspensions were monitored for all fifth to ninth grade students in the city during throughout the academic year. This included the ninth graders trained as eighth graders in Study No. 1. The SIS Social Skills Questionnaire (SISSSQ) was administered before and after training to the fifth graders, to the incoming sixth graders in the previous year’s treatment school, and to sixth to eighth graders in one of the previous year’s control schools. The Subjective Feedback Questionnaire (SFQ) was administered after SIS.

Study No. 3

A 6-month pretraining baseline period was used to monitor juvenile police offenders among all 740 ninth to 12th graders in a city. The most rigorous design was applied to the ninth grade. SIS was offered to all ninth graders, and 186 out of 208 participated. The number of juvenile offenders among this trained group of students was compared with offenders among 211 ninth graders who were not trained during the following school year and thus provided a control group. Comparisons for these two groups were done during equivalent timeframes (Feb. 1 through Aug. 24) of two consecutive years. SIS was also

conducted with 108 out of 221 tenth graders, 35 out of 166 eleventh graders, and 28 out of 145 twelfth graders. Participants in the program were administered the SSISSQ before and after SIS and the SFQ after SIS.

Study No. 4

This study involved a large-scale replication done by 96 teachers, counselors, school nurses, school administrators, and community volunteers and two project coordinators who were trained to facilitate SIS with students, parents, and communities in high-risk environments. They trained 2,781 third through 12th graders in classrooms, in student support groups, in a school within a chemical dependency treatment facility, and in a school within a detention facility. They also trained 227 parents and other adults. Two parent groups had Spanish-speaking trainers, and questionnaires were administered in Spanish. The SSISSQ was administered before and after SIS with students. Five additional questions pertaining to sexual behavior were added to the SSISSQ and were used by some of the trainers with 9th through 12th graders. The SIS Communications Questionnaire (measuring empowering and disempowering communications/behaviors), the Quality of Life/Family Questionnaire (QLQ–F), and the Quality of Life/Group Questionnaire (QLQ–G) were administered to the adults before and after SIS. Students and adults both received the SFQ after SIS.

Study No. 5

Effectiveness of SIS was evaluated with 36 mothers in residential chemical dependency treatment with their children. All were indigent, 32 had previous criminal offenses, 14 were on probation or parole at the time of training, and 27 had dual diagnoses. Their ages ranged from 19 to 42. The average number of days in treatment before beginning SIS was 85.6, with a range of 10 to 223 days. Although it was not possible to assign women to treatment and control conditions, it was possible to compare women in treatment a relatively short time (an average of 40 days) with women in treatment a much longer time (an average of 141 days) prior to SIS training to evaluate the impact of SIS. The following questionnaires were administered before and after SIS: the SIS Communication Questionnaire, QLQ–F, QLQ–G, and the Rosenberg Self-Esteem Questionnaire. The SFQ was administered after SIS.

Study No. 6

This study evaluated SIS in a residential treatment facility (chemical dependency, sexual compulsivity, compulsive gambling, eating disorders, as well as psychiatric diagnosis) with 26 men and women. Effectiveness of SIS was measured by comparing leaves from the treatment facility against medical advice before SIS and during SIS, as well as with questionnaires used in Study No. 5. Another questionnaire was used to evaluate anomie (the sense of alienation) before and after SIS.

Evaluation Outcome:

Study No. 1

Students in the treatment school were significantly less likely to have alcohol- and other drug-related school suspensions and referrals during the academic year than were students in the two control schools. Notably, of the 12 suspensions and referrals that occurred in the treatment school, none occurred after SIS. Students trained in the treatment school were followed during the entire next academic year. Not a single “new user” (defined by alcohol- and other drug-related school suspensions) was identified among them.

In addition, only students in the treatment school showed statistically significant positive shifts on the SSISSQ that indicated a greater willingness to implement constructive decisions in difficult situations and feel more at ease doing so after SIS. These shifts were highly “statistically significant.” Finally, on the SFQ students indicated that they had learned and were motivated to use the skills and knowledge taught by the program when faced with a relevant situation in real life.

Study No. 2

Alcohol- and drug-related school suspensions were significantly lower among the 1,483 sixth through ninth graders who received SIS, compared with 1,295 students who did not have SIS. The fifth graders were excluded from this analysis because no such suspensions were incurred either by trained or untrained fifth graders.

Scores on the SSISSQ showed highly “statistically significant” increases for fifth through eighth graders after SIS. A subjective feedback questionnaire was also administered to these students. As in Study No. 1, in every grade students reported on the SFQ that they had learned and were motivated to use the skills learned.

Study No. 3

This study demonstrates the long-range effectiveness of SIS in reducing the number of juvenile police offenders among 9th to 12th graders. The police department monitored juvenile police offenses for all 9th through 12th graders for a baseline period of 6 months before SIS and 19 months after SIS. During the pretraining period, the number of offenders among the 357 students who would later receive SIS did not differ statistically from the number of offenders among the 383 students who would not receive SIS. During 19 months after SIS, there were statistically significantly fewer juvenile police offenders (behaviors ranging from aggravated assaults, vandalism, and burglaries to traffic violations) among 9th through 12th graders who received SIS compared with students who did not receive SIS. Further, students who did not receive SIS had more severe offenses, as ranked by the police department, compared with program participants.

Scores on the SSISSQ showed highly “statistically significant” increases for 9th, 10th, and 12th graders after SIS and were not significant for 11th graders after SIS. Students in all grades reported on the SFQ that they had learned and were motivated to use the skills learned.

Study No. 4

Although 2,781 students were trained, data analysis was based on 2,695 students for whom paired pretest and posttraining questionnaires were available. Data loss occurred because of absences during pretest or posttest, lack of ID numbers to allow matching pretests and posttests, and two teachers who administered different pretests and posttests (making analysis impossible). All grades showed statistically significant increases on the SSISSQ, with 4th through 12th grades showing highly significant results. Analysis by gender showed the same results.

Scores on the five added sexual behavior questions also showed highly “statistically significant” increases, even when analysis was done by gender. Students in all grades reported on the SFQ that they had learned and were motivated to use the skills learned. Students in detention and treatment showed similar results to students in regular school settings. In addition, a group of eight students in the treatment facility were evaluated by their counselors on the Communications Questionnaire before and after SIS. The counselors evaluated the students as being highly “significantly more likely” to use

empowering communications/behaviors after SIS and engaging highly “significantly less” in disempowering communications/behaviors after SIS.

In regard to parents and other community adults, these adults reported highly “statistically significant” increases in empowering communications/behaviors and highly significant decreases in disempowering communications/behaviors, as measured on the SIS Communications Questionnaire, and highly significant increases on QLQ–F and QLQ–G after SIS. Adults reported on the SFQ that they had learned and were motivated to use the skills learned.

Study No. 5

For the whole group of women, disempowering communications/behaviors showed highly significant decreases after SIS. Empowering communications/behaviors showed significant or highly significant increases on QLQ–F and QLQ–G. Self-esteem, assessed with one group of eight mothers, also showed a highly significant increase after SIS. Self-reports on the SFQ regarding training effectiveness also were highly positive. Some examples of what mothers reported: “Now I feel I can get my messages clearer to my children”; “I can speak from the heart how I truly feel”; “I am learning to say it straight to my mom and son; this is increasing my self-esteem.” A limitation to this study is the lack of a control group.

Study No. 6

Self-reports of empowering behaviors, quality of family and group life, and self-esteem showed highly significant increases following SIS. Self-reports of disempowering behaviors showed highly significant decreases following SIS. Anomie showed a significant decrease. Subjective reports regarding training effectiveness were also highly positive. One resident reported “finding his voice” as a result of SIS and how this was important for him in coping with triggers for relapse. Treatment staff reported that SIS resulted in a prevalent attitude of increased concern among residents for one another’s recovery and willingness on the part of residents to go out of their way to assist staff in forestalling residents leaving against medical advice as well as to intervene informally on their own with greater frequency. This attitude was reflected in a decrease of over 50 percent in leaves against medical advice, thereby increasing treatment retention and completion.

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Creating Lasting Family Connections

Intervention:

Creating Lasting Family Connections (CLFC) is a comprehensive family strengthening and substance abuse and violence prevention curriculum designed to help youths and families in high-risk environments become strong, healthy, and supportive. CLFC serves African-American, white, Native American, Asian, Pacific Islander, and Hispanic youths ages 9 to 17 and their families living in rural, suburban, or urban settings. Its curriculum is designed for use in a community system (churches, schools, recreation centers, court-referred settings) that provides significant contact with parents and youths, has existing social outreach programs, and is linked with other human service providers.

Because youth programs have a greater chance of being effective with community support, the program begins with community and school mobilization. Next comes the parent and youth training component, consisting of five or six weekly sessions. Parent trainings are designed to increase parent resiliency by improving knowledge of ATOD (alcohol, tobacco, and other drug) abuse, family management skills, communication skills, family role modeling of alcohol use, youth involvement in community activities, and the use of community services as needed. Youth trainings are similarly designed to increase resiliency through teaching communication and refusal skills and encouraging bonding with family. CLFC's final component involves early intervention and case management services, to provide a support system for the families in the program. Case management services are given for 6 months following the parent and youth trainings.

Evaluation Methodology:

CLFC was evaluated rigorously, using a true experimental design in which youths were randomly assigned to either the program or a comparison group. There were no significant differences between the two groups. The evaluation used three repeated measures over 1 year to allow the measurement of both short-term and sustained gains. During the first wave, data was collected on 143 parents and 183 youths. Seven months later, data was collected on 114 parents and 149 youths. At the 1-year follow-up, data was collected on 104 parents and 131 youths. The evaluation used multivariate analysis methods to uncover direct and conditional relationships between the program and

outcomes.

Performance Measures:

Measure: Increase knowledge regarding ATOD use	Source:CLFC Youth and Parent Surveys
Measure: Decrease attitudes favorable to ATOD use	Source:CLFC Youth and Parent Surveys
Measure: Increase family bonding	Source:CLFC Youth and Parent Surveys
Measure: Increase parent-child communication	Source:CLFC Youth and Parent Surveys
Measure: Increase level of family participation	Source:CLFC Youth and Parent Surveys
Measure: Increase in the number of used services	Source:CLFC Youth and Parent Surveys
Measure: Increase level of family functioning	Source:CLFC Parent Survey
Measure: Increase level of family violence	Source:CLFC Youth Survey
Measure: Increase problem solving /conflict resolution skills	Source:CLFC Youth Survey

Evaluation Outcome:

The evaluation found 1) increases in knowledge and healthy beliefs about ATOD by parents, 2) increased youth involvement in setting and following family ATOD rules, 3) increased use of needed community services by families, 4) increased bonding between children and parents, 5) increased level of (honest and deep) communication, 6) increased use of community services by youths, 7) delayed onset of ATOD use by youth, and 8) reduced ATOD use by youth.

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Family Integrated Transitions (FIT)

Intervention:

The Family Integrated Transitions (FIT) program provides integrated individual and family services to juvenile offenders who have mental health and chemical dependency disorders during their transition from incarceration back into the community. The goals of the FIT program include lowering the risk of recidivism, connecting the family with appropriate community supports, achieving youth abstinence from alcohol and other drugs, improving the mental health of the youth, and increasing prosocial behavior.

FIT is based on components of three programs: multisystemic therapy (MST), dialectical behavior therapy (DBT), and motivational enhancement therapy (MET). The overarching framework of FIT is derived from MST, a preservation model for community-based treatment. This treatment component uses therapists to coach caregivers in establishing productive partnerships with schools, community supports, parole, and other systems and help caregivers develop skills to be effective advocates for those in their care. While the MST component concentrates on the extent to which environments around the youth support prosocial behavior, FIT incorporates elements of DBT to address individual-level characteristics by replacing maladaptive emotional and behavioral responses with more effective and skillful responses. Finally, FIT uses aspects of MET to engage youths in treatment, with the objective of increasing their commitment to change. FIT therapists use MET techniques to develop the initial engagement of all parties and to maintain the commitment throughout the treatment.

The FIT program begins in a youth's final 2 months in a Juvenile Rehabilitation Administration (JRA) facility and continues for 4 to 6 months during parole supervision. The FIT team consists of contracted therapists, including children's mental health specialists and chemical dependency professionals. The FIT team serves four to six families at any given time. Services are available 24 hours a day, 7 days a week. JRA is responsible for identifying eligible youths and works closely with the therapists and FIT families. To be eligible for the youth program a youth must be under 17½, be in a JRA institution and scheduled to be released to 4 or more months of parole, reside in one of four designated Washington State counties (King, Kitsap, Pierce, or Snohomish), have a substance abuse or dependence disorder and any of the following: any Axis 1 disorder, a currently prescribed psychotropic medication, or demonstrated suicidal behavior within the last 3 months.

Evaluation Methodology:

This evaluation used a quasi-experimental design. The sample included 104 youths who participated in FIT and served as the treatment group. The control group included 169 FIT-eligible youths who did not participate in FIT because they returned to counties where the project was unavailable; this group received usual JRA parole services. Since the study did not use random assignment, logistic regression was used to determine any significant differences between groups. There were no significant differences for gender, age at release, Native American ethnicity, age at first prior conviction, prior drug convictions, criminal history, or prior person (violent) convictions. However, there were significant differences on four variables: ISCA risk assessment scores, African-American ethnicity, Hispanic ethnicity, and the degree to which a county was either urban or rural. The ISCA is JRA's tool that measures an offender's overall risk for re-offense. Treatment group participants were more likely to be African-American and less likely to be Hispanic. This was expected because the counties that were eligible for the FIT program were more urban, more and ethnically black, and less Hispanic than the non-FIT counties. This evaluation compared the recidivism rates of both the treatment and control groups to determine program effects.

Evaluation Outcome:

The evaluation found that the FIT program has a statistically significant effect on the felony recidivism rate. At 18 months postrelease, the felony recidivism was 34 percent less for FIT youth (27 percent) than for the comparison group (41 percent). However, there was no significant effect on the total recidivism rate (including felony or misdemeanor reconstructions), though the results are in the direction of lowering this rate. There was also no significant effect on the violent felony recidivism rate (which is usually a relatively rare event in the 18-month follow-up period), though the results are in the direction of lowering this rate as well. A cost-benefit analysis of the FIT program indicated that for every \$1.00 spent on FIT, \$3.15 is saved in criminal justice expenses and avoided criminal victimization.

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HOMEBUILDERS

Intervention:

HOMEBUILDERS is an intensive, in-home family preservation and reunification program for families with children (birth to 18) returning from or at risk of placement into foster

care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities. The HOMEBUILDERS Model is designed to eliminate barriers to service, while using research-based interventions to improve parental skills, parental capabilities, family interactions, children's behavior, and family safety.

The core program strategies are

- *Accessibility.* Services are provided in the family's home and community (e.g., school) at times convenient to families, including evenings, weekends, and holidays. HOMEBUILDERS therapists are available 24 hours a day, 7 days a week for crisis intervention.
- *Flexibility.* Intervention strategies and methods are tailored to meet the needs, values, and lifestyles of each family.
- *Time limited and low caseload.* Families can be referred for either a 4- to 6-week high-intensity intervention (therapist caseload of two) or for a 90-day moderate-intensity intervention (therapist caseload of five to six). Service duration is based on safety and treatment needs; 80–100 hours of total service are provided, with an average of 45 hours of face-to-face contact with the family.
- *Strengths based.* Therapists help clients identify and prioritize goals, strengths, and values and help them use and enhance strengths and resources to achieve their goals.
- *Ecological/holistic assessment and individualized treatment planning.* Assessments of family strengths, problems, and barriers to service/treatment, and outcome-based goals and treatment plans are completed collaboratively with each family.
- *Research-based treatment practices.* Therapists use evidence-based treatment practices, including motivational interviewing, behavioral parent training, cognitive behavior therapy and change strategies, and relapse prevention. Therapists teach family members a variety of skills, including child behavior management, effective discipline, positive behavioral support, communication skills, problem-solving skills, resisting peer pressure, mood management skills, safety planning, and establishing daily routines.
- *Support and resource building.* Therapists help families assess their formal and informal support systems and develop and enhance ongoing supports and resources for maintaining and facilitating changes.
- *Critical thinking framework.* Therapists, supervisors, and managers use a critical thinking framework for assessing, planning, implementing, and evaluating progress and outcomes.

The primary intervention components of the HOMEBUILDERS Model are engaging and motivating family members; conducting holistic, behavioral assessments of strengths and problems; developing outcome-based goals; using evidence-based cognitive/behavioral interventions; teaching skills to facilitate behavior change; and developing and enhancing

ongoing supports and resources. HOMEBUILDERS programs have been successfully implemented in diverse and multiethnic/multicultural communities across the United States and other countries.

Evaluation Methodology:

HOMEBUILDERS has been evaluated both formally and informally since it was established in 1974. The most comprehensive evaluation was the Michigan Families First Effectiveness Study. Michigan Families First uses the HOMEBUILDERS Model with its clients. The evaluation consisted of an experimental design with randomization to Families First (n=120) or foster care (n=82). The treatment group was 55 percent male, with an average age of 7.7 (SD=5.4 years). The comparison group was 48 percent male, with an average age of 7.3 (SD=4.6 years). The parents of the children in both groups were mostly African-American (77.5 percent and 62 percent, respectively) or white (18.5 percent and 27.5 percent, respectively). Data was collected from the birth parent or primary caregiver at baseline, then again at 6 months' and 12 months' follow-up.

Performance Measures:

Measure: Improve school performance	Source:North Carolina Family Assessment Scale
Measure: Decrease the number of problem behaviors	Source:North Carolina Family Assessment Scale
Measure: Decrease the number of out of home placements	Source:North Carolina Family Assessment Scale
Measure: Improve level of family functioning	Source:North Carolina Family Assessment Scale
Measure: Improve level of family bonding	Source:North Carolina Family Assessment Scale
Measure: Improve use of positive parenting skills	Source:North Carolina Family Assessment Scale
Measure: Improve level of parental supervision	Source:North Carolina Family Assessment Scale
Measure: Decrease level of family violence	Source:North Carolina Family Assessment Scale
Measure: Decrease frequency of AOD use	Source:North Carolina Family Assessment Scale

Evaluation Outcome:

The Michigan Families First study showed that at 12 months 93 percent of treatment children were still living at home, while only 43 percent of those in the comparison group were living at home. Both groups reported little to no subsequent abuse and neglect after the start of the study. Also, there was little police involvement and there were few arrests in both groups. School behavior between the two groups was similar.

Other evaluations of the HOMEBUILDERS program generally report positive outcomes. For instance, a single-group study of 1,506 children reported that 83 percent avoided out-of-home placement 12 months after intake. Another study of 453 families showed that few children in the treatment group were in out-of-home placement by the end of treatment, and 12 months after the start of treatment this increased to about one third of the sample. In addition, placement rates were higher for the comparison group than for the treatment group (85 percent of the comparison group compared with 44 percent of the treatment group) 12 months after the program. Some program outcomes produced mixed results, possibly owing to the use of heterogeneous client samples.

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Parenting Wisely

Intervention:

Parenting Wisely (PW) is a self-administered, computer-based program that teaches parents and their children important skills to enhance relationships and decrease conflict through behavior management and support. The program is designed to enhance child adjustment and has the potential to reduce delinquency, substance abuse, and involvement with the juvenile justice system. In addition, it seeks to improve problem-solving, parent–school communication, school attendance, and grades while reducing disciplinary infractions.

The program uses an interactive CD–ROM in which parents view video scenes of common family problems. The program instructs parents in effective parenting skills through the use of demonstration, quizzing, repetition, rehearsal, recognition, and feedback for correct and incorrect answers. For instance, for each problem, parents choose one of several solutions, only one of which is an effective and adaptive method of dealing with the problem. After choosing a solution, a parent sees the chosen solution

acted out in the video. The parent then receives feedback through an on-screen question-and-answer format that explains any problems associated with the selected solution as well as why the common mistakes in parenting portrayed in the incorrect solutions lead to difficulties. If the correct solution is chosen, the parent receives feedback on specific skills used in that situation that made it effective. Finally, several review questions follow the feedback to further reinforce the skills. After completing the review questions, the parent moves to the next problem. The video program covers communication skills, problem-solving skills, speaking respectfully, assertive discipline, reinforcement, chore compliance, homework compliance, supervision of children hanging out with peers who are a bad influence, stepfamily problems, single-parent issues, and violence. The program is administered in one to three sessions in 2 to 2½ hours, depending on the amount of discussion in which users engage. Parents using the program also receive a workbook for future reference that outlines all problems and solutions included in the program.

The target population is families with parents who do not usually seek or complete mental health or parent education treatment for children's problem behaviors. Single-parent families and stepfamilies with children who exhibit behavior problems constitute most of the families targeted. PW has been tested with families in rural and urban areas and is equally appealing to African-American, Hispanic/Latino, and white families.

Evaluation Methodology:

Numerous studies were conducted to assess the effectiveness of PW, using a variety of different methods, including random assignment. Evaluations were conducted in juvenile detention, child protective services, health and mental health centers, probation departments, schools, and families' homes. Represented among these studies were some 990 families of white (including Appalachian), African-American, Hispanic/Latino, Asian, and Portuguese origin and primarily from lower income homes.

One of the most comprehensive studies was conducted in Ohio, using an experimental design in which eight classes of pregnant or parenting adolescents were randomly assigned to either the control (29 students) or experimental (22 students) group. Most of the subjects were female and white. The average age of the total sample was 16.9 years, with a mean of 11 years of education. Twenty-three of the students were pregnant with their first child, and 39 already had at least one other child. Most students were single, living with their parents, and reported a mean family income of \$15,000 to \$20,000. The only significant difference between the two groups was age; students in the control group were older than students in the intervention group (17.2 to 16.6). The measures used in the study included a parenting knowledge test, parental attitudes questionnaire, and a supplementary questionnaire.

Additional details on this and other PW studies are available on the Parenting Wisely Web site (<http://www.parentingwisely.com>).

Evaluation Outcome:

In general, the Ohio evaluation found that, compared with the control group, PW students scored significantly higher at the 2-month follow-up on measures of parenting knowledge, belief in the effectiveness of adaptive parenting practices, and the application of adaptive parenting skills to hypothetical problem situations.

In general, outcomes for parents receiving the intervention in other studies include

- Improved problem-solving
- Setting of clear expectations
- Increased knowledge and use of good parenting skills
- Reduced spousal violence and reduced parental violence toward children

For children, clinically significant behavior improvement occurred between 20 percent and 55 percent of the time that their parents used the program. Program completion rates for parents ranged from 83 percent to 91 percent.

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Selected Examples of School and Community Prevention Programmes

Across Ages

Intervention:

Across Ages is a research-based mentoring initiative designed to increase the resiliency and protective factors of at-risk youths through a comprehensive intergenerational approach. The basic concept of the program is to pair older adult volunteers (55 and older) with students (10 to 13 years old) to create a special bonding relationship. The project also uses community service activities, provides a classroom-based life-skills curriculum, and offers parent-training workshops. Older mentors—by acting as advocates, challengers, nurturers, role models, and friends—help children develop the awareness, self-confidence, and skills they need to resist drugs and overcome overwhelming obstacles.

Evaluation Methodology:

The Across Ages program was evaluated using a randomized pretest–posttest control group design. Pretest and posttest data was collected at the beginning and end of each academic year from 1991 through 1994. Each year the same three Philadelphia, Pa., urban middle schools participated in the program. Experimental and control groups were randomly selected from among the sixth grade classes whose teachers agreed to participate in the program and then were assigned to one of three groups. Group C was the control group receiving no intervention. Group PS was an experimental group that participated in the classroom-based life skills curriculum, performed community service, and had parent workshops. Finally, Group MPS participated in the classroom-based life skills curriculum, performed community service, had parent workshops, and received mentoring from older adults. The evaluation research tested the hypothesis that students in the treatment groups would demonstrate more positive outcomes on the posttest than those in the control group and that the most multifaceted approach (MPS) would result in the most positive change. Of the 729 students completing the pretest, 562 also completed the posttest. The sample was 53 percent female, 52.2 percent African-American, 15.8 percent white, 9.1 percent Asian-American, 9.0 percent Hispanic, and 13.9 percent “other.”

Performance Measures:

Measure: Increase level of knowledge regarding AOD use	Source:n/a
Measure: Improve attitude toward school	Source:n/a
Measure: Increase self esteem	Source:n/a
Measure: Increase number of prosocial activities	Source:n/a

Measure: Improve prosocial values **Source:**n/a

Evaluation Outcome:

The evaluation results indicate significant positive outcomes on numerous resiliency factors for at-risk youths. The program interventions, especially those for the mentored group, do the following:

- Encourage appropriate reactions to situations in which students are offered drugs or alcohol by peers
- Increase positive attitudes toward school, youths' futures, older people, and youths' participation in community service
- Increase sense of self-worth and promote feelings of well-being
- Reduce feelings of sadness and loneliness and discourage use of various substances

The findings indicate that mentoring was critical to the success of the program, but interventions in multiple domains are critical for success. To be effective, prevention initiatives must unite youths and important adults in their lives in a collaborative effort to develop positive coping skills and strategies for resisting alcohol, tobacco, and other drugs.

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Aggression Replacement Training® (ART®)

Intervention:

Aggression Replacement Training® (ART®) is a multimodal psychoeducational intervention designed to alter the behavior of chronically aggressive adolescents and young children. The goal of ART® is to improve social skill competence, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger-control training, and training in moral reasoning. *Skill-streaming* uses modeling, role-playing, performance feedback, and transfer training to teach prosocial skills. In *anger-control training*, participating youths must bring to each session one or

more descriptions of recent anger-arousing experiences (hassles), and over the duration of the program they are trained in how to respond to their hassles. *Training in moral reasoning* is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others and to train youths to imagine the perspectives of others when they confront various moral problem situations.

The program consists of a 10-week, 30-hour intervention administered to groups of 8 to 12 juvenile offenders thrice weekly. The 10-week sequence is the "core" curriculum, though the ART® curriculum has been offered in a variety of lengths. During these 10 weeks, participating youths typically attend three 1-hour sessions per week, one session each of skill-streaming, anger-control training, and training in moral reasoning. The program relies on repetitive learning techniques to teach participants to control impulsiveness and anger and use more appropriate behaviors. In addition, guided group discussion is used to correct antisocial thinking. The ART® training manual presents program procedures and the curriculum in detail and is available in both English and Spanish editions. ART® has been implemented in school, delinquency, and mental health settings.

Evaluation Methodology:

The ART® program has been evaluated in numerous studies. In general, the studies were comprehensive and used acceptable evaluation designs, psychometrics, and data analysis techniques. But many of the studies did not provide a demonstrated effect on violent behavior or on other conduct problems 1 year or longer beyond baseline.

One evaluation used a quasi-experimental design with nonequivalent comparison groups. The sample was collected from a New York State Division for Youth facility and included 60 youths, most of whom had been incarcerated for crimes such as burglary, robbery, and various drug offenses. Twenty-four of these youths received the 10-week ART® program. Another 24 youths were assigned to a no-ART®, brief-instructions control group. This condition controlled for the possibility that any apparent ART®-derived gains in skill performance were not due to ART® per se. Finally, 12 youths were placed in the no-treatment control group.

A second study was designed to both replicate the procedures and findings of the aforementioned study as well as extend them to youths incarcerated for substantially more serious felonies. The study sample included 51 youths who were incarcerated for murder, manslaughter, rape, sodomy, attempted murder, assault, and robbery. In all of its procedural and experimental details, the second study replicated the effort of the first. The second study employed the same preparatory activities, materials, ART® curriculum, testing, staff training, resident training, supervision, and data analysis procedures.

A third evaluation was designed to examine the efficacy of ART® as a community-based, postrelease intervention. This study also employed a quasi-experimental design with a three-way comparison of ART®. Condition 1 provided the ART® program to youths and to youths' parents or other family members. Condition 2 provided the ART® program to youths only. Condition 3 provided neither parents nor youths with ART®. For the most part, youths were assigned to project conditions on a random basis, with departures from randomization becoming necessary on occasion as a function of the five-city, multisite, time-extended nature of the project.

A fourth study conducted by Washington State Institute for Public Policy used a pseudo-

random assignment waitlist procedure to assign 1,229 adjudicated youths to either a control (n=525) or treatment group (n=704). Youths who met the selection criteria and had sufficient time on supervision to complete the program were assigned by court staff to the appropriate program. When the program reached capacity (all therapists had full caseloads or sessions were full), the remaining eligible youths were assigned by court staff to the control group and never participated in the program; instead, they received the usual juvenile court services. The sample was roughly 80 percent 15-year-old males. The analyses use multivariate statistical techniques to control for systemic differences between the program and control groups on key characteristics (gender, age, and domain risk and protective factor scores). Recidivism was measured by using conviction rates for subsequent juvenile or adult offenses. The follow-up “at risk” period for each youth is 18 months.

Evaluation Outcome:

The findings from the first two studies reveal ART® to be an effective intervention for incarcerated juvenile delinquents. It enhanced prosocial skill competency and overt prosocial behavior, reduced the level of rated impulsiveness, and—in one of the two samples studied—decreased (where possible) the frequency and intensity of acting-out behaviors and enhanced the participants’ levels of moral reasoning.

The first study revealed that, compared with both control groups, youths who participated in the ART® program significantly acquired and transferred 4 of the 10 skill-streaming skills: expressing a complaint, preparing for a stressful conversation, responding to anger, and dealing with group pressure. Similarly significant ART®-versus-control-group comparisons emerged for the number and intensity of in-facility acting out and for staff-rated impulsiveness. During the 1-year follow-up, 54 youths were released from the facility. Of those released, 17 had received ART® and 37 had not. In four of the six areas rated—namely, *home and family*, *peer*, *legal*, and *overall*, but not *school* and *work-ART®*—youths were rated significantly superior at in-community functioning than were youths who had not received ART®. Similar findings were reported in the second study.

In the third evaluation (the postrelease community-based study), results indicated that, though they did not differ significantly from one another, the two ART® groups each increased significantly in their overall interpersonal skill competence compared with the control youths. Perhaps more important, however, rearrest rates were tracked during the 3 months in which youths in the two intervention groups received the ART® program and during the 3 subsequent no-ART® months. Meaningful differences in favor of the two intervention groups were found. Youths in both of the ART® groups were rearrested less often than youths not receiving ART®. And the ART® youths-plus-family-members group did better than the ART® youths-only group.

The Washington State study found that when ART is delivered competently, the program reduces felony recidivism and is cost effective. For the five courts rated as not competent, the adjusted 18-month felony recidivism rate is 27 percent compared with 25 percent for the control group. This difference is not statistically significant. However, for the 21 courts rated as either competent or highly competent, the 18-month felony recidivism rate is 19 percent. This is a 24 percent reduction in felony recidivism compared with the control group, which is statistically significant. Moreover, the cost-benefit analysis demonstrates that when ART is delivered by competent courts, it generates \$11.66 in benefits (avoided crime costs) for each \$1.00 spent on the program. When not competently delivered, ART

costs the taxpayer \$3.10. Averaging these results for all youths receiving ART, regardless of court competence, results in a net savings of \$6.71 per \$1.00 of costs.

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All Stars™

Intervention:

All Stars™ is a character-based approach to preventing high-risk behaviors such as substance use, violence, and premature sexual activity in teens ages 11 to 15. The program is based on strong research identifying the critical factors that lead young people to begin experimenting with substances and engaging in other high-risk behaviors. It is designed to reinforce positive qualities that are typical of youths at this age. It works to strengthen five specific qualities vital to achieving preventive effects:

- Establishing positive norms
- Building strong personal commitments
- Promoting positive parental attentiveness
- Developing positive ideals and future aspirations
- Promoting bonding with school and community organizations

A program specialist or regular classroom teacher can implement the program. All Stars™ consists of whole classroom sessions, small group sessions outside of the classroom, and one-on-one sessions between the instructor and the child. The program is interactive, including debates, games, and general discussion. Homework assignments are given to include parents in the program and to increase parent–child interactions. All Stars™ is also used in community-based settings such as afterschool programs, faith-based communities, Girls and Boys Clubs, and community centers.

Evaluation Methodology:

The most comprehensive evaluation of All Stars™ consisted of a single-cohort longitudinal design with pretest, posttest, and 1-year follow-up. Sixth and seventh grade students in 14 middle schools participated in the evaluation. The sample consisted of 1,655 students, of which 55 percent were female and 69 percent white, 25 percent African-American, and 6 percent Hispanic. Schools were matched and randomized to the specialist-run treatment condition (n=629), teacher-run treatment condition (n=287), or control condition (n=739). Pretest and posttest questionnaires measured substance use, sexual behavior, violence, and the mediating variables of bonding, commitment, ideals, and perceived norms.

All Stars™ was then reevaluated using a similar technique. Fourteen middle schools (n=1,857) were randomly assigned to the specialist treatment group, teacher treatment group, or control group. The sample was 54 percent female and 69 percent white, 23.3 percent African-American, 7.7 percent other ethnicities. All participants were 11 to 13 years old. Students were given a pretest before program implementation and a posttest at

the end of the school year to assess sexual behavior and alcohol, tobacco, and other drug use.

Performance Measures:

Measure: Decrease frequency of AOD use	Source:n/a
Measure: Delay onset of sexual activity	Source:n/a
Measure: Increase normative beliefs	Source:n/a
Measure: Improve attitude toward high risk behavior	Source:n/a
Measure: Increase level of parent-child communication	Source:n/a
Measure: Increase level of parental supervision	Source:n/a

Evaluation Outcome:

The comprehensive evaluation of All Stars™ indicated that when implemented by teachers the program influenced the mediators of problem behaviors for white students. However, these were only short-term changes. When a specialist delivered the program, there were delayed effects on mediating variables for Hispanic students. And there were delayed effects for African-American students regardless of who implemented the program. This evaluation showed limited positive results for the All Stars™ program.

The next evaluation resulted in more positive changes, though the evaluation looked only at short-term results. When teachers implemented the program, there were significant reductions in the use of alcohol, cigarettes, smokeless tobacco, and inhalants. Although there were no significant effects for marijuana use or sexual activity, there were changes in the desirable direction. The program had a significant effect in changing normative beliefs, lifestyle incongruence, commitment to school, impulsive decision-making, and sensation-seeking behavior. These results were found only for the teacher-implemented program.

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Girls Inc. Preventing Adolescent Pregnancy®

Intervention:

Girls Inc. Preventing Adolescent Pregnancy® (GIPAP) is an abstinence-based program aimed at decreasing pregnancy in adolescent and teenage girls. Developed by Girls Incorporated and offered nationwide through a 1,000-site network, GIPAP is based on the idea that there are four components to preventing teen pregnancy: family communication about sexuality, skills in resisting pressure to be sexually active, motivation and resources to postpone pregnancy, and overcoming barriers to effective contraception for sexually active teens. The program has four components: Growing TogetherSM (ages 9–11), Will Power/Won't Power[®] (12–14), Taking Care of BusinessSM (15–17), and Health BridgeSM (also 15–17).

The Growing Together component concentrates on improving one comfort and skill in communicating within the family about sexual information. Parent–daughter pairs or family groups attend it in five 2-hour sessions.

The Will Power/Won't Power component concentrates on delaying the initiation of sexual intercourse among participants by helping girls develop attitudes and skills for dealing with sexuality and health issues. It consists of six 2-hour sessions.

The Taking Care of Business component develops the motivation behind good decision-making regarding sexual activity—that is, choosing either to abstain from sexual

intercourse or to use effective and consistent contraception. This consists of nine 2-hour sessions.

The Health Bridge component is a healthcare delivery system that links girls to community healthcare professionals and services. Its key characteristics include accessible and anonymous services, comfort with health personnel, case management, and health education conducted by clinic staff. This component has the most variation, with health professionals ranging from social workers to volunteer nurses.

Evaluation Methodology:

This study used a pretest–posttest quasi-experimental design at four Girls Incorporated affiliates, each of which administered all four components of the program. Girls were recruited to participate at each site. Girls who volunteered to enroll in the program served as the treatment group, while girls who declined to enroll served as the comparison group. The full sample at the beginning of the study consisted of 343 girls and young women ages 12–15. About 69 percent (237) of the subjects, designated as program participants, participated in at least one program component at some time during the 2-year period. About 31 percent (106) did not participate in any of the four components and were designated as nonparticipants and served as a comparison group. Several variables often associated with teen pregnancy were compared among nonparticipants, participants in one program component, and participants in two or more program components to test for self-selection bias, which revealed that all groups were similar. The groups were similar in age, racial and ethnic background, educational expectation, degree of association with others who experienced teenage pregnancy, and level of sexual activity at baseline. The principal measuring instrument was the annual survey, a questionnaire that was given over a 2-year period: at the beginning of each program year, before the programming started, and at the end of the last program year. The annual survey included questions about sexual behaviors, attitudes toward pregnancy educational and career expectations, and social and economic background. The analytic strategy consisted of both bivariate and multivariate analyses.

Evaluation Outcome:

The evaluation compared those who participated in two or more program components with nonparticipants and those who participated in one program component on two outcome variables: sexual intercourse without birth control, and pregnancy experience of the participants. The findings indicate that those who participated in one or more program components were significantly less likely to experience pregnancy than nonparticipants (5.9 percent versus 12.3 percent, respectively).

In addition, the study found that those who participated in two or more program components were significantly less likely to engage in sexual intercourse without birth control than those who participated in a single program component (8.9 percent versus 20.6 percent). (Notably, this finding is significant only for the bivariate analysis). However, those who participated in two or more program components were as likely to have sexual intercourse without birth control as nonparticipants.

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LifeSkills Training

Intervention:

LifeSkills Training (LST) is a classroom-based tobacco, alcohol, and drug abuse prevention program for upper elementary and junior high school students. LST targets individuals who have not yet initiated substance use. The program is designed to prevent the early stages of substance use by influencing risk factors associated with substance abuse, particularly occasional or experimental use. The LST approach is based on the latest scientific evidence, teaching general personal and social skills in combination with drug resistance skills and normative education. Its prevention curriculum specifically

- Provides students with the necessary skills to resist social pressures to drink alcohol, smoke cigarettes, and use drugs
- Helps them develop greater self-esteem, self-mastery, and self-confidence
- Increases knowledge of the immediate consequences of substance abuse
- Gives students tools to cope effectively with social anxiety
- Enhances cognitive and behavioral competency to prevent and reduce a variety of health risk behaviors

The middle school program is designed to be taught in a sequence over 3 years, with the 1st year's curriculum more intensive with 15 class meetings, and the following 2 years' curriculum acting as a refresher and review. The elementary school program offers 24 classes to be taught during either third, fourth, fifth, or sixth grade. An LST program for parents is also available. The specific program activities are based on cognitive-behavioral principles, including role-playing, modeling, immediate feedback, and reinforcement of positive behaviors. Students are encouraged to practice the lessons of the day through homework assignments.

The program has been tested in urban and suburban schools with white, African-American, Hispanic, and Asian-American students in grades 7 through 12 (ages 11 to 18).

Evaluation Methodology:

LST has been evaluated in a series of studies since 1980. The studies were designed to systematically facilitate the development, as well as to measure the effectiveness, of this prevention program. The early research examined LST's usefulness as a cigarette-smoking prevention program. A pretest, posttest, 3-month-follow-up quasi-experimental design was used to compare short-term smoking rates among 281 junior high school students. Health professionals conducted the program while the control school received treatment as usual. In a subsequent study using a randomized sample to test the effectiveness of peer leaders as LifeSkills providers, data collection was supported by a saliva test, which enhanced the validity of self-reports and served as a more objective measurement of smoking status.

To test the effect of LST on frequency of alcohol use, episodes of drunkenness, and heavy drinking, two comparable New York City, N.Y., schools were randomly assigned to experimental and control conditions. Program participants received information regarding consequences of alcohol use and were taught refusal skills. A larger replication study was expanded to take into account (along with alcohol prevention) marijuana and tobacco prevention and included more than 1,300 seventh grade students from 10 suburban New York schools. Schools were randomly assigned to five conditions: 1) a teacher-led LST curriculum, 2) a peer-led LST curriculum, 3) a teacher-led curriculum with booster sessions, 4) a peer-led curriculum with booster sessions, and 5) no treatment control. Pretest, posttest, and 1-year follow-up data was collected.

In a study to determine the long-term effectiveness of LST on preventing tobacco, alcohol, and other drug use in junior high school students, 56 middle schools numbering nearly 6,000 students were randomly assigned to prevention or a control condition. Students received the program in the seventh grade with booster sessions in the eighth and ninth grades. Follow-up data was collected at the end of their 12th grade year. Classroom teachers who were specially trained taught the program.

Evaluation Outcome:

Large-scale, long-term outcome evaluations of LST showed significantly lower smoking, alcohol, and marijuana use 6 years after initial baseline assessment. Prevalence of use of these substances was 44 percent lower for those receiving LST than for the control students. Regular (weekly) use of multiple drugs was 66 percent lower for those receiving the program. The LST program has been extensively evaluated in more than a dozen federally funded studies and has been tested and proven effective among white, African-American, and Hispanic adolescents from a variety of socioeconomic backgrounds. The program was found effective when implemented under different scheduling formats, with different levels of project staff involvement, and whether the program providers are adults or peer leaders. Stronger prevention effects were found for students in the high-implementation fidelity group—that is, students who received 60 percent or more of the 30 lessons over the 3-year span.

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Project ALERT

Intervention:

Project ALERT teaches children to establish no-drug-use norms, to develop reasons not to use drugs, and to resist prodrug pressures. The program consists of a 14-lesson curriculum, participatory activities, and videos. Guided classroom discussions and small group activities stimulate peer interaction and challenge students, while intensive role-playing encourages students to practice and master resistance skills. Parent-involved homework assignments extend the learning process for participants.

The program is highly effective with middle school youths, ages 11 to 14, from widely diverse backgrounds and communities. Project ALERT has proved successful with high- and low-risk white, African-American, Hispanic, Asian-American, and Native American youths from urban, rural, and suburban communities and a variety of socioeconomic backgrounds. The original program was tested in schools in different geographic areas with varied population densities and among students from a range of racial/ethnic and economic backgrounds.

Evaluation Methodology:

The program used a rigorous experimental pre–post design with random assignment to

place 30 schools in either a control or one of two treatment conditions. Seventh and eighth graders in 20 of the schools went through the Project ALERT curriculum. Adults taught the classes in 10 of the schools, while older teens drawn from nearby high schools assisted the adults in 10 others. In the remaining 10 schools, students were not exposed to Project ALERT but continued to receive whichever drug-information programs their schools offered. The schools encompassed urban, suburban, and rural communities. Nine schools had a minority population of 50 percent or more. Eighteen drew from neighborhoods with household incomes below the State median.

To establish a baseline before the program began, the researchers surveyed 6,500 seventh graders about substance use and attitudes toward drugs. Over the next 5 years, the team conducted six follow-up surveys with nearly 4,000 of these teens as they moved through grade 12. The surveys compared students' drug use and related attitudes before, during, and after their exposure to Project ALERT's curriculum with similar data from students who had no contact with the program. Trained data collectors administered student surveys in all schools before and after program lessons. Self-reported drug use was validated by testing saliva samples collected from students and by consistency analyses over time. Logistic regression was used to analyze substance use outcomes as a function of treatment and baseline covariates. Multiple controls helped rule out alternative explanations of treatment effects. All analyses were adjusted for attrition and clustering of students within schools.

Evaluation Outcome:

Evaluation reports conclude that Project ALERT reduces the initiation of marijuana and tobacco use by 30 percent, reduces heavy smoking among experimenters by 50–60 percent, is effective for both high- and low-risk students (including minorities), and performs equally well in a variety of socioeconomic settings. The program's early gains erode after the lessons stop. Maintaining the effects of prevention lessons requires booster programs after adolescents make the transition to high school.

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Project Northland—Class Action

Intervention:

Project Northland is a school-based, alcohol-use–prevention curriculum series that significantly reduces alcohol use and binge-drinking by high school students. It delays the onset of alcohol use, reduces use among youths who have already tried alcohol, and limits the number of alcohol-related problems experienced by young drinkers. The program consists of two phases.

Phase 1 occurs during grades 6–9. The first 3 years (grades 6–8) include a social-behavioral classroom curriculum, parent involvement programs, peer leadership opportunities, and community task forces. A brief five-session classroom program titled *Shifting Gears* is implemented in ninth grade. The emphases are drunk driving and peer and media pressures to drink. There is no programming for 10th grade.

Phase 2 occurs during grades 11–12. This phase includes parent-involved programs, print media campaigns, peer action teams, community action teams, and a classroom curriculum called Class Action.

Based on the social influences theory of behavior change, the *Class Action* curriculum uses interactive, peer-led sessions to discuss and debate the consequences of substance abuse, thus changing the social norms around alcohol use and turning negative peer pressure into positive peer pressure. The Class Action intervention develops resistance, decision-making, social competence, and leadership skills. It can be used as part of the Project Northland series or as a standalone program. Results highlighted here (and reviewed by the National Registry of Evidence-Based Programs and Practices) come from communities that were part of a Project Northland study.

The *Class Action* curriculum is delivered during 8 to 10 weekly classroom sessions. During the sessions, students are divided into six “legal” teams to prepare and present hypothetical civil cases in which someone has been harmed as a result of underage drinking. Using a casebook, along with audiotaped affidavits and depositions, students build legal cases and present them to a jury of their peers. The six case topics are date rape, drinking and driving, drinking and vandalism, drinking and violence, fetal alcohol syndrome, and school alcohol policies. *Class Action* encourages community involvement through the use of outside speakers within classroom sessions or for the entire school, student research on alcohol-use issues in their own community, and student involvement in community events (using ideas from Project Northland’s SuperCharged! materials). Parent education involves the distribution of four colorful postcards with key messages for parents about teen alcohol use and their role in preventing it.

Evaluation Methodology:

Twenty-four school districts were randomized to treatment and delayed treatment (control) groups in 1991. The students in these school districts (n=3,151) were followed from 6th through 12th grades, from 1991 to 1998, and were the study cohort. By 12th grade—in 1998, when the analysis was conducted—the sample consisted of 2,953 students, with 53 percent male, 93 percent white, and 5 percent American Indian. The

schools remained in the same treatment conditions through high school. The main outcome measure, alcohol use, came from an annual survey of all the students in the study cohort. The survey consisted of individual items and scales. In addition, process measures were used to assess the degree of fidelity to the intervention. One measure involved young-looking 21-year-old females making purchase attempts at all of the communities' alcohol outlets throughout the school district.

Evaluation Outcome:

The multicomponent communitywide approach, targeting high school students' access to alcohol and changing community norms, appears to have been effective in reducing the growth rate in alcohol use in the intervention communities. The trend data showed significantly less increase in alcohol use among students in the intervention communities, as measured by the Tendency to Use Alcohol Scale, binge-drinking, and (marginally) past-month alcohol use ($p < 0.07$). The Tendency to Use Alcohol Scale incorporates intentions to use alcohol in the future as well as current levels of monthly and weekly use, providing a dynamic measure of alcohol use for this population. The reduction in binge-drinking is particularly important, since underage youths have been shown to engage in more binge-drinking than those of legal drinking age, and binge-drinking is clearly a problem for the younger age group. Additional program benefits include a 33 percent reduction in the usual increase in alcohol use and intentions to use alcohol in high school, through the 12th grade, a 50 percent reduction in the usual increase in binge-drinking during high school (through 12th grade), and an 80 percent reduction in underage alcohol purchases in off-outlets sale (i.e., liquor and convenience stores).

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Safe Dates

Intervention:

Safe Dates is a school-based program designed to stop or prevent the initiation of psychological, physical, and sexual abuse on dates or between individuals involved in a dating relationship. Its goals are to change adolescent dating violence norms, change adolescent gender-role norms, improve conflict resolution skills for dating relationships, promote victims' and perpetrators' beliefs in the need for help and awareness of community resources for dating violence, promote help-seeking by victims and perpetrators, and improve peer help-giving skills. Intended for middle and high school students, the Safe Dates program can stand alone or fit easily within a health education, family, or general life-skills curriculum. Because dating violence is often tied to substance abuse, Safe Dates also may be used with drug and alcohol prevention and general violence prevention programs.

The Safe Dates program includes a curriculum with nine 50-minute sessions, a 45-minute play to be performed by students, and a poster contest. The sessions:

1. *Defining Caring Relationships*. Students are introduced to Safe Dates and discuss how they wish to be treated in dating relationships.
2. *Defining Dating Abuse*. Discussing scenarios and statistics, students clearly define what dating abuse is.
3. *Why Do People Abuse?* Students identify the causes and consequences of dating abuse through large- and small-group scenario discussions.
4. *How to Help Friends*. Students learn why it is difficult to leave abusive relationships and how to help an abused friend through a decision-making exercise and dramatic reading.
5. *Helping Friends*. Students use stories and role-playing to practice skills for helping abused friends or confronting abusing friends.
6. *Overcoming Gender Stereotypes*. Students learn about gender stereotypes and how they affect dating relationships through a writing exercise, scenarios, and small-group discussions.
7. *Equal Power Through Communication*. Students learn the eight skills for effective communication and practice them in role-plays.
8. *How We Feel, How We Deal*. Students learn effective ways to recognize and handle anger through a diary and a discussion of "hot buttons," so that anger does not lead to abusive behavior.
9. *Preventing Sexual Assault*. Students learn about sexual assault and how to prevent it through a quiz, a caucus, and a panel of peers.

Safe Dates involves family members through its parent letter and parent brochure, which provide information about and resources for dealing with teen dating abuse. In addition, schools can get parents more involved by hosting parent education programs or by talking with parents of children who are victims or perpetrators of dating abuse. Teachers are encouraged to connect with community resources by locating and using community domestic violence and sexual assault information, products, and services that provide valid health information.

Evaluation Methodology:

The evaluation examined 14 public schools in a rural county in North Carolina. Schools were matched by size and randomly assigned to the treatment or control group. The control group was exposed only to the community activities, while the treatment group was exposed to both the school and community activities.

Baseline data was collected in October 1994, in the form of an in-school self-administered questionnaire, on 80 percent of the eligible 2,344 students (n=1,886). The questionnaire measured victimization and perpetration variables, perceived dating violence norms, awareness of services, help-seeking behaviors, conflict management skills, and responses to anger. There were no significant differences between the treatment and control groups at the baseline level.

Program activities took place between November 1994 and March 1995. In May 1995, 90 percent of the original 1,886 participant completed follow-up questionnaires (n=1,700). In May 1996, another follow-up questionnaire was distributed (n=1,603). A multivariate logistic regression showed no significant differences between the attrition rates of the control and treatment groups.

During the 3rd year after the treatment was completed, a follow-up study was conducted that used 10 of the schools in the original study (5 treatment and 5 control). Half of the students in the original treatment group were randomly assigned to receive a booster treatment. This consisted of a newsletter with information and worksheets based on the content of the Safe Dates curriculum. Students were given information on “red flags” of an abusive relationship, effective communication strategies, and safe dating tips. They were asked to write down how they did and did not wish to be treated by others and to think about the short- and long-term consequences of being in an abusive relationship. Four weeks after the mailing, students in this group were contacted by a health educator who answered any questions they had. If the health educator determined that a student had completed all of the worksheets, then the student was mailed \$10. A questionnaire was sent to all three groups 4 years after the original treatment to determine levels of perpetration and victimization (n=460).

Evaluation Outcome:

Researchers found that at the 1-month follow-up, compared with students in control schools, students in treatment schools exhibited 25 percent less psychological abuse perpetration, 60 percent less sexual violence perpetration, and 60 percent less violence perpetration against their current dating partner. Conversely, receiving the treatment did not reduce the likelihood of being the victim of psychological abuse, nonsexual violence, or sexual violence in a current dating relationship. Most program effects were explained by changes in the participant’s dating violence norms, gender stereotyping, and awareness of services. Gender was not a significant variable in the results.

At the 1-year follow-up, researchers found that there were no differences between the treatment group’s and the control group’s levels of victimization or perpetration. However, the treatment group continued to report being less accepting of dating violence and more aware of services than the control group did.

After 4 years, there were significantly more females participating in the study. Using a linear regression model, the researchers determined that gender still was not a significant factor in the results. Those students participating in the Safe Dates program exhibited

significantly less sexual, physical, and serious physical abuse perpetration than the control group did. They also experienced significantly less sexual victimization. There were no differences seen between the Safe Dates group that received the booster and the Safe Dates group that did not. Therefore, the Safe Dates program showed a resurgence of positive results, while the booster did not show any additional positive effects.

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SOS Signs of Suicide® Program

Intervention:

The SOS Signs of Suicide® Program (SOS) is a school-based suicide prevention that serves secondary school students ages 13 to 18. The program teaches students that suicide is directly related to mental illness—typically depression—and that it is not a normal reaction to stress or emotional upset. This approach stands in direct contrast to other programs that seek to destigmatize suicide by separating it from mental illness. SOS concentrates on teaching youths to recognize the signs of suicide and depression in themselves and others and the specific actions needed to respond to those signs. SOS is also currently being used in other nonschool settings that serve youth.

The main teaching materials are a video and a discussion guide. The video includes dramatizations depicting the right and wrong ways to treat someone who is depressed and suicidal. It features interviews with people whose lives have been touched by suicide as well as interviews with school-based professionals and experts in the child psychiatry and child suicide prevention fields. After watching the video, students are asked to complete the Brief Screen for Adolescent Depression (BSAD)—a seven-question screening instrument for depression, suicidality, and its related risk factors. The students themselves score the screening form. A score of 4+ on the BSAD is considered a strong indicator of depressive disorder, and students who score so high are encouraged to seek help immediately. Students answering affirmatively to questions about suicidal thoughts or attempts are strongly recommended to see a mental health professional regardless of

their total score. Schools participating in the program receive a kit of materials containing the video, a discussion guide, screening forms for students (in English and Spanish), a training video for staff, and other educational and promotional items. They also receive a procedure manual that describes best practices for implementing the program and addressing some of the issues involved (e.g., parental notification, referrals, anonymous versus identified screening, staff training, ensuring follow-up with at-risk youth). Templates for sample materials are provided, including a parent letter, a student-tracking form, information for school staff, and consent forms. There are also educational flyers, posters, and an additional parent screening form (in English and Spanish) that is sent home to help parents determine whether their child is exhibiting symptoms of depression and suicidal ideation.

Evaluation Methodology:

There have been two published studies evaluating the SOS program. The first presented process and outcome data from an evaluation of the safety, efficacy, and feasibility of implementing the SOS prevention program using data collected from 92 schools during the 2000–2001 school year. A large majority of the participating schools were public (86 percent), containing an average of 900 students. Most of the students were white (76 percent); there was a slight overrepresentation of white students in the sample (76 percent in the sample versus 64 percent nationally), while Hispanics were underrepresented (5 percent in the sample versus 14 percent nationally). Roughly similar proportions of students resided in urban, suburban, and rural areas. About 25 percent of the students in participating schools qualified for free or reduced school lunches. The data for the evaluation was collected in three separate, structured questionnaires completed by the site coordinators (typically the school psychologist, a school counselor, or a nurse) immediately after implementation, 30 days after implementation, and 3 months following implementation.

The second published study examined the effectiveness of the SOS program in reducing suicidal behavior. The experimental design consisted of randomized treatment and control groups and posttest-only data collection, using 2,100 high school students from two schools in Columbus, Ga. (n=665), and three schools in Hartford Conn. (n=1,435). The student populations of the two schools in Columbus were mostly white and living in working- or middle-class families. Conversely, most of the students from the three Hartford schools were economically disadvantaged youths from diverse racial and ethnic backgrounds (63 percent Latino; 21 percent African-American). Twenty percent of the Hartford students had been placed in a remedial English or bilingual program during high school.

Students in both the treatment (n=1,027) and control groups (n=1,073) were asked to complete a short questionnaire in a group setting during class time, roughly 3 months following the implementation of the program. The questionnaire included items relevant to three specific outcomes: 1) suicidal ideation and suicide attempts, 2) knowledge and attitudes about depression and suicide, and 3) help-seeking behavior.

Evaluation Outcome:

The first study found that, in general, the program and its materials were well received. The vast majority of site coordinators reported that the program was effective in increasing help-seeking; in improving communication among students, parents, and

teachers; and in bringing students in need of help to the school's attention. A particularly compelling finding was the nearly 60 percent increase in help-seeking among students who participated in the program: site coordinators reported that the number of students seeking counseling for depression or suicidal ideation increased from an average of 6.79 per month over the past year to 10.63 in the 30 days following the program's implementation. Contrary to the belief that some suicide intervention programs may actually increase the risk of suicide among adolescents, no high schools reported any adverse reactions among students exposed to the SOS program.

In the second study, significantly lower rates of suicide attempts and greater knowledge and more adaptive attitudes about depression and suicide were observed among students in the intervention group. The modest changes in knowledge and attitudes partially explained the beneficial effects of the program on suicide attempts. The research found that SOS was the first school-based suicide prevention program to demonstrate significant reductions in self-reported suicide attempts in a study using a randomized experimental design.

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Teenage Health Teaching Modules

Intervention:

Teenage Health Teaching Modules (THTM) is a comprehensive school health curriculum for grades 6 to 12. THTM has three primary components: 1) health tasks of adolescence, 2) health content areas, and 3) essential health skills and themes. Health tasks incorporated in THTM include having friends and building positive relationships, recognizing feelings and managing them in positive ways, and protecting oneself and others from use of tobacco, alcohol, and other drugs. Health content areas include personal health; disease prevention and control; nutrition; alcohol, tobacco, and other drug use; injury and violence prevention; mental and emotional health; consumer health; healthy relationships; community and environmental health; and family life. Examples of health skills addressed in THTM are risk assessment, self-assessment, communication, decision-making, goal setting, health advocacy, and healthy self-management. THTM also reinforces themes of protection, responsibility, interdependence, and respect throughout the curriculum. One of the modules—Aggressors, Victims, and Bystanders—concentrates on middle school violence prevention.

Materials are organized by developmentally based health tasks of concern to adolescents, rather than by content area. THTM is composed of a series of modules,

each of which consists of a teacher's guide with a detailed framework for conducting classroom activities and handouts to be duplicated for student use. Teachers are encouraged to add their own supplementary activities, materials, and ideas. The program does not require a particular implementation sequence, use of a minimum number of modules, or prior training of teachers. All modules are intended to develop five skills: self-assessment, communication, decision-making, health advocacy, and healthy self-management.

Evaluation Methodology:

The evaluation employed a quasi-experimental pretest–posttest control group design to assess THTM's effectiveness in an experimental setting, in which rigorous control was exercised over exposure to teacher training and choice of curriculum materials (modules) used and a naturalistic setting involving users who had made the independent decision to adopt THTM before the study, with less rigorous control of the teacher training and choice of curriculum materials.

Classes were selected differently for the two types of schools. In experimental schools, one academic subject area was generally selected by school administrators as the appropriate "home" for THTM, and one class section was selected randomly as the treatment group from all class sections at the designated grade level. Likewise, a second academic subject was selected as an appropriate control, and one class section was selected randomly as the control group from available class sections. Control sections were required to contain limited or no health content.

In naturalistic settings, since THTM was already in place, one THTM group was selected randomly from among sections scheduled to receive the selected THTM modules during the observation period. One naturalistic control group was selected randomly from a different academic subject. Again, control sections contained little or no health content.

An attempt was made to select THTM and control classrooms at the same grade level from different academic subjects with mutually exclusive enrollments. In practice, two conditions made such selection difficult: 1) when small schools had only one class section at a grade level, and 2) when larger schools elected to require THTM of all students at the grade level. Under both conditions, the control group was selected randomly at the next higher grade level.

The evaluation study used five data collection instruments. One instrument was administered to students, and teachers completed another instrument. Investigators conducted the evaluation in 149 junior high/middle schools and senior high schools in seven States. The final sample included 4,806 students with matched pretest and posttest questionnaires (2,530 who received THTM and 2,276 controls).

Evaluation Outcome:

THTM produced positive effects on knowledge, attitudes, practices, and some self-reports of behaviors in selected subgroups of students. Junior high/middle school students and senior high school students who were exposed to THTM exhibited more knowledge about health issues in both experimental and naturalistic classrooms. Senior high school students in both experimental and naturalistic settings and junior high/middle school students in naturalistic schools showed desired attitudinal changes.

Exposure to THTM also resulted in several important self-reported behavioral changes. For example, students in senior high experimental and naturalistic schools reported a reduction in drug use and cigarette smoking. Self-reported levels of alcohol consumption also were reduced among senior high school students in naturalistic schools. THTM had no discernible effects on the self-reported behaviors of junior high/middle school students.

The evaluation also found that teachers who received THTM training before they used the curriculum felt more prepared to teach THTM, were less apt to modify the curriculum, and achieved more positive effects on student knowledge (and, at the senior high school level, on attitudes) than teachers who did not receive such training. Fidelity (tendency to implement the curriculum without modification) and proficiency (adaptation of the curriculum to meet student needs) were related independently to various teacher characteristics and to selected students outcomes.

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Violence Prevention Curriculum for Adolescents

Intervention:

The Violence Prevention Curriculum for Adolescents (VPC) provides adolescents with information on risk factors for interpersonal violence and skills for choosing alternatives to fighting. The 10- to 18-session curriculum uses lectures, discussions, and interactive role-plays. Sessions generally last 40 minutes. The goals of the curriculum are to 1) illustrate that

violence is preventable, 2) teach students that anger is a normal part of life and that anger can be expressed and channeled in healthy, constructive ways, 3) help students understand that controlling anger and violence is part of maturing, 4) identify positive ways for students to express their anger, and 5) help them think about and use alternatives to violence in conflict situations. VPC is part of the Teenage Health Teaching Modules program, a comprehensive school health education curriculum for adolescents.

Evaluation Methodology:

This program was evaluated by two separate studies. The first used a quasi-experimental design with comparison groups. The study examined the effectiveness of the VPC curriculum on 978 sixth grade students from six different schools. The curriculum was put into practice using a staggered implementation design; students received the curriculum during different semesters to allow comparisons between treatment and no-treatment groups. Participants were asked to complete the subscales: the Violent Behavior Scale, the Problem Behavior Scale, and the Drug Use Scale from the Behavioral Frequency Scale. Baseline data was collected to ensure there were no significant differences between the treatment groups at pretest and to test for attrition.

The second study examined the impact of two intervention conditions on 1,523 sophomore high school students' suspension rates. The first condition was the VPC curriculum. The second condition was a schoolwide violence prevention initiative, which included various violence prevention activities, such as school presentations on violence prevention and seminars on death and dying. A prospective design using archival data was used to track three panels of students over their sophomore and junior years. School records provided access to relevant independent variables such as age, gender, ethnicity, standardized test scores, and absenteeism. These two conditions were compared with a nonexposed comparison group. Each condition was nonrandomly assigned to a high school. The schoolwide violence prevention initiative was analyzed for 3 consecutive years (1985–87). The class-specific educational intervention was combined with the schoolwide initiative and analyzed in 1 year only (1986).

Evaluation Outcome:

The first study suggested that the curriculum reduced the immediate risk of becoming a perpetrator or victim of violence for boys, but not for girls.

Specifically, the study found significantly lower frequencies of armed threats and physical fighting for boys in the curriculum versus the comparison group. Moreover, boys receiving the curriculum showed significantly lower rates of problem behavior and drug use. No significant effects were noted for girls or for the overall curriculum sample.

The results of the second study indicate that students receiving the in-class curriculum showed a 71 percent reduction in suspension rates, while the nonclassroom participants showed no change in their suspension rates. Students in the schoolwide exposure condition showed a decrease in suspension rates, but these results were statistically insignificant. Overall, results suggest that violence prevention education can reduce negative school behaviors, particularly when supplemented by other supportive curricula and activities.

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Working Things Out Schools Programme

<http://www.workingthingsout.ie/school-prog.html>

The **World Health Organization** makes explicit reference to the importance of schools as important sites for socialisation and primary health promotion activities. The development of the **European Network of Health Promoting Schools (ENHPS)** movement has also highlighted the role of schools in promoting good health (WHO, 1996). Recent years have witnessed an expanding role for schools and teachers in promoting good health practices, with increasing recognition of the complexities of this process (Rowling & Jeffreys, 2006). For **professionals wishing to promote positive mental health in young people**, schools provide a unique opportunity to carry out such work, through provision of a "captive audience" (Rutter et al., 1979).

There is a growing evidence-base on what schools need to do to promote mental health effectively (Weare & Markham, 2005). The most effective mental health promotion programmes in schools are multi-dimensional and use a 'whole school' approach which **creates a supportive climate of warmth, empathy, positive expectations and clear boundaries**. Such programmes

involve teachers, pupils and parents in their development and implementation, and provide effective training and support for those who deliver the programmes. Programmes which respect **adolescents' own coping styles**, rather than imposing adults' views of 'healthy coping' are more effective, as are those which include an element of **peer modelling** (Oliver et al., 2006).

In Ireland, the **Social, Personal and Health Education Programme**, under the auspices of the Department of Education and Science, is part of the curriculum for all Primary schools, and for the first three years in Post-primary schools, with plans to extend it throughout the Post-primary cycle (**Social Personal and Health Education, 2000**). It involves a whole school approach to the promotion of positive personal development, including general health and mental health. While time is set aside each week within the curriculum for discussion of aspects of the **SPHE programme**, teachers are encouraged to use opportunities presented throughout the school day to explore and foster personal development. Strands of the programme ('Myself'; 'Myself and Others'; 'Myself and the Wider World' ;) are taught throughout the student's school life, using an approach which is consistent with the developmental level of the students. **'Working Things Out'** stories are being used to bring aspects of the SPHE programme to life, by showing young people talking about the **effects on them of bullying** and how they coped (Sam's story and Kevin's story), the **importance of communication** (Jack's story), and when and how to seek **help for emotional difficulties** (Linda story, Ciara's story, Jack's story).

Evaluation:

In order to examine the effectiveness of enhancing SPHE by using **'Working Things Out' stories**, a pilot study was conducted over two years in seven post-primary schools in the Dublin area.

The schools (2 all-female, 2 all-male and 3 co-educational) were randomly assigned to control and enhanced conditions. Those in the control group received standard SPHE instruction while **those in the enhanced group received the WTO resource materials** as well as teacher training and ongoing support. The Children's Coping Strategy Checklist (CCSC, Ayers, 1996) and the Strengths and Difficulties Questionnaire (SDQ, Goodman 1997) were administered to 306 students at pre, post and 6-8 month follow-up.

Pupils were also asked to listen to two audio vignettes and answer a number of questions around **problem identification, emotions and help-seeking**. Students experiencing the highest level of difficulty (borderline-clinical range on SDQ) were found to gain most benefit from the programme. **Schools, teachers and pupils all reported positive gains from this work**, particularly in the areas of mental health awareness and information, teacher comfort in discussing "sensitive" topics and in schools' commitment to a whole-school health approach.

This pilot study confirmed previous promising findings about the usefulness of schools' mental health promotion work. While the **results of this pilot are very promising** the refinement of both teaching approaches and the evaluation methodologies used remains an ongoing challenge for workers in the schools' mental health area.

<http://parentsplus.ie/catproduct.php?pid=7>

Working Things Out DVD

Working Things Out: A therapeutic resource for adolescents dealing with depression and other mental health problems

WTO is an interactive CD ROM/DVD that contains the personal stories of eleven adolescents who have managed difficult problems in their lives such as depression, bullying, eating problems and self-harm. The stories are illustrated by animation and graphics, narrated by the young people and backed up by mental health information and handouts for facilitators.

Working Things Out was co-scripted by the young people and coordinated by Eileen Brosnan, Carol Fitzpatrick and John Sharry, (mental health professionals at the Mater Hospital, Dublin) in collaboration with a group of animators and multimedia professionals.

The project was made possible with funding from the Parents Plus Charity, the Mater Foundation, the Northern Area Health Board, and The National Suicide Review Group and was supported by the Therapeutic Technologies Group and the Compute Clubhouse at Media Lab Europe.

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Each Working Things Out Resource pack includes a CD-ROM & DVD with a comprehensive facilitator's manual

Working Things Out is designed to be used as an educational and therapeutic resource with other young people experiencing mental health problems, either individually or in small groups with the support of a professional facilitator. It can also be used preventatively to raise awareness of mental health issues among young people.

Lifelines

Program description

Lifelines is a school-based suicide prevention curriculum comprised of four 45-minute lessons. Lesson content includes:

1. Information and attitudes about suicide, help seeking, and school resources;

2. A discussion of warning signs of suicide and role-playing exercises for students who may encounter a suicidal peer, (including an emphasis on seeking adult help); and,
3. Two videos: one that depicts appropriate and inappropriate responses to a suicidal peer, and one that documents an actual response of 3 eighth-grade boys to a suicidal peer after they had participated in Lifelines.

The program also includes school-based model policies and procedures for responding to at-risk youth, suicide attempts, and completions; presentations for educators and parents; and a one-day workshop to train teachers to provide the curriculum.

Evaluation design and outcomes

Lifelines curriculum was evaluated utilizing a Solomon four-group design (Kalafat & Elias, 1994). This design was particularly strong because it allowed for the examination of pretest as well as program effects. The Lifelines curriculum was given to the experimental group during a required health class (the control group attended a PE class; they received Lifelines instruction the following semester). A total of 253 10th-grade students from two suburban schools participated in the study. Students were not randomly assigned to the health and PE classes; however, an examination of pretest scores indicated no statistically significant differences in the two groups.

Four outcomes were studied: knowledge about suicide, attitudes toward suicide, responses toward suicidal peers, and satisfaction with the suicide class. Lifelines students demonstrated significantly greater knowledge about suicide when compared with control group students. Lifelines students also demonstrated increased positive attitudes towards suicide prevention, especially attitudes related to help-seeking behavior. To assess student response to suicidal peers, students were asked to evaluate how they would respond to a possibly suicidal peer and to a clearly suicidal peer. In both cases, Lifelines students responded more appropriately than control group students. No pretesting effects were found for any of these outcomes: the fact that the students completed a pretest did not impact their scores on the posttest. Students also rated the Lifelines curriculum more favorably than their regular health class curriculum.

Generalizability

The Lifelines curriculum was studied in two suburban, middle-class schools in the Northeast. Fifty-seven percent of participants were male; the authors found no gender-based differences although they suggest further research is needed in this area. A breakdown of participant ethnicity was not included in the evaluation.

Implementation Essentials

To ensure that the school environment is prepared for increased help-seeking by students, appropriate suicide prevention education must be provided to school personnel.

Targeted protective and risk factors

Lifelines impacts the following risk and protective factors that have been targeted by the National Strategy for Suicide Prevention for the reduction of suicide in the United States.

Increased Protective Factors	Decreased Risk Factors
Easy access to a variety of clinical interventions and support for help-seeking	Stigma associated with help-seeking behavior
Strong connections to family and community support	

Program costs

Implementation costs will vary depending upon the number of teachers and staff-members trained. The Lifelines curriculum manual, which is available directly from the developer, costs \$40.

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The **Reach for Health (RFH)** classroom curriculum is a school-sponsored community youth service program reduces self-reported violent behaviors among young urban adolescents. The framework for the RFH classroom health instruction was provided by the *Teenage Health Teaching Modules* (THTM) (20), a curriculum based on the Health Belief Model and theories of social learning, cognitive mediation, or habits of thought, planned behavior, and social inoculation (21–23). The RFH instructional component focuses on the three primary health risks among inner-city adolescents: drug and alcohol use; violence; and sexual behaviors that result in HIV infection, other STDs, and pregnancy. The curriculum promotes skill development within a developmentally appropriate, culturally sensitive, interactive framework. The curriculum consists of 35 lessons divided into four main units. The first unit consists of framing lessons that set the stage for the next three sections, each of which focuses on one of the primary risk domains. The **Reach for Health Community Youth Service program (CYS)** is the community service component of this curriculum. Under the guidance of teachers and community nurses, students spend several hours each week providing service in local health care agencies. Community placements can include nursing homes, neighborhood health clinics, child day care centers, and a senior citizen center. In their field placements, students perform a variety of tasks, such as reading to elders; assisting with meals; and helping with exercise, recreation, and arts and crafts groups.

Community Youth Service is a method of instruction in which students learn and develop through active participation in service experiences that meet actual community needs and are integrated into the students' academic curriculum. In keeping with theoretical models of the development of social competence and social skills critical to risk reduction, community youth service has the potential to provide youth with opportunities to practice decision-making,

communication, goal-setting, self-assessment, and self-management skills. It is noted that *service learning may be particularly important for economically disadvantaged adolescents* who, compared with more affluent youth, are less likely to be engaged in and thus benefit from more conventional types of community activities or involvement with adults who can serve as role models and mentors. When offered to students in early adolescence, service learning may provide much needed developmentally appropriate opportunities to forge links with other adults, test values, and try out new roles.

The Leadership and Resiliency Program (LRP) is a school and community-based program for high school students, 14 to 19 years of age that enhances youths' internal strengths and resiliency while preventing involvement in substance use and violence. The program includes resiliency groups that are held during the school day, as well as alternative activities offered after school, on weekends, and during the summer. These include adventure/outdoor activities, working with abused and neglected animals, and performing puppet skits for young children. The alternative activities focus on community service, altruism, learning about managed risk, social skills improvement, and conflict resolution. The program operates year-round with increased alternative programming when school is not in session. Participants may stay involved with the program throughout their high school years.

Selected Examples of Validated Leadership and Youth Development Programmes

All Stars™

Intervention:

All Stars™ is a character-based approach to preventing high-risk behaviors such as substance use, violence, and premature sexual activity in teens ages 11 to 15. The program is based on strong research identifying the critical factors that lead young people to begin experimenting with substances and engaging in other high-risk behaviors. It is designed to reinforce positive qualities that are typical of youths at this age. It works to strengthen five specific qualities vital to achieving preventive effects:

- Establishing positive norms
- Building strong personal commitments
- Promoting positive parental attentiveness
- Developing positive ideals and future aspirations
- Promoting bonding with school and community organizations

A program specialist or regular classroom teacher can implement the program. All Stars™ consists of whole classroom sessions, small group sessions outside of the classroom, and one-on-one sessions between the instructor and the child. The program is interactive, including debates, games, and general discussion. Homework assignments are given to include parents in the program and to increase parent–child interactions. All Stars™ is also used in community-based settings such as afterschool programs, faith-based communities, Girls and Boys Clubs, and community centers.

Evaluation Methodology:

The most comprehensive evaluation of All Stars™ consisted of a single-cohort longitudinal design with pretest, posttest, and 1-year follow-up. Sixth and seventh grade students in 14 middle schools participated in the evaluation. The sample consisted of 1,655 students, of which 55 percent were female and 69 percent white, 25 percent African-American, and 6 percent Hispanic. Schools were matched and randomized to the specialist-run treatment condition (n=629), teacher-run treatment condition (n=287), or control condition (n=739). Pretest and

posttest questionnaires measured substance use, sexual behavior, violence, and the mediating variables of bonding, commitment, ideals, and perceived norms.

All Stars™ was then reevaluated using a similar technique. Fourteen middle schools (n=1,857) were randomly assigned to the specialist treatment group, teacher treatment group, or control group. The sample was 54 percent female and 69 percent white, 23.3 percent African-American, 7.7 percent other ethnicities. All participants were 11 to 13 years old. Students were given a pretest before program implementation and a posttest at the end of the school year to assess sexual behavior and alcohol, tobacco, and other drug use.

Performance Measures:

Measure: Decrease frequency of AOD use	Source:n/a
Measure: Delay onset of sexual activity	Source:n/a
Measure: Increase normative beliefs	Source:n/a
Measure: Improve attitude toward high risk behavior	Source:n/a
Measure: Increase level of parent-child communication	Source:n/a
Measure: Increase level of parental supervision	Source:n/a

Evaluation Outcome:

The comprehensive evaluation of All Stars™ indicated that when implemented by teachers the program influenced the mediators of problem behaviors for white students. However, these were only short-term changes. When a specialist delivered the program, there were delayed effects on mediating variables for Hispanic students. And there were delayed effects for African-American students regardless of who implemented the program. This evaluation showed limited positive results for the All Stars™ program.

The next evaluation resulted in more positive changes, though the evaluation looked only at short-term results. When teachers implemented the program, there were significant reductions in the use of alcohol, cigarettes, smokeless tobacco, and inhalants. Although there were no significant effects for marijuana use or sexual activity, there were changes in the desirable direction. The program had a significant effect in changing normative beliefs, lifestyle incongruence, commitment to school, impulsive decision-making, and sensation-seeking behavior. These results were found only for the teacher-implemented program.

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Teen Outreach

Intervention:

Teen Outreach (TO) is a preventive program that uses volunteer community service to reduce teen pregnancy, school failure, and school suspension rates among high school students. The program targets both males and females who

enroll voluntarily into the program as a health curriculum elective course in response to a teacher's or guidance counselor's suggestion. TO has an explicit developmental concentration, helping teens understand and evaluate their future life options, such as those surrounding career and relationship choices. This emphasis attempts to further teens' progress in the developmental task of establishing their competence and autonomy in a context that maintains their sense of their relationships to important adults.

The TO program consists of three interrelated elements: supervised community volunteer service, classroom-based discussions of service experiences, and classroom-based discussions and activities related to key social-developmental tasks of adolescence.

Students select volunteer activities under the supervision of trained staff and adult volunteers. These activities, which are intended to respond to the needs and capacities of both students and local communities, include work as aides in hospitals and nursing homes, participation in walkathons, peer tutoring, and a wide range of other work. TO sites are required to provide at least 20 hours a year of volunteer service for each participant. In addition to volunteer service, students participate in classroom discussions at least once a week during the school year, led by trained facilitators—often schoolteachers or guidance personnel.

All classroom discussions and activities are based on the *Teen Outreach Curriculum*, which is designed to engage students through structured discussions, group exercises, role plays, guest speakers, and informational presentations. Service learning discussions concentrate on helping students prepare for their service experiences, think about what they have experienced while volunteering, and listen to others share their experiences.

In developmentally oriented classroom discussions and activities, the facilitator leads small groups of students in activities and topics of particular interest to young people. Topics for classroom discussions and activities include understanding oneself and one's values, life skills, dealing with family stress, human growth and development, and issues related to the social and emotional transitions from adolescence to adulthood.

Evaluation Methodology:

This program was evaluated with a true experimental design study of 25 randomly assigned sites. In addition, students were randomly assigned to either the treatment program or a control condition (traditional health curriculum) at the student level (students were randomly selected to the treatment or control condition because of an excess of students interested in the program) or, less frequently, the classroom level (classrooms were randomly selected to offer TO in lieu of the regular health curriculum). The sample included 342 students who participated in the program and 353 control students, all in the 9th through 12th grades. Students sought to enter the program as part of their health curriculum,

as an academic elective, and as an afterschool activity before being randomly assigned to the participant or control groups. Both participant and control groups were similar in age (15) and ethnicity (majority African-American), with both groups having more than 80 percent females. However, the control group demonstrated higher levels of prior teen pregnancy, course failure, and school suspension. Self-report questionnaires were used to provide demographic information and assess students' problem behaviors. Students were assessed during the 1st several weeks of the school year and then again at program exit at the end of the school year. The evaluation measured teen pregnancy, school failure, and school suspension rates of the students in both participant and control groups.

Evaluation Outcome:

The evaluation found that program participants experienced significantly lower levels of teenage pregnancy, school failure, and school suspension rates, even after accounting for baseline levels of the behaviors and for sociodemographic characteristics of students. The risk of teen pregnancy in the participant group was 41 percent as large as the risk for the control group. The risk of school failure in the participant group was 42 percent as large as the risk for the control group. The risk of school suspension in the participant group was 39 percent as large as the risk for the control group.

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Truancy Prevention

INTRODUCTION

Truancy has been referred to as a "first step to a lifetime of problems" for youth (Garry, 1996). Truant students have a higher risk than nontruant students of involvement in drug and alcohol use, violence, and gang activity (U.S. Department of Education and U.S. Department of Justice, 1996). Police departments across the nation report that many students who are not in school during regular hours are committing crimes, including vandalism, shoplifting, and graffiti. According to a 1996 report, 44 percent of violent juvenile crime occurred between 8:30 a.m. and 1:30 p.m. in San Diego, Calif., (U.S. Department of Education and U.S. Department of Justice). Thus, student nonattendance is a problem that extends much further than the school. Truancy affects the student, the family, and the overall community (ERIC Clearinghouse on Educational Management and Office of Educational Research and Improvement, 1999).

Examination of the truancy problem requires investigation into the possible reasons that students may choose to engage in truant behavior. Statistics have shown that a student's decision to skip or drop out of school might be the product of many factors, including family problems, drug and alcohol abuse, illiteracy, and teenage pregnancy (Cantelon and LeBoeuf, 1997). According to the U.S. Department of Education, when young people start skipping school, they are telling their parents, their school, and the community at large that they are in trouble and need our help if they are to keep moving forward in life (U.S. Department of Education and U.S. Department of Justice, 1996).

The self-reported reasons for truancy vary considerably. According to a 1992 report by the National Center for Education Statistics (McMillen et al., 1993), 4 dropouts in 10 said that they left school because they were failing or they did not like school, and males and females reported in roughly equal numbers that they were leaving school because of personality conflicts with teachers. More males than females dropped out of school because of school suspension or expulsion. The dropout rate among 16- to 24-year-olds who had repeated more than one grade was 41 percent, compared with 17 percent of those who had repeated only one grade and 9 percent of those who had not repeated any grades. Dropout rates were highest among those who had repeated grades 7, 8, or 9. Although most dropouts reported school-related reasons for leaving school, most female dropouts reported family-related reasons. Among dropouts, 21 percent of females and 8 percent of males dropped out because they had become parents (McMillen et al., 1993).

Not all indicators of truancy point to students' personal or family problems. In fact, students and school staff often disagree on the reasons for truancy. In one survey, students cited boredom, loss of interest in school, irrelevant courses, suspensions, and bad relationships with teachers as major factors leading to the decision to skip school. In contrast, school staff believed truancy to be related to students' problems with their families and peers (ERIC Clearinghouse on Educational Management and Office of Educational Research and Improvement, 1999).

Consistent with the observations of some school staff, some criminal justice scholars have speculated that parental neglect may be a common cause of truancy. According to Garry (1996): "Many parents of truant students do not value education. Some children are kept at home to work or babysit preschool siblings. Others are prevented from attending school because of problems at home, at school, or in neighborhoods." Rohrman (1993) conveys that most parents appreciate the need for children to attend school, but some are unaware that children are truant, do not know how to increase their attendance, or may believe that meeting family needs is a satisfactory reason for absence. Rohrman also points out that some immigrant parents may not understand that attendance is compulsory.

An additional consideration is that the trip to and from school takes some students through sections of their neighborhoods where they may feel intimidated. In one study on factors contributing to school truancy, 80 percent of youth surveyed said they feared the trip to and from school, reporting that they were forced to cross the "turf" of hostile gangs and that they often skipped school rather than risk violence (University of Colorado at Boulder, 2000).

THEORETICAL CONTEXT

Truancy has been clearly identified as one of the early warning signs that youth potentially are headed for delinquent activity, social isolation, or educational failure. Several studies have established lack of commitment to school as a risk factor for substance abuse, delinquency, teen pregnancy, and dropping out of school (Bell, Rosen, and Dynlacht, 1994; Dryfoos, 1990; Huizinga, Loeber, and Thornberry, 1995; Rohrman, 1993). In addition, decades of research have also identified a link between truancy and later problems such as violence, marital problems, job problems, adult criminality, and incarceration (Dryfoos, 1990; Catalano et al., 1998; Robins and Ratcliff, 1978; Snyder and Sickmund, 1995). More recent studies, such as OJJDP's Program of Research on the Causes and Correlates of Delinquency (Kelley et al., 1997), indicate that truancy

may be a precursor to serious violent and nonviolent offenses and that the connection between truancy and delinquency appears to be particularly acute among males. Moreover, findings from OJJDP's Study Group on Very Young Offenders (Loeber and Farrington, 2000) indicate that chronic truancy in elementary school is linked to serious delinquent behavior at age 12 and under. The financial impact of truancy and the dropouts that result can be measured in at least four ways:

- A less educated workforce
- The business loss attributable to youth who "hang out," shoplift, or do both during the day
- Higher daytime crime rates (in some cases)
- The cost of social services for families of children who are habitually truant

Truancy, however, has an even more direct financial impact on communities: the loss of Federal and State education funding (Baker, Sigmon, and Nugent, 2001).

TYPES OF TRUANCY PREVENTION PROGRAMS

Truancy prevention programs are designed to promote regular school attendance through one or more strategies, including the following:

- Court alternatives
- Mentoring programs
- Law enforcement participation
- Increasing parental involvement
- Other strategies, such as improving parent-teacher communication and drawing upon community resources

EVIDENCE OF IMPACT

The U.S. Department of Education and U.S. Department of Justice suggest that the communities that have had the most success in deterring truancy not only have concentrated on improving procedures but also have implemented a comprehensive strategy that emphasizes incentives and sanctions for truants and their parents. They name five primary elements of a comprehensive community and educational strategy to combat truancy:

- Involve parents in all truancy prevention activities (e.g., increasing parent-teacher communication and initiating programs such as "homework hotlines" and appointing a parent liaison).
- Ensure that students face firm sanctions for truancy (school districts should communicate a "zero tolerance" policy that carries strict ramifications for violators).
- Create meaningful incentives for parental responsibility to ensure that children go to school (e.g., parents of truant children may be asked to participate in parenting education programs, truancy can be subject to formal sanction, or demonstration of regular school attendance could directly affect parents' eligibility for certain public assistance).
- Establish ongoing truancy prevention programs in school by addressing the needs of individual children and developing initiatives to combat the root causes of truancy (e.g., tutoring, increased security, drug prevention, mentorship, increasing parental involvement, and providing referrals).

- *Involve local law enforcement in truancy reduction efforts (e.g., community-run detention centers or "sweeps" of neighborhoods in which truants are often found). [U.S. Department of Education and U.S. Department of Justice, 1996]*

Similarly, the National Association of Secondary School Principals makes several recommendations concerning attendance policies that work (Bartlett et al., 1978):

- *Policies should be strong. Schools that invest thought and effort into solving problems make the most headway.*
- *Participation in the formulation of the attendance policies should be broadly based.*
- *Attendance expectations, as well as consequences of good and poor attendance, should be specified in writing.*
- *Policies should be well publicized.*
- *Policies should be consistently enforced at every level-by teacher, counselor, and principal.*
- *Student absences should be followed by a telephone call or letter home from a school official.*

In addition to the points made above, other professionals have contended that schools should clearly state that attendance is the responsibility of the student and parents, and that they will be held accountable for absences. Policies should be educational rather than punitive, should include due process provisions, and should be flexible enough to deal with extenuating circumstances (ERIC Clearinghouse on Urban Education and Office of Educational Research and Improvement, 1997).

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Truant Recovery Program

Intervention:

The Truant Recovery Program is a collaborative effort between the school district and all community police jurisdictions within its boundaries. The program is preventive rather than punitive. Its primary task is to return truant students to school as soon as possible. The program operates under the authority of the Student Welfare and Attendance (SWAT) Office. The program authorizes the local police jurisdictions to make contact with students on the streets during school hours. Students without a valid excuse slip are taken into temporary custody and transported to the SWAT office for processing. SWAT personnel attempt to contact the youth's parents for an in-person meeting, in which both can be counseled and the parent can return the child to school. If a parent cannot be reached, SWAT personnel return the youth to school. The school site is also contacted, and both the school and SWAT Office closely monitor the student's attendance in the future.

Three additional components of the program provide both accountability and consequences. First, the Department of Probation assigns an officer to the SWAT program to screen all contacted juveniles for probation violations and bench warrants. Second, the Student Attendance Review Board reviews records for habitual truancy cases and refers cases to the juvenile court for review and adjudication. Finally, the Suspension Alternative Class (SAC) is designed to make sure truant students are not rewarded for truancy by missing more school. Instead, students in SAC remain in school but are unable to engage in regular classes.

Evaluation Methodology:

The Truant Recovery Program was evaluated using a quasi-experimental design. One hundred seventy-eight students were randomly selected from all of the truant youths picked up in Richmond, Calif., during autumn 1997. Of all the truant youths picked up, 69 percent were male, 60 percent were African-American, 25 percent were Hispanic, 8 percent were Asian-American, and 3 percent were white. The median age was 15. For those youths in the sample, local and State criminal justice data was collected for the years prior to their truancy through 18 to 21 months after contact with the program. Academic data was collected for 3 years prior to the truancy until 2 years after the contact.

Evaluation Outcome:

The evaluation of the Truant Recovery Program suffered from problems of missing data. The results show an increase in conformity to school regulations after contact with the program and a decrease in the number of disciplinary actions. However, during this same period there was an increase in formal contacts with the justice system and an increase in the proportion of arrests (4 percent of the truants were arrested before autumn 1997, compared with 8 percent after the fall, though this is not a significant increase). The number of both excused and unexcused absences decreased after contact with the program, which was the goal of the program. Academics improved slightly after contact with the program; however, the large amount of missing data makes it difficult to make a true analysis of this variable.

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Operation New Hope**Intervention:**

Operation New Hope (formerly Lifeskills '95) is a curriculum-based parole reentry program designed to treat high-risk chronic offenders postrelease by helping them cope with the problems of everyday life. The program reinforces small successes while addressing a chronic offender's fears of the real world. The approach used by Lifeskills '95 is based on six programmatic principles believed to help with reintegration:

1. Improve the basic socialization skills necessary for successful reintegration into the community.
2. Significantly reduce criminal activity in terms of amount and seriousness.
3. Alleviate the need for or dependence on alcohol or illicit drugs.
4. Improve overall lifestyle choices (social, education, job training, and employment).
5. Reduce the individual's need for gang participation and affiliation as a support mechanism.
6. Reduce the high rate of short-term parole revocations.

The treatment consists of 13 consecutive weekly meetings that concentrate on different coping skills: 1) Program Introduction, 2) The "Pit"—Dealing With Your Emotions, 3) Unmanageability, 4) Denial, 5) The Problem of Thinking You Can Do It Alone, 6) "Letting Go," 7) Perceptions, 8) Expectations, 9) Reality, 10) Love, 11) Family Dynamics, 12) Living With Addiction, 13) Continuous Practice. The meetings last 3 hours. The first 1½ are used for lectures, the last 1½ for group discussion. Participants may begin the program during any point in the curriculum.

Evaluation Methodology:

The program was evaluated using a quasi-experimental design with a nonrandomized treatment and a control group. The two groups were made up of parolees released from a secured facility between Feb. 1 and Dec. 31, 1995, who were assigned to the California Youth Authority's Inland Parole Office. If a juvenile reported a residence that was within a 25-mile radius of the Inland Parole Office at the time of release, the youth was placed in the treatment group. If the address was beyond the 25-mile radius, the youth was in the control group. Coincidentally, n=115 for both the treatment and the control group. The overwhelming majority of participants were male—97.4 percent in the treatment group and 95.7 percent in the control group. The average ages were 20.0 and 20.2, respectively. The treatment group was 40.9 percent African-American, 39.1 percent Hispanic, and 14.8 percent white. The control group was 50.4 percent Hispanic, 24.3 percent African-American, and 20.0 percent white. The treatment group was required to attend all 13 Lifeskills '95 classes, while the control group was not.

Data was collected through semistructured interviews and surveys of parolees, treatment facilitators, and parole agents. Random drug tests were also performed. Data was collected three times: 1) the 1st week after release, 2) after the treatment was complete (3 months after release), and 3) at the end of the evaluation period (Feb. 28, 1996). During this analysis, n=106 for the treatment group and nine parolees became involved in an additional program and were removed from the sample.

Evaluation Outcome:

Ninety days after release from secure confinement, control group youths were twice as likely as the experimental group to have been rearrested, to be unemployed and to lack the resources necessary to find and maintain a job, to have a poor attitude toward working, and to have frequently abused drugs or alcohol. Control group youths were three times as likely to associate with former gang members, to have "serious problems" with family relationships, to be unresponsive and negative in their commitments to parole, and to associate almost exclusively with negative, unfavorable peer groups.

A year after the evaluation began, the results were just as favorable for the Lifeskills '95 program. The control group youths were twice as likely as the experimental group to have one or more arrests, to be associated with negative peer groups, and to be unemployed without means of financial support. They were also twice as likely to have failed in their parole, meaning they had their parole revoked owing to a technical or criminal violation, were in jail awaiting a new criminal charge, were in temporary detention awaiting a revocation hearing, or they were missing. Control group youths were three times as likely as experimental group youths to continue their abuse of drugs.

All of these findings were significant.

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Selected Examples of Validated Training Programmes

The Applied Suicide Intervention Skills Training (ASIST) program is a two day intensive workshop designed to provide caregivers with knowledge and 'suicide first aid'. ASIST has been used extensively in Australia to deliver mental health knowledge and skills to identify and interact with people who are at risk of suicide.

The Mental Illness Education Australian Capital Territory (MIEACT) program makes use of people who have personal experience of living with the effects of mental illness and aims to increase mental health literacy and reduce the negative stigma associated with mental illness in the community. The MIEACT program is based on the premise that contact with people who have experienced mental illness and have an increased knowledge about mental illness will result in decreased reported social distance toward people with mental illness, and decreased stigma.

The Missouri Department of Mental Health, in a cooperative relationship with the University of Missouri—Columbia to initiate a more proactive (vs. reactive) strengths-based (vs. pathology based) approach to prevention, formulated the **Center for the Advancement of Mental Health Practices in Schools (CAMHPS)-** <http://schoolmentalhealth.missouri.edu/>, a training program for professionals dedicated to emphasizing the prevention of mental health problems within schools, families, and communities, and the promotion of positive mental well-being for all children.

The Center is committed to serving as a mechanism which supports the mental health needs of *all* students, their families and the school based personnel who serve them. As such, the Center has pioneered a number of programs designed to integrate innovative multidisciplinary approaches to mental health practices in schools.

The Center's mission is to (a) promote the *awareness* of positive mental health practices impacting school systems; (b) Increase the *knowledge* of school personnel and their role in preventing mental health problems through evidence-based practices; and, (c) Provide school personnel and other mental health providers the *skills* to problem-solve mental health issues.

The curricular focus is based upon a preventative, strengths-based approach to mental health, utilizing available evidence-based practices. The program is offered entirely online and courses are taught by doctoral level professionals from a broad range of disciplines including medicine, nursing, law, psychology, psychiatry, special and general education and educational leadership.

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Selected Examples of Validated Academic Skills Enhancement Programmes

Title: [Skills, Opportunity, and Recognition \(SOAR\)](#)

PREVENTION

Intervention: The Skills, Opportunity, and Recognition (SOAR) program (formerly known as the Seattle Social Development Project) has its roots in the Social Development Model, which posits that positive social bonds can reduce antisocial behavior and delinquency. ...

Title: [Broader Urban Involvement and Leadership Development Program \(BUILD\)](#)

PREVENTION

Intervention: Chicago, Ill.'s BUILD (for Broader Urban Involvement and Leadership Development) program combines several popular gang prevention strategies in an ambitious attempt to curb gang violence in some of the city's most depressed and crime-ridden neighborh...

Title: [Extended-Service Schools Initiative](#)

PREVENTION

Intervention: The Extended-Service Schools (ESS) Initiative promotes academic and nonacademic development of young people during their out-of-school hours. While the programs differ in organizational structure and management, all ESS programs operate their program...

Title: [Girls' Circle](#)

PREVENTION

IMMEDIATE SANCTIONS

Intervention: Girls' Circle is a structured support group that addresses the specialized needs of girls ages 9–18 by integrating relational–cultural theory (RCT), resiliency practices, and skills training into a specific format designed to increase positive connec...

Title: [Let Each One Teach One](#)

PREVENTION

Intervention: Let Each One Teach One is based on literature findings that mentor relations facilitate academic success. The program uses the relationship between an elementary or middle school student and an older, more experienced student role model to provide li...

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Vocational/Job Training

http://www.dsgonline.com/mpg2.5/vocational_job_prevention.htm

INTRODUCTION

It is well established in the scientific literature that prison inmates are, in general, less well educated and have fewer marketable job skills than the general population (Andrews and Bonta, 1994). As a result, providing youths with employment opportunities is a common strategy to discourage future delinquency and incarcerations. These strategies can be directed toward several different points in the juvenile justice continuum, including early intervention, residential intervention, and aftercare. This section concentrates on early intervention strategies that are designed as prevention programs either to divert youths from entering the juvenile justice system or to prevent youths from continuing their involvement within the system (Frey, 1999).

Over the last few years, large sums of money have been used to develop various vocational training and work experience programs for youths in high crime and high unemployment communities (Bushway and Reuter, 1998). In general, these programs are designed to increase earnings, raise self-esteem, instill a positive work ethic, bind juveniles to conventional norms, occupy idle time to decrease the opportunities for delinquency (Ploeger, 1997). These employment and vocational programs tend to take three forms, arrayed below in order of increasing expense and program intensity (Bushway and Reuter, 1998). These types of programs include the following:

- *Summer work and subsidized employment.* These types of programs generally last about 3 months. An excellent example is the Department of Labor's Summer Youth Employment and Training Program. It provides minimum wage jobs and some education to disadvantaged youths and school to work programs.
- *Short-term training with job placement.* These short-term vocational skills programs generally last 6 months and help youths find employment after graduation. A well-known example of this type of program is the Job Training and Partnership Act.
- *Long-term intensive residential programs.* These programs provide vocational and life skills training, general education, and job placement after graduation. The well-known JobCorps is one such program.

THEORETICAL CONTEXT

Vocational training and employment programs are intended primarily to increase earnings. A second and more important objective, however, is to improve participants' social and educational functioning (Ploeger, 1997). There are several major theoretical explanations that link employment and crime (Fagan, 1995; Uggen 1994; and Bushway and Reuter, 1998). Two of the most prominent are economic choice theory and control theory:

- *Economic Choice Theory* implies that individuals choose work that is more rewarding and attractive, even if that work is illegal or criminal (Ehrlich, 1973). However, education attainment plays a mitigating factor in framing that choice. In other words, if the legal labor market opportunities appear weak, a youth is less likely to make adequate investment in acquiring the human capital necessary for success in the legal labor market. Subsequently, low educational attainment puts youths at risk of frequent periods of unemployment and of achieving only low paying jobs. Consequently, bolstering vocational skills and employability theoretically provides a buffer to the drawl of the illegal labor market.
- *Control Theory* posits that employment exerts social control over an individual (Gottfredson and Hirschi, 1990). On an individual level, the absence of employment leads to a breakdown of positive social bonds and increased criminal or delinquent activity. Thus, reduced future offending is not a product of an increase in employability but rather stems from an increase in opportunities for social control.

Depending on their focus, vocational training and employment programs may address several risk factors, including academic failure, alienation and rebelliousness, association with delinquent and violent peers, and low commitment to school. Protective factors enhanced can include opportunities to acquire job experience, job skills, and recognition for work performed.

EVIDENCE OF IMPACT

There have been several evaluations of major youth employment and training programs in the last decade. Bushway and Reuter (1998) reviewed the findings of 19 job training programs specifically connected to the criminal justice system. Unfortunately, most of the programs had negligible or only very modest success, suggesting that the impact of employment and vocational skills training on delinquency and protective factors is mixed.

For instance, Career Beginnings provides a combination of educational and employment services to high school students. Specifically, it targets students with average grades from economically and/or educationally disadvantaged family backgrounds who are unlikely to attend college. The program provides workshops, classes, and counseling on educational and career planning and preparation. The evaluators used a true experimental design to assess program impacts at seven sites across the United States. At each site, program applicants who met the eligibility criteria were randomly assigned to the experimental or control group. The results indicated that experimental youths had a significantly higher rate of college attendance at 1-year follow-up (Cave and Quint, 1990).

One of the most renown employment programs is JobCorps, a 33-year-old national training and employment program administered by the U.S. Department of Labor and delivered primarily through residential settings to economically disadvantaged young people. Participants in the program must be 16 to 24 years old, economically

disadvantaged, be a high school dropout, not be on probation or parole, have no serious medical or behavioral problems, come from a disruptive background, and stay in the program for approximately 8 months. An evaluation by Mathematica Policy Research found that JobCorps substantially increased the education and training services that participants received, improved their educational attainment, and generated positive employment and earning by 3 years after random assignment (Schochet, Burghardt, and Glazerman, 2000).

Another employability program based on the JobCorps model is JOBSTART. JOBSTART provides a long-term combination of basic skills education, occupational training, support services, and job placement assistance to young, low-skilled dropouts-but at a lower level of intensity than JobCorps and in a nonresidential setting. JOBSTART was evaluated (Cave et al., 1993) at 13 sites across the United States, with eligible youths randomly assigned to experimental and control groups. At the 48-month follow-up, significantly more participants (42 percent) than controls (29 percent) had earned a GED or high school diploma. There were also significant long-term program impacts on reducing public assistance for women who did not live with their children. Finally, JOBSTART participants who had not been arrested between age 16 and entry into the program were significantly less likely to be arrested in the first year. This effect, however, disappeared in subsequent years. In summary, however, the overall program did not significantly affect earnings or employment, except during program training. A limited benefit-cost analysis showed no overall economic benefit from the program. This conclusion was not based on all program outcomes (such as criminal behavior and drug use) and may be premature, given that the net overall benefits were steadily increasing over the last 2 years of the 4-year follow-up period.

The Job Training Partnership Act (JTPA) is another major source of employability and vocational training programs. Bloom and colleagues (1994) evaluated the impact of the programs under this act. The programs included a diverse set of interventions for out-of-school youths between ages 16 and 21, including classroom training in occupational skills, on-the-job training, job search assistance, remedial education, and miscellaneous other services. In 16 sites, JTPA applicants were randomly assigned to an experimental or control group. Thirty months later, there were no significant program impacts on earnings or employment. At 36 months after the program, however, male experimental youths who had not been arrested before were significantly more likely to be arrested. A cost-benefit analysis showed that JTPA produced greater costs than benefits.

In summary, the available evidence regarding employment and vocational skills training programs is mixed.

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[Vocational/Job Training Programs](#)

Supporting Adolescents with Guidance and Employment (SAGE)

Intervention:

Supporting Adolescents with Guidance and Employment (SAGE) is a violence-prevention program developed specifically for African-American adolescents. The program consists of three main components, namely a Rites of Passages (ROP) program, a summer jobs training and placement (JTP) program, and an entrepreneurial experience that uses the Junior Achievement (JA) model.

The purpose of the first component, ROP, is to develop a strong sense of African-American cultural pride and ethnic identity in the participants and instill a sense of responsibility in their community, their peers, and themselves. In seminars held every other week over 8 months, the program curriculum (developed in 1993 by the Durham, N.C., Business and Professional Chain) also promotes self-esteem, positive attitudes, and the avoidance of a range of risky behaviors. Instructors cover topics such as conflict resolution, African-American history, male sexuality, and manhood training. Mentors from the community provide outreach experiences and tutoring.

The second component, the JTP experience, places youths in summer jobs at desirable worksites such as dentist offices, local museums, and recreational centers. Site supervisors are encouraged to provide structure. Youths are trained in appropriate business behavior and dress. Job counselors work with the youths to resolve issues such as transportation.

The third component, JA, teaches how to develop and implement a small business. With the guidance of volunteer advisers from the local business community, youths form a legal corporation, develop a business plan, elect officers, and sell stock to family and friends. They also market and sell a product (e.g., T-shirts, caps).

The overall approach of SAGE is based on the theory that positive gains in personal and social responsibility, educational aspirations, and academic achievement—in tandem with employment training and opportunities fostered by community mentors—will make a positive impact on reducing violence among the participants.

Evaluation Methodology:

SAGE was assessed using a longitudinal, randomized field trial in which program applicants were assigned to one of three programmatic conditions: 1) guidance plus employment (ROP, JTP, and JA), 2) employment only (JTP and JA), and 3) a comparison group eligible for delayed participation in JA only. Survey data collection points occurred at baseline, at 18 months, and at 30 months after the program began. After completion of baseline questionnaires, the 255 eligible youths (African-American males ages 12–16) were assigned to each group: 86 to the guidance and employment (ROP/JTP/JA) condition, 84 to the employment-only (JTP/JA) condition, and 85 to the comparison condition. The mean age of the participants was 14. Fifty-three percent reported receiving free lunches at school; 18 percent reported that their mothers had not completed high school; and 50 percent were not living with a father. Self-report and archival data was used to assess the effectiveness of SAGE on behavioral outcomes for a variety of risk behaviors (e.g., violence-related behaviors such as physical fighting, carrying or using a weapon; alcohol-, tobacco-, and other drug-related behaviors such as use, abuse, and commerce; and risky sexual behaviors). In addition to outcome measurements, the self-report survey included questions regarding process measurement. Baseline data indicated that during the previous year, many had engaged in various violence-related behaviors, including fighting (63 percent) and carrying a gun (22 percent) or a knife (30 percent).

Evaluation Outcome:

Despite the absence of statistical significance, the pattern of results from the evaluation provides tentative evidence that participation in SAGE can reduce the likelihood of violence-related and other health-risk behaviors among African-American male adolescents. At the 18-month follow-up, the mean number of problem behaviors reported by the employment-with-guidance group declined, in contrast to the slight increase of the comparison group and to no change in the employment-only group. Examining each behavioral outcome individually, differences in a positive direction for employment-with-guidance were observed for 8 of the 10 outcomes, relative to the control group. For the employment-only group, positive differences were observed for 7 of the 10 outcome measures. Of the 10 behavioral outcomes examined, the program seemed to have the greatest benefits for reducing reports for carrying a gun, selling illegal drugs, and injuring others with a weapon. However, programmatic gains were not sustained over the 30-month follow-up. Assessment of the

psychosocial constructs (e.g., increasing self-esteem, educational aspirations, beliefs supporting aggression) found no statistically significant effects. The relatively small group sizes in this study may have diminished the possibilities for finding statistically significant effects. In addition, the analysis was performed on all participants according to the group to which they were randomly assigned, regardless of their actual level of exposure to the programmatic components. This “intent to treat” approach is viewed as the most rigorous approach for assessing programmatic effects in randomized designs, but it is also a conservative one that may underestimate the actual impact if all the young men had participated fully in the intervention activities. Including all participants—regardless of their level of exposure to treatment—may have contributed to the lack of statistically significant findings and may have underestimated the actual impact of the program.

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Afterschool/Recreation

The hours between the end of the school day and when parents return from work is a risky time for young people. In contrast to the statistics for adults, serious violent crime committed by juveniles increases during the hours immediately after school. “In general, the number of violent crimes committed by adults increases hourly from 6 a.m. through the afternoon and evening hours, peaks at 11 p.m., and then drops to a low point at 6 a.m.,” according to Snyder and Sickmund (1999). “In stark contrast, violent crimes by juveniles peak in the afternoon between 3 p.m. and 4 p.m., the hour at the end of the school day.” This same research reports that “19 percent of all juvenile violent crimes occur in the 4 hours between 3 p.m. and 7 p.m. on school days.” Moreover, a comparison of the crime patterns for school and nonschool days finds that the 3 p.m. peak occurs only on school days (Snyder and Sickmund, 1999).

Juveniles are also at the highest risk of being victimized during this critical period. Recent analyses of the FBI National Incident-Based Reporting System (NIBRS) data indicates that juveniles are at the highest risk of being the victims of violent crime in the 4 hours following the end of the school day (roughly 2–6 p.m.). In fact, victimization surveys find that even more delinquent acts occur between noon and 6 p.m. (which

includes the hours after school) than indicated by the NIBRS data. For example, the National Crime Victimization Survey indicates that “half (51 percent) of all robberies occur between noon and 6 p.m., while the police data show that only 32 percent of juvenile robberies occurred during this period” (Snyder and Sickmund, 1999).

This dramatic temporal discrepancy in delinquent activity is likely due to children returning after the school bell to homes with in little or no supervision, because their parents are at work. Research findings estimate that 35 percent of 12-year-olds are left by themselves regularly while their parents are at work. In fact, the gap between parent work schedules and child school schedules can total 20 to 25 hours per week (U.S. Department of Justice, 2000). This unsupervised time is a risk factor for serious and violent behavior among youths. The evidence supports the proposition that children “who are unsupervised during the hours after school are more likely to use alcohol, drugs, tobacco . . . , receive poor grades, and drop out of school than those children who have the opportunity to benefit from constructive activities supervised by responsible adults” (U.S. Department of Justice, 2000). Moreover, Gottfredson, Gottfredson, and Weisman (2001) find that youths who are unsupervised during afterschool hours are found to be more delinquent at all times and not only after school.

Because the hours directly after school can be so dangerous for school-aged children, delinquency prevention programs should be used to reduce the probability of these incidences. Quality afterschool programs are widely supported as a buffer against the danger of delinquency. Nearly 100 percent of those polled agreed that it is important for children to have an afterschool program that helps them develop academic and social skills in a safe, caring environment (U.S. Department of Justice, 2000). But despite this support, there is a lack of affordable, accessible afterschool opportunities in many communities. For instance, in some urban areas, the supply of afterschool programs was expected to meet only about 20 percent of the demand by 2002 (GAO/HEHS, 1997).

THEORETICAL CONTEXT

Quality afterschool programs that reduce risk factors and increase protective factors for the youths served can offer a host of intriguing and rewarding experiences for youths and their families. Afterschool programs keep children of all ages safe and out of trouble because they meet family needs by providing responsible adult supervision of children during nonschool hours. They also offer rewarding, challenging, and age-appropriate activities in a safe, structured, positive environment. In fact, research has identified three major functions provided by afterschool programs. They 1) provide supervision, 2) offer enriching experiences and positive social interaction, and 3) improve academic achievement (Fashola, 1999). As a result of these functions, studies indicate that afterschool programs can

- Improve students’ social skills
- Improve their self-confidence
- Improve their homework quality

- Give them higher aspirations
- Enhance their academic achievement
- Increase their interest and ability in reading
- Encourage them to develop new skills and interests
- Improve school attendance and reduce dropout rate
- Prevent negative influences that lead to risky behaviors
- Increase family and community involvement with children
- Reduce grade retention and placement in special education
- Prevent crime, juvenile delinquency, and violent victimization

EVIDENCE OF IMPACT

Afterschool programs come in all shapes, sizes, and modalities, and there is no single formula for their success. Some programs concentrate on recreational activities. Others address academics or cultural enrichment. Some of the best programs are traditional scholastic extracurricular activities. Research indicates that scholastic extracurricular activities have numerous social benefits. For example, Mahoney and Cairns (1997) and McNeal (1995) find that extracurricular participation is related to a decrease in school dropouts, particularly during the early years of high school and for high-risk youth. Gerber (1996) found that extracurricular participation is not detrimental to student performance and that participation in such activities promotes greater academic achievement. Mahoney (1997) found a link between participation in extracurricular activities and reduced rates of criminal offending. Youniss, Yates, and Su (1997) find that adolescents involved in a broad range of activities report lower levels of substance abuse. Finally, Eccles and Baber (1999) find that participation in prosocial activities of any kind is linked to positive educational trajectories in middle to late adolescent development and to low rates of involvement in risky behavior.

Specifically, interscholastic athletic participation has been demonstrated to produce prosocial outcomes. This research suggests that, compared with non-athletes, individuals who participate in athletics have higher educational aspirations (Braddock, 1981; Holland and Andre, 1987; Otto, 1982; Picou and Curry, 1974; Otto and Alvin, 1977; Snyder and Spreitzer, 1977) and higher self-esteem (Braddock, 1981; Hanks, 1979) and achieve greater educational attainment (Anderson, 1998). They also show increased academic performance (Silliker and Quirk, 1997; Gerber, 1996), are less likely to drop out of school (McNeal, 1995; Melnick, Sabo, and Vanfossen, 1992), and have increased earnings when they enter the work world (Ewing, 1995; Long and Caudill, 1991).

Other than traditional interscholastic programs, practitioners and researchers find that the best afterschool programs combine several different activities. For instance, an evaluation of the Quantum Opportunities Program—a year-round program that provides a balanced sequence of educational, development, and service opportunities to small groups of youths from families—find that the participants had more positive outcomes in educational attainment and social achievement (Hahn et al., 1994). In addition, Gottfredson, Gottfredson, and Weisman (2001) argue that factors such as social competencies, social bonding, and inadequate supervision produce delinquency during afterschool hours and that the effectiveness of afterschool programs for reducing delinquency will depend on their ability to address these other factors.

Specifically, the types of activities found in a quality afterschool programs include

- Mentoring
- Computer instruction
- Homework assistance centers
- College awareness and preparation
- Activities linked to law enforcement
- Employment preparation or training
- Courses and enrichment in culture and the arts
- Volunteer and community service opportunities
- Drug and violence prevention curricula and counseling
- Supervised recreation and athletic programs and events
- Language instruction, including English as a second language
- Youth leadership activities (e.g., Boy Scouts, Girl Scouts, academic clubs)
- Tutoring and supplementing instruction in basic skills, such as reading, math, and science [U.S. Department of Justice, 2000]

Poor programs, by contrast, allow children to spend far too much time in passive activities such as watching television or movies. They also exhibit poor facilities, staff, or both. Research demonstrates that successful afterschool programs have several common elements:

- **Goal setting and string management:** Programs need to set and communicate goals from the beginning, develop a solid organizational structure, and be managed effectively.
- **Quality staffing:** Staffing arrangements vary according to a program’s size, management structure, and goals. But all programs need staff who are qualified and committed, have appropriate experience, have realistic expectations, and can interact productively with regular school staff—whether the program is school-based or not.
- **Attention to safety:** Programs should be safe, close to home, and accessible to all children and youth who want to participate. They should have adequate space for a variety of indoor and outdoor activities. Safe transit can be provided through means such as public transportation, staff escorts, and crossing guards.
- **Effective partnerships with community-based organizations:** Implementing quality afterschool program activities requires collaboration among diverse partners—not only parents and educators but also community residents, law enforcement agencies, service providers, community-based and civic organizations (e.g., the United Way, YWCAs, YMCAs, Girl Scouts, Boy Scouts, Junior Achievement, Boys and Girls Clubs), colleges, employers, arts and cultural institutions, museums, park and recreation services, and public officials. Effective programs aim to draw on all of a community’s diverse resources, including the participation of children and youths in program planning, to best address the concerns of the entire community.
- **Strong family involvement:** Thirty years of research shows the level of difference family involvement makes in children’s learning and chances for adult success. Family involvement in afterschool programs is just as important. The success of an afterschool program depends on the involvement of both families and the community.
- **Enriching learning opportunities:** By providing structured enriching learning opportunities, afterschool programs can be a vital resource for improving academic performance, as well as for meeting social, emotional, and physical development needs.
- **Linkages between school-day and afterschool personnel:** Quality programs support and coordinate their activities with the school in a way that supports true partnership. In those afterschool programs physically housed in school buildings, there is the opportunity to link together school-day and afterschool personnel and resources in a seamless continuum of activities that concentrate on the well-being and growth of participants.
- **Evaluation of program progress and effectiveness:** Afterschool programs are, by nature, varied and complex. No matter how well designed they are, programs must also take into account experience. Effective afterschool programs have a continual evaluation component built into their design, so program planners can objectively gauge their success based on the clear goals set for the program. [U.S. Department of Justice, 2000]

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Boys and Girls Club Gang Prevention Through Targeted Outreach

Intervention:

The overall philosophy of the program is to give at-risk youths ages 6 to 18 what they seek through gang membership (supportive adults, challenging activities, and a place to belong) in an alternative, socially positive format. There are four components of the initiatives as stated by the Boys and Girls Clubs of America (BGCA): 1) community mobilization of resources to combat the community gang problem; 2) recruitment of 50 youths at risk of gang involvement (prevention) or 35 youths already involved in gangs (intervention) through outreach and referrals; 3) promoting positive developmental experiences for these youths by developing interest-based programs that also address the youths' specific needs through programming and mainstreaming of youths into the Clubs; and 4) providing individualized case management across four areas (law enforcement/juvenile justice, school, family, and Club) to target youths to decrease gang-related behaviors and contact with the juvenile justice system and to increase the likelihood that they will attend school and improve academically.

Evaluation Methodology:

The evaluation included 21 Boys and Girls Clubs that used the prevention approach and 3 Clubs that used the intervention approach. BGCA selected the sites through a competitive process in summer 1997. All of the prevention Clubs began using Gang Prevention Through Targeted Outreach (GPTTO) either simultaneous with the start of the evaluation or 1 year beforehand. The intervention Clubs developed their projects between 1 and 3 years before the start of the evaluation. The study included 932 prevention youths and 104 intervention youths who were recruited to each Club/project over about a 10-month period. The target youth survey subsample consisted of 236 prevention and 66 intervention youths. Given the complexity of the Gang Intervention Through Targeted Outreach and

GPTTO models, the evaluation used multiple methods for gathering information, including a review of case management records, questionnaires, and interviews and focus groups with program youths and Club directors.

Evaluation Outcome:

The evaluation concluded that more frequent GPTTO Club attendance is associated with the following positive outcomes: 1) delayed onset of one gang behavior (less likely to start wearing gang colors); 2) less contact with the juvenile justice system (less likely to be sent away by the court); 3) fewer delinquent behaviors (less likely to steal and less likely to start smoking pot); 4) improved school outcomes (higher grades and greater valuing of doing well in school); and 5) more positive social relationships and productive use of out-of-school time (engaging in more positive afterschool activities and increased levels of positive peer and family relationships).

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Broader Urban Involvement and Leadership Development Program (BUILD)

Intervention:

Chicago, Ill.'s BUILD (for Broader Urban Involvement and Leadership Development) program combines several popular gang prevention strategies in an ambitious attempt to curb gang violence in some of the city's most depressed and crime-ridden neighborhoods. Founded on the principle that youths join gangs because they lack other, more constructive opportunities and outlets, BUILD tries to "reach out to young people and provide alternatives to increasing violence" by

- Deploying trained street workers, who seek to establish a rapport

with gang-involved youth and serve as positive role models

- Organizing afterschool sports programs and other recreational activities for at-risk and gang-involved youths
- Designing and delivering violence prevention curricula in local schools
- Designing and delivering a violence prevention curriculum at the Cook County Juvenile Temporary Detention Center
- Providing career training, college counseling, and financial aid to students from low-income schools
- Working with corporate sponsors, community leaders, parents, and activists to coordinate local antiviolence initiatives and coalitions

Established in 1969 to address gang violence in Chicago's West Town community, BUILD has since expanded its activities to six other low-income, high-crime areas (Cabrini–Green, Humboldt Park, Logan Square, Ravenswood, Lakeview, and Uptown). The program's violence prevention curriculum at the local detention center reaches both male and female youths from throughout Cook County. BUILD estimates its various activities to date have involved more than 77,000 youths from around the Chicago area.

Evaluation Methodology:

In 1999 a team of researchers from Loyola University examined the impact of BUILD's detention center curriculum on detainees' recidivism rates. Their evaluation used a quasi-experimental design—comparing a random sample of 60 BUILD students with a matched random sample of 60 detainees who received no BUILD instruction. While some girls were included in the program, most participants were African-American males, ages 10–17. Juveniles in both the treatment and control groups were released into the community after their stays and followed for 1 year to determine their rates of recidivism and time to recidivism. The amount of time (or number of classroom days) BUILD participants were involved in the program was also tracked to determine whether length of stay affected recidivism patterns.

In the mid-1990s the Center for Latino Research at DePaul University also conducted an 18-month nonexperimental process evaluation, assessing the implementation of all of BUILD's programs in two of its target

communities: Cabrini–Green and Uptown. This evaluation collected service records and qualitative data from interviews with staff, clients, focus groups, site visits, and monthly reports to form a subjective impression of how well BUILD staff were meeting their stated objectives of community resource development, prevention, and remediation.

Evaluation Outcome:

The Loyola study of BUILD’s detention program found that BUILD youths had significantly lower recidivism rates than their counterparts from the control group. According to the study, only 33 percent of BUILD youths recidivated within 1 year, versus 57 percent of non-BUILD participants. BUILD participants who did recidivate also had a longer average time to recidivism than youths from the control group (9.6 months versus 7.6 months). Finally, the study found that BUILD students who recidivated spent significantly fewer days in the BUILD classroom (an average of 6.17) than nonrecidivators (an average of 9.35 days).

The Center for Latino Research’s process evaluation of BUILD found that the program was extremely well implemented. Overall, the team reported, “the program’s objectives were accomplished and in many instances exceeded, [owing] to the efforts of BUILD’s dedicated staff.” BUILD’s policy of hiring staff with strong connections to the local community (including former gang members) and its strong emphasis on staff development were repeatedly identified as critical factors in the program’s success.

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Project Back-on-Track

Intervention:

Project Back-on-Track is an afterschool diversion program designed to help divert youths in early stages of delinquency from committing future crimes. It uses a multifaceted approach that targets factors contributing to delinquent behavior. Program youths participate in a 4-week cycle of treatment consisting of group and family therapies, parent groups, educational sessions, community service projects, and empathy-building exercises. These youths attend the program 2 hours a day for 4 days a week, allowing 32 hours of contact with the program per cycle. Parents attend the program 15 hours per cycle. Most youths (93 percent) are referred to the program by the District State Attorney's Office. Referrals are based on a youth's being an early career offender and living in the local juvenile justice district. The program accepts violent offenders (domestic assault, aggravated assault, sexual assault), drug offenders, and property offenders.

Evaluation Methodology:

The evaluation used a quasi-experimental design with a nonequivalent control group and a 1-year follow-up. The study participants were the first 30 youths who were referred to and completed the afterschool diversion program. These youths, ages 9–17 (with 19 of them female, 19 African-American, 10 white, and 1 Hispanic), were enrolled between July 1997 and July 1998. Most study youths (16 of them) are first-time juvenile offenders. The repeat offenders (the other 14) had committed a mean of 1.57 offenses before committing the referral offense. The comparison group (n=30) was created by matching age, sex, race, and delinquency stage. Both groups were assessed for recidivism rates and psychopathology.

Evaluation Outcome:

The evaluation indicated that Project Back-on-Track completers were significantly less likely than the matched controls to have committed subsequent criminal offenses within 12 months following their participation in the program. In addition, they had significantly fewer subsequent criminal charges at 9- and 12-month follow-up intervals than the controls. Finally, by decreasing the frequency of criminal recidivism, it was

estimated that the program resulted in a savings of \$1,800 per youth enrolled after 1 year.

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SMART Leaders

Intervention:

SMART Leaders is a 2-year booster program that follows from Stay SMART (for Skills, Mastery, And Resistance Training). Both are components of SMART Moves, a comprehensive drug and sexual activity prevention program offered through the Boys and Girls Clubs of America (BGCA). Stay SMART is a curriculum-based program for 13- to 15-year-olds that teaches a broad spectrum of social and personal competence skills to help youths identify and resist peer and other social pressures to smoke, drink, and engage in sexual activity. The program consists of 12 sessions: 1) gateway drugs, 2) decision-making, 3) advertising, 4) self-image and self-improvement, 5) coping with change, 6) coping with stress, 7) communication skills, 8) social skills: meeting and greeting people, 9) social skills: boy meets girl, 10) assertiveness, 11) relationships, and 12) life planning skills.

SMART Leaders reinforces the skills and knowledge learned during Stay SMART and encourages participants to stay involved in prevention activities and to be positive, drugfree role models for their peers. SMART Leaders I involves five small group sessions consisting of role-playing and videotapes about identifying different peer pressures to use drugs and engage in sexual activity and learning to resist those pressures. SMART Leaders II is taught in a three-session video format, with one session dedicated to resisting alcohol, one session to resisting drugs, and one to resisting early sexual activity. Participants are encouraged to become involved in other programs and activities at the BGCA and encourage their

peers to be drugfree.

(SMART Moves includes the Family Advocacy Network Club, which is designed for the parents of high-risk, early-adolescent youths involved in the drug prevention program. This aspect of SMART Moves is designed to strengthen the parent–child bond through four types of activities: basic support, parental support, educational programs, and leadership activities.)

Evaluation Methodology:

A pretest–posttest nonequivalent group design was used to evaluate the SMART Leaders and Stay SMART programs. Fourteen BGCA clubs were chosen on the basis of their performance in the pilot study on the effectiveness of SMART Moves. Five clubs offered Stay SMART, five offered Stay SMART plus the 2-year booster, and four served as the control group (offering no prevention program). The 14 clubs were located in cities with populations of 17,000 to 630,000 in every region of the country—many in urban areas, and all in economically disadvantaged areas. For treatment sites, all 13-year-old club members were invited to participate in the program, until 24 youths had enrolled. For control sites, all 13-year-old club members were invited to participate in testing, until 30 youths had signed up. At baseline the average age was 13.6. Forty-five percent of participants were white, 42 percent African-American, and 14 percent Hispanic. Seventy-five percent were male.

Over the 27-month testing period, 161 of the youths completed all treatment sessions and testing that was required to be included in the study (52 in Stay SMART Only, 54 in Stay SMART + Boosters, and 55 control). Using an analysis of variance (or ANOVA) the researchers found that those who dropped out of the study had at baseline perceived more social benefits from using alcohol and marijuana and had more marijuana-related behavior. Researchers also found that those in the Stay SMART + Boosters and the control groups who stayed through the end of the project were predominantly white, while those who stayed in the Stay SMART Only group were predominantly African-American.

Outcomes were assessed using a confidential self-report questionnaire administered by program staff for the two program groups and BGCA staff for the control group. Questions addressed attitudes, behaviors, and knowledge of alcohol, marijuana, other drugs and cigarettes. The pretest was conducted before the Stay SMART program began. Three posttests were conducted: 1) after the completion of Stay SMART (3 months), 2)

after the first booster (1 year), and 3) after the second booster (2 years).

Evaluation Outcome:

Over the course of the evaluation, the Stay SMART + Boosters group came to perceive fewer social benefits from drinking alcohol, while the Stay SMART Only and control groups came to perceive more social benefits from drinking. The youths in the Boosters group also perceived significantly fewer social benefits from smoking marijuana than those in the other two groups. However, both the Stay SMART Only and the Stay SMART + Boosters groups reported less marijuana-related behavior. Both the Stay SMART Only and the Stay SMART + Boosters groups reported less alcohol-related behavior than the control group, though this finding was only marginally significant. Both program groups showed significantly less drug- and cigarette-related behavior and significantly more knowledge concerning drug use than the control group.

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Wilderness Camp

Wilderness camps or challenge programs generally are residential placements that provide participants with a series of physically challenging outdoor activities, such as backpacking or rock climbing. These programs vary widely in terms of settings, types of activities, and therapeutic goals. But their treatment components are grounded in experiential learning that advocates "learning by doing" and facilitates opportunities for personal growth. Such programs have their origins in two distinct sources: forestry camps for youthful offenders and the Outward Bound model, originated in Wales during the Second World War (Roberts, 2004).

While military-style boot camps have consistently failed to demonstrate any positive impact on juvenile offenders' recidivism rates, the data on wilderness camps is much more encouraging. Lipsey's meta-analysis (2000) of 29 different studies of wilderness programs, involving more than 3,000 juvenile offenders, indicates that program participants experience recidivism rates that are about 8 percentage points lower than comparison subjects (29 percent versus 37 percent). However, these moderately positive results do not reflect the marked inconsistencies in individual program results.

Lipsey (2000) found that programs involving a combination of "relatively intense physical activity and therapeutic enhancement such as individual counseling, family therapy, and therapeutic group sessions" were especially effective, while those that involved less physically challenging activities and little or no therapeutic content had a less significant impact.

One of the best-known and most studied wilderness programs in the United States is VisionQuest. Founded in 1973, this national program provides alternatives to incarceration for serious juvenile offenders. VisionQuest youths typically spend 12 to 15 months in various challenging outdoor impact and therapeutic treatment programs. A normal treatment course often includes a 3-month stay at a wilderness orientation program (where the youth live in tepees or comparable primitive conditions); a 5-month adventure program (during which juvenile offenders can embark on wagon train odysseys, cross country biking trips, or ocean voyages); and a 5-month community residential/therapeutic program. The program also features an aftercare program called HomeQuest that offers support to youth and families upon reentry.

Controlled studies of VisionQuest have consistently demonstrated its efficacy in lowering participants' recidivism rates. One evaluation, performed by the RAND Corporation in the 1980s (Greenwood and Turner, 1987), found that VisionQuest graduates consistently outperformed a control group from a conventional correctional facility, despite the fact that the VisionQuest group contained more serious offenders. When differences in group characteristics were statistically controlled, VisionQuest youth were about half as likely as subjects in the control group to be rearrested after 1 year (Howell, 1998).

Despite such promising results, numerous questions about the efficacy of wilderness programs remain unanswered. Lipsey's meta-analysis (2000) found that the length of

wilderness programs seemed to have an inverse effect on treatment results (i.e., the longer the program, the less chance of its achieving statistically significant results on treatment outcomes). Such a finding seems counterintuitive and puzzling in light of the success of some long-term programs, such as VisionQuest.

Lipsey (2000) and others have also noted that, thus far, the majority of participants in wilderness programs have been white male juvenile offenders. Little is known about the program's effectiveness with African-Americans, Hispanics, and females. Additional research is still required to conclusively demonstrate the efficacy of such programs across different treatment types and diverse target populations (Fuentes, 2002).

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Validated Programmes

VisionQuest

Intervention:

VisionQuest is a wilderness challenge program that provides an alternative to incarceration for serious juvenile offenders. It also offers youths a consistent educational plan that extends throughout the program and an individualized treatment plan that is constantly reevaluated.

Most VisionQuest youths are committed to the program by the juvenile court. VisionQuest staff interview youths prior to placement to ensure that they are appropriate candidates. Eligible youths must then make four commitments before entering the program—that they will a) complete three high-impact programs, b) abstain from drugs, sex, alcohol, and tobacco, c) participate for a minimum of 1 year, and d) face their problems.

Program youths spend 12 to 15 months in various challenging outdoor impact programs. The program is divided into three phases: a) 3 months in an orientation wilderness camp, b) 5 months in an adventure program, and c) 5 months in a community residential program.

The first phase of the VisionQuest program is a wilderness camp where youths live outdoors in tepees, with a tepee family of 6 to 10 youths and a counselor. In this phase, juveniles receive an orientation to the program and undergo educational, psychological, and behavioral evaluations. They also undergo an intensive physical conditioning program in addition to their regular schoolwork.

The second phase involves an adventure program, such as a wagon train. On a wagon train, youths travel across the western States on mule-drawn wagons and assume responsibility for everything from feeding the animals to setting up nightly camps. Each wagon train consists of about 50 youths and 50 staff. The wagon train experience teaches juveniles the value of cooperation, self-discipline, and the work ethic. In addition to the wagon train, youths may engage in various quests that differ in theme, scope, and duration. Examples include ocean voyages, cross-country bike trips, hikes through wilderness, and “breaking” mustangs or camels.

In the last phase, youths enter the residential program, where they live in group homes. This living situation is designed to prepare youths to return to home by concentrating on educational goals, family relationships, and plans for the future.

Evaluation Methodology:

The evaluation employed a quasi-experimental design with nonequivalent comparison-groups design. The first group studied consisted of 257 male juveniles placed at a probation camp. The second group (the treatment group) consisted of 90 males released from the VisionQuest program. Notably, one fourth of the juveniles rejected their assignment to the VisionQuest program and became the third group in the study. These 66 males were assigned to various placements. Although the experimental VisionQuest group consisted of more serious offenders than the comparison group, the differences between the groups were controlled statistically through the careful selection of relevant variables. Recidivism was the primary outcome measure in an 18-month follow-up.

Evaluation Outcome:

The evaluation revealed that VisionQuest youths were substantially less likely to be rearrested in the 1st year after release than the traditional group (55 percent compared with 71 percent). When differences in group characteristics were statistically controlled, 1st year re-arrest rates for VisionQuest youths were about half that of the control youths. In addition, a cost–benefit analysis showed that VisionQuest was more expensive to implement than the comparison programs, but the authors show that the benefits of reduced recidivism outweigh these higher costs.

References:

Greenwood, Peter W., and Susan Turner. 1987. *The VisionQuest Program: An Evaluation*. Santa Monica, Calif.: The RAND Corporation.

Insights into adolescents' mental health during Outward Bound programs

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Abstract

Mental health is an important outcome for outdoor education and personal development programs. Two factors - psychological distress and psychological well-being - are considered to be separate but related aspects of mental health. The effects of Outward Bound Australia high school programs on the mental health factors were examined using the General Well-Being (GWB), a 35-item self-report instrument. There were three mental health assessments: pre-program (one to two weeks before the program), during program, and followup (six to eight weeks after the program). The experimental group consisted of 143 males and 108 females. A control group consisted of 56 males and 59 females. Overall, adolescents reported experiencing a temporary reduction in the quality of their mental health during the Outward Bound program. In followup results, however, the adolescents reported gains in the quality of mental health, above what they had reported experiencing prior to the Outward Bound program. These apparent improvements in mental health are confounded by significant control group results. Hence full confirmation of the findings awaits further control group testing. The results also presented some gender differences. Generally, female adolescents tended to report better mental health than male adolescents. Male adolescents reported a greater increase in psychological distress during their Outward Bound program. Males also reported less psychological well-being during the Outward Bound program than females. However, these differences could have been contributed to by non-gender factors, such as different high schools and different weather conditions during the programs. According to these findings, temporary reductions in mental health quality can lead to longer-term mental health benefits. This notion highlights a moral and ethical dilemma. If outdoor organisations and leaders are knowingly putting people through experiences which can cause temporary compromises in the quality of mental health, it is imperative that there are proven long-term benefits. On the other hand, simply conducting programs which are enjoyable may be to forgo a vast range of developmental opportunities.

Selected Examples of Peer Intervention-Focused Evidence-Based Practices

Reconnecting Youth (RY) is an indicated school-based program for youth in grades 9 to 12 (14 to 18 years of age) at risk for school dropout and exhibit multiple behavior problems. It uses a partnership model involving peers, school personnel, and parents to deliver interventions that address decreased drug involvement, increased school performance, and decreased emotional distress.

Helping Friends builds on the existing peer helping networks in schools to improve the availability, accessibility and appropriateness of social and personal support. It increases young people's knowledge of and access to referral options (in and out of school) and assists in the development of a safe and supportive school environment. The *Helping Friends* program is an adaptation of the *Natural Helpers* program (Comprehensive Health Education Foundation, 1997). It includes a program overview (describing the rationale and instructions for planning and implementing the program), a facilitator's manual (containing the program content and guidelines for presentation), participant workbooks (activity sheets and handouts used in the workshop) and CD ROM (PowerPoint presentation and templates for program documentation).

The Suicide Intervention Project (SIP) is a peer-based mental health promotion program, designed as a partnership between the University of Canberra, Australia and the YWCA of Canberra. It is based on a multi-layered peer education strategy that aims to use prevention and early intervention methods as a means of improving capacity to respond to suicide within the university community. Participants in the SIP are trained to recognise mental health problems in others, feel comfortable talking to other students about mental health issues, and have knowledge of mental health support services available to students. The SIP encourages students to talk more openly about feelings, particularly around suicide, and works to demystify mental health problems