Los Angeles County Department of Mental Health

Prevention and Early Intervention (PEI)

Evidence-Based Practices, Promising Practices, and Community-defined Evidence Practices

Resource Guide 2.0

April 25, 2011

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Introduction

The County of Los Angeles Department of Mental Health, Prevention and Early Intervention *Evidence-based Practices, Promising Practices, and Community-defined Evidence Practices Resource Guide 2.0*, has been developed by the California Institute for Mental Health (CIMH)* to support Los Angeles County's planning efforts for the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA). This guide is designed to inform the deliberations of the Los Angeles County Service Area PEI Steering Committees, as well as the Los Angeles County Countywide Populations Steering Committee, as they identify priorities to be addressed in the county MHSA PEI Plan. The guide also contains information that will help in the development of the plan once the priorities have been identified.

How to Use the Guide

The guide is a tool crafted to support local stakeholder program recommendations. Many practices and programs listed in the Resource Guide may be used for prevention and/or early intervention purposes as defined in *the Mental Health Services Act: Proposed Guidelines, Prevention and Early Intervention Component of the Three-year Program and Expenditure Plan (California Department of Mental Health, (Sept 2007)*. Prevention practices listed in this guide are consistent with the Institute of Medicine (IOM) definitions of Universal and Selective Prevention and address conditions occurring prior to a diagnosis for a mental illness. Universal prevention practices target the general public or a whole population group that has not been identified on the basis of individual risk. Selective prevention practices target individuals or a subgroup whose risk of developing mental illness is significantly higher than average. Early Intervention practices must be short duration, relatively low intensity, and address a mental health condition early in its manifestation. The short duration and low intensity criteria for early intervention practices and programs do not apply when addressing individuals at first onset of a serious psychiatric illness with psychotic features.

During deliberations, steering committee members should consult this guide as questions arise regarding the suitability of a particular program or practice in relation to the needs of a specific population or geographic area. In this sense, the guide serves as reference material for the PEI Menu of Options (the service area/countywide lists of possible PEI programs that may be included in the PEI Plan). The guide contains a great deal of information and steering committee members are advised to carefully weigh the relative merits of each program or practice along with its relative limitations as they make their recommendations. In some cases, committee members will find the guide information incomplete or entirely lacking. Such omissions usually reflect the paucity of proven programs for a given population. In these cases, planning efforts will be particularly challenging and steering committees' expertise will be needed to work through these situations as best as possible.

How the Guide Was Developed

Information about some of the practices and programs in the present guide was derived from reputable evidence-based practice web sites and each of these practices or programs were rated in terms of their scientific support. (See Appendix A for the rating scale). Additional practices were identified through the community-defined evidence practices solicitation, technical assistance, and review process.

As a starting point, the *Mental Health Services Act Prevention and Early Intervention Resource Materials* developed by the California Department of Mental Health was used to initially screen practices and programs. Practices included in the California Department of Mental Health's *Resource Materials* that did not meet the needs of the Los Angeles County MHSA PEI planning process were excluded from the present guide. Additionally, practices and programs were added where national and Los Angeles County experts identified gaps in programs or practices that could address important Los Angeles County needs.

Community-defined evidence practices were identified through a solicitation, technical assistance, and review process. This process consisted of two phases. The first phase involved releasing a set of Community-defined Evidence Practices Guidelines and reviewing practices submitted for consideration based on the Guidelines. The second phase involved providing technical assistance to practice developers that had submitted practices for consideration in Phase I and adding clarifying information to the Guidelines to help developers understand community-defined evidence and refine the description of their practices for resubmission (see Appendix D for the latest version of the Guidelines). Practices submitted in Phase I and resubmitted in Phase II were reviewed and selected for inclusion in the Resource Guide based on whether they were sufficiently well-articulated to be delivered in a consistent manner and replicated by others and whether they had some level of demonstrated effectiveness.

Ultimately, decisions regarding the practices included in this document were guided by parameters and guidelines established by the California Department of Mental Health and the Mental Health Services Act Oversight and Accountability Commission.

What the Guide Contains

The current guide includes information about Evidence-based, Promising, and Community-defined Evidence Practices designed to support local planning activities. The *Resource Guide* is organized by the priority populations established by the MHSA PEI guidelines mentioned above. Practices are grouped by the following priority populations:

- Underserved Cultural Populations
- Individuals Experiencing Onset of Serious Psychiatric Illness
- Children/Youth in Stressed Families
- Trauma-exposed
- Children/Youth at Risk for School Failure
- Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

Each practice or program reviewed in the Resource Guide includes one or two tables of information. All practices are listed with a Practice Analysis table. Evidence-based and Promising Practices are also listed with an Implementation Guide table. Community-defined Evidence practices do not contain an Implementation Guide table because implementation and support processes are still in development. It is expected that this information will be included in the Resource Guide as Community-defined Evidence practice developers further refine their implementation processes and make this information available.

Practice Analysis. The first table – Practice Analysis – describes the program and intended outcomes. Each Practice Analysis table includes the following information:

- Population – Identifies key characteristics of individuals for whom the practice/program was developed.
- Cultural Evidence – Specifies where research documents outcomes for diverse and under-represented ethnic populations. In addition, practices developed for specific ethnic populations and practices with ethnic-specific adaptations are identified in the Underserved Cultural Populations section of the Resource Guide.
- Risk and Protective Factors – Consistent with the field of Prevention, lists the risk factors addressed and protective factors supported. Risk factors are any circumstances that may increase the likelihood of an individual developing a mental illness. Conversely, protective factors are any circumstances that promote healthy behaviors and decrease the likelihood that an individual will develop a mental illness.
- Level of Evidence – Describes the strength of empirical evidence (See Appendix A).
- Outcomes – Lists the specific outcomes derived.

- Prevention – Identifies whether the program/practice qualifies as Universal and/or Selective prevention.
- Early Intervention – Describes early intervention function, if any.
- Description – A brief description of the characteristics, strategies, orientations, etc.

Implementation Guide. The second table for Evidence-based and Promising practices/programs – Implementation Guide – outlines characteristics associated with implementation that must be taken into consideration prior to selection. Practices and programs vary considerably in the extent to which there is a well-developed process and support for implementation. Given this variability, as well as the complicated nature of system and service planning, implementation information is not always readily available. When CIMH was unable to locate information on websites and in publications, or successfully contact practice/program developers, the guide notes that information was not available at the time of its publication. Each Implementation Guide table includes the following information:

- Staffing Requirements – Outlines qualifications necessary to staff the practice/program.
- Service Delivery Setting – Describes where services can be offered.
- Implementation Costs – Lists costs of training, technical assistance, materials and other associated services needed for start-up.
- Service Delivery Costs – It was beyond the scope of this project to research specific costs. This section describes the manner in which services are delivered to offer context to inform understanding of ongoing service costs.
- Standard Training Protocol – Describes training activities to initiate implementation.
- Proprietary – Indicates if an entity owns the rights to a practice or program, if no entity owns it, or if there is a mix of the two (for example, materials copyrighted but practice can be adopted freely).
- Sustainability – Includes strategies available to agencies to maintain the practice/program over time.
- Contact – Contact information for practice/program implementers.

The fields of prevention and early intervention research are vast and ever-changing. Therefore, the information addressed in this guide is also dynamic and this document must be considered in this context.

*** Conflict of Interest Statement**

Some practices and programs are not proprietary, and multiple trainers are available to support implementation. To provide information regarding implementation processes and costs for some of these practices, this guide utilizes information from CIMH implementation efforts, where CIMH plays an intermediary role. This information is offered to provide data for the decision-making process and is not intended to promote CIMH participation in future Los Angeles County MHSA PEI activities. Wherever CIMH is referenced as a contact for practice/program implementation, there are other agencies and individuals who can support future training and technical assistance. The exception is Functional Family Therapy (FFT) which is proprietary, and in which the FFT national training center works solely with CIMH to support implementation of FFT in California.

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Summary Table

Program	Age	Prevention or Early Intervention	Level of evidence	Cultural Evidence
Abuse Focused Cognitive Behavioral Therapy for Child Physical Abuse	6-12	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with all ethnic groups. Strong support for use with African Americans.
Across Ages	6-17	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Strong support for use with African Americans
Adolescent Transitions Program	11-18	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups.
Aggression Replacement Therapy	12-17	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with all ethnic groups.
All Stars	11-14	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with all ethnic groups. Moderate support for use with African Americans
Al's Pals	3-8	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☑ Supported ☐Promising ☐ Emerging	Designed for use with all ethnic groups. Strong support for use with African Americans
American Indian Life Skills	13-17	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with Native Americans.
Asian American Family Enrichment Network Program	12-18	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☐ Promising ☑ Emerging	Designed for use with Asian immigrant parents and youth.
Asian Mentoring and Advocacy Support to Enhance Resiliency in Youth	11-14	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with Asian immigrant parents and youth.

Summary Table

Program	Age	Prevention or Early Intervention	Level of evidence	Cultural Evidence
Bicultural Competence Skills Approach	**12-18**	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	**Designed for use with Native Americans.**
Boys And Girls Club Project Learn	**7-18**	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with all ethnic groups. Strong support for use with African Americans and some support for use with Latinos.**
Brand New Day	**21-65**	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☐ Promising ☑ Emerging	**Designed for use with all ethnic groups.**
Breaking Cycles	**12-17**	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with all ethnic groups. Strong support for use with Latinos.**
Brief Strategic Family Therapy	**10-18**	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups. Strong support for use with Latinos.**
Caring for our Family	**5-11**	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with Cambodian and Korean immigrant families and children.**
Caring School Community	**5-12**	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups. Moderate support for use with Latinos, moderate support for use with African Americans.**
Celebrating Families	**4-17**	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☐ Promising ☑ Emerging	**Designed for use with all ethnic groups. Moderate support for use with Latinas.**
Center for the Assessment and Prevention of Prodromal States	**16-25**	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with all ethnic groups.**

Summary Table

Program	Age	Prevention or Early Intervention	Level of evidence	Cultural Evidence
Child-Parent Psychotherapy	**0-7**	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups. Strong support for use with Latinos.**
Circus Arts for Homeless Youth	**15-25**	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with all ethnic groups.**
Clinician-Based Cognitive Psychoeducational Intervention for Families	**Parents**	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups.**
Creating Lasting Family Connections	**9-17**	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups.**
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	**10-14**	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	**Designed for use with ethnic minorities and immigrants. Support for use with Latinos, African Americans, and Native Americans.**
Cognitive Behavioral Therapy (CBT) for Anxiety	**14-17**	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups. Modified for use with African Americans.**
Cognitive Behavioral Therapy (CBT) for Depression (with antidepressant medication)	**18-55**	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups. Modified for use with Latinas and African Americans.**
Cognitive Behavioral Therapy for Late Life Depression	**55+**	☐ Prevention ☑ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups. Random clinical trials have demonstrated effectiveness among Latinos, Chinese, and African-Americans.**

Summary Table

Program	Age	Prevention or Early Intervention	Level of evidence	Cultural Evidence
Community Outreach and Resources Center	5-65	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☐ Promising ☑ Emerging	Designed for use with Latino families.
Coping Power Program	10-13	☑ Prevention ☑ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Strong support for use with African Americans.
Coping with Depression	45+	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Developed for use with Native Americans.
Culturally Adapted Parent Management Training for Latinos	11-14	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Adapted for use with Latinos.
Culturally-Modified Trauma-Focused Treatment (CM-TFT)	4-18	☑ Prevention ☑ Early Intervention	☑ Well-Supported for TFCBT, adaptations being evaluated ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Adapted for use with Latinos
Early Detection and Intervention for the Prevention of Psychosis (EDIPP)	12-25	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with all ethnic groups.
Early Psychosis Prevention and Intervention Centre (EPPIC)	15-25	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☐ Promising ☑ Emerging	Designed for use with all ethnic groups.
Early Risers Skills for Success	6-12	☐ Prevention ☑ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Strong support for use with African Americans
Effective Black Parenting	0-18	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with African Americans.
Families and Schools Together	4-12	☑ Prevention ☐ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Strong support for use with African Americans, strong support for

Program	Age	Prevention or Early Intervention	Level of evidence	Cultural Evidence
				use with Native Americans.
Family Connections	Families	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with all ethnic groups. Strong support for use with African Americans.
Family Coping Skills Program (FCSP)	Adults	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☐ Promising ☑ Emerging	Developed for use with Latinas.
Family Effectiveness Training	6-12	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	Developed for use with Latinos.
Family Health Promotion	3-8	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with Latinos.
Focus on Families	3-14	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Some support for use with African Americans.
Functional Family Therapy	11-18	☐ Prevention ☑ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups.
Gang Resistance is Paramount	7-16	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☐ Promising ☑ Emerging	Designed for use with all ethnic groups. Strong support for use with Latinos.
Gatekeeper Case-Finding Model	55+	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☐ Promising ☑ Emerging	Designed for use with all ethnic groups.
GLTB CHAMPS	15-25	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☑ Emerging	Designed for use with African-American GLTB transition-aged youth.

Summary Table

Program	Age	Prevention or Early Intervention	Level of evidence	Cultural Evidence
Group Cognitive Behavioral Therapy (CBT) of Major Depression	Adults	☑ Prevention ☑ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Modified for use with Latinos and African Americans.
Healthy Steps for Young Children	0-3	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups.
Homebuilders	0-18	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups.
IMPACT! A Youth Development and Leadership Program	14-18	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with Asian immigrant youth.
Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)	60+	☐ Prevention ☑ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups.
Incredible Years	3-12	☑ Prevention ☑ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Some support for use with African Americans, Asians, and Latinos.
Incredible Years Parenting Program Used with Korean American Mothers	3-8	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic populations. Adapted for use with Koreans.
"Integrated Treatment" as Evaluated by the OPUS trial	18-45	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☐ Promising ☑ Emerging	Designed for use with all ethnic groups.
Interpersonal Psychotherapy (IPT) for Depression	12-18	☑ Prevention ☑ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Modified for use with Latinos.
Loving Intervention for Family Enrichment	10-17	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported	Designed for use with Latino

Summary Table

Program	Age	Prevention or Early Intervention	Level of evidence	Cultural Evidence
Program (LIFE)			☑ Promising ☐ Emerging	children and families.
Live Well, Live Long, Steps to Mental Wellness	60+	☑ Prevention ☑ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups.
Making Parenting a Pleasure	0-8	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with all ethnic groups.
Maternal Wellness Center	21-65	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☐ Promising ☑ Emerging	Designed for use with low-income ethnic minority high-risk women.
Mindful Parenting Groups	0-5	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with gay and lesbian families and bi-racial couples.
Multidimensional Family Therapy	11-18	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Strong support for use with African Americans.
Multidimensional Treatment Foster Care	11-18	☐ Prevention ☑ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups.
Multisystemic Therapy	11-18	☐ Prevention ☑ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Strong support for use with African Americans.
Nurse Family Partnership	Pregnancy-2	☑ Prevention ☑ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Strong support for use with African Americans.
Nurturing Parenting Program	5-18	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with all ethnic groups. Strong support for use with Latinos, some support for use with Native Americans
Olweus Bullying	6-14	☑ Prevention	☐ Well-Supported	Designed for use with all ethnic

Summary Table

Program	Age	Prevention or Early Intervention	Level of evidence	Cultural Evidence
Prevention Program		☐ Early Intervention	☐ Supported ☑ Promising ☐ Emerging	**groups.**
Parent-Child Interaction Therapy (PCIT): "*Guiando a Niños Activos* (GANA) Program"	**3-6**	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with all ethnic groups. Adapted for use with Latinos.**
Parent-Child Interaction Therapy (PCIT): "Honoring Children, Making Relatives"	**3-7**	☑ Prevention ☑ Early Intervention	☑ Well-Supported for PCIT-adaptations not yet evaluated ☐ Supported ☐ Promising ☐ Emerging	**Designed for use with all ethnic groups. Adapted for use with Native Americans.**
Parenting Wisely	**3-18**	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with all ethnic groups.**
Peacemakers	**10-14**	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with all ethnic groups. Strong support for use with African Americans**
Personal Assessment and Crisis Evaluation (PACE)	**12-25**	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with all ethnic groups.**
Positive Directions	**10-17**	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with Latino youth.**
Prevention and Early Treatment of Depression in Primary Care	**21-65**	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	**Designed for use with low-income ethnic minority primary care patients.**
Prevention of Suicide in Primary Care Elderly	**60+**	☑ Prevention ☑ Early Intervention	☑ Well-Supported ☐ Supported	**Designed for use with all ethnic**

Summary Table

Program	Age	Prevention or Early Intervention	Level of evidence	Cultural Evidence
(PROSPECT)			☐ Promising ☐ Emerging	groups.
Program of All-Inclusive Care for the Elderly (PACE)	60+	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with all ethnic groups.
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)	60+	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Moderate support for use with African Americans.
Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorders	18-65+	☐ Prevention ☑ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Moderate support for use with African Americans.
Promoting Alternative Thinking Strategies	3-12	☑ Prevention ☐ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Moderate support for use with African Americans
Promotores de salud para nuestra tercera edud	55+	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☐ Promising ☑ Emerging	Designed for use with all Latino groups.
Psychogeriatric Assessment and Treatment in City Housing (PATCH)	60+	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☑ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups.
Psychological First Aid for Students and Teachers	3-18	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☐ Promising ☑ Emerging	Designed for use with all ethnic groups.
Reflective Parenting Program (RPP)	2-12	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☐ Promising ☑ Emerging	Designed for use with all ethnic groups.
Resilience and Effectiveness of Asian Adolescents in Countering Hostility	11-14	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with Asian immigrant youth.
SafeCare	0-5	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with all ethnic groups.

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Summary Table

Program	Age	Prevention or Early Intervention	Level of evidence	Cultural Evidence
Safe Dates	**13-15**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-Supported** ☑ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups.**
Second Step	**6-12**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-Supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups.**
Seeking Safety	**15-55**	☐ **Prevention** ☑ **Early Intervention**	☐ **Well-Supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Moderate support for use with African Americans.**
School, Community, and Law Enforcement Program	**14-18**	☐ **Prevention** ☑ **Early Intervention**	☐ **Well-Supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with Asian immigrant adolescents and their families.**
Social Decision-Making and Problem-Solving	**5-13**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-Supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups.**
Strengthening Bonds of Chicano Youth and Families	**9-16**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-Supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with Latinos.**
Strengthening Families	**3-16**	☑ **Prevention** ☑ **Early Intervention**	☐ **Well-Supported** ☑ **Supported** ☐ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups. Moderate support for use with African Americans, some support for use with Latinos.**
SITCAP-ART **Structured Sensory Intervention for Traumatized Children, Adolescents and Parents**	**12-17**	☐ **Prevention** ☑ **Early Intervention**	☐ **Well-Supported** ☐ **Supported** ☑ **Promising** ☐ **Emerging**	**Designed for use with all ethnic groups.**
Supporting Adolescents with Guidance and Employment	**12-16**	☑ **Prevention** ☐ **Early Intervention**	☐ **Well-Supported** ☐ **Supported** ☐ **Promising** ☑ **Emerging**	**Developed for use with African Americans. Strong support for use with African Americans.**

Summary Table

Program	Age	Prevention or Early Intervention	Level of evidence	Cultural Evidence
The Mothers and Babies Course "Mamás y Bebés"	16-35 – Mothers with babies 0-2	☑ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with Latinas.
Trauma Focused Cognitive Behavioral Therapy	3-18	☐ Prevention ☑ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups.
Trauma-Focused CBT (TF-CBT): "Honoring Children, Mending the Circle"	3-18	☑ Prevention ☐ Early Intervention	☑ Well-Supported-TFCBT-adaptations not yet evaluated ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups. Adapted for use with Native Americans.
Triple P – Positive Parenting Program	0-18	☑ Prevention ☑ Early Intervention	☑ Well-Supported ☐ Supported ☐ Promising ☐ Emerging	Designed for use with all ethnic groups.
UCLA TIES Transition Model	0-8	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with all ethnic groups.
Un Paso Mas	0-65	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☐ Promising ☑ Emerging	Designed for use with Latino families.
Ventanas	12-18	☐ Prevention ☑ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with Latino adolescents and their families.
Why Try?	7-18	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☑ Promising ☐ Emerging	Designed for use with low-income African-American, Latino, and Asian youth.
Winners	5-12	☑ Prevention ☐ Early Intervention	☐ Well-Supported ☐ Supported ☐ Promising ☑ Emerging	Designed for use with African-American children.

Children/Youth at Risk for School Failure

Program	Across Ages – NOT a Stand Alone Program
Population	School age children and youth – ages 6-17 at risk for substance use and school failure
Cultural Evidence	52% of study participants were African American
Risk and Protective Factors	**Risk:** • Favorable attitudes toward drug use • Poor family bonding • Dropping out • Low academic achievement **Protective:** • High expectations • Good relationship with parents • Strong school motivation
Level of Evidence	Supported
Outcomes	1. Improved school attendance 2. Improved drug refusal skills
Prevention: Universal/Selective	Selective
Early Intervention	
Description	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 (10-13 years old/transitioning to middle school) 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 awareness, self-confidence, and skills they need to resist drugs and overcome overwhelming obstacles. The overall goal of the program is to increase protective factors for high-risk students to prevent, reduce, or delay the use of alcohol, tobacco, and other drugs and the problems associated with substance use. Four intervention components: (1) a minimum of 2 hours per week of mentoring by older adults who are recruited from the community, matched with youth, and trained to serve as mentors; (2) 1-2 hours of weekly community service by youth, including regular visits to frail elders in nursing homes; (3) monthly weekend social and recreational activities for youth, their families, and mentors; and (4) 26 45-minute social competence training lessons taught weekly in the classroom using the Social Problem-Solving Module of the Social Competence Promotion Program for Young Adolescents developed by Roger Weissberg and colleagues.

Children/Youth at Risk for School Failure

Program	Across Ages
Staffing Requirements	• Teachers/volunteers (over 55) • 1-full time project director • 1 half time project coordinator • 1 outreach coordinator • Support staff (10 hrs per week) • Project director –Masters level • Project coordinator - B.A. or equivalent • Outreach coordinator- community experience
Service Delivery Setting	• Classroom based • Community based
Implementation Costs	• Seminar Workshop on site—basic 2 days; refresher 1-2 days TA cost estimate $1001—$5000 • 2 day package $1,000 per day plus expenses • Onsite TA $500 per day plus expenses • Telephone TA $30/hr • Training manual $75.00 • Handbook for parents $25.00 • Mentor handbook $25.00 • Evaluation protocol $25.00 • Video $65.00 • Criminal/background checks
Service Delivery Costs	• 1 staff member for 30-40 mentors/60 youth • 15-20 mentors for 30 youth • 15-20 youth for 10-15 nursing home residents • 12 months in program; minimum 2 hrs per week • Social Competence Training has 26 lessons; 45 minutes each • Monthly family activities
Standard Training Protocol	• Yes
Proprietary	• Yes
Sustainability	• No information available at this time
Contact	Andrea Taylor, Ph.D. Center for Intergenerational Learning 1601 North Broad Street, USB 206 Temple University Philadelphia, PA 19122 215-204-6733 Fax: 215-204-3195 ataylor@temple.edu www.temple.edu/across_ages

Children/Youth at Risk for School Failure

Program	All Stars
Population	11-14 year old youth in middle school and/or junior high
Cultural Evidence	42% of study participants were African American
Risk and Protective Factors	**Risk:** • Poor refusal skills • Favorable attitudes towards drug use **Protective:** • Social competencies and problem solving skills
Level of Evidence	Promising
Outcomes	1. Positive change in normative beliefs 2. Increase in school commitment 3. Improvement in impulsive decision-making
Prevention: Universal/Selective	Universal/Selective
Early Intervention	
Description	All Stars is a multiyear school-based program for middle school students (11 to 14 years old) designed to prevent and delay the onset of high-risk behaviors such as drug use, violence, and premature sexual activity. The program focuses on five topics important to preventing high-risk behaviors: (1) developing positive ideals that do not fit with high-risk behavior; (2) creating a belief in conventional norms; (3) building strong personal commitments; (4) bonding with school, prosocial institutions, and family; and (5) increasing positive parental attentiveness. The All Stars curriculum includes highly interactive group activities, games and art projects, small group discussions, one-on-one sessions, a parent component, and a celebration ceremony. The All Stars Core program consists of thirteen 45-minute class sessions delivered on a weekly basis by teachers, prevention specialists, or social workers. The All Stars Booster program is designed to be delivered 1 year after the core program and includes nine 45-minute sessions reinforcing lessons learned in the previous year. Multiple program packages are available to support implementation by either regular teachers or prevention specialists.

Program	All Stars
Staffing Requirements	• "Program specialist' or classroom teacher • Training is provided in English or Spanish
Service Delivery Setting	• In classroom • Small group sessions outside classroom • Community based settings • One on one sessions (not defined where)
Implementation Costs	• A 2-day onsite training for up to 20 participants • Costs $3,000 plus travel expenses • Teacher manuals cost $125 per attendee and must be purchases at least 2 weeks in advance • Off-site trainings are available for $250 per attendee plus their travel expenses • Online training is conducted in four 2-hour modules for $2,400 plus manual costs but is limited to 10 participants.
Service Delivery Costs	• Incorporated into classroom protocol • Ongoing technical assistance provided through email contact
Standard Training Protocol	• Two day training with online follow up TA
Proprietary	• Yes
Sustainability	• Ongoing TA available and manuals are frequently revised.
Contact	Kathleen Nelson-Simley Tanglewood Research 420 Gallimore Dairy Road, Suite A Greensboro, NC 27409 800-822-7148 kathleen@ tanglewood.net

Program	Al's Pals	
Population	3-8 year olds in pre-school and early elementary (K-3)	
Cultural Evidence	Largest study carried out in Head Start – 83% of the children were African American	
Risk and Protective Factors	Risk: • Early onset of aggression	Protective: • Social competence and problem solving skills • Effective parenting • Presence and involvement of caring and supportive adults
Level of Evidence	Supported	
Outcomes	1. Improved social competence 2. Decreases in aggression and anti-social behaviors	
Prevention: Universal/Selective	Universal	
Early Intervention		
Description	Al's Pals: Kids Making Healthy Choices is a school-based prevention program that seeks to develop social-emotional skills such as self-control, problem-solving, and healthy decision making in children ages 3-8 in preschool, kindergarten, and first grade. The program fosters both the personal traits of resilience and the nurturing environments children need to overcome difficulties and fully develop their talents and capabilities. Through fun lessons, engaging puppets, original music and materials, and appropriate teaching approaches, the Al's Pals curriculum helps young children regulate their own feelings and behavior; creates and maintains a classroom environment of caring, cooperation, respect, and responsibility; teaches conflict resolution and peaceful problem-solving; promotes appreciation of differences and positive social relationships; prevents and addresses bullying behavior; conveys clear messages about the harms of alcohol, tobacco, and other drugs; and builds children's abilities to make healthy choices and cope with life's difficulties. The program consists of a year-long, 46-session interactive curriculum delivered by trained classroom teachers who use Al's Pals teaching approaches to infuse the concepts into daily interactions with the children. Ongoing communication with parents is also part of Al's Pals. Teachers regularly send parents letters to update them about the skills the children are learning, suggest home activities to reinforce these concepts, and inform parents about their child's progress.	

Program	Al's Pals
Staffing Requirements	• Classroom teachers • Mental health clinicians (SW, Ph.D)
Service Delivery Setting	• Preschool, early elementary schools • After school programs • Childcare centers • After school programs can be individually tailored to other environments (e.g. residential)
Implementation Costs	• Onsite training for 24 staff is $6,500 • For 30 staff is $8,000 (both plus trainer travel costs) presentation "kit." This is a 2-day session • Also newly instituted is an online course comprising of 7 sessions at 2 hours each. Limited to 12-15 attendees costing $325 each • Booster training and TA available • Annual update of materials provided
Service Delivery Costs	• Designed to be integrated into classroom instruction (MH providers encouraged to participate but not required).
Standard Training Protocol	• Training sessions required for teachers of a manualized curriculum.
Proprietary	• Yes
Sustainability	• Fidelity assessment and evaluation available • Annual 3 hour refresher course and a 3 hour advanced training available • Annual follow up calls from a TA staff with a checklist for self measurement and a reminder list sent to prompt necessary tasks • Ongoing relationship with local coordinator sought
Contact	Susan Geller Wingspan, LLC. 4196-A Innslake Dr. Glen AllenM, VA 23060 804-967-9002 contact@wingspanworks.com www.wingspanworks.com

Program	Asian Mentoring and Advocacy Support to Enhance Resiliency in Youth (MASTERY): A Mentoring Program
Developer	Terry Gock, PhD, MPA
Submitted by	Asian Pacific Family Center-East
Description	• Bicultural, community-based program for middle-school Asian immigrant youth; intensive one-to-one mentoring and 42-week Life Skills curriculum focused on self-awareness & identity, cultural identity, goal setting, communication, anger management, selection of prosocial peer group, and refusal skills for alcohol, tobacco, and other drugs
Population	• Middle-school age Asian immigrant youths at high risk of substance abuse and other delinquent behaviors
Cultural Evidence	• Curriculum has been implemented with Asian immigrant youth • Evaluation measures used were specifically developed for and tested with Asian immigrant population
Risk and Protective Factors	• Enhanced self-awareness and cultural identity • Enhanced relationships with significant adults and prosocial peers • Increased school bonding • Increased knowledge and use of prosocial skills
Level of Evidence	• Promising
Outcomes	• Decreased substance use • Decreased association with substance-using peers • Decreased risk of using alcohol, tobacco, or other drugs
Prevention: Universal/Selective	• Selective

Program	Boys and Girls Club Project Learn	
Population	7-18 year old youth, living in poverty and at risk for school drop out	
Cultural Evidence	63% of study participants were African American and 19% were Latino	
Risk and Protective Factors	Risk: • Dropping out of school • Low academic achievement • Negative attitude toward school	Protective: • Social competencies and problem solving • Involvement in organized religious activities • Effective parenting
Level of Evidence	Promising	
Outcomes	1. Improved school attendance 2. Improved enjoyment with academic subjects 3. Improved scores in reading, spelling, history and social science	
Prevention: Universal/Selective	Selective	
Early Intervention		
Description	This program involves enhancing the educational performance of economically disadvantaged adolescents who live in public housing. Program delivery teams consist of local BGCA staff, representatives from the youths' schools, the housing authority, resident councils of the local public housing developments, and parent leaders. Each week the program engages youth in structured activities designed to improve educational enhancement: • 1 to 2 hours of creative writing • 4 to 5 hours of leisure reading • 5 to 6 hours completing school homework • 4 to 5 hours of discussion with knowledgeable adults • 2 to 3 hours helping other youths with school homework, projects, and skill acquisition • 4 to 5 hours of board games and other recreational pursuits that draw on cognitive skills and talents transferable to school lessons. Incentives are given such as school supplies, field trips, additional computer time, and special privileges with their local Boys & Girls Club. Parents are encouraged to become involved in the program by helping their child with homework; reading, discussing current events, and playing board games with their child; and taking part in other educational skill acquisition.	

Program	Boys and Girls Club Project Learn
Staffing Requirements	• Local BGCP Staff/Parent Leaders/School Representatives/Housing Authority
Service Delivery Setting	• Boys and girls club site
Implementation Costs	• Information not available at this time
Service Delivery Costs	• 4/5 hours weekly discussions • 4/5 hours weekly leisure reading • One hour weekly writing activities • 5/6 hours per week homework help • 2/3 hours community service • 4/5 hours games using cognitive skills
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Boys/Girls Club of America 404-487-5700 Fax 404-487-5789 1239 Peachtree Street, NW Atlanta, GA 30309 jatkinson@bgca.org info@bcga/org

Program	Caring School Community	
Population	Elementary school children 5-12 years old	
Cultural Evidence	2 of 4 studies report outcomes by ethnicity. 25% - Latino in one study 37% African American in a second study	
Risk and Protective Factors	Risk: • Mental health problem • Low academic achievement • Negative attitude toward school • Poorly organized and functioning school	Protective: • Social competencies and problem-solving skills • Effective parenting • High teacher expectations
Level of Evidence	Supported	
Outcomes	1. Decreased alcohol and marijuana use 2. Improved academic achievement 3. Increased concern for others 4. Decreased discipline referrals	
Prevention: Universal/Selective	Universal	
Early Intervention		
Description	Caring School Community (CSC), formerly called the Child Development Project, is a universal elementary school (K-6) improvement program aimed at promoting positive youth development. The program is designed to create a caring school environment characterized by kind and supportive relationships and collaboration among students, staff, and parents. The CSC model is consistent with research-based practices for increasing student achievement as well as the theoretical and empirical literature supporting the benefits of a caring classroom community in meeting students' needs for emotional and physical safety, supportive relationships, autonomy, and sense of competence. By creating a caring school community, the program seeks to promote prosocial values, increase academic motivation and achievement, and prevent drug use, violence, and delinquency. CSC has four components designed to be implemented over the course of the school year: (1) Class Meeting Lessons, which provide teachers and students with a forum to get to know one another and make decisions that affect classroom climate; (2) Cross-Age Buddies, which help build caring cross-age relationships; (3) Homeside Activities, which foster communication at home and link school learning with home experiences and perspectives; and (4) Schoolwide Community-Building Activities, which link students, parents, teachers, and other adults in the school. School-wide implementation of CSC is recommended because the program builds connections beyond the classroom.	

Program	Caring School Community
Staffing Requirements	• Teachers, principals and coaches
Service Delivery Setting	• Schools
Implementation Costs	• Approximately $2000 in curriculum materials. Training costs not available.
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	For more information contact: Ginger Cook, Ph.D. CSC Project Manager Developmental Studies Center 800.666.7270, ext. 263 ginger_cook@devstu.org

Program	Early Risers Skills for Success
Population	6-12 year old elementary school students who are at high risk for substance abuse and behavior problems leading to early school failure
Cultural Evidence	86% of the research participants were African American
Risk and Protective Factors	**Risk:** • Early onset of aggression • Life stressors • Poor refusal skills • Presence of a mental health problem • Family management problems • Low academic achievement • Poorly organized and functioning schools • Peer rejection • Association with aggressive peers **Protective:** • Self-efficacy • Involvement in organized religious activities • Effective parenting • Good relationships with parents • High expectations for students • Presence and involvement of caring and supportive adults
Level of Evidence	Well Supported
Outcomes	1. Improved academic achievement 2. Improvements in self-regulation for severely aggressive children 3. Improvement in parental distress for parents of severely aggressive children 4. Improvement in the use of effective parental discipline
Prevention: Universal/Selective	
Early Intervention	Early intervention – elementary school children are referred due to significant behavior problems
Description	Early Risers is based on the premise that early, comprehensive, and sustained intervention is necessary to target multiple risk and protective factors. The program uses integrated child-, school-, and family-focused interventions to move high-risk children onto a more adaptive developmental pathway. A "family advocate" (someone with a bachelor's degree and experience working with children/parents) coordinates the child- and family-focused components. The child-focused component has three parts: (1) Summer Day Camp, offered 4 days per week for 6 weeks and consisting of social-emotional skills education and training, reading enrichment, and creative arts experiences supported by a behavioral management protocol; (2) School Year Friendship Groups, offered during or after school and providing advancement and maintenance of skills learned over the summer; and (3) School Support, which occurs throughout each school year and is intended to assist and modify academic instruction, as well as address children's behavior while in school, through case management, consultation, and mentoring activities performed by the family advocate at school. The family-focused component has two parts: (1) Family Nights with Parent Education, where children and parents come to a center or school 5 times per year during the evening, with children participating in fun activities while their parents meet in small groups for parenting-focused education and skills training; and (2) Family Support, which is the implementation of an individually designed case plan for each family to address their specific needs, strengths, and maladaptive patterns through goal setting, brief interventions, referral, continuous monitoring, and, if indicated, more intensive and tailored parent skills training.

Program	Early Risers Skills for Success
Staffing Requirements	• A "family advocate" (someone with a bachelor's degree and 3-5 years experience working with children/parents) coordinates the child- and family-focused components • One family advocate should be hired for every 25 children/families to be served
Service Delivery Setting	• Center or school • Home • Rural and/or frontier • School • Suburban • Urban
Implementation Costs	• $7,000 training fee includes 2 days of training; travel costs for the trainer; shipping costs for materials; 5 manuals, each with a CD that contains all Early Risers forms (additional manuals may be purchased for $75 each); the rights to use, duplicate, or modify the forms provided in the materials; documentation of training completion (a certificate or letter). • $629 for the PATHS Basic Kit (grades 1-6) or $719 for the PATHS Basic Kit plus the PATHS Turtle Unit (for kindergartners) • $800-$1,200 for school supplies • Staff salaries $25,000-$30,000 per year plus fringe benefits • Total annual cost is approximately $1,500-$2,500 per student
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• On site 2-day training
Proprietary	• The rights to use, duplicate, or modify the forms provided in the materials are bought
Sustainability	• Ongoing technical assistance after the training, sites are strongly encouraged to purchase the Promoting Alternative Thinking Strategies (PATHS) curriculum, which is used in the program's social skills component and is referenced during the training
Contact	Gerald J. August, Ph.D. **Division of Child and Adolescent Psychiatry** **2450 Riverside Avenue, F256/2B West** **Minneapolis, MN 55454–1495** **Phone: (612) 273-9711** **Fax: (612) 273-9779** **E-mail: augus001@tc.umn.edu**

Program	Families and Schools Together
Population	School aged children 4-12 at risk for academic failure
Cultural Evidence	Four random assignment studies have been conducted. In one 100% of the participants were African American and in another 100% of the children were Native American
Risk and Protective Factors	**Risk:** • Early onset of aggression • Child maltreatment • Family conflict • Low school achievement • Low community attachment **Protective:** • Social competencies and problem solving skills • Effective parenting • Teacher high expectation of students
Level of Evidence	Well Supported
Outcomes	1. Improved social skills 2. Decreased aggression 3. Improved academic performance 4. Increased parent involvement in school
Prevention: Universal/Selective	Selective
Early Intervention	
Description	This is a multi-family group intervention program designed to build protective factors for children (ages 4-12), to empower parents to be the primary prevention agents for their own children, and to build supportive parent-to-parent groups. The overall goal of the FAST program is to intervene early to help at-risk youth succeed in the community, at home, and in school and thus avoid problems such as adolescent delinquency, violence, addiction, and dropping out of school. Another goal of the FAST program is to produce changes at the levels of individual child functioning and the local social network. The program begins when a teacher or other school professional identifies a child with problem behaviors who is at risk for serious future academic and social problems. Trained recruiters then meet with the family at home to discuss the concerns and invite them into the program. The family then gathers with 8-12 other families for eight weekly meetings, usually held at school. The meetings last 2 ½ hours and include: planned opening and closing routines, a family meal, structured family activities and communications, parent mutual-support time, and parent-child play therapy. A trained team consisting of a parent, a school professional, a clinical social worker, and a substance abuse counselor facilitates the meetings. The team is also required to represent the culture of the families participating in the program. After graduation at 8 weeks, the families then continue to participate in monthly follow-up meetings, run by the families, for 2 years.

Program	Families and Schools Together (FAST)
Staffing Requirements	• Parent • School professional • Clinical social worker • Substance abuse counselor
Service Delivery Setting	• Usually in a school setting
Implementation Costs	• Approximately $21,000 per cycle which includes a 2 day orientation, 3 onsite coaching visits in phase II and a one-day onsite training in phase III after the evaluation has been completed. This is a total cost including manuals and other materials. • Evaluation and monthly TA supports included in cost • Approximate 153 hours of instruction included during each cycle
Service Delivery Costs	• Eight to 12 weekly sessions with families
Standard Training Protocol	• Manualized with fidelity measures
Proprietary	• Yes
Sustainability	• Program evaluation is built into cost of implementation
Contact	Lynn McDonald Wisconsin Center for Education Research 1025 W. Johnson St. University of Wisconsin—Madison Madison, WI 53706 608-253-6338 mrmcdona@facstaff.wisc.edu Technical Assistance Provider Fast National Training and Evaluation Center 2801 International Lane, Suite 105 Madison, WI 53704 888-629-2481

Program	IMPACT! (Inspire & Mobilize People to Achieve Change Together): A Youth Development and Leadership Program
Developer	Terry Gock, PhD, MPA
Submitted by	Asian Pacific Family Center-East
Description	• Bicultural, school-based, 26-week skill-based curriculum focused on increasing pro-social skills and preventing externalizing behavior problems in Asian immigrant adolescent youth
Population	• High-school age Asian immigrant youths at high risk of behavioral problems
Cultural Evidence	• Curriculum has been implemented with 169 Asian immigrant youth • Evaluation measures used were specifically developed for and tested with Asian immigrant population
Risk and Protective Factors	• Increased self-efficacy • Increased pro-social peer interactions • Increased pro-social connections in school and with family • Decreased substance abuse • Decreased engagement in risky sexual activities • Decreased engagement in delinquent behaviors
Level of Evidence	• Promising
Outcomes	• Increased knowledge of healthy and pro-social behaviors • Increased pro-social attitudes • Increased pro-social behaviors
Prevention: Universal/Selective	• Selective

Program	Incredible Years
Population	3-12 year old children at risk for school failure and juvenile justice involvement
Cultural Evidence	One study comparing outcomes among diverse groups: 22% Asian (Vietnamese and Chinese) 19% Latino 10% African American 4% Native American
Risk and Protective Factors	**Risk:** • Mental health problems • Early onset of aggression • Maternal depression • Family management problems • Parental conflict • Negative attitude toward school **Protective:** • Effective parenting • Opportunities for prosocial school involvement • Involvement with positive peer group activities
Level of Evidence	Well Supported
Outcomes	1. Increase in positive and nurturing parenting 2. Decrease in harsh discipline 3. Reduction in child behavior problems at home and in school 4. Improvements in children's social competence and school readiness skills 5. Improved parent-child bonding 6. Improved parent-teacher and school involvement
Prevention: Universal/Selective	Selective
Early Intervention	Early intervention for children referred by teachers and pediatricians
Description	Incredible Years is a set of comprehensive, multifaceted, and developmentally based curricula targeting 2-12 year old children and their parents and teachers. The parent, child, and teacher training interventions that compose Incredible Years are guided by developmental theory on the role of multiple interacting risk and protective factors in the development of conduct problems. The three program components are designed to work jointly to promote emotional and social competence and to prevent, reduce, and treat behavioral and emotional problems in young children. The parent training intervention focuses on strengthening parenting competencies and fostering parents' involvement in children's school experiences to promote children's academic and social skills and reduce delinquent behaviors. The Dinosaur child training curriculum aims to strengthen children's social and emotional competencies, such as understanding and communicating feelings, using effective problem-solving strategies, managing anger, practicing friendship and conventional skills, and behaving appropriately in the classroom. The teacher training intervention focuses on strengthening teachers' classroom management strategies, promoting children's prosocial behavior and school readiness, and reducing children's classroom aggression and noncooperation with peers and teachers. The intervention also helps teachers work with parents to support their school involvement and promote consistency between home and school. In all three training interventions, trained facilitators use videotaped scenes to structure the content and stimulate group discussions and problem solving.

Program	Incredible Years
Staffing Requirements	• Teachers • Parents
Service Delivery Setting	• Home • School • Community
Implementation Costs	• One-time start-up costs include $400-$500 per leader for leader training and $1,500 per series for program materials (the cost for the child program is slightly higher due to the price of puppets) • Ongoing costs include $500 annually for each leader to receive consultation, $476 for each parent in parent groups, $775 for each child in child treatment groups, $15 for each child receiving the Dinosaur curriculum in school, and $30 for each teacher receiving the teacher training.
Service Delivery Costs	• For detailed cost information associated with each program component see the Incredible Year web site
Standard Training Protocol	• Three day on site training for parenting and 2 day on site for the child curriculum. Certification takes place after group leaders complete two group cycles and have video tapes reviewed by the developer.
Proprietary	• Mix of public and proprietary
Sustainability	• Mentor who functions as a trainer in the local context.
Contact	Lisa St. George Administrative Director Incredible Years 1411 Eighth Avenue, West Seattle, WA 98119 Phone: (888) 506-3562 Fax: (888) 506-3562 E-mail: lisastgeorge@comcast.net Carolyn Webster-Stratton, Ph.D. Professor and Director of Parenting Clinic, University of Washington Developer and Director, Incredible Years 1411 Eighth Avenue, West Seattle, WA 98119 Phone: (888) 506-3562 Fax: (888) 506-3562 E-mail: cwebsterstratton@comcast.net www.incredibleyears.com

Program	LIFE (Loving Intervention for Family Enrichment) Program
Developer	Special Service for Groups – Occupational Therapy Training Program
Submitted by	Special Service for Groups – Occupational Therapy Training Program
Description	• Adaptation of Parent Project® national model (22-week skills based curriculum for parents of children at risk of or involved with the juvenile justice system) and multi-family group therapy
Population	• Low income Latino families with monolingual (Spanish) parents of children ages 10-17 at high-risk of delinquency and/or school failure
Cultural Evidence	• Outcomes achieved with Los Angeles County target population
Risk and Protective Factors	• Poor school attendance and performance • Poor relationships with peers, parents, and other authority figures • Antisocial behavior • Substance use/abuse • Parental stress • Inadequate parenting skills
Level of Evidence	• Promising
Outcomes	• Decreases in youth aggressive behaviors and social problems • Improved youth self-efficacy • Improved parenting skills and parenting competence
Prevention: Universal/Selective	• Selective

Program	Olweus Bullying Prevention Program	
Population	Elementary and junior high school students ages 6-14	
Cultural Evidence	No information available	
Risk and Protective Factors	Risk: • Early onset of aggression • Exposure to violence/victimization • Poorly organized and functioning schools • Negative attitude towards school • Truancy/frequent absences • Negative attitude toward school • Peer rejection • Association with antisocial peers	Protective: • High expectations • Perception of social support from peers and adults • Social competencies and problem solving skills • Good relationships with peers • Involvement with positive peer group activities • High teacher expectations • Rewards for prosocial school involvement
Level of Evidence	Promising	
Outcomes	1. Reduction in reports of bullying and victimization 2. Reduction in student reports of general antisocial behavior – fighting, truancy and vandalism 3. Significant improvement in social climate of the class – less disruption, more order and discipline	
Prevention: Universal/Selective	Universal	
Early Intervention		
Description	This is a universal intervention developed to promote the reduction and prevention of bullying behavior and victimization problems for children ages 6-14 years. The program is based on an ecological model, intervening with a child's environment on many levels: the individual children who are bullying and being bullied, the families, the teachers and students with the classroom, the school as a whole, and the community. The main arena for the program is the school, and school staff have the primary responsibility for introducing and implementing the program. Schools are provided ongoing support by project staff.	

Program	Olweus Bullying Prevention Program
Staffing Requirements	• School counselors • Part or full time coordinator
Service Delivery Setting	• Classroom • School setting
Implementation Costs	• Materials costs - $400 • Training costs - $3000 for a two day on site training – if two school site are trained together the costs are $4500 (two trainers) • Travel costs for trainer(s) • $1500 for 12 mos. of consultation calls per school site. • Peacemakers - Materials costs - $101.40 for a teacher manual and $7.20 per student workbook
Service Delivery Costs	• 25-52 weeks • Weekly 20-40 minute classroom meetings
Standard Training Protocol	• Yes • $1001 to $5000 • Teachers handbook • Olweus core program against bullying at school • Victim questionnaire • Computer software • Bullying video • Supplemental lesson plans----$300 • Training groups of 12, one certified trainer per school, training materials $1000
Proprietary	• Yes
Sustainability	Information not available at this time
Contact	Marlene Snyder, Ph.D. Institute of Family and Neighborhood Life 158 Poole Agricultural Center Clemson University Clemson, SC 29634 Susan Limber, Ph.D. Institute of Family and Neighborhood Life Clemson University 158 Poole Agricultural Center Clemson, sc 29634 864-656-6320 864-656-6281 fax 864-710-4562

Program	Peacemakers	
Population	Students in the 4th through 8th grades	
Cultural Evidence	88% of study participants were African American	
Risk and Protective Factors	Risk: • Early onset of aggression • Poor refusal skills • Lack of guilt and empathy • School suspensions	Protective: • High expectations • Self-efficacy • Social competencies and problem solving skills
Level of Evidence	Promising	
Outcomes	1. Decreases in aggression for boys and middle school students 2. Reductions in school suspensions for middle school students	
Prevention: Universal/Selective	Universal	
Early Intervention		
Description	The Peacemakers Program is a school-based violence reduction intervention for grades 4 through 8. The program content is based on studies of psychosocial variables associated with individual differences in aggression and on existing interventions proven to be effective, and is influenced by social and developmental psychology research. Peacemakers consists of a 17-lesson curriculum for teachers and a remediation component for school psychologists and counselors for students referred for aggressive behavior. Each lesson takes 45 minutes to conduct and addresses beliefs supporting the acceptability and utility of violent behavior and deficits in conflict-related psychosocial skills. There are a variety of classroom activities including didactic instruction, discussion, use of the Socratic method, role-plays, and experiential exercises. Emphasis is placed on infusing program content into students' everyday lives by helping them recognize potentially problematic situations and then recall what they have learned in the program. The goal is to have the principles and strategies of the program become a part of the culture at the school.	

Program	Peacemakers
Staffing Requirements	• Teachers • School psychologists • Counselors
Service Delivery Setting	• Classroom
Implementation Costs	• $65 for teacher's manual • The Leader's Guide is $169.00. • $50 for counselor's manual. There is no longer a separate manual for counselors • Averages $11 per student, including manuals, workbooks, and training • $150 per hour plus expenses for the 6–8 hours of training • The full-day, 6-hour training is now $1750 + travel expenses if you make arrangements directly with me; it's $2500 if you make arrangements through the publisher.
Service Delivery Costs	• 18 lesson curriculum; 45 minutes per session
Standard Training Protocol	• 6-Hour training with developer
Proprietary	• Proprietary
Sustainability	• New staff trained by experienced staff no certification process
Contact	Solution Tree 304 West Kirkwood Avenue, Suite 2 Bloomington, IN 47404-5132 888-763-9045 812-336-7790—FAX Jeremy Shapiro The Peacemakers Program: Violence Prevention for Students in Grades 4–8 Applewood Centers, Inc. 2525 East 22nd St. 2669 Belvoir Blvd., Shaker Hts., OH 44122 Cleveland, OH 44115 Telephone: 216-696-5800, ext. 1144 216-292-2710 Fax: 216-696-6592 E-mail: jeremyshapiro@yahoo.com Web site: www.applewoodcenters.org/peacemakers.htm

Program	Promoting Alternative Thinking Strategies	
Population	Preschool and elementary school students	
Cultural Evidence	3 studies for elementary school children where at least 30% of participants were African American and in the Preschool study, 47% of the participants were African American	
Risk and Protective Factors	Risk: • Early onset of aggression • Poor refusal skills • Mental health problem • Poor family attachment • Sibling antisocial behavior • Poorly organized and functioning schools • Identified as learning disabled	Protective: • Perception of social support from adults and peers • Self-efficacy • Social competencies and problem-solving • Effective parenting • Good relationship with parents • Rewards for prosocial family involvement • Rewards for prosocial school involvement
Level of Evidence	Well Supported	
Outcomes	1. Improved self-control 2. Improved understanding and recognition of emotions 3. Use of more effective conflict resolution strategies 4. Decreased anxiety and depressive symptoms for special needs students 5. Decreased behavior problems for special needs students	
Prevention: Universal/Selective	Universal	
Early Intervention		
Description	Promoting Alternative Thinking Strategies (PATHS) and PATHS Preschool are school-based preventive interventions for children in elementary school or preschool. The interventions are designed to enhance areas of social-emotional development such as self-control, self-esteem, emotional awareness, social skills, friendships, and interpersonal problem-solving skills while reducing aggression and other behavior problems. Skill concepts are presented through direct instruction, discussion, modeling, storytelling, role-playing activities, and video presentations. The elementary school PATHS Curriculum is available in two units: the PATHS Turtle Unit for kindergarten and the PATHS Basic Kit for grades 1-6. The curriculum includes 131 20- to 30-minute lessons designed to be taught by regular classroom teachers approximately 3 times per week over the course of a school year. PATHS Preschool, an adaptation of PATHS for children 3 to 5 years old, is designed to be implemented over a 2-year period. Its lessons and activities highlight writing, reading, storytelling, singing, drawing, science, and math concepts and help students build the critical cognitive skills necessary for school readiness and academic success. The PATHS Preschool program can be integrated into existing learning environments and adapted to suit individual classroom needs.	

Program	Promoting Alternative Thinking Strategies
Staffing Requirements	• Teachers
Service Delivery Setting	• Classroom curriculum
Implementation Costs	• The complete elementary school PATHS Curriculum, including the Turtle Unit for kindergarten and the Basic Kit for grades 1-6, is available for $719. Purchased separately, the Turtle Unit is $189 and the Basic Kit is $629. The PATHS Preschool Kit is $459. Discounts are available for quantities of 10 or more • A 2-day on-site workshop for up to 30 participants is $4,000, plus travel and accommodation expenses for the trainer • Additional costs may include space rental and teacher in-service pay. Developers suggest that all PATHS teachers attend along with assistants, support staff, school principals, and other administrators • Implementers also may choose to attend the PATHS International Learning Community, which is held every 2 years and brings together PATHS practitioners from across the globe for continuing education and peer-to-peer learning opportunities
Service Delivery Costs	• 20-30 minutes teaching time • 130 modules • Estimated costs for implementing PATHS in an elementary school depend on how existing support staff (e.g., counselors, head teachers) will be used • If a school counselor can serve as the curriculum consultant at least half time, curriculum and training costs approximately $12,000 ($25 per student/year) over the first 3 years, with reduced costs in subsequent years ($10 per student/year) assuming staff turnover is not high • Costs are closer to $80 per student/year if a curriculum consultant must be hired but would continue to decline by half each subsequent year, for an approximate overall cost of $45 per student/year over 3 years
Standard Training Protocol	• Yes
Proprietary	• Yes
Sustainability	• On-site training-of-trainers workshops are also available The developer offers technical assistance by phone and e-mail ($75 per hour) and on site ($2,000 per day plus travel expenses)
Contact	Mark Greenberg, Ph.D. Prevention Research Center 109 Henderson Building South Pennsylvania State University University Park, PA 16802-6504 814-86-0112 814-865-2530 FAX Carol A. Kusche, Ph.D. Paths Training, LLC 627 10TH Avenue East Seattle, WA 98102 206-323-6688 Mark T. Greenberg, Ph.D. Director, Prevention Research Center

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Program	Resilience and Effectiveness of Asian Adolescents in Countering Hostility (REAACH) Program
Developer	Terry Gock, PhD, MPA
Submitted by	Asian Pacific Family Center-East
Description	• Bicultural, school-based, 14-week skill-based curriculum focused on increasing pro-social conflict-management skills in Asian immigrant middle-school youth
Population	• Intermediate-school age Asian immigrant youths at high risk of aggression and behavioral problems
Cultural Evidence	• Curriculum has been implemented with 75 Asian immigrant youth • Evaluation measures used were specifically developed for and tested with Asian immigrant population
Risk and Protective Factors	• Reductions in immigrant-specific stress • Enhanced extended family support • Enhanced connections with school • Increased bicultural competence
Level of Evidence	• Promising
Outcomes	• Decreased engagement in violent and aggressive behaviors when dealing with conflict
Prevention: Universal/Selective	• Selective

Children/Youth at Risk for School Failure

Program	Second Step	
Population	6-12 year old elementary school children	
Cultural Evidence	Very small percentages of diverse cultural groups have participated in the research	
Risk and Protective Factors	Risk: • Early onset of aggression • Poor refusal skills • Mental Health problem • Poor family attachment • Sibling antisocial behavior • Poorly organized and functioning schools • Identified as learning disabled	Protective: • Perception of social support from adults and peers • Self-efficacy • Social competencies and problem-solving • Effective parenting • Good relationship with parents • Rewards for prosocial family involvement • Rewards for prosocial school involvement
Level of Evidence	Promising	
Outcomes	1. Improvements in social competence and prosocial behavior 2. Decreases in negative, aggressive and antisocial behavior	
Prevention: Universal/Selective	Universal	
Early Intervention		
Description	Second Step is a classroom-based social-skills program for children 4 to 14 years of age that teaches socio-emotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. The program builds on cognitive behavioral intervention models integrated with social learning theory, empathy research, and social information-processing theories. The program consists of in-school curricula, parent training, and skill development. Second Step teaches children to identify and understand their own and others' emotions, reduce impulsiveness and choose positive goals, and manage their emotional reactions and decision making process when emotionally aroused. The curriculum is divided into two age groups: preschool through 5th grade (with 20 to 25 lessons per year) and 6th through 9th grade (with 15 lessons in year 1 and 8 lessons in the following 2 years). Each curriculum contains five teaching kits that build sequentially and cover empathy, impulse control, and anger management in developmentally and age-appropriate ways. Group decision making, modeling, coaching, and practice are demonstrated in the Second Step lessons using interpersonal situations presented in photos or video format.	

Program	Second Step
Staffing Requirements	• Teachers
Service Delivery Setting	• Classroom
Implementation Costs	• Training costs include $499 per participant for preschool through grade 9 (2 1/2-day training) and $169 per participant for preschool through grade 9 (1-day training) • The cost of training includes all training materials but not the Second Step curriculum • Family Guide facilitatory training is $169 per participant for preschool through grade 5; this cost does not include the Family Guide, which is purchased separately • Materials costs include $289 for the Pre-K DVD Kit (ages 4-6), $159 for individual grade-level kits (grades 1-5), $295 each for Level 1 Foundation Lessons (middle school), $149 each for Level 2 Skill Building Lessons (middle school), $149 for Level 3 Skill Building Lessons (middle school), $359 for the Second Step Family Guide, $599 for the Second Step Family Guide and Pre-K DVD kit, $359 for the Spanish-language Family Guide, $39 for the Family Overview Video, $39 for the Spanish-language Family Overview Video, and $59 for the Family Overview DVD (in Spanish and English)
Service Delivery Costs	• The curriculum is divided into 2 age groups: preschool through 5th grade (with 20 to 25 lessons per year) and 6th through 9th grade (with 15 lessons in year 1 and 8 lessons in the following 2 years) • Each curriculum contains 5 teaching kits that build sequentially and cover empathy, impulse control, and anger management in developmentally and age-appropriate ways • Group decision making, modeling, coaching, and practice are demonstrated in the Second Step lessons using interpersonal situations presented in photos or video format
Standard Training Protocol	• Yes
Proprietary	• Mix of public and proprietary
Sustainability	• Train the Trainer Model
Contact	Claudia Glaze Committee for Children 568 First Avenue South, Suite 600 Seattle, WA 98104-2804 Phone: (206) 438-6500

Program	School, Community and Law Enforcement Program
Developer	Terry Gock, PhD, MPA
Submitted by	Asian Pacific Family Center
Description	• Comprehensive intervention designed for Asian immigrant adolescents and their families at risk to school failure and or juvenile justice involvement. Core components include: a) Holistic Family Needs Assessment b) Individualized Life Skills Mentoring and Counseling c) Family Case Management Service Linkage d) Community Education and Consultation
Population	• Asian immigrant youth (adolescents) and their families at risk to school failure and juvenile justice involvement
Cultural Evidence	• The program was developed with input from local Asian community stakeholders. It was designed to specifically capitalize on those Asian cultural values and traditions associated with "extended family."
Risk and Protective Factors	•
Level of Evidence	• Promising
Outcomes	• Decreases in school disciplinary actions • Decreases in missed homework assignments • Improvements in school attendance • Decreased risk for delinquent behavior
Prevention: Universal/Selective	• Early intervention

Program	Social Decision-Making and Problem-Solving	
Population	Students in grades K-8	
Cultural Evidence	Not enough information to evaluate	
Risk and Protective Factors	Risk: • Early onset of aggression • Mental health problems • Life stressors • Victimization and exposure to violence • Family management problems • Dropping out of school	Protective: • Social competencies and problem solving skills • Effective parenting • Presence and involvement of caring and supportive adults
Level of Evidence	Promising	
Outcomes	1. Improved social decision making and problem-solving skills 2. Improved prosocial behavior in school 3. Greater ability to cope with stress upon transitioning to middle school	
Prevention: Universal/Selective	Universal	
Early Intervention		
Description	The Social Decision Making and Problem Solving Program (SDM) is a social and emotional learning program that assists students in acquiring social and decision-making skills and in developing their ability to effectively use those skills in real-life, with the aim of preventing violence, substance abuse, and related problem behavior. It is a primary prevention program conceptually rooted in research from public health, child development, clinical psychology, cognitive sciences, and organizational and community psychology. The program provides a framework in which students have the ability to learn, reinforce, and practice applying skills necessary to develop social competence. SDM is intended for use with all students (regular and special education) in kindergarten through eighth grade, regardless of ability level, ethnic group, or socioeconomic level. The program has been successfully implemented in urban, suburban, and rural settings nationwide.	

Program	Social Decision-Making and Problem-Solving
Staffing Requirements	• Teachers
Service Delivery Setting	• Classrooms
Implementation Costs	• Training costs are negotiable and include a per diem plus travel expenses for the trainer and approximately $28 per participant (typically limited to 30 people) for workshop materials for a school building-based training. Costs for regional trainings may vary. • Staff provide a two-day curriculum lab training workshop for those teachers and practitioners who will be teaching Social Decision Making directly to the students. Members of the Social Decision Making Committee stay for a third day to prepare them for their role. Information is also available regarding how to bring parents on board with Social Decision Making. • The UMDNJ offers training opportunities to individual schools and/or school districts. At the school district level, training can be tailored to suit each district's local needs. The SDM/PS program staff provides 2-3 day in-service training for a team of up to 30 teachers, administrators, and support personnel. Participants are provided with all of the curriculum materials, classroom posters, and worksheets needed to implement the program immediately following training. • To help ensure that the program becomes an integrated part of the school's curricula, an on-site SDM/PS leadership team is formed to plan and guide the program toward institutionalization. The leadership team consists of a small group of representative teachers, the school principal, and other key resource staff such as a guidance counselor. A half- or full-day of leadership and management training for the leadership team upon the conclusion of the regular training workshop is strongly recommended. • Training for individual teachers or counselors is also available if the number of people to be trained is too small to warrant district-level training. Training sessions cosponsored by the UMDNJ and Rutgers University are held several times per year. • The total cost of the program must include training costs which are estimated to be around $1,600 plus materials and travel. There are also periodic leadership-management trainings that last a half day and cost $400. • The start-up training costs are $800 per day and they typically last for 2 days. The half-day leadership-management trainings are $400 each.
Service Delivery Costs	• In at least one dedicated classroom session per week
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Linda Bruene-Butler University of Medicine and Dentistry of New Jersey University Behavioral Healthcare Behavioral Research and Training Institute 151 Centennial Avenue, Suite 1140 Piscataway, NJ 08854 732-235-9275 732-235-9280 FAX bruene@umdnj.edu www.ubhcisweb.org/sdm

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Program	**Strengthening Families**
Population	**Children and youth 3-16 years old and their families**
Cultural Evidence	**Two studies have been conducted. In one study 30% of the participants were African American and in the second, 36% of the participants were African American and 17% were Latino**
Risk and Protective Factors	**Risk:** • **Early onset of aggression** • **Poor refusal skills** • **Family history of substance abuse** • **Family management problems** • **Pattern of high family conflict** **Protective:** • **Perception of social support from adults and peers** • **Self-efficacy** • **Social competencies and problem-solving skills** • **Effective parenting** • **Good relationships with parents** • **Parental high expectations**
Level of Evidence	**Supported**
Outcomes	**1. Decreases in child behavior problems and depressive symptoms** **2. Improvement in positive parenting** **3. Improvement in family cohesion and communication**
Prevention: Universal/Selective	**Universal and selective**
Early Intervention	**Early intervention with families where one or both parents has a substance abuse problem**
Description	**The Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14) is a family skills training intervention designed to enhance school success and reduce youth substance use and aggression among 10- to 14-year-olds. The program includes seven 2-hour sessions and four optional booster sessions in which parents and youth meet separately for instruction during the first hour and together for family activities the second hour. The sessions provide instruction for parents on understanding the risk factors for substance use, enhancing parent-child bonding, monitoring compliance with parental guidelines and imposing appropriate consequences, managing anger and family conflict, and fostering positive child involvement in family tasks. Children receive instruction on resisting peer influences to use substances. Sessions, which are typically held once a week, can be taught effectively by a wide variety of staff.**

Program	Strengthening Families
Staffing Requirements	• Low risk program (SFP10-14) is staffed by school personnel • High risk program (SFP3-5, 6-11 or 12-16) staffed by community agencies familiar with working with high risk children • Not necessarily mental health workers; can be service agencies • Not necessarily licensed personnel • Level of schooling not an issue • Service delivery staff must have the following: good interpersonal skills; desire to help, knowledge of the program
Service Delivery Setting	• School setting • Community agency
Implementation Costs	• A Master set of materials for SFP3-5, 6-11 or 12-16 is available on CD for $450 and includes the SFP implementation manual; manuals for the parent, child, and family group leaders; handbooks and handouts for parents and children; evaluation instruments; and other implementation materials. Purchase of the CD carries a limited site license for the purchasing agency to make unlimited copies of the materials for its own use • Course materials for SFP10-14 are purchased in hard copy from the extension service of Iowa State University and include master copies for parents' and children's handouts • Costs for a 2-day SFP3-5, 6-11 or 12-16 group leader training for up to 35 trainees is $3,650 (plus travel expenses, lodging, and per diem for 2 trainers). The training fee includes one copy of the SFP master set of course materials on CD, limited site license to reproduce unlimited copies for the agency's own use, and technical assistance in implementation. Reduced fees for smaller groups are available. Training in the United States is available in English and Spanish. Some agencies may find it economical to attend a training hosted by another agency. (LutraGroup SP, the entity that coordinates SFP training and technical assistance, can help in locating other trainings.) Technical assistance and evaluation of SFP implementation are also available. • Implementation of SFP3-5, 6-11 or 12-16 requires a minimum of 5 trained staff: 2 group leaders for the parents, two group leaders for the children, and a site coordinator • SFP10-14 requires only one group leader for the parents, as their curriculum is primarily on video
Service Delivery Costs	• Personnel costs
Standard Training Protocol	• Includes two trainers (usually male/female; diverse ethnicity) • Training 10-35 per group • Two day training - First day didactic. Second day practice.
Proprietary	• Yes
Sustainability	• Availability to train agency personnel to be a certified trainer • Certification process consists of 4 step process. Trained as a group leader • Deliver a training as a group leader • Deliver parts of a training with 2 experienced trainers, deliver roughly half of a training with one experienced trainer
Contact	Karol Kumpfer, Ph.D., Professor Department of Health Promotion and Education 21901 East South Campus Drive, Room 214 University of Utah Salt Lake City, UT 84112 Tel. 801-582-1562

	Fax: 801-581-5872 kkumpfer@xmission.com www.strengtheningfamilies/program.org Henry Whiteside Lutra Group SP 5215 Pioneer Fork Road Salt Lake City, UT 84108 801-583-4601 801-583-7979 FAX Hwhiteside@LUTRAGROUP.com

Program	**Ventanas**
Developer	SPIRITT Family Services
Submitted by	SPIRITT Family Services
Description	• Seven week family communication skills curriculum developed for adolescent youth and their families at risk to school failure and juvenile justice involvement. Skills taught are based upon known risk factors for involvement in delinquent behavior and school failure
Population	• Latino adolescents and their families at risk to school failure and juvenile justice involvement.
Cultural Evidence	• The program has been adapted to serve Latino families. Cultural themes and metaphors are incorporated into the intervention. • Bilingual/bicultural facilitators help parents bridge the parenting practices learned in their country of origin to those more acceptable in the U.S.
Risk and Protective Factors	•
Level of Evidence	• Promising
Outcomes	• Increased family communication skills • Increased problem solving skills • Decreased adolescent aggression • Satisfaction with services for Latino parents
Prevention: Universal/Selective	• Early intervention

Program	Why Try? Program
Developer	Martha Marquez, LCSW
Submitted by	Los Angeles Unified School District Student Health and Human Services – School Mental Health Services
Description	• National, evidence-based 10-week group curriculum (45 mins each) designed to prevent delinquency and school failure
Population	• Low income, minority students (2nd thru 12th grade) at risk of school failure, dropping out of school, substance use/abuse, and/or juvenile justice involvement
Cultural Evidence	• This model is being used with low income, minority youth in Los Angeles County
Risk and Protective Factors	• Increased social skills • Increased conflict resolution skills • Increased coping skills
Level of Evidence	• Promising
Outcomes	• Increases in indicators of student resiliency
Prevention: Universal/Selective	• Selective

Program	Winners
Developer	Darnell Bell
Submitted by	Avalon Carver Community Center
Description	• The Winners program is a school based classroom and after school activities program for African American elementary age students who are trauma exposed and at risk to school failure. The curriculum focuses on developing or enhancing positive ethnic identity which is protective against school failure, problem behavior and substance use abuse.
Population	• African American elementary aged students who are trauma exposed and at risk to substance abuse and school failure. The service is delivered in Service Area 6 of Los Angeles County
Cultural Evidence	• The curriculum was developed specifically for African American children and youth utilizing Afrocentric concepts from family psychology.
Risk and Protective Factors	•
Level of Evidence	• Emerging
Outcomes	• Increases in positive ethnic identity • Increases in participation in positive school activities
Prevention: Universal/Selective	• Selective for African American elementary school children

Program	Adolescent Transitions Program
Population	11-18 year old youth at risk for substance abuse or behavior problems
Cultural Evidence	No information available. The developer is currently testing adaptations for Native American, Latino and African American families.
Risk and Protective Factors	**Risk:** • Family management problems/poor monitoring and supervision • Poor family attachment • Parental use of harsh physical punishment **Protective:** • Effective parenting • Good relationships with parents • Social competencies and problem solving skills
Level of Evidence	Supported
Outcomes	1. Significant improvement in family interactions 2. Improved child behavior 3. Parental positive problem solving with teens
Prevention: Universal/Selective	Universal and selective
Early Intervention	Family check up is used with families referred due to teen behavior problems
Description	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.

Program	Adolescent Transition Program
Staffing Requirements	• Behavioral family therapy, parenting, groups, or case management services • School staff
Service Delivery Setting	• Middle school • Home • The Family Resource Center
Implementation Costs	• Family Management Curriculum 1-2 people, $750 + $75 each/materials (excluding tapes) 3+ people, $1000 + $75 each/materials (excluding tapes) • Family Resource Centers: 1–2 people, $500 + $25 each/materials, 3-5 people, $750 + $25 each/materials • Family Check-Up: 1–2 people, $1350 + $75 each/materials (includes feedback on your implementation), 3+ people, $1850 + $75 each/materials (includes feedback on your implementation • Dishion, T. J., & Kavanagh, K. (2003). Intervening in adolescent problem behavior: A family-centered approach. New York: Guilford paper back: $24.00
Service Delivery Costs	• Information not available at this time
Standard Training Protocol	• Family Management Curriculum*: Length: 1.5 days • Family Resource Centers: Length: 6 hours • Family Check-Up: Length: 2 days
Proprietary	• Yes
Sustainability	• Consultation $75/hour (any format: tape review, video conferencing, phone, review of materials, and so forth)
Contact	kolkodj@upmc.edu Phone: 412-246-5888 Elizabeth 412-246-5886

Program	Asian American Family Enrichment Network (AAFEN) Program
Developer	Terry Gock, PhD, MPA
Submitted by	Asian Pacific Family Center-East
Description	• Bicultural 12-week skill-based parenting program for Asian immigrants • Outreach, engagement, and support activities also part of curriculum
Population	• Asian immigrant parents and/or primary caregivers of teenage children
Cultural Evidence	• Curriculum has been evaluated with over 350 immigrant parents of Chinese, Korean, and Vietnamese origin • Evaluation measures used were specifically developed for and tested with Asian immigrant population
Risk and Protective Factors	• Increased bicultural parenting skills • Improved parent/child relationships • Decreased family conflict
Level of Evidence	• Emerging
Outcomes	• Improved family functioning • Improved family relationships and attitudes
Prevention: Universal/Selective	• Selective

Program	Caring for Our Family (CFOF)
Developer	Special Service for Groups – Asian Pacific Counseling and Treatment Centers
Submitted by	Special Service for Groups – Asian Pacific Counseling and Treatment Centers
Description	• Culturally appropriate adaptation of national “Family Connections” model • Includes community outreach, family assessment, individually tailored program of counseling, referrals and linkages • Direct services provided for minimum of six months, minimum one hour weekly
Population	• Los Angeles County Cambodian and Korean immigrant and refugee families with children between the ages of 5-11
Cultural Evidence	• Monolingual and bilingual services provided • Independent evaluation of adapted model conducted by external third party
Risk and Protective Factors	• Increased social support • Enhanced parenting competence • Decreased parent depression, anxiety, and stress
Level of Evidence	• Promising
Outcomes	• Improved child well-being
Prevention: Universal/Selective	• Selective

Program	Celebrating Families!
Population	Parents where one or both are substance abusing; risk for domestic violence and child abuse
Cultural Evidence	Two studies in which 42% and 45% of the participants were Latinas
Risk and Protective Factors	None noted
Level of Evidence	Emerging
Outcomes	1. Improved positive parenting 2. Decreased parental drug and alcohol use 3. Decreased parental depression 4. Improved family cohesion and communication
Prevention: Universal/Selective	Selective
Early Intervention	Early intervention for parents participating in substance abuse programs
Description	Celebrating Families! (CF!) is a parenting skills training program designed for families in which one or both parents are in early stages of recovery from substance addiction and in which there is a high risk for domestic violence and/or child abuse. The CF! program uses a cognitive behavioral theory (CBT) model to achieve three primary goals: • Break the cycle of substance abuse and dependency within families, • Decrease substance use and reduce substance use relapse, and • Facilitate successful family reunification. The CBT model defines substance use as a learned social behavior that is acquired through modeling or imitation of the observed behavior in others with whom one has some type of social relationship. In this model, addiction is considered a disease. The CF! program provides weekly instruction focusing on a healthy lifestyle free from drugs and alcohol, addressing risk and protective factors as well as developmental assets of family members. Following a family dinner, parents and children participate in separate 90-minute instructional group sessions devoted to a particular theme. Parents then reunite with their children for a 30-minute activity to practice what has been presented and learned and to receive feedback on their performance. Themes include (1) healthy living, (2) nutrition, (3) communication, (4) feelings and defenses, (5) anger management, (6) facts about alcohol, tobacco, and other drugs, (7) chemical dependency as a disease, (8) the effects of chemical dependency on the whole family, (9) goal setting, (10) making healthy choices, (11) healthy boundaries, (12) healthy friendships and relationships, and (13) individual uniqueness. Originally designed for the Family Treatment Drug Court (FTDC) system, CF! is currently used by drug courts, dependency courts, faith-based organizations, residential and outpatient treatment services, and social service agencies serving parents and children ages 4-17. Started in the mid-1990s, the FTDC is the most recent and the fastest growing type of drug court in the United States. It provides a setting for all the participants in the child protection system to come together to determine the individual treatment needs of substance-abusing parents whose children are wards of the court. The goal of the FTDC is to rehabilitate the parents as competent caretakers so that their children can be safely returned to their parents' care.

Program	Celebrating Families!
Staffing Requirements	• Staff in community-based organizations • Women's residential treatment facility • Trained interns • Volunteers
Service Delivery Setting	• Other community settings • Outpatient • Residential • Suburban • Urban
Implementation Costs	• Complete set of program materials: a set of 5 spiral-bound facilitator guides (volumes 1-5) plus appendixes, master handouts and posters, and a program CD and DVD, is $215 plus $9 for shipping and handling • The recommended site implementation package: 10 sets of the facilitator guides, is $1,350 plus $80 for shipping and handling • For those ordering this package, additional facilitator guide sets are available for $135 each plus $8 for shipping and handling. Additional CDs are $8 each plus $3 shipping and handling, and additional DVDs are free other than the $3 shipping and handling charge. Celebrating Families! brochures are free • A 2-day training workshop is $4,000 plus travel expenses, and technical assistance is offered at $100 per hour
Service Delivery Costs	• The projected program operating budget for a 16-session program with 2 weeks allotted for planning and organizing is about $694 per participant, assuming 40 participants per program cycle The cost can be significantly reduced to as little as $360 per participant with the use of staff flex time, trained interns and volunteers to administer the program, and in-kind donations of food, space, and transportation
Standard Training Protocol	• A 2-day training workshop
Proprietary	• Mix of public and proprietary
Sustainability	• Technical assistance is offered at $100 per hour
Contact	www.celebratingfamilies.net Steve Hornberger, M.S.W. Program Director National Association for Children of Alcoholics 11426 Rockville, Suite 301 Rockville, MD 20852 Phone: (301) 468-0985 Fax: (301) 468-0987 E-mail: shornberger@nacoa.org

Children/Youth in Stressed Families

Program	Clinician-Based Cognitive Psychoeducational Intervention for Families
Population	Families with a parent with a significant mood disorder
Cultural Evidence	There is an adaptation for low-income culturally diverse communities but ethnicity was not reported in the research articles
Risk and Protective Factors	None noted
Level of Evidence	Supported
Outcomes	1. Improvements in child –related behaviors and attitudes towards parent's illness 2. Improvement in children's understanding of parental illness
Prevention: Universal/Selective	Selective
Early Intervention	Early Intervention
Description	Based on public health models, the intervention is designed to provide information about mood disorders to parents, equip parents with skills they need to communicate this information to their children, and open dialogue in families about the effects of parental depression. The intervention consists of 6-11 sessions that include separate meetings with parents and children, family meetings, and telephone contacts or refresher meetings at 6- to 9-month intervals. Sessions are conducted by trained psychologists, social workers, and nurses. The core elements of the intervention are (1) an assessment of all family members, (2) teaching information about affective disorders and risks and resilience in children, (3) linking information to the family's life experience, (4) decreasing feelings of guilt and blame in children, and (5) helping children to develop relationships within and outside the family to facilitate their independent functioning in school and in activities outside the home. In family meetings, parents talk about their own sessions, their treatment, and how they are working to build resilience and protect their children.

Program	Clinician-Based Cognitive Pyschoeducational Intervention for Families
Staffing Requirements	• Trained psychologists • Social workers • Nurses
Service Delivery Setting	• Office • Phone
Implementation Costs	• Initial training costs in the United States include the Master Trainer fee (at a standard rate of $1,000 per day), the commitment of staff time to learn this intervention (several 1-day or 1/2-day training sessions), and commitment of staff time to use the intervention and receive ongoing peer supervision
Service Delivery Costs	• The cost of delivery is 7-10 hours of clinician time per family (including parent, child, and family sessions)
Standard Training Protocol	• Several 1-day or 1/2-day training sessions
Proprietary	• Public
Sustainability	• Ongoing peer supervision
Contact	William R. Beardslee, M.D. Academic Chair, Department of Psychiatry, Children's Hospital Boston Gardner Monks Professor of Child Psychiatry, Harvard Medical School One Autumn Street, Suite 435 Boston, MA 02215 Phone: (617) 355-6087 Fax: (617) 730-0271 E-mail: william.beardslee@childrens.harvard.edu

Children/Youth in Stressed Families

Program	Creating Lasting Family Connections	
Population	Family focused program for youth 9-17 at risk for or with substance abuse problems	
Cultural Evidence	Data not reported	
Risk and Protective Factors	Risk: • Early onset of aggression • Favorable attitudes toward dug use • Poor refusal skills • Family management problems • Negative attitude toward school • Community instability • Community crime	Protective: • Social competencies and problem solving skills • Effective parenting • Good relationships with parents • High expectations • Presence of supportive and caring adults
Level of Evidence	Supported	
Outcomes	1. Increased use of community resources when family or personal problems arose 2. Increases in parent knowledge about substance abuse 3. Delayed onset of drug or alcohol use 4. Decreased use of drugs and alcohol	
Prevention: Universal/Selective	Universal and Selective	
Early Intervention	Indicated for families with an adolescent who is abusing illegal substances	
Description	Creating Lasting Family Connections (CLFC), the currently available version of Creating Lasting Connections (CLC), is a family-focused program that aims to build the resiliency of youth aged 9 to 17 years and reduce the frequency of their alcohol and other drug (AOD) use. CLFC is designed to be implemented through a community system, such as churches, schools, recreation centers, and court-referred settings. The six modules of the CLFC curriculum, administered to parents/guardians and youth in 18-20 weekly training sessions, focus on imparting knowledge and understanding about the use of alcohol and other drugs, including tobacco; improving communication and conflict resolution skills; building coping mechanisms to resist negative social influences; encouraging the use of community services when personal or family problems arise; engendering self-knowledge, personal responsibility, and respect for others; and delaying the onset and reducing the frequency of AOD use among participating youth. The program emphasizes early intervention services for parents and youth and follow-up case management services for families. Manuals for trainers, notebooks for participants, and other materials are available, but the program is intended to be modified with each implementation to reflect the needs of the participants and the skill level of the trainers. Creating Lasting Connections was an experimental program implemented and evaluated in church communities with the families of high-risk 11- to 14-year-old youth. CLC served as the basis for CLFC, which is now in use.	

Program	Creating Lasting Family Connections
Staffing Requirements	• Information not available at this time
Service Delivery Setting	• Community system, such as churches, schools, recreation centers, and court-referred settings
Implementation Costs	• Materials are $1,425, which includes all curricula, participant notebooks, posters, and a custom evaluation kit • Daily fees for on-site assistance range from $300 to $1,250 • Most organizations should budget at least $750 for 1 week of CLFC implementation training, plus travel costs, for each person needing training • The minimum typical budget is between $15,000 and $25,000 to serve approximately 15 to 25 families
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• Implementation training is highly recommended but not required • There are standard 5- and 10-day trainings
Proprietary	• Yes
Sustainability	• On-site training and technical assistance also can be arranged according to the needs and resources of the agency implementing the program
Contact	Ted N. Strader **COPES, Inc.** **845 Barret Avenue** **Louisville, KY 40204** **Phone: (502) 583-6820** **Fax: (502) 583-6832** **E-mail: tstrader@sprynet.com** **Web site: www.copes.org**

Children/Youth in Stressed Families

Program	Family Connections	
Population	Families at risk for child emotional and physical neglect	
Cultural Evidence	88% of the research participants were African American	
Risk and Protective Factors	Risk: • Caregiver depressive symptoms • Parental stress	Protective: • Parental sense of competence • Family cohesion and communication • Social support
Level of Evidence	Promising	
Outcomes	1. Decreased depressive symptoms 2. Decreased parental stress	
Prevention: Universal/Selective		
Early Intervention	Early Intervention – families are referred by child welfare workers.	
Description	Family Connections (FC) is a multifaceted, community-based service program that works with families in their homes and in the context of their neighborhoods. The goal of FC is to help these families meet the basic needs of their children and reduce the risk of child neglect. Nine practice principles guide FC interventions: community outreach; individualized family assessment; tailored interventions; helping alliance; empowerment approaches; strengths perspective; cultural competence; developmental appropriateness; and outcome-driven service plans. The core components of FC include: (a) emergency assistance/concrete services; (b) home-based family intervention (e.g. family assessment, outcome-driven service plans, individual and family counseling); (c) service coordination with referrals targeted toward risk (e.g. substance abuse treatment) and protective factors (e.g. mentoring program); and (d) multi-family supportive recreational activities (e.g. theme-based gatherings such as Black History month, trips to museums, etc.).	

Children/Youth in Stressed Families

Program	Family Connections
Staffing Requirements	Social worker Masters level or BA supervised by Masters level
Service Delivery Setting	• Community agency • Family home
Implementation Costs	• Trained social worker • Transportation costs • Emergency needs fund • Weekly supervision
Service Delivery Costs	• One hour face to face with social worker once weekly • 3-9 months
Standard Training Protocol	• Yes/Manualized • On-site, video-conference • Online course/curriculum developed by University of Maryland, School of Social Work • Manual
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	University of Maryland School of Social Work 410-706-3609 www.family.unmaryland.edu

Program	Focus on Families	
Population	Families who have children 3 to 14 years of age and where a parent is addicted to drugs	
Cultural Evidence	18% of the research participants were African American	
Risk and Protective Factors	Risk: • Antisocial behavior and alienation • Poor refusal skills • Family management problems • Parental use of harsh physical punishment • Poor family attachment/bonding • Low academic achievement	Protective: • Self-efficacy • Social competencies and problem solving skills • Effective parenting • Good relationships with parents • Above average academic achievement • Student bonding
Level of Evidence	Supported	
Outcomes	1. Decreased parental drug use 2. Decreased domestic conflict 3. More clearly defined household rules	
Prevention: Universal/Selective		
Early Intervention	Early Intervention	
Description	Focus on Families is designed for families with parents who are addicted to drugs. Based on the social development model, the program aims to prevent parents' relapse, help them cope with its occurrence (if it did occur), and reduce the likelihood of substance abuse among their children. It is most appropriate for parents enrolled in methadone treatment who have children ages 3 to 14. Eligible families participate in a 5-hour "family retreat" in which they learn about the curriculum, identify their goals, and participate together in trust-building activities. The first session is followed by 32 curriculum sessions (90 minutes each), conducted twice weekly for 16 weeks. Parent sessions are conducted in the mornings, with practice sessions held in the evenings for parents and children together. Content covered includes family goal setting, relapse prevention, family communications skills, family management skills, creating family expectations about drugs and alcohol, teaching skills to children, and helping children succeed in school. Parent session, follow-up, and home-based care management are provided by masters-level social workers using a structured cognitive-affective-behavioral skills training curriculum.	

Children/Youth in Stressed Families

Program	Focus on Families
Staffing Requirements	• Masters level social workers
Service Delivery Setting	• Home based and family based
Implementation Costs	• Manual costs $200.00
Service Delivery Costs	• Five hour family retreat—followed by 32 curriculum sessions, 2x a week 90 five-hour family retreat—followed by 32 curriculum sessions, 2x a week 90 minutes EKS • F.U. 9 months treatment
Standard Training Protocol	Information not available at this time
Proprietary	• Material can be copied
Sustainability	Information not available at this time
Contact	Kevin Haggerty Social Development Research Group 9725 Third Avenue, NE, Suite 401 Seattle, WA 98115-2024 206-543-3188 Fax 206-543-4507 catalano@u.washington.edu depts.washington.edu/sdrg haggerty@u.washington.edu

Program	Healthy Steps for Young Children	
Population	Pediatric developmental services for young children 0-3 and their parents. Quality of care intervention.	
Cultural Evidence	Data not reported	
Risk and Protective Factors	Risk: • Maternal depression • Harsh discipline	Protective: • Secure attachment • Parental confidence
Level of Evidence	Supported	
Outcomes	1. Decreased use of severe discipline	
Prevention: Universal/Selective	Universal	
Early Intervention		
Description	Healthy Steps for Young Children (Healthy Steps) is a national initiative that focuses on the importance of the first three years of life. Healthy Steps emphasizes a close relationship between health care professionals and parents in addressing the physical, emotional, and intellectual growth and development of children from birth to age three. Each Healthy Steps team includes a Healthy Steps Specialist, who enhances the information and services available to parents. The Healthy Steps Specialist can be a new team member or a nurse, child development specialist, or social worker already working in the practice. The Specialists have special training in child development and address major behavioral and developmental issues, focusing on a whole baby, whole family brand of primary care. The Healthy Steps approach is being implemented in pediatric and family practices across the country and is meeting an array of community needs while preserving its unique linkage to a team of health care professionals	

Program	Healthy Steps for Young Children
Staffing Requirements	• Training in social work • Child development • Nursing • Interest in working with young children is prerequisite
Service Delivery Setting	• Pediatric offices • Community • Homes
Implementation Costs	• Training is approximately $600; a DVD is available • Healthy steps multimedia training and resource kit DVD $99 • Original multimedia KD for training is $350
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• Yes—there is a standard training given in Chicago • DVD available to purchase
Proprietary	• Yes—however, advocate health care just want to be credited with the materials
Sustainability	• Certification offered through the original training
Contact	Enedina Robles, MSW Health Steps Specialist Childrens Health Center 4460 East Huntington Blvd. Fresno, CA 93702 559-459-4180 559-459-3502--fax

Program	Homebuilders	
Population	Children and families from birth to 18 at risk for placement into foster care, group home or psychiatric hospitals	
Cultural Evidence	Data not reported	
Risk and Protective Factors	Risk: • Family management problems • Child maltreatment • High family conflict • Poor family attachment • Victimization and exposure to violence • Early onset of aggression	Protective: • Effective parenting • Good relationships with parents • Stable family • Perception of social support from adults and peers
Level of Evidence	Supported	
Outcomes	1. Decreased use of placement 2. Increased reunification 3. Improved service provision	
Prevention: Universal/Selective		
Early Intervention	Early Intervention	
Description	HOMEBUILDERS provides intensive, in-home crisis intervention, counseling, and life-skills education for families who have children at imminent risk of placement in state-funded care. The goal is to prevent the unnecessary out-of-home placement of children through intensive, on-site intervention, and to teach families new problem-solving skills to prevent future crises. The program only accepts families referred by the state, in which one or more children are in imminent danger of being placed in foster, group, or institutional care. It is also used for families whose children are being returned from out-of-home care, and for difficult post-adoption situations. Therapists see families when they are in crisis. Client families are seen within 24 hours of referral. Almost all services take place in the client's home or the community where the problems are occurring and ultimately where they need to be resolved. Therapists are on call to their clients 24 hours a day, 7 days a week. Services are time-limited and concentrated in a period targeted at 4 weeks. Each family receives an average of 40-50 hours of direct service. Therapists carry only 2-3 cases at a time. Therapists utilize a range of research-based interventions, including crisis intervention, motivational interviewing, parent education, skill building, and cognitive/behavioral therapy. Services are provided when and where the client wishes. Services include helping clients meet the basic needs of food, clothing, and shelter, to the most sophisticated therapeutic techniques.	

Program	Homebuilders (Intensive Family Preservation and Reunification)
Staffing Requirements	• Professional therapists
Service Delivery Setting	• Home • Community
Implementation Costs	• Program consultation and quality training and assurance skills for Homebuilders supevisors (2-3) days training approx. $11,670 including all expenses • Homebuilders core competency on site up to 15 service providers approx $13, 912 including all expenses • Other workshops available • Site visit 3x times per year; 2.5 day visit approx $16,512 • Telephone consultations 100 hours per team @ $75/per hour • Written record reviews—4 record reviews per therapist $6,000 • First year cost estimated at $67,864 • Costs depend upon the site
Service Delivery Costs	• Services are time limited and intensive • Four weeks approx. 40-50 hours of direct service • Case load is 2 families • Supervisors/administrators/therapists available 24 hrs per day • Estimated cost savings for child welfare system, and victim health and mental health costs, per participant: $731 - $7,818. (Lee, et al., 2008)
Standard Training Protocol	• Workshop training • Infrastructure building • Clinical consultation • Technical assistance • Fidelity measures
Proprietary	• (QUEST) Quality enhancement system—focus is on quality assurance • The material is proprietary.
Sustainability	• There is no Train the Trainers Model in place yet but one is under development • No certification process
Contact	Institute for Family Development www.institutefamily.org 253-874-3630 Shelley Leavitt – sleavitt@institutefamily.org

Program	Making Parenting a Pleasure	
Population	A parenting program for highly stressed parents of children birth to 8	
Cultural Evidence	Data not reported	
Risk and Protective Factors	Risk: • Social isolation • Parental stress	Protective: • Self-efficacy • Social support
Level of Evidence	Promising	
Outcomes	1. Decrease in inappropriate discipline 2. Increase in parental self-esteem 3. Decrease in parental stress 4. Decrease in child abuse potential	
Prevention: Universal/Selective	Universal	
Early Intervention		
Description	Make Parenting a Pleasure is a comprehensive group-based positive parenting curriculum for stressed parents of children birth to eight. This curriculum is designed for professional parent educators and does not require additional training, although training is recommended. Parents learn: • The importance of taking care of themselves so they can better care for their children • Practical stress management and communication skills • Effective parenting skills and positive approaches to discipline Parents gain: • Greater understanding of their children • A social support network that can continue after groups end This curriculum is built on the following assumptions: • Parenting is the most important and challenging job there is • Parents are their children's first and most important teachers • There are many right ways to be a parent or a child • Parents are the foundation of the family • Getting and giving support is essential for parents	

Program	Making Parenting a Pleasure
Staffing Requirements	• Trained parenting experts
Service Delivery Setting	• Schools • Churches • Community centers • Service clubs
Implementation Costs	• Curriculum costs $899 • Training at program site costs $3800, plus air fare/per diem/hotel/transportation costs for two trainers • At Birth to Three site; $250 per person/ site/ two 8 hour days • Individualized training can be arranged (25 person limit)
Service Delivery Costs	• Staff • Site costs • TV • DVD • Supplies • Baby sitting
Standard Training Protocol	• Yes—curriculum
Proprietary	• Yes
Sustainability	• Curriculum based • Training not necessary although recommended
Contact	Connie Rose Birth to Three 86 Centennial Loop Eugene, OR 97401 connier@birthto3.org birthtothree@birthto3.org ww.birthto3.org 541-484-5316 Fax 541-484-1449

Program	Maternal Wellness Center
Developer	Emily C. Dossett
Submitted by	LAC+USC Medical Center
Description	• Culturally appropriate, evidence-based prevention and early intervention for perinatal depression through co-location of psychiatric services and perinatal care; includes screening, assessment, individual and/or group therapy, and medication management and support through six months postpartum (employs validated measures and cognitive-behavioral therapy).
Population	• Low income, ethnic minority, high-risk women and infants served in prenatal clinics
Cultural Evidence	• Educational materials for patients and training materials for providers are available in English and Spanish
Risk and Protective Factors	• Untreated depression • Financial stress • Poor social support • Chronic illness or disease (e.g., diabetes, hypertension, HIV) • Increased education regarding perinatal depression • Decreased stigma
Level of Evidence	• Emerging
Outcomes	• Increased identification of perinatal depressive symptoms and disorders • Increased access to care • Increased engagement in care
Prevention: Universal/Selective	• Selective

Program	Mindful Parenting Groups
Developer	Diane Reynolds and Wendy Denham
Submitted by	Center for Mindful Parenting
Description	• Twelve week parenting program for parents and caregivers of infant, toddler and preschool children at risk to mental health problems and disrupted adoptions. Weekly sessions are sequenced to include parental engagement and skill building.
Population	• Children and youth in stressed families. Includes families with child neglect and children at risk to disrupted adoptions.
Cultural Evidence	• Bilingual-Bicultural clinicians offer this service to monolingual Spanish speaking parents. In addition, the groups have been successful with gay and lesbian parents and bi-racial couples. The intervention is tailored to the parenting traditions and cultures of the parents in the group. In addition, discrimination (particularly as it relates to non traditional families) is explored as an additional parenting stressor
Risk and Protective Factors	•
Level of Evidence	• Promising
Outcomes	• Increased secure attachment
Prevention: Universal/Selective	• Selective

Program	Nurse Family Partnership	
Population	Home visiting program for first time low income mothers	
Cultural Evidence	92% of research participants from the "Memphis study" were African American	
Risk and Protective Factors	Risk: • Early sexual involvement • Early onset of aggression • Mental health problem • Teen parenthood • Victimization and exposure to violence • Economic deprivation • Family violence • Maternal depression	Protective: • Self-efficacy • High expectations • Social support • Effective Parenting • Having a stable family • Presence and involvement of caring and supportive adults
Level of Evidence	Well Supported	
Outcomes	1. Improved maternal prenatal health 2. Fewer injuries to children 3. Reduced child abuse and neglect 4. Reduced arrests among mothers 5. Reducing arrests among adolescents of mothers participating in NFP	
Prevention: Universal/Selective	Selective	
Early Intervention	Early intervention	
Description	The Nurse-Family Partnership (NFP) program provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday. Ideally, nurses begin 60-90 minute visits with pregnant mothers early in their pregnancy (about 16 weeks gestation). Registered nurses visit weekly for the first month after enrollment and then every other week until the baby is born. Visits are weekly for the first 6 weeks after the baby is born, and then every other week through the child's first birthday. Visits continue on an every-other-week basis until the baby is 20 months. The last 4 visits are monthly until the child is 2 years old. Nurses use their professional nursing judgment and increase or decrease the frequency and length of visits based on the client's needs. Clients are able to participate in the program for two-and-a-half years and the program is voluntary.	

Program	Nurse Family Partnership
Staffing Requirements	• Registered nurses
Service Delivery Setting	• Home • Hospital
Implementation Costs	• Minimum number for implementation of the program is typically 100 families • The application process includes an estimated budget that addresses all the cost categories, including training and materials • 3-year cost to establish a program for 100 families is $780,000, most of which goes for nurse salaries
Service Delivery Costs	• Approximately $4,500 per family per year to fund, and can range from $2,914 to $6,463 per family per year • Estimated cost savings juvenile justice system, crime victim & tax payers: $2,067 to $15,918 (Aos, et al., 2001). • Estimated cost savings for child welfare system, and victim health and mental health costs, per participant: $731 - $7,818. (Lee, et al., 2008)
Standard Training Protocol	• A 4-day intensive training in the model, usually provided by the National Center in Denver • Supervisors receive an additional day of training following completion of the 4 days of intensive training. • A 2-day regional training program is offered 4 months after program implementation begins for training on implementing the infancy guidelines. Supervisors receive an additional day of training • Training following the 2 days of training • A 2-day regional training prepares nurses to conduct intervention during the toddler period
Proprietary	Information not available at this time
Sustainability	• Community education, grants, etc.
Contact	The Nurse–Family Partnership National Office **Nurse–Family Partnership National Office** **1900 Grant Street, Suite 400** **Denver, CO 80203** **Phone: (866) 864-5226** **Fax: (303) 327-4260** **E-mail: info@nursefamilypartnership.org** **Web site: www.nursefamilypartnership.org**

Program	Nurturing Parenting Program
Population	Family based program for the prevention of child abuse
Cultural Evidence	In one study 60% of the participants were Latino and 10% were Native American
Risk and Protective Factors	**Risk:** • Early onset of aggression • Early sexual involvement • Child maltreatment • Family violence • Poor family attachment **Protective:** • Self-efficacy • Effective parenting • Perception of social support from adults and peers • Having a stable family
Level of Evidence	Promising
Outcomes	1. Positive changes in parenting and childrearing attitudes 2. Clear differentiation of parent-child roles 3. Decrease in the use of corporal punishment
Prevention: Universal/Selective	Selective
Early Intervention	Early intervention for parents with substantiated reports of child maltreatment
Description	The Nurturing Parenting Programs are family-based programs utilized for the treatment and prevention of child abuse and neglect. Program sessions are offered in group-based and home-based formats ranging from 12-48 sessions. Programs are designed for parents with young children birth to 5 years old, school-aged children 5-11 years old, and teens 12-18 years old. In addition, programs for children 5-11 years old and teens 12-18 years old are also offered. Parents and their children meet in separate groups that meet concurrently. Developed from the known behaviors that contribute to the maltreatment of children, the goals of the curriculum are: (1) to teach age-appropriate expectations and neurological development of children, (2) to develop empathy and self worth in parents and children, (3) to utilize nurturing, non-violent strategies and techniques in establishing family discipline, (4) to empower parents and children to utilize their personal power to make healthy choices, and (5) to increase awareness of self and others in developing positive patterns of communication while establishing healthy, caring relationships.

Program	Nurturing Parenting Programs
Staffing Requirements	• B.A. in a related field and experience with groups skills for implementing parent and child sessions.
Service Delivery Setting	• A variety of community settings including home, schools, mental health and social service agencies, prisons or residential care facilities.
Implementation Costs	• $900-1800 in training materials and 1-3 days in training (cost not specified)
Service Delivery Costs	• Weekly group sessions from 2.5 to 3 hours. Home based sessions run 90 minutes. • 12-48 weeks
Standard Training Protocol	Information not available at this time
Proprietary	• Yes
Sustainability	Information not available at this time
Contact	www.nurturingparenting.com

Program	Parent-Child Interaction Therapy
Population	Families with young children (3-6) experiencing emotional or behavioral problems. There is an adaption for parents who have physically abused their children (4-12).
Cultural Evidence	40% of the research participants in one study were African American
Risk and Protective Factors	None reported
Level of Evidence	Well Supported
Outcomes	1. Decreased child behavior problems 2. Decreases in re-reports of child abuse 3. Parents report using higher levels of praise and lower levels of criticism
Prevention: Universal/Selective	
Early Intervention	Early intervention
Description	PCIT is an evidence-based treatment model with highly specified, step-by-step, live-coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions, and, using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. Generally the therapist provides the coaching from behind a one-way mirror. The emphasis is on changing negative parent/caregiver-child patterns. PCIT was initially targeted for families with children ages 2-7 with oppositional defiant and other externalizing behavior problems. It has been adapted successfully to serve physically abusive parents with children 4-12. PCIT may be conducted with parents, foster parents, or others in a parental/caretaker role. Caregiver and child must have regular, ongoing contact to allow for daily homework assignments to be completed.

Program	Parent Child Interaction Therapy
Staffing Requirements	• Teachers • Therapists • Researchers • Masters degree or better
Service Delivery Setting	• Twelve to twenty sessions
Implementation Costs	• Forty hours of direct training with ongoing supervision • Consultation for 4 to 6 months via conference calls, videotapes, distance learning • $3,000 per person (5 day workshop)
Service Delivery Costs	• Clinic based • Community based • Home based • Estimated cost savings for child welfare system, and victim health and mental health costs, per participant: $228 - $5,189. (Lee, et al., 2008)
Standard Training Protocol	• Yes • Assessment instruments • Scoring forms • Step by step clinician guide • Manualized training, coding of sessions and handouts.
Proprietary	• Yes
Sustainability	Information not available at this time
Contact	Erical Pearl/Erna Olafson, Ph.D, Psy.D Trauma Treatment Training Center Cincinnati Children's Hospital 3333 Burnett Avenue MLC 3008 Cincinnati, Ohio www.OhioCanDo4kids.org Care Diagnostic and Treatment Center UC Davis Health Systems 3300 Stockton Blvd. Sacramento, CA 95820 800-770-6992 chinh.pham@ucdmc.ucdavis.edu

Program	Parenting Wisely	
Population	Parents of children 3-18	
Cultural Evidence	Research studies have been carried out with predominately Caucasian participants	
Risk and Protective Factors	Risk: • Life stressors • Poor refusal skills • Lack of empathy • Family management problems • Poor family attachment • Negative attitude toward school	Protective: • Self-efficacy • Social competencies and problem solving skills • Effective parenting • Presence and involvement of caring and supportive adults • Good relationships with peers
Level of Evidence	Promising	
Outcomes	1. Improvement in child behavior 2. Increased knowledge of adaptive parenting practices 3. Improvements in parental sense of competency	
Prevention: Universal/Selective	Universal Selective	
Early Intervention	Early Intervention	
Description	Parenting Wisely is a set of interactive, computer-based training programs for parents of children ages 3-18 years. Based on social learning, cognitive behavioral, and family systems theories, the programs aim to increase parental communication and disciplinary skills. The original Parenting Wisely program, American Teens, is designed for parents whose preteens and teens are at risk for or are exhibiting behavior problems such as substance abuse, delinquency, and school dropout. Parents use this self-instructional program on an agency's personal computer or laptop, either on site or at home, using the CD-ROM or online format. During each of nine sessions, users view a video enactment of a typical family struggle and then choose from a list of solutions representing different levels of effectiveness, each of which is portrayed and critiqued through interactive questions and answers. Each session ends with a quiz. All nine sessions can be completed in 2 to 3 hours. Parents also receive workbooks containing program content and exercises to promote skill building and practice. Adaptations of the original Parenting Wisely program have been created for various groups of youth. One of these adaptations, Young Children, targets children ages 3-9 years. Although the studies reviewed in this summary primarily evaluated the original version of Parenting Wisely, the Young Children version was also evaluated, as were adaptations created to be implemented with groups of parents.	

Program	Parenting Wisely
Staffing Requirements	• Receptionist or practitioner to introduce family to program • No minimum provider qualifications
Service Delivery Setting	• Adoptive Home • Birth Family Home • Community Agency • Foster Home • Hospital • Outpatient Clinic • Residential Care Facility • School
Implementation Costs	• Parent workbooks (100 pages) are required, one per family cost from $9 to $5.75 depending on the quantity. • The program is delivered on a CD-Rom, which must be purchased for $599. The CD-ROM comes with a kit which includes a manual for community implementation, 5 parent workbooks, program completion certificates, program brochures, referral cards, and a floppy disk containing evaluation forms • Also available in an abbreviated and non-interactive form on a set of three videotapes which can be used as a booster for in-home use after the family has used the CD-ROM. The videotape set is $199 for purchasers of the CD-ROM, and $299 for others • Desktop and laptop computers, small private room • For group administration, LCD projector, screen, and room to hold 10-16 people • No expendable supplies are required, but incentives to get parents to use the program often help
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• 1-2 days, 7-14 hours • No training to implement and one staff member can deliver the program
Proprietary	• Proprietary
Sustainability	• Free telephone consultation is provided if needed
Contact	Donald A. Gordon, Ph.D. **Family Works, Inc.** **34 West State Street, Room 135B, Unit 8** **Athens, OH 45701–3751** **Phone: (866) 234-9473** **Fax: (541) 482-2829** **E-mail: familyworks@familyworksinc.com** **Web site: www.familyworksinc.com**

Program	Reflective Parenting Program (RPP)
Developer	John Grienenberger, PhD and Paulene Popek, Ph.D.
Submitted by	Vista Del Mar and the Center for Parenting Studies at the New Center for Psychoanalysis
Description	• A 10-week curriculum to help parents build strong, healthy bonds with their children • One and one-half hour workshops actively engage parents in an experiential learning process that includes strategies, techniques, and exercises designed to enhance parental reflective functioning
Population	• Expecting mothers; parents of children age 2-5; parents of children age 6-12 • Families with risk factors: immigration, low socio-economic status, histories of loss or trauma, teen parenthood, single parenthood
Cultural Evidence	• Has curriculum for Spanish speaking parents
Risk and Protective Factors	• Enhanced secure attachment between children and parents • Enhanced caregiver-child relationship and parental reflective functioning
Level of Evidence	• Emerging
Outcomes	• Increases in parent reflective functioning
Prevention: Universal/Selective	• Selective

Program	SafeCare
Population	Parents at risk to child maltreatment. In-home parenting model.
Cultural Evidence	Not reported
Risk and Protective Factors	None noted
Level of Evidence	Promising
Outcomes	1. Lower rates of re-abuse reporting 2. Significant improvements in health, safety and parenting
Prevention: Universal/Selective	
Early Intervention	Early intervention – families are referred by child welfare workers.
Description	SafeCare is an in-home parenting model program that provides direct skill training to parents in child behavior management and planned activities training, home safety training, and child health care skills to prevent child maltreatment. Weekly sessions approximately 1.5 hours each for 18-20 weeks, there is a homework component, and it is typically conducted in an adoptive home, birth family home, and foster home. The parent component addresses difficulty managing behavior and child health and safety concerns. The child component is for children 0-5 and addresses difficult behavior and inability to do developmentally appropriate daily living tasks.

Program	SafeCare
Staffing Requirements	• Home visitor • Coach • BA preferable but not necessary
Service Delivery Setting	• Community based • In home • Foster homes • Adoptive homes
Implementation Costs	• Small numbers trained at a time • Implementation costs depend on number of staff being trained
Service Delivery Costs	• Weekly session 1. 5 hrs • 18-20 weeks
Standard Training Protocol	• Trained on site by certified trainers • Five days per week • 8 hours per day
Proprietary	• Yes
Sustainability	• Training provided on-site by certified trainers • Site can have a staff trained as a certified coach who can train new staff
Contact	John Lutzker, Ph.D. SAFE/CARE/UCCED Centers 404-413-1299--fax 404-413-1284 jlutzker@gsu.edu www.safecarecener.org Daniel Whitaker" <dwhitaker@gsu.edu>

Program	Triple P – Positive Parenting Program
Population	Parents and caregivers of children birth through age 18. Multi-level system of parenting and family support.
Cultural Evidence	One study carried out in Hong Kong and a prevention trial underway in South Carolina with a significant percent of African American participants.
Risk and Protective Factors	None noted
Level of Evidence	Well supported
Outcomes	1. Decreased child behavior problems 2. Increased parental competence 3. Decreased parental stress 4. Higher levels of parental self-efficacy in handling home and work responsibilities
Prevention: Universal/Selective	Universal and selective prevention
Early Intervention	Early intervention for referred families
Description	The Triple P—Positive Parenting Program is a multilevel system or suite of parenting and family support strategies for families with children from birth to age 12, with extensions to families with teenagers ages 13-16. Developed for use with families from many cultural groups, Triple P is designed to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. The program, which also can be used for early intervention and treatment, is founded on social learning theory and draws on cognitive, developmental, and public health theories. Triple P has five intervention levels of increasing intensity to meet each family's specific needs. Each level includes and builds upon strategies used at previous levels. • Level 1: Universal Triple P is a media-based information strategy. • Level 2: Selected Triple P provides specific advice on how to solve common child developmental issues and minor child behavior problems includes parent tip sheets and videos delivered in 1-2 brief 20-minute consultations. • Level 3: Primary Care Triple P targets children with mild to moderate behavior difficulties and includes active skills training with rehearsal and self evaluation delivered through brief and flexible consultation, four 20-minute sessions. • Level 4: Standard Triple P and Group Triple P is an intensive strategy for parents of children with more severe behavior difficulties. This level is delivered in 10 individual or 8 group sessions totaling 10 hours. • Level 5: Enhanced Triple P is an enhanced behavioral family strategy for families in which parenting difficulties are complicated by other sources of family distress, includes practice sessions, mood management strategies, stress coping skills, and partner support skills. Enhanced Triple P extends Standard Triple P by adding 3-5 sessions tailored to the needs of the family.

Program	Triple P- Positive Parenting Program
Staffing Requirements	• Professional practitioners • Post-secondary qualifications are required in Health, Education, or Social Services • Practitioners should have knowledge of child/ adolescent development with experience working with families, plus accreditation
Service Delivery Setting	• Adoptive Home • Birth Family Home • Child Care Center • Community Agency • Foster Home • Hospital • Outpatient Clinic • Religious Organization • Residential Care Facility • School
Implementation Costs	• Depends on program level, number of participants, and organizational configuration.
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• Attendance at a dedicated training course • Implementation of Triple P in the workplace, including development of peer support networks • Completion of accreditation requirements • Access to Triple P Provider Network • 2-5 day training plus 1 day accreditation depending on level of intervention
Proprietary	• Yes
Sustainability	• Depends on program level, number of participants, and organizational configuration.
Contact	Triple P America 1205 Lincoln Street • Columbia, SC 29201 PO Box 12755 • Columbia, SC 29211 (803) 451.2278 email: contact.us@triplep.net

Program	UCLA TIES Transition Model (TTM)
Developer	Susan B. Edelstein, LCSW
Submitted by	UCLA TIES for Adoption
Description	• Multi-tiered transitional and supportive intervention • All adoptive parents of high-risk children participate in three 3-hour psycho-educational groups • Additional service and support options available to families, including older children, for up to 1 year (e.g., monthly support sessions, adoption-specific counseling, home visiting if child is less than age 3, interdisciplinary educational and pediatric consultation)
Population	• Children age 0-8 transitioning to or in adoptive placement at high risk for mental health problems and/or placement disruption (including biological vulnerabilities and environmental risk factors)
Cultural Evidence	• Has been delivered to an ethnically and racially diverse population of over 1,000 children in Los Angele's foster care system; provided in English & Spanish; and has served diverse adoptive situations, including transracial (56%), single parent (32%), and gay & lesbian individuals and couples (26%)
Risk and Protective Factors	• Decreased parental stress; increased parental satisfaction with adoption
Level of Evidence	• Promising
Outcomes	• Fewer placement disruptions than national average and comparison groups receiving standard community of care • Fewer child mental health problems after 1 year of intervention in comparison to children receiving standard community care
Prevention: Universal/Selective	• Selective

Program	Brand New Day
Developer	Robert Myers, PhD
Submitted by	Universal Care
Description	• Comprehensive program based on model of care that includes active community treatment, individualized case management, motivational interviewing, problem solving therapy and behavior modification
Population	• Transition age youth and adults ages 21-65 years experiencing a first onset • Primary diagnostic categories are schizophrenia, schizoaffective disorder and bipolar disorder
Cultural Evidence	• Serves individuals speaking English, Spanish or Vietnamese
Risk and Protective Factors	• Increased activity level • Improved motivation toward meaningful use of time • Promotes ability to live independently • Improved compliance to treatment • Improved ability to connect in the community • Improved acquisition of part-time or full-time employment or participation in vocational training or a higher education program
Level of Evidence	Emerging
Outcomes	• Reduced psychiatric hospitalization, medical-surgical hospitalization and emergency room visit • Improved psychosocial functioning and physical health
Prevention: Universal/Selective	• Selected

Program	Center for the Assessment and Prevention of Prodromal States (CAPPS)
Developer	Tyrone D. Cannon, PhD
Submitted by	University of California, Los Angeles
Description	• Universal prevention through public education and community outreach efforts • Selective prevention of and early intervention for youth at-risk of or experiencing their first episode of psychotic illness through multi-modal, comprehensive psychiatric and psychosocial interventions for one year, with booster sessions as needed for a second year
Population	• Transition age youth experiencing prodromal symptoms of first-break psychosis
Cultural Evidence	• Services provided in English and Spanish
Risk and Protective Factors	• Increased knowledge about and coping skills for identifying and managing psychiatric symptoms • Increased education and support for family members • Reduced stress
Level of Evidence	• Promising
Outcomes	• Increased early identification • Increased knowledge about symptoms • Improved functioning (clinical symptoms, family relationships, social, school/work)
Prevention: Universal/Selective	• Universal • Selective

Program	Cognitive Behavioral Therapy for Late Life Depression
Population	Older adults (55+) being treated on an outpatient basis for depression
Cultural Evidence	Random Clinical trials have demonstrated effectiveness among Latino, Chinese, and African-American consumers
Risk and Protective Factors	Protective: • Identification of negative thoughts and ability to challenge and develop more adaptive thoughts • Engagement in pleasant activities
Level of Evidence	Well-Supported
Outcomes	1. Reduced depressive symptoms 2. Reduced depression and re-occurrence of depression 3. Improved life satisfaction 4. Improved overall adjustment and coping strategies 5. Decreased psychiatric symptoms
Prevention: Universal/Selective	
Early Intervention	Early Intervention
Description	This program is an active, directive, time-limited, and structured problem-solving approach program that follows the conceptual model and treatment program developed by Aaron Beck and his colleagues. CBT for Late-Life Depression includes specific modifications for elderly depressed individuals who are being treated as outpatients. The intervention includes strategies to facilitate learning with this population, such as repeated presentation of information using different modalities, slower rates of presentation, and greater use of practice along with greater use of structure and modeling behavior. Patients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and develop more adaptive and flexible thoughts. Where appropriate, emphasis is also placed on teaching patients to monitor and increase pleasant events in their daily lives using behavioral treatment procedures. The intervention consists of up to 20 50- to 60-minute sessions following a structured manual.

Program	Cognitive Behavioral Therapy for Late Life Depression
Staffing Requirements	• Minimum masters level clinician (ideally trained in CBT)
Service Delivery Setting	• Traditionally delivered in clinic settings, but flexible
Implementation Costs	• Manuals can be downloaded for free from Stanford University's Older Adult and Family Center website (http://oafc.stanford.edu) • Hard copies can be obtained by paying copying and postage to Stanford's clinic
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• None
Proprietary	• No
Sustainability	• No criteria
Contact	Larry W. Thompson, Ph.D. Professor, Emeritus Stanford University School of Medicine P.O. Box 3926 Los Altos, CA 94024-0926 Phone: (650) 400-8171 E-mail: larrywt@stanford.edu Dolores Gallagher-Thompson, Ph.D., ABPP Research Professor Department of Psychiatry and Behavioral Sciences Stanford University School of Medicine P.O. Box 3926 Los Altos, CA 94024-0926 Phone: (650) 400-8172 E-mail: dolorest@stanford.edu

Program	Early Detection and Intervention for the Prevention of Psychosis (EDIPP)
Population	Young people experiencing ARMS Teens and TAY ages 12-25
Cultural Evidence	No information available
Risk and Protective Factors	None noted
Level of Evidence	Promising: • Ongoing trials
Outcomes	1. Delayed onset of a psychotic disorder 2. Reduced symptoms 3. Improved functioning
Prevention: Universal/Selective	Universal and selective
Early Intervention	Early Intervention for individuals experiencing a first break
Description	Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program – currently underway in six sites, funded by the Robert Wood Johnson Foundation and built on the findings of TIP, PACE, EPPIC and PIER programs (PIER serves as program office for funded sites): • PIER (Maine Medical Center/Portland, ME) • RAP (Zucker Hillside Hospital/Queens, NY) • EDAPT (UC Davis/Sacramento, CA) • EAST (Mid-Valley Behavioral Health Care Network/Salem, OR) • EARLY (Univ. of NM/Albuquerque, NM) • M3P (Univ. of Michigan/Ypsilanti, MI) a) Targeted and universal community education and outreach aimed at increasing early identification b) Universal community education aimed at reducing stigma and removing barriers to treatment c) Clinical service activities aimed at engagement and treatment Psychosocial interventions and medication; emphasis on family psycho-education and supported education and employment. The focus of these efforts is to interrupt the very early progression of psychotic disorders. The goals are to improve outcomes and prevent the onset of the psychotic phase of illnesses like Bipolar Disorder, Major Depression, and Schizophrenia. The program seeks to: 1. Educate and train the provider community, the school professional work force, and other key professionals who might encounter young persons in the early stages of deterioration toward psychosis. This extends to the education of the entire area population. 2. Identify, and help others to identify, young people who are manifesting prodromal (early signs) or active symptoms and signs of schizophrenia and other major psychotic disorders. 3. Evaluate individuals' risk for actual psychosis. 4. Treat those who are at substantial risk with an empirically-tested package of psychosocial and psychopharmacological interventions. 5. Maintain a long-term relationship with individuals and their families to assure the clinical and human support that have been found to be necessary to achieve a full secondary prevention effect.

The program advocates psychosocial and drug treatments that can be tailored to individual levels.

The critical feature is the clinical outreach by a team to general practitioners, guidance counselors, and, the population at large to educate and inform them about the early signs of psychosis. This project will use state-of-the-art treatments in a new application: secondary prevention of psychosis in vulnerable individuals.

This three-phase program initially targets health and educational professionals who work most closely with youth. A team of mental health professionals will reach out to physicians, schools and colleges, social workers, guidance counselors, high school nurses, police and others likely to encounter young persons at risk for psychosis. The second phase is educating the community. Phase three is the establishment of an assessment and treatment service that will identify potential program participants and provide family intervention and education, along with medication therapy, as necessary. The staff will intervene with these at-risk or already ill young persons, with the capacity for longer-term follow-up.

The program provides comprehensive diagnostic and treatment services for children and young adults who have recently developed a psychotic disorder, or who are at high risk for one of these disorders and are experiencing what might be prodromal symptoms.

A multi-site study funded by the Robert Wood Johnson Foundation is being implemented to identify and provide mental health services to individuals and their families who are experiencing early signs and symptoms of psychosis.

The goal of the participating sites is to intervene as early as possible in order to prevent the development of disease-related deficits and treatment-related side effects. In addition, the program attempts to empower individuals to become active participants in their treatment and to help people progress toward their personal, social and occupational goals. The program provides targeted medication and psychosocial interventions, as well as case management services, with the goals of early diagnosis, treatment, and disability prevention.

Individuals Experiencing Early Onset of Serious Psychiatric Illness

Program	**Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program:** • PIER – program office (Maine Medical Center/Portland, ME) • RAP (Zucker Hillside Hospital/ Queens, NY) • EDAPT (UC Davis/ Sacramento, CA) • EAST (Mid-Valley Behavioral Health Care Network/Salem, OR) • EARLY (Univ. of NM/Albuquerque, NM) • M3P (Univ. of Michigan/ Ypsilanti, MI) • Targeted and universal community education & outreach aimed at increasing early identification • Universal community education aimed at reducing stigma & removing barriers to treatment • Clinical service activities aimed at engagement and treatment • Psychosocial interventions and medication; emphasis on family psycho-education and supported education and employment
Staffing Requirements	(This info reflects their current thought process, they are working with RWJF on specifics of dissemination.) • .5 FTE Administrative Asst • .5 FTE Child Psychiatrist • 1 FTE Master's level licensed clinician • 1 FTE RN/Team Leader • .2 FTE O/T
Service Delivery Setting	• Clinic based • Outreach is largely to middle and high schools with health care providers as secondary audience
Implementation Costs	• First year of training, supervision and materials w/b between $95k and $110k • Second year w/b additional but significantly less than first
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• Yes • One week initial assessment and clinical training • First year would include intensive monitoring - e.g, fidelity assessments (likely multiple modes), monthly supervision of approx. 1 hour in <u>each</u> component (assess, clinical, multi-family groups, outreach). Any additional training needs w/b met within context of supervision.
Proprietary	• Yes
Sustainability	• Assuming satisfactory performance after first year of fidelity monitoring and supervision, certification is granted • Currently no ongoing criteria for maintaining certification
Contact	William McFarlane, MD PIER Program 932 Congress St. Portland, ME 04102 1-877-880-3377

Program	Early Psychosis Prevention and Intervention Centre (EPPIC)
Population	Young people experiencing psychosis • TAY 15-25
Cultural Evidence	No information available
Risk and Protective Factors	None noted
Level of Evidence	Emerging
Outcomes	1. Reduced symptoms 2. Improved functioning
Prevention: Universal/Selective	
Early Intervention	Early Intervention
Description	Early Psychosis Prevention and Intervention Centre (EPPIC) is a program within the ORYGEN Youth Health Program in Melbourne, Australia: • EPPIC is a comprehensive service addressing the needs of young people with psychotic disorders. EPPIC aims to facilitate early identification and treatment of psychosis and therefore reduce the disruption to the young person's functioning and psychosocial development. There is often an extended period of delay (2-3 years on average) when problems intensify, and there may be a failure to access appropriate help or help may be sought in inappropriate settings. These delays may be damaging to a young person, often in the crucial period of adolescence. Secondary problems such as substance abuse, unemployment and behavioral problems may develop or intensify and the illness itself may become more deeply entrenched. EPPIC aims to change this through: • Early identification and treatment of primary symptoms of psychotic illness • Improved access and reduced delays in initial treatment • Reducing frequency and severity of relapse; and increasing time to first relapse • Reducing secondary morbidity in the post-psychotic phase of illness • Reducing disruption to social and vocational functioning, and psychosocial development in the critical period following onset of illness when most disability tends to accrue • Promote well-being among family members and reduce the burden for caregivers EPPIC takes a 'whole person' approach to mental illness. It aims to: • Explore the possible causes of psychotic symptoms and treat them • Educate the young person and their family about the illness • Reduce disruption in a young person's life caused by the illness • Support the young person through recovery • Reduce the young person's chances of having another psychotic experience in the future • Involvement of youth clients at multiple levels • Case management • Med management • Group treatment • Inpatient treatment • Family psycho-education

Program	**Early Psychosis Prevention and Intervention Centre (EPPIC) is a program within the ORYGEN Youth Health Program in Melbourne, Australia:** • Involvement of youth clients at multiple levels • Case management • Med management • Group treatment • Inpatient treatment • Family psycho-education
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	• All costs below are in AUD and would also include GST (goods & service tax) • Package of training manual & video/DVD $55 • Additional supp videos/DVDs $12-30/each • Additional manuals $18-50/each • CAARMS training manual & video/DVD $90 • Community training resources $110 • Education and training package for MH workers $110 (unclear if avail outside Australia) • Distance learning on depression in young people, assessment, treatment and risk $273
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• Training and Consultation provided w/in Australia • Manuals, videos, DVDs, info sheets, and training packages avail from website, and state c/b tailored to meet individual needs
Proprietary	• Not specified (except for CAARMS assessment protocol)
Sustainability	Information not available at this time
Contact	

Program	Gatekeeper Case-Finding Model
Population	Older adults (55+) who may be experiencing signs and symptoms of distress
Cultural Evidence	No information available
Risk and Protective Factors	Risk: • Social isolation
Level of Evidence	Emerging
Outcomes	1. Increased identification of older adults in need of mental health, health, and/or social services 2. Increased enrollment and retention in case management services
Prevention: Universal/Selective	Selective
Early Intervention	-
Description	This program is designed to identify at-risk older adults who do not typically come to the attention of the mental health and aging service delivery systems. With this technique, nontraditional community referral sources are organized and trained to identify high-risk elders who may be experiencing problems that threaten their ability to live independently and safely in the community. Once identified, Gatekeepers refer the older person to a designated agency for a comprehensive assessment and evaluation with subsequent linkage to needed mental health, aging, medical, or other social services. Gatekeepers are employees of corporations, businesses, and other community organizations. They include meter readers, utility workers, residential property appraisers from the county assessor's office, bank personnel, apartment and mobile home managers, postal carriers, fuel oil dealers, police, sheriff and fire department personnel, and code enforcement employees. Gatekeepers are trained to become keen observers of an older adult person's personal appearance, mental and emotional states, personality changes, physical changes and losses, social problems, substance abuse, conditions of the home, caregiver stress, abuse or neglect, financial hardship and risk factors of suicide, any of which may indicate that an older person needs assistance.

Program	Gatekeeper Case-Finding Model
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Information not available at this time

Program	Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)
Population	Older adults (60+) who have major depression or dysthymic disorder
Cultural Evidence	Evaluation included African-American and Latino consumers
Risk and Protective Factors	Protective: • Behavioral activation (physical activity or engagement in pleasant activities) • Anti-depressant medication when chosen by patient • Problem solving treatment in primary care when chosen by patient
Level of Evidence	Well-Supported
Outcomes	1. Reduced severity of depressive symptoms 2. Improved functioning
Prevention: Universal/Selective	
Early Intervention	Early Intervention
Description	IMPACT is an intervention for patients 60 years or older who have major depression or dysthymic disorder. The intervention is a 1-year, stepped collaborative care approach in which a nurse, social worker, or psychologist works with the patient's regular primary care provider to develop a course of treatment. Intervention participants receive a 20-minute educational videotape and a booklet about late-life depression and are encouraged to have an initial visit with a depression care manager (DCM). During the first visit, the DCM completes an initial assessment, provides education about treatment, and discusses the patient's preference for depression treatment. All patients are encouraged to engage in behavioral activation such as physical activity or pleasant events scheduling. The IMPACT treatment algorithm suggests an initial choice of an antidepressant medication or a course of Problem Solving Treatment in Primary Care, 6-8 sessions of brief structured psychotherapy delivered by a DCM in the primary care setting. The DCM works with the patient and his or her primary care provider to establish a treatment plan according to the recommended treatment algorithm; the patient and provider make the actual treatment choices. The DCM follows up with patients monthly during the continuation phase.

Program	Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)
Staffing Requirements	• Depression Case Manager, or DCM (c/b nurse, social worker, or licensed counselor – approx. caseload 100-150 patients) • DCMs work with primary care providers and consulting psychiatrists as an integrated team (not simply co-location)
Service Delivery Setting	• Clinic
Implementation Costs	• The estimated cost per participant is $500 per year. Start-up costs vary depending on how the organization chooses to implement. • All program materials are available free of charge, either via the IMPACT Implementation Center Web site (http://impact-uw.org) or in hard copy from the Center. In-person training is the primary start-up cost; however, free online training is available. If an organization chooses in-person training for DCMs, the average cost is $200 per trainee. • Case-based training in the evidence-based Problem Solving Treatment (PST-PC) technique costs approximately $1,000-$1,500 per trainee (required for certification in PST, whether initial training is in person or online).
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• Initial training can be in person or on-line. Case supervision following initial training averages 9 recorded sessions with 2-3 patients to become certified in evidence-based Problem-Solving Treatment (PST) • No booster trainings or ongoing consultation
Proprietary	• No
Sustainability	• No criteria beyond certification in PST
Contact	IMPACT Implementation Center University of Washington Psychiatry & Behavioral Sciences 1959 NE Pacific, Box 356560 Seattle, WA 98195-6560 Diane Powers, Program Manager 206-685-7095 Andrea Panniero, Program Coordinator 206-221-3637

Program	"Integrated Treatment" as evaluated by the OPUS trial
Population	• Young adults and adults experiencing their first episode of psychosis • Adults 18-45
Cultural Evidence	No information available
Risk and Protective Factors	None noted
Level of Evidence	Emerging
Outcomes	1. Reduced symptoms 2. Improved functioning 3. Decreased family burden (outcomes maintained at 1- and 2-yr follow-ups)
Prevention: Universal/Selective	
Early Intervention	Early Intervention
Description	"Integrated Treatment" as evaluated by the OPUS trial (Norway; Nordentoft et al, 2005) • Max caseload of 10 (standard 25) • Assertive community treatment • Multifamily groups • Psycho-education • Social skills training Integrated treatment consisted of assertive community treatment, psychoeducational multi-family groups and social skills training. Further description unavailable in English.

Program	**"Integrated Treatment" as evaluated by the OPUS trial (Norway; Nordentoft et al, 2005)** • **Assertive community treatment** • **Multifamily groups** • **Psycho-education** • **Social skills training**
Staffing Requirements	• **Case management for min 2 yrs** • **1:10 max caseload** • **Psychiatrist** • **No clear specs on who runs groups or provides social skills training**
Service Delivery Setting	• **Community and clinic based** • **Multi-disciplinary team provides integrated services (best if co-located)**
Implementation Costs	**Information not available at this time**
Service Delivery Costs	**Information not available at this time**
Standard Training Protocol	**Information not available at this time**
Proprietary	**Information not available at this time**
Sustainability	**Information not available at this time**
Contact	

Program	Live Well, Live Long, Steps to Mental Wellness
Population	Older adults with symptoms of depression and/or anxiety
Cultural Evidence	Intervention guidelines include culturally specific information for addressing depressive symptoms among a variety of diverse racial/ethnic and cultural groups
Risk and Protective Factors	Protective: • Physical activity • Good nutrition • Adequate rest and sleep • Stress reduction activities • Optimistic attitude • Optimal medication management • Emotionally enriched environments
Level of Evidence	Components are well-supported
Outcomes	Outcomes of specific components include: 1. Reduced depression and/or anxiety symptoms 2. Improved functioning
Prevention: Universal/Selective	Selective
Early Intervention	Early Intervention
Description	Health promotion strategies and materials developed by the American Society on Aging through a cooperative agreement with the Centers for Disease Control and Prevention. The materials are in the public domain and can be use by staff in senior citizen centers, health education or public health settings or other community based organizations serving older adults at risk to depression and anxiety.

Program	Live Well, Live Long, Steps to Mental Wellness
Staffing Requirements	• Flexible – need a leader, a speaker for the program, someone who can coordinate efforts
Service Delivery Setting	• Flexible – work with existing community agencies to find venues that are convenient and accessible for older adults
Implementation Costs	• Materials can be downloaded for free from the American Society on Aging program website (http://www.asaging.org/cdc/module5/home.cfm) • Includes handouts, questions to consider in planning, implementation steps, depression screening tools, and steps for evaluation and follow-up
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• None
Proprietary	• No
Sustainability	• No criteria
Contact	

Program	Personal Assessment and Crisis Evaluation (PACE)
Population	Young people experiencing ARMS • TAY 15-25
Cultural Evidence	No information available
Risk and Protective Factors	None noted
Level of Evidence	Promising: • Ongoing trials in Australia • Components evaluated in US and UK
Outcomes	1. Delayed onset of a psychotic disorder 2. Improved functioning (initially and at follow-up, with med adherence)
Prevention: Universal/Selective	Selective
Early Intervention	Early Intervention
Description	Personal Assessment and Crisis Evaluation (PACE) clinic within the ORYGEN Youth Health program in Melbourne, Australia: • Cognitive-behavioral therapy • Meds (antipsychotics and atypicals) PACE works with young people, aged 15-25 who might be at risk of developing psychosis. By identifying people who are at risk of psychosis and providing them with appropriate treatment, it is hoped that early symptoms will be reduced, while also delaying or perhaps preventing the development of mental health problems. Young people who come to PACE often describe other changes such as: • Having more difficulty than usual coping with work or school • Feeling tired, lacking energy, paranoid or worried about other people and their actions • Noticing a change in the way things look or sound, or seeing things in the environment that other people do not. PACE aims to reduce these issues on the young person, and stop them from getting worse. PACE Clinic offers a free confidential counseling service and can assist in referring to other services if necessary or more appropriate.

Program	**Personal Assessment and Crisis Evaluation (PACE)—clinic within the ORYGEN Youth Health program in Melbourne, Australia:** • **Cognitive-behavioral therapy** • **Meds (antipsychotics and atypicals)**
Staffing Requirements	• **Case management as needed** • **Psychiatry as needed** • **No specs on who provides CBT interventions as needed**
Service Delivery Setting	• **Clinic based**
Implementation Costs	**Information not available at this time**
Service Delivery Costs	**Information not available at this time**
Standard Training Protocol	**Information not available at this time**
Proprietary	**Information not available at this time**
Sustainability	**Information not available at this time**
Contact	**Information not available at this time**

Program	Prevention of Suicide in Primary Care Elderly (PROSPECT)
Population	Older adults presenting to primary care with signs of depression and/or suicidal ideation
Cultural Evidence	No information available
Risk and Protective Factors	Protective: • Application of treatment algorithm for geriatric depression in primary care • Ongoing treatment management
Level of Evidence	Well-Supported
Outcomes	1. Reduced depression 2. Reduced suicidal ideation
Prevention: Universal/Selective	Selective
Early Intervention	Early Intervention
Description	PROSPECT aims to prevent suicide among older adult primary care patients by reducing suicidal ideation and depression. The intervention components are: (1) recognition of depression and suicide ideation by primary care physicians, (2) application of a treatment algorithm for geriatric depression in the primary care setting, and (3) treatment management by health specialists (e.g., nurses, social workers, and psychologists). The treatment algorithm assists primary care physicians in making appropriate care choices during the acute, continuation, and maintenance phases of treatment. Health specialists collaborate with physicians to monitor patients and encourage patient adherence to recommended treatments. Patients are treated and monitored for 24 months.

Program	Prevention of Suicide in Primary Care Elderly (PROSPECT)
Staffing Requirements	• Health specialists (c/b nurse, social worker or psychologist) who conduct 24-month care management and coordinate with primary care providers • Also a licensed clinician (c/b same as health specialist or c/b different) trained in delivering interpersonal psychotherapy (or the PST intervention trained in IMPACT)
Service Delivery Setting	• Clinic
Implementation Costs	• Funding was only for the effectiveness trial, no formal dissemination materials exist or are planned; • Dr. Paul Raue (praue@med.cornell.edu) is happy to share his hard-copy procedures manual with any site interested in implementing PROSPECT. Per Dr. Raue, intervention is very similar to the IMPACT intervention.
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Patrick J. Raue, Ph.D. Associate Professor of Psychology in Psychiatry Weill Medical College of Cornell University White Plains, NY 10605 Phone: (914) 997-8684 Fax: (914) 682-6979 E-mail: praue@med.cornell.edu

Program	Program of All-Inclusive Care for the Elderly (PACE)
Population	Older adults who meet criteria for admission to a nursing facility but choose to remain in the community (a capitated benefit of integrated Medicare and Medicaid financing)
Cultural Evidence	Evaluated with diverse racial/ethnic groups including African-Americans, Asians, and Latinos
Risk and Protective Factors	None noted
Level of Evidence	Promising
Outcomes	1. Decreased use of high-end medical services and increased use of ambulatory services 2. Increased use of support services 3. Improved health status, quality of life, and 4. Functional status 5. Decreased morbidity 6. Decreased comorbid diagnoses
Prevention: Universal/Selective	Selective
Early Intervention	
Description	The Program of All-Inclusive Care for the Elderly (PACE) features a comprehensive and seamless service delivery system and integrated Medicare and Medicaid financing. Eligible individuals are age 55 years or older and meet the clinical criteria to be admitted to a nursing home but choose to remain in the community. An array of coordinated services is provided to support PACE participants to prevent the need for nursing home admission. An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participants' needs; develops care plans; and delivers or arranges for all services (including acute care and, when necessary, nursing facility services), either directly or through contracts. PACE programs provide social and medical services, primarily in an adult day health center setting referred to as the "PACE center," and supplement this care with in-home and referral services in accordance with the participants' needs. Each participant can receive all Medicare- and Medicaid-covered services, as well as other care determined necessary by the interdisciplinary team.

Program	Program of All-Inclusive Care for the Elderly (PACE)
Staffing Requirements	• An interdisciplinary team, consisting of professional and para-professional staff, assesses participants' needs; develops care plans; and delivers or arranges for all services (including acute care and, when necessary, nursing facility services), either directly or through contracts.
Service Delivery Setting	• PACE programs provide social and medical services, primarily in an adult day health center setting referred to as the "PACE center," and supplement this care with in-home and referral services in accordance with the participants' needs.
Implementation Costs	• For a health care organization to be approved as a PACE program, the State must elect PACE as a voluntary State option under its Medicaid plan. In addition, the prospective PACE organization and the State must work together in the development of the PACE provider application. On behalf of the prospective provider, the State submits the application to the Centers for Medicare and Medicaid Services (CMS) with assurance of the State's support of the application and its contents. Each approved PACE program receives a fixed amount of money per PACE participant regardless of the services the participant utilizes. • A membership with the National PACE Association includes access to all the materials needed to implement the program. The fee for the first year of membership, called Exploring PACE, is $3,000, and the fee for subsequent years is $8,500. Other startup costs vary for each facility. PACE programs receive Medicare and Medicaid dollars to support the costs of services; in 2006, the Medicare and Medicaid capitation rate average (per member, per month) was $1,981.16 and $2,968.76, respectively.
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• PACE Technical Assistance Centers (TAC) are comprised of existing PACE programs that provide guidance for prospective PACE providers as well as initial and ongoing consultation for programs. • Not a standard training protocol, per se, but standards must be met and maintained. • (www.npaonline.org)
Proprietary	• Mix of public and proprietary
Sustainability	• Ongoing membership in National PACE Association required, with ongoing state and federal monitoring of regulatory requirements.
Contact	National PACE Association 801 N. Fairfax Street, Suite 309 Alexandria, VA 22314 info@npaonline.org Phone 703/535-1565 Fax 703/535-1566

Program	Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)
Population	Older adults (60+) with minor depression or dysthymia receiving home-based social services from community services agencies
Cultural Evidence	Evaluation included African-American consumers (36%)
Risk and Protective Factors	Protective: • Recognizing depressive symptoms • Increasing engagement in social and pleasant activities
Level of Evidence	Supported
Outcomes	1. Reduced symptoms of depression 2. Improved health-related quality of life in functional and emotional well-being
Prevention: Universal/Selective	Selective
Early Intervention	Early Intervention
Description	PEARLS is an intervention for people 60 years and older who have minor depression or dysthymia and are receiving home-based social services from community services agencies. The program is designed to reduce symptoms of depression and improve health-related quality of life. PEARLS provides eight 50-minute sessions with a trained social service worker in the client's home over 19 weeks. Counselors use three depression management techniques: (1) problem-solving treatment; (2) social and physical activity planning; (3) planning to participate in pleasant events. Counselors encourage participants to use existing community services and attend local events.

Program	Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)
Staffing Requirements	• Organizational leader • PEARLS manager • Case Manager (counselors can case manage, but shouldn't serve both roles for any given client) • PEARLS counselor (licensed clinician) • Data coordinator • Clinical supervisor (psychiatrist familiar with Problem Solving Treatment)
Service Delivery Setting	• Home-based
Implementation Costs	• A toolkit can be downloaded free from the PEARLS website (http://depts.washington.edu/pearlspr/) which includes all screening tools, step-by-step instructions for delivering the intervention, a clinician self-assessment for model adherence, and other forms and program materials • A 3-day in-person training is offered intermittently by University of Washington, $500 per trainee (not required to be a PEARLS site, but strongly recommended) • While they have not yet, they are considering traveling to conduct on-site training, particularly in CA b/c w/b convenient (approx 20-25 trainees at a time)
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• Strongly recommend participation in 3-day training • Their clinical research psychiatrist provides ongoing consultation & supervision in PST to local WA sites – recommend something similar in other implementation sites
Proprietary	• Mix of public and proprietary
Sustainability	• No criteria
Contact	For general PEARLS questions, please contact Sheryl Schwartz at sheryls@u.washington.edu or 206-685-7258.

Program	Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorders
Population	Adults (ages 18-65+) who have experienced single or multiple/continuous traumas and have posttraumatic stress disorder (PTSD)
Cultural Evidence	Evaluations included African-American consumers (25-44%)
Risk and Protective Factors	Protective: • Ability to process traumatic event/s • Symptom management
Level of Evidence	Well-Supported
Outcomes	1. Reduced severity of PTSD symptoms 2. Reduced symptoms of depression 3. Improved social adjustment
Prevention: Universal/Selective	
Early Intervention	Early Intervention
Description	This is a cognitive-behavioral treatment program for adult men and women (ages 18-65+) who have experienced single or multiple/continuous traumas and have post-traumatic stress disorder (PTSD). The program consists of a course of individual therapy designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety. PE has three components: (1) post-trauma difficulties, (2) imaginal exposure (also called revisiting the trauma memory in imagination), repeated recounting of the trauma memory, and (3) in vivo exposure, gradually approaching trauma reminders that are feared and avoided despite being safe. Treatment is individualized and is conducted by social workers, psychologists, psychiatrists, and other therapists trained to use the PE manual, which specifies the agenda and treatment procedures for each session. Standard treatment consists of 8-15 sessions conducted once or twice weekly for 90-minutes each. The duration of treatment can be shortened or lengthened depending on the needs of the client and his or her rate of progress.

Program	Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorder
Staffing Requirements	• Masters level and higher clinicians, preferred experience treating trauma victims
Service Delivery Setting	• Clinic based • Veterans centers • Private practice office • Inpatient units
Implementation Costs	• Four day clinician training $950 (in Philadelphia) • Follow up consultation for a fee • Video or audio recordings for supervision • Reading list • Some materials available for no cost • Train 30 people per training group
Service Delivery Costs	• Individual treatment • Nine to 12 sessions 1-2 times a week; 90 minutes (varies) • Therapist uses the manual
Standard Training Protocol	• Reading lists • Treatment manual • Complete 4-5 day workshop, training varies from ½ day; 2-day; 4-day, requires two clients in treatment for supervision
Proprietary	• Mix of public/proprietary
Sustainability	• Do have a train the trainer model
Contact	Center for the Treatment and Study of Anxiety Department of Psychiatry, University of Pennsylvania 3535 Market Street, 600 N. Philadelphia, pa 19104 ctsa@mail.med.upenn.edu Contact Person: Melissa aworly@mail. med.upenn.edu

Program	Psychogeriatric Assessment and Treatment in City Housing (PATCH)
Population	Older adult (60+) public housing residents identified in need of ongoing mental health services
Cultural Evidence	Evaluation included African-American residents
Risk and Protective Factors	Risk: • Stigma • Decreased mobility • Lack of knowledge about depression and other forms of mental illness
Level of Evidence	Supported
Outcomes	1. Reduced symptoms of depression and other psychiatric symptoms
Prevention: Universal/Selective	
Early Intervention	Early Intervention
Description	Psychogeriatric Assessment and Treatment in City Housing, also known as PATCH, is a program intended to meet the mental health needs of the elderly who live in public housing. In an effort to maintain the elderly in their existing environment, PATCH attempts to improve and coordinate community services to the elderly and to educate caregivers about their special needs. With two part-time psychiatrists and a nurse, it provides mental health assessments and referrals of the elderly for whom traditional treatment settings have been ineffective.

Program	Psychogeriatric Assessment and Treatment in City Housing (PATCH)
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Information not available at this time

Program	Aggression Replacement Therapy	
Population	12-17 year old youth who are aggressive	
Cultural Evidence	Data not reported	
Risk and Protective Factors	Risk: • Pattern of high family conflict • Family violence • Poor parental supervision • Association with delinquent or aggressive peers • Mental health problem • Life stressors • Early onset of aggression	Protective: • Effective parenting • Good relationships with peers • Social competencies and problem-solving • Self-efficacy
Level of Evidence	Promising	
Outcomes	1. Reduced impulsiveness 2. Improved interpersonal skills 3. Decreased recidivism	
Prevention: Universal/Selective	Universal for the Skills Streaming component Selective for the complete program	
Early Intervention	Youth are referred	
Description	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.	

Program	Aggression Replacement Therapy (Using Teaching Pro-Social Skills)
Staffing Requirements	• Facilitators (minimum of 2 for each group) trained in ART • Clinicians, Bachelor's or paraprofessionals
Service Delivery Setting	• Versatile – outpatient and inpatient settings • Juvenile halls • Camps • Detention centers • School settings, etc.
Implementation Costs	• CIMH Community Development Team Protocol - $8,000 for Team (1 Administrator, 5 Practitioners)
Service Delivery Costs	• Frequency and length of groups vary by implementation. • Some outcome measures must be purchased from publisher – cost determined by order. • Estimated cost savings juvenile justice system, crime victim & tax payers: $8,287 to $33,143 (Aos, et al., 2001).
Standard Training Protocol	CIMH Community Development Team Training Protocol • Pre-implementation Planning calls • Initial Clinical Training 2-3 days • One Booster Training – 1 day (approximately 4 months following initial clinical) • Twenty one hour team based phone consultation calls • Twelve Administrator Calls • Review of 2 video tapes per trained facilitator • All group instructional materials • Outcome evaluation protocols with measures, data base and twice yearly dashboard reports
Proprietary	• All Aggression Replacement Training materials are available through Research Press • Practice is Public
Sustainability	• Regular group supervision • Use of the ART Fidelity Checklist • Agency Trainer Protocol - $2,500 per Agency Trainer. • Replacement Training to address attrition of staff - $950 per Facilitator • Routine collection of evaluation protocol
Contact	Todd Sosna, Ph.D. Senior Associate California Institute for Mental Health 2125 19th St. tmq@verizon.net (916) 549-5506

Program	Asian Mentoring and Advocacy Support to Enhance Resiliency in Youth (MASTERY): A Mentoring Program
Developer	Terry Gock, PhD, MPA
Submitted by	Asian Pacific Family Center-East
Description	• Bicultural, community-based program for middle-school Asian immigrant youth; intensive one-to-one mentoring and 42-week Life Skills curriculum focused on self-awareness & identity, cultural identity, goal setting, communication, anger management, selection of prosocial peer group, and refusal skills for alcohol, tobacco, and other drugs
Population	• Middle-school age Asian immigrant youths at high risk of substance abuse and other delinquent behaviors
Cultural Evidence	• Curriculum has been implemented with Asian immigrant youth • Evaluation measures used were specifically developed for and tested with Asian immigrant population
Risk and Protective Factors	• Enhanced self-awareness and cultural identity • Enhanced relationships with significant adults and prosocial peers • Increased school bonding • Increased knowledge and use of prosocial skills
Level of Evidence	• Promising
Outcomes	• Decreased substance use • Decreased association with substance-using peers • Decreased risk of using alcohol, tobacco, or other drugs
Prevention: Universal/Selective	• Selective

Program	Breaking Cycles	
Population	Youth 12-17 who are at risk to juvenile justice involvement or who become engaged in delinquent behaviors	
Cultural Evidence	52% of the research participants were Latino	
Risk and Protective Factors	Risk: • School suspensions • Pattern of high family conflict • Association with delinquent peers • Favorable attitudes towards drug use • Early onset of aggression	Protective: • Effective parenting • Involvement with positive peer group activities • Positive expectations
Level of Evidence	Promising	
Outcomes	1. Decreased probation referrals	
Prevention: Universal/Selective	Selective for youth not adjudicated	
Early Intervention	Early intervention for youth on probation	
Description	Breaking Cycles has components of both prevention and graduated sanctions. The prevention component targets youths who are not yet involved in the juvenile justice system but who exhibit problem behavior such as disobeying their parents, violating curfew, repeated truancy, running away from home, or experimenting with drugs or alcohol. Youths can also self-refer if they experience parental neglect or abuse or they have other problems at home. Community Assessment Teams (CATs)—consisting of a coordinator, case managers, probation officers, and other experts—assess the needs of the youth and his or her family and then provide direct services or referrals to resources in the community to reduce the high-risk behaviors. CATs speak many different languages to communicate directly with their clients. Whenever possible, services are brought directly to the client and family. The graduated sanctions component tries to prevent further involvement in delinquency by combining sanctions with treatment. A juvenile who is at risk of an out-of-home placement can be referred to Breaking Cycles through a Juvenile Court Order, then a screening committee determines whether the juvenile will enter the program by examining his or her current offense, prior criminal history, and other personal, social, and family characteristics. A youth is brought to Breaking Cycles, put into Juvenile Hall, and begins a 10- to 14- day evaluation of educational performance, mental health needs, drug/alcohol dependencies, self and family resiliency, institutional adjustment, and strengths and future goals. A case plan is developed for each youth by a multidisciplinary team, with the family's input. A youth can be placed in a community-based institution or a home. Many youths start in a highly structured environment and, through goal attainment, step down to a lower level of commitment. Reassessments are performed weekly on the basis of public safety, the youth's rehabilitation, and subsequent compliance with the program's case plan developed in the assessment plan.	

Program	Breaking Cycles
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	

Program	Brief Strategic Family Therapy	
Population	Families of youth 10-18 with substance use and conduct problems	
Cultural Evidence	Studies have been done primarily with Latino (Cuban) families	
Risk and Protective Factors	Risk: • Family management problems • Pattern of high family conflict • Antisocial behavior and alienation • Favorable attitudes toward drug and alcohol use • Early onset of aggression	Protective: • Effective parenting • Involvement with positive peer group activities • Social competencies and problem-solving
Level of Evidence	Supported	
Outcomes	1. Decrease in drug use 2. Decrease in conduct problems 3. Improvement in family functioning	
Prevention: Universal/Selective	Selective for youth at risk for substance abuse and conduct problems	
Early Intervention	Families with a youth on probation	
Description	Brief Strategic Family Therapy (BSFT) is a family-based intervention designed to prevent and treat child and adolescent behavior problems. BSFT targets children and adolescents who are displaying—or are at risk for developing—behavior problems, including substance abuse. BSFT is based on the assumption that adaptive family interactions can play a pivotal role in protecting children from negative influences and that maladaptive family interactions can contribute to the evolution of behavior problems and consequently are a primary target for intervention. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems. Therapy is tailored to target the particular problem interactions and behaviors in each client family. Therapists seek to change maladaptive family interaction patterns by coaching family interactions as they occur in session to create the opportunity for new, more functional interactions to emerge. Major techniques used are joining (engaging and entering the family system), diagnosing (identifying maladaptive interactions and family strengths), and restructuring (transforming maladaptive interactions). BSFT is a short-term, problem-oriented intervention. A typical session lasts 60 to 90 minutes. The average length of treatment is 12 to 15 sessions over more than 3 months. For more severe cases, such as substance-abusing adolescents, the average number of sessions and length of treatment may be doubled. Treatment can take place in office, home, or community settings.	

Program	Brief Strategic Family Therapy
Staffing Requirements	• Licensed staff preferred • Non-licensed staff (case manager/B.A. Level) possible if a part of a treatment team
Service Delivery Setting	• Office • Home • Community setting
Implementation Costs	• $50,000 - $60,000 Per cohort for first year of implementation • Five therapists per cohort • Total cost of 3 year implementation depends on which out year components are selected and number and length of consultation sessions. • Particular skills area deficiencies can be addressed on an individual basis.
Service Delivery Costs	• Interventions are 12-15 sessions of 60-90 minutes over a period of three months. The entire team is expected to participate.
Standard Training Protocol	• A 2-day on-site consultation with program leadership to determine if BSFT is a good programmatic fit • Training consists of four 3-day sessions with 4 to 6 months of telephone supervisions
Proprietary	• Yes
Sustainability	• In addition to the telephone supervision, best results are achieved if there is an in-house supervisor who has gone through separate supervisor curriculum training • Monthly clinical tapes are submitted for critique and to asses the adherence to the model with up to 40 individually identified skills rated. (Nine to 12 months post training)
Contact	Olva Hervis Family Therapy Training Institute of Miami 1221 Brickell Ave. 9TH Floor Miami, FL 33133 888-527-3828 ohervis@bsft-av.com TA PROVIDER Kathleen Shea 305-668-0850 kshea@bsft-av.com

Program	Coping Power Program
Population	Preadolescent boys who are aggressive and their parents
Cultural Evidence	The majority of the research participants were African American
Risk and Protective Factors	**Risk:** • Low academic achievement • Family management problems • Association with aggressive peers • Poor refusal skills • Life stressors • Mental health problems **Protective:** • Presence and involvement of caring and supportive adults • Good relationships with parents • High expectations • Good relationships with peers • Social competencies and problem-solving
Level of Evidence	Well-supported
Outcomes	1. Decrease in aggression 2. Decrease in peer rejection 3. Decrease in substance use and in parental substance use 4. Improvement in behavior at school
Prevention: Universal/Selective	Selective
Early Intervention	Early Intervention
Description	The Coping Power Program is a multicomponent preventive intervention for aggressive children that use the contextual sociocognitive model as its conceptual framework. The sociocognitive model concentrates on the contextual parenting processes and on children's sequential cognitive processing. It posits that aggressive children have cognitive distortions at the appraisal stage of sociocognitive processing because of their difficulties in encoding incoming social information and in accurately interpreting social events and others' intentions. These children also have cognitive deficiencies at the problem solution stage of sociocognitive processing, and tend to generate maladaptive solutions for perceived problems. The model also emphasizes parenting processes in the development and escalation of problem behaviors. Child aggressive behavior arises fundamentally out of early contextual experiences with parents who provide harsh or irritable discipline, poor problem-solving, vague commands, and poor monitoring of their children's behavior. On the basis of this model, Coping Power Program was developed with parent and child components. Intervention covers 15 months (the 2nd half of 1 academic year and all of the next). The child component includes 8 intervention sessions in the 1st intervention year and 25 in the 2nd intervention year. Each group session lasts 40–60 minutes. The sessions include four to six boys and are co-led by a program specialist with a master's or doctoral degree in psychology or social work and by a school guidance counselor. The Coping Power child component was derived from a previously evaluated 18-session Anger Coping Program. The Coping Power child component sessions emphasize the following: behavioral and personal goal-setting, awareness of feelings and associated physiological arousal, use of coping self-statements, distraction techniques and relaxation methods when provoked and made angry, organizational and study skills, perspective taking and attribution retraining, social problem–solving skills, and dealing with peer pressure and neighborhood-based problems by using refusal skills. The parent component consists of 16 group sessions over the same 15-month intervention period. It is delivered in groups of four to six single parents or couples. Groups usually meet at the boys' schools and are led by two staff persons. Assertive attempts are made to promote parent attendance and to include both mothers and fathers in parent groups. The content of the parent component was derived from social-learning-theory–based parent training programs. Parents learn skills for identifying prosocial and disruptive behavioral targets in their children, rewarding appropriate child behaviors, giving effective instructions, establishing age-appropriate rules and expectations for children, applying effective consequences to negative child behavior, and establishing ongoing family communication

	through weekly family meetings. In addition, parents learn to support the sociocognitive skills that children learn in the Coping Power child component and to use stress-management skills to remain calm and in control during stressful or irritating disciplinary interactions with their children.

Program	Coping Power Program
Staffing Requirements	• Masters/Doctorate in psychology or social work • School guidance counselor
Service Delivery Setting	• Schools in group setting
Implementation Costs	• Includes a 2-3 day initial trainings session • Two days if only the child component is selected and 3 if the parental component is selected • Costs are $1,500 per trainer per day (roughly one trainer per 25 trainees) • Trainings occur onsite or there are 2 residential sessions at the university annually
Service Delivery Costs	• There are 34 sessions for the child and 16 for the parents
Standard Training Protocol	• The curriculum is manualized and there are fidelity measures
Proprietary	• Yes
Sustainability	• There is group phone supervision (10-12 trainees per call) bi-weekly for 1 year costing $100 per hour • Additionally, review of taped sessions is available for evaluation of skill learning and model adherence • The cost for the latter is in the range of $4,000-$5,000 annually depending on the number of sessions chosen
Contact	John Lochman Department of Psychology University of Alabama 383 Gordon Palmer Hall P.O. BOX 870348 Tuscaloosa, AL 35487 205-348-7678 jlocjman@gp.as.us.edu

Program	Functional Family Therapy
Population	Family-based program for youth 11-18 with conduct and substance use/abuse problems
Cultural Evidence	Data not reported
Risk and Protective Factors	**Risk:** • Association with delinquent peers • Family management problems • Pattern of high family conflict **Protective:** • Effective parenting
Level of Evidence	Well-Supported
Outcomes	1. Reduced re-arrests 2. Improved family functioning
Prevention: Universal/Selective	
Early Intervention	Early Intervention – families are referred
Description	Functional Family Therapy (FFT) is a family-based prevention and intervention program for dysfunctional youths ages 11 to 18 that has been applied successfully in a variety of multi-ethnic, multicultural contexts to treat a range of high-risk youths and their families. It integrates several elements (established clinical theory, empirically supported principles, and extensive clinical experience) into a clear and comprehensive clinical model. The FFT model allows for successful intervention in complex and multidimensional problems through clinical practice that is flexibly structured and culturally sensitive. The model includes specific phases: engagement/motivation, behavior change, and generalization. Engagement and motivation are achieved through decreasing the intense negativity often characteristic of high-risk families. The behavior change phase aims to reduce and eliminate the problem behaviors and accompanying family relational patterns through individualized behavior change interventions (skill training in family communication, parenting, problem-solving, and conflict management). The goal of the generalization phase is to increase the family's capacity to adequately use multisystemic community resources and to engage in relapse prevention. FFT ranges from 8 to 12 one-hour sessions for mild cases and incorporates up to 30 sessions of direct service for families in more difficult situations. Sessions are generally spread over a 3-month period and can be conducted in clinical settings as an outpatient therapy and as a home-based model.

Program	Functional Family Therapy
Staffing Requirements	• Bachelor's level practitioners • Masters level clinicians
Service Delivery Setting	• Family Home • Community • Clinic
Implementation Costs	• Phase I Training and Consultation Fee $46,750.00 • Phase II Training and Consultation Fee $23,500.00 • Phase III Training and Consultation Fee $8,000.00
Service Delivery Costs	• Teams comprised of 3-8 FFT Practitioners • Ideally full-time practitioners, but must be at least half-time • Caseload size is 10-15 families per full-time practitioner, 5-6 families per half-time practitioner • 8-20 family sessions over approximately 3-6 months • Estimated cost savings juvenile justice system, crime victim & tax payers: $14,149 -$59,067 (Aos, et al., 2001)
Standard Training Protocol	Phase I • 20-days of training in 1st year • Weekly team consultation conference calls • Monthly administrator conference calls • Bi-Annual Outcome Evaluation Dashboard Reports Phase II • 6-days of training in 2nd year • Bi-monthly team consultation conference calls • Monthly administrator conference calls • Bi-Annual Outcome Evaluation Dashboard Reports Phase III • 1-2 day FFT Symposium • Monthly team consultation conference calls • Monthly administrator conference calls • Bi-Annual Outcome Evaluation Dashboard Reports
Proprietary	• Yes
Sustainability	• Replacement training for new staff $3000 per practitioner – 9 days of training over 1 yr. • Twice per year training offered
Contact	Pam Hawkins, Associate II California Institute for Mental Health 2125 19th Street, Suite 200 Sacramento, CA 95818 (916) 556-3480 ext. 135 phawkins@cimh.org

Program	Gang Resistance Is Paramount
Population	Gang prevention program for youth 7 -16 and their parents
Cultural Evidence	78% of the research participants were Latino
Risk and Protective Factors	**Risk:** • Favorable attitudes toward drug and alcohol abuse • Poor refusal skills • Victimization and exposure to violence • Family management problems • Family transitions • Low parent education level • Low academic achievement • Association with delinquent peers **Protective:** • High expectations • Self-efficacy • Social competencies and problems-solving • Strong school motivation • Involvement in positive peer activities
Level of Evidence	Emerging
Outcomes	1. Decrease in favorable attitudes towards gang activity
Prevention: Universal/Selective	Universal
Early Intervention	
Description	Gang Resistance Is Paramount (GRIP) began as an attempt to curb gang membership and discourage future gang involvement. The program's objectives are to educate students about the dangers of gangs, discourage the city's youth from joining gangs, educate the students' parents about the signs of gang involvement, and provide parents with resources that will help them eliminate gang activities in their homes and neighborhoods. GRIP staff are familiar with gang activity, but have avoided gang involvement. Most of them are community members who live or have lived in Paramount. Their training is updated continually, and the program has had low turnover. GRIP has five elements: 1. A school-based curriculum, consisting of 26 to 29 lessons, for 2nd and 5th graders. The 2nd graders are taught about peer pressure, drugs, alcohol, self-esteem, family, crime, gangs and territory, and gangs and vandalism. They are discouraged from joining a gang through video presentations, coloring exercises, songs, and discussion of alternatives to gangs such as recreational activities. 5th graders review topics such as the danger of many gang activities and alternatives to gang membership. Gang membership is discouraged through the promotion of recreational activities, video presentations, current event discussions, and open dialog between students. An in-school follow-up program in the 9th grade caps the program. Topics such as drugs, alcohol, high school dropout, teen pregnancy, self-esteem, consequences of a criminal lifestyle, higher education, and career opportunities are discussed. 2. Parent education in the form of neighborhood meetings where parents are taught about warning signs of gang involvement and provided with tools to keep their children out of gangs. Handouts are given in both English and Spanish and include everything from information on programs and activities at the city's recreation department to information about tattoo removal programs and graffiti hotline numbers. 3. Counseling of parents and youths regarding the youths' gang activities. Sessions are set up by request or referral and occur in the parents' home, over the phone, or in-office. 4. Recreational activities are offered. Sports, classes, special events, and programs specifically for teens are provided, during which gang clothing is not allowed. 5. Neighborhood Watch meetings are combined with the parent meetings, during which information on city services is provided. GRIP has undergone six separate studies. The first two tested elementary students before

	and after participation in the program. Prior to the program, 50 percent of students were undecided about gang involvement, after participation 90 percent responded negatively toward gangs compared to a control group who showed no change over that time period. The third and fourth studies surveyed seventh and ninth graders who had participated in the program, both showed that 90 percent still had negative attitudes toward gangs. The fifth study cross-checked the names of program participants with police records and found that 96 percent were not identified as gang members.

Program	**Gang Resistance is Paramount**
Staffing Requirements	• **1 program manager** • **4 full-time instructors** • **1 part-time intern** • **College educated staff are familiar with gang activity, but avoided gang involvement. Most of them community members who live or have lived in Paramount**
Service Delivery Setting	• **School** • **Home** • **Phone** • **Office** • **Community**
Implementation Costs	• **All staff members are equipped with a GRIP curriculum manual,** • **Instructional videos, program instruction slides, student workbooks, program posters, program coloring books, and handouts for parent meetings and recreational activities** • **$58 per child per year**
Service Delivery Costs	• **$300,000 annual budget from general fund: salaries, maintenance costs, operational costs, and external conferences costs, etc.** • **"Internal training"** • **The staff is provided with and briefed on the curriculum prior to entering the classroom and is then immersed in the program**
Standard Training Protocol	**Information not available at this time**
Proprietary	**Information not available at this time**
Sustainability	• **GRIP staff members continuously attend conferences and seminars in and around Los Angeles County in order to continue to be educated about gangs, gang activity, and the latest educational resources.**
Contact	Tony Ostos, Manager **Gang Resistance Is Paramount Program** **16400 Colorado Avenue** **Paramount, CA 90723** **Phone: (562) 220-2120** **Fax: (562) 630-2713** **E-mail: tostos@paramountcity.com** **Web site: www.paramountcity.com**

Program	IMPACT! (Inspire & Mobilize People to Achieve Change Together): A Youth Development and Leadership Program
Developer	Terry Gock, PhD, MPA
Submitted by	Asian Pacific Family Center-East
Description	• Bicultural, school-based, 26-week skill-based curriculum focused on increasing pro-social skills and preventing externalizing behavior problems in Asian immigrant adolescent youth
Population	• High-school age Asian immigrant youths at high risk of behavioral problems
Cultural Evidence	• Curriculum has been implemented with 169 Asian immigrant youth • Evaluation measures used were specifically developed for and tested with Asian immigrant population
Risk and Protective Factors	• Increased self-efficacy • Increased pro-social peer interactions • Increased pro-social connections in school and with family • Decreased substance abuse • Decreased engagement in risky sexual activities • Decreased engagement in delinquent behaviors
Level of Evidence	• Promising
Outcomes	• Increased knowledge of healthy and pro-social behaviors • Increased pro-social attitudes • Increased pro-social behaviors
Prevention: Universal/Selective	• Selective

Program	LIFE (Loving Intervention for Family Enrichment) Program
Developer	Special Service for Groups – Occupational Therapy Training Program
Submitted by	Special Service for Groups – Occupational Therapy Training Program
Description	• Adaptation of Parent Project® national model (22-week skills based curriculum for parents of children at risk of or involved with the juvenile justice system) and multi-family group therapy
Population	• Low income Latino families with monolingual (Spanish) parents of children ages 10-17 at high-risk of delinquency and/or school failure
Cultural Evidence	• Outcomes achieved with Los Angeles County target population
Risk and Protective Factors	• Poor school attendance and performance • Poor relationships with peers, parents, and other authority figures • Antisocial behavior • Substance use/abuse • Parental stress • Inadequate parenting skills
Level of Evidence	• Promising
Outcomes	• Decreases in youth aggressive behaviors and social problems • Improved youth self-efficacy • Improved parenting skills and parenting competence
Prevention: Universal/Selective	• Selective

Program	Multidimensional Family Therapy	
Population	Family intervention for 11-18 year olds with conduct and substance abuse problems	
Cultural Evidence	72% of the research participants were African American	
Risk and Protective Factors	Risk: • Antisocial behavior and delinquent beliefs • Early sexual involvement • Family management problems • Parental use of harsh physical punishment or inconsistent discipline • Association with aggressive or delinquent peers • Peer use of alcohol, drugs and tobacco	Protective: • Self-efficacy • Social competencies and problem solving • Effective parenting • Involvement with positive peer group activities
Level of Evidence	Supported	
Outcomes	1. Decreased drug use 2. Improved family functioning 3. Decreased conduct problems	
Prevention: Universal/Selective	Selective for youth at risk to juvenile justice involvement	
Early Intervention	Early intervention for families where a youth is on probation	
Description	Multidimensional Family Therapy (MDFT) is a family-based treatment and substance-abuse prevention program developed for adolescents with drug and behavior problems. The multidimensional perspective suggests that symptom reduction and enhancement of prosocial and appropriate developmental functions occur by facilitating adaptive developmental events and processes in several domains of functioning. The treatment seeks to significantly reduce or eliminate an adolescent's substance abuse and other problem behavior and to improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. The objectives for the adolescent include transformation of a drug-using lifestyle into a developmentally normative lifestyle and improved functioning in several developmental domains. The objectives for the parent include blocking parental abdication by facilitating parental commitment and investment, improving the overall relationship and day-to-day communication between parent and adolescent, and increasing knowledge about and changes in parenting practices (e.g., limit-setting, monitoring, appropriate autonomy granting). There are two intermediate intervention goals for every family: helping the adolescent achieve an interdependent attachment bond to parents and family, and helping the adolescent forge durable connections with prosocial influences such as schools, peer groups, and recreational and religious institutions.	

Program	Multidimensional Family Therapy
Staffing Requirements	• One team consists of: 2 -3 full time therapists (Masters level) • 1 therapist assistant (high school/Bachelor's level) • On-site clinical supervision
Service Delivery Setting	• Home • Clinic
Implementation Costs	• Training for the 6-month certification is between $25,000-$30,000 per team. This includes all training costs.
Service Delivery Costs	• One MDFT Team (2 therapists, 1 therapist assistant) carry 10-16 families on its caseload. • Each family receives 3-5 visits a week for 3-6 mos.
Standard Training Protocol	• 6-month intensive process leading to certification for 1 year, annual re-certification thereafter
Proprietary	• Yes
Sustainability	• Certified teams need annual re-certification and additional training to address attrition/expansion - $3,000.
Contact	Center for Treatment Research on Adolescent Drug Abuse, University of Miami, Miller School of Medicine www.miami.edu/ctrada Gayle Dakof, Ph.D. (305) 243-3656 gdakof@med.miami.edu

Program	Multidimensional Treatment Foster Care	
Population	Alternative to residential and group care for youth 11-18 who are on probation, have emotional and behavioral problems and are placed out of home	
Cultural Evidence	Most research participants have been Caucasian	
Risk and Protective Factors	Risk: • Family management problems • Pattern of high family conflict • Antisocial behavior and alienation • Favorable attitudes toward drug and alcohol use • Early onset of aggression • Mental health problems	Protective: • Perception of social support from adults and peers • Social competencies and problem solving skills • Effective parenting • Good relationships with parents • Involvement with positive peer group activities
Level of Evidence	Well-supported	
Outcomes	1. Decreased hard drug use 2. Decreased recidivism 3. Fewer days in locked settings 4. Significantly fewer psychiatric symptoms 5. Improved school adjustment	
Prevention: Universal/Selective		
Early Intervention	Early Intervention – youth and families are referred	
Description	Multidimensional Treatment Foster Care (MTFC) is a behavioral treatment alternative to residential placement for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. It is based on the Social Learning Theory model that describes the mechanisms by which individuals learn to behave in social contexts and the daily interactions that influence both prosocial and antisocial patterns of behavior. The intervention is multifaceted and occurs in multiple settings. The intervention activities include behavioral parent training and support for MTFC foster parents, family therapy for biological parents (or other aftercare resources), skills training for youth, supportive therapy for youth, school-based behavioral interventions and academic support, and psychiatric consultation and medication management, when needed. There are three components of the intervention that work in unison to treat the youth: MTFC Parents, the Family, and the Treatment Team. 1. *MTFC Parents:* The program places a youth in a family setting with specially trained foster parents for 6 to 9 months. The foster parents are recruited, trained, and supported to become part of the treatment team. They provide close supervision and implement a structured, individualized program for each child. MTFC parents are supported by a case manager who coordinates all aspects of their youth's treatment program. In addition, MTFC parents are contacted daily (Monday through Friday) by telephone to provide the Parent Daily Report (PDR) information, which is used to relay information about the child's behavior over the last 24 hours to the treatment team and to provide quality assurance on program implementation. MTFC parents are paid a monthly salary and a small stipend to cover extra expenses. 2. *The Family:* The birth family receives family therapy and parent training. Families learn to provide consistent discipline, to supervise and provide encouragement, and to use a modified version of the behavior management system used in the MTFC home. Therapy is provided to prepare parents for their child's return home and to reduce conflict and increase positive relationships in the family. Family sessions and home visits during the child's placement in MTFC provide opportunities for the parents to practice skills and receive feedback. 3. *The Treatment Team:* The MTFC treatment team is led by a program supervisor who also provides intensive support and consultation to the foster parents, and also includes a family therapist, an individual therapist, a child skills trainer, and a daily telephone contact person. The team meets weekly to review progress on each case, review the daily behavioral information collected by telephone, and adjust the child's individualized treatment plan.	

	There are three versions of MTFC, each serving specific age groups. Each version has been subjected to rigorous scientific evaluations. The versions are MTFC–P (for preschool children, ages 3 to 5), MFFC–L (for latency-aged children, 6–11), and MTFC–A (for adolescents, 12–17).

Program	Multidimensional Treatment Foster Care (MTFC)
Staffing Requirements	• A team which includes a full time program supervisor (Master's level); half time family therapist, ½ time child therapist; foster parent recruiter, trainer, PDR caller (at least B.A. level) and two hourly skills trainers (no degree requirement)
Service Delivery Setting	• Foster Homes
Implementation Costs	• Approximately $40,000 for the first year of implementation and $20,000 in the second with $4000 a year of ongoing costs for WEB Based PDR and certification costs.
Service Delivery Costs	• One team serves 10 youth for 6-9 months. The program is intended for youth who would ordinarily be placed in level 12-14 group homes. • Estimated cost savings juvenile justice system, crime victim & tax payers: $21,836 to $87,622 (Aos, et al., 2001).
Standard Training Protocol	• Program supervisor – 5 day training in Eugene, Oregon • Foster parent recruiter, family and child therapists – 4 day training in Eugene, Oregon • Initial foster parent training in local community • Weekly video tape review and telephone consultation with the program supervisor • Two site visits
Proprietary	• Yes
Sustainability	• Program Certification that typically takes 1 to 2 years to achieve
Contact	Lynne Marsenich, LCSW lmarsenich@cimh.org (909) 816-1284

Program	Multisystemic Therapy	
Population	Family based intervention for youth 11-18 at risk for out of home placement and on probation	
Cultural Evidence	Five studies report ethnicity data. The range of African American participants is from 50 to 81%	
Risk and Protective Factors	Risk: • Low academic achievement • Family management problems • Association with delinquent or aggressive peers • Favorable attitudes towards drugs and alcohol • Early onset of aggression • Mental health problems	Protective: • Effective parenting • Involvement with positive peer group activities • Perception of social support from adults and peers
Level of Evidence	Well-Supported	
Outcomes	1. Decreased re-arrest rates 2. Significantly fewer criminal arrests as an adult 3. Decreased alcohol and drug use 4. Decreased peer aggression	
Prevention: Universal/Selective		
Early Intervention	Early Intervention – Families are referred	
Description	Multisystemic Therapy (MST) typically uses a home-based model of service delivery to reduce barriers that keep families from accessing services. Therapists have small caseloads of four to six families; work as a team; are available 24 hours a day, 7 days a week; and provide services at times convenient to the family. The average treatment involves about 60 hours of contact during a 4-month period. MST therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g., extended family, neighbors, friends, church members) and removing barriers (e.g., parental substance abuse, high stress, poor relationships between partners). Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including behavioral, cognitive-behavioral, and the pragmatic family therapies. This family–therapist collaboration allows the family to take the lead in setting treatment goals as the therapist helps them to accomplish their goals.	

Program	Multisystemic Therapy
Staffing Requirements	• Masters level therapists • In some case Bachelor level with supervision
Service Delivery Setting	• Public mental health or private providers • Home based model
Implementation Costs	• Five days regular training supervisors/staff stakeholders from other agencies • Weekly MST consultation • Regular booster trainings • Track progress/outcomes by completing specific forms • Participate in weekly supervision • Quarterly on site booster sessions • Master License $4000 • Team License $2500 • Program development and start up fees: $10,000—includes on site 5 day orientation for up to 4 teams Booster Training • Single Team $26,000 (5,000) GA services • Two teams jointly $20,000 per year • Three or more $17,000 • Replacement staff 5 day on site $8,000 plus travel costs • If staff goes to Charleston, $750 per day
Service Delivery Costs	• Provide on an as needed basis and regular appointments • Caseload is 4/6 families/ range of treatment is 4-6 months • Estimated cost savings juvenile justice system, crime victim & tax payers: $31,661 – $131,918 (Aos, et al., 2001)
Standard Training Protocol	• Yes—manualized training and program
Proprietary	• Yes •
Sustainability	• New staff must receive the 5-day training either in Charleston or new training on site
Contact	MST SERVICES 710 J. Dodds Blvd. Suite 200 Mt. Pleasant, SC 29464 Keller.Strother@mstservices.com 843-856-8226 FAX 843-856-8227 CIMH 2125 19TH ST. Sacramento, CA 95818 Bill Carter, LCSW bcarter@cimh.org Tel. 916-556-3480 X 130 Fax 916-446-4519

Program	Positive Directions
Developer	Special Service for Groups – HOPICS Family Center
Submitted by	Special Service for Groups – HOPICS Family Center
Description	• A comprehensive package of three national evidence-based interventions for the prevention and early intervention of substance use/abuse and delinquency including: (1) SAMHSA's Anger Management curriculum; (2) Cannabis Youth Treatment (CYT), based on motivational interviewing and cognitive-behavioral techniques; and, (3) a Life Skills for Teens curriculum. Youth participate for 9-12 months and receive individual case management in addition to the three 12-week, group-based, consecutively delivered interventions.
Population	• Low income, ethnically diverse youth ages 10-17 with substance use/abuse problems at risk of or involved with the juvenile justice system
Cultural Evidence	• Delivered in English and Spanish
Risk and Protective Factors	• Substance abuse • Community violence • Poor school attendance
Level of Evidence	• Promising
Outcomes	• Decreased substance abuse • Increased pro-social behavior • Increased knowledge of and skill use in anger management and conflict resolution • Increased knowledge of and skill use in problem solving, goal setting and communication skills • Increased utilization of community support system, particularly around relapse prevention
Prevention: Universal/Selective	• Selective

Program	School, Community and Law Enforcement Program
Developer	Terry Gock, PhD, MPA
Submitted by	Asian Pacific Family Center
Description	• Comprehensive intervention designed for Asian immigrant adolescents and their families at risk to school failure and or juvenile justice involvement. Core components include: a) Holistic Family Needs Assessment b) Individualized Life Skills Mentoring and Counseling c) Family Case Management Service Linkage d) Community Education and Consultation
Population	• Asian immigrant youth (adolescents) and their families at risk to school failure and juvenile justice involvement
Cultural Evidence	• The program was developed with input from local Asian community stakeholders. It was designed to specifically capitalize on those Asian cultural values and traditions associated with "extended family."
Risk and Protective Factors	•
Level of Evidence	• Promising
Outcomes	• Decreases in school disciplinary actions • Decreases in missed homework assignments • Improvements in school attendance • Decreased risk for delinquent behavior
Prevention: Universal/Selective	• Early intervention

Program	Ventanas
Developer	SPIRITT Family Services
Submitted by	SPIRITT Family Services
Description	• Seven week family communication skills curriculum developed for adolescent youth and their families at risk to school failure and juvenile justice involvement. Skills taught are based upon known risk factors for involvement in delinquent behavior and school failure
Population	• Latino adolescents and their families at risk to school failure and juvenile justice involvement.
Cultural Evidence	• The program has been adapted to serve Latino families. Cultural themes and metaphors are incorporated into the intervention. • Bilingual/bicultural facilitators help parents bridge the parenting practices learned in their country of origin to those more acceptable in the U.S.
Risk and Protective Factors	•
Level of Evidence	• Promising
Outcomes	• Increased family communication skills • Increased problem solving skills • Decreased adolescent aggression • Satisfaction with services for Latino parents
Prevention: Universal/Selective	• Early intervention

Program	Why Try? Program
Developer	Martha Marquez, LCSW
Submitted by	Los Angeles Unified School District Student Health and Human Services – School Mental Health Services
Description	• National, evidence-based 10-week group curriculum (45 mins each) designed to prevent delinquency and school failure
Population	• Low income, minority students (2nd thru 12th grade) at risk of school failure, dropping out of school, substance use/abuse, and/or juvenile justice involvement
Cultural Evidence	• This model is being used with low income, minority youth in Los Angeles County
Risk and Protective Factors	• Increased social skills • Increased conflict resolution skills • Increased coping skills
Level of Evidence	• Promising
Outcomes	• Increases in indicators of student resiliency
Prevention: Universal/Selective	• Selective

Program	Abuse Focused Cognitive Behavioral Therapy for Child Physical Abuse	
Population	School aged children who have been physically abused and their parents	
Cultural Evidence	53% of research participants were African American. In addition the developer has conducted focus groups with African American parents to explore the relevance and the utility of the intervention.	
Risk and Protective Factors	Risk: • Family violence • Victimization • Family management problems	Protective: • Effective parenting • Social competencies and problem-solving
Level of Evidence	Promising	
Outcomes	1. Improved parental anger 2. Decreases in physical discipline	
Prevention: Universal/Selective		
Early Intervention	Families referred for child physical abuse	
Description	AF-CBT is a treatment based on principles derived from learning and behavioral theory, family systems, cognitive therapy, and developmental victimology. It integrates specific techniques to target school-aged abused children, their offending caregivers, and the larger family system. Through training in specific intrapersonal and interpersonal skills, AF-CBT seeks to promote the expression of appropriate/pro-social behavior and discourage the use of coercive, aggressive, or violent behavior. Essential components include: education about CBT model and physical abuse, establish agreement with family to refrain from using physical force, review child's exposure to emotional abuse, identify and address cognitive contributors to abusive behavior in caregivers, teach affect management skills, teach parents behavioral strategies to reinforce and punish behavior as alternatives to physical discipline, and teach pro-social communication and problem-solving skills to the family and help them to establish them as everyday routines. Recommend 1-2 contacts per week with a minimum one-hour per contact. Typical outpatient course of treatment lasts for 12-18 hours of direct service (or longer), generally spanning 3-6 months. Delivery sites include: adoptive home, birth family home, hospital, outpatient clinic, residential care facility. Parent component addresses: anger management, stress, difficult child behavior, and inadequate parent-child communication and problem-solving skills. Child component addresses: aggression/behavioral dysfunction; poor social skills and limited interpersonal competence; and emotional and cognitive effects of recent abuse for children ages 6-15.	

Program	Abuse Focused Cognitive Behavioral Therapy for Child Physical Abuse
Staffing Requirements	• Masters level clinicians • Or experienced BA level • Small case load • Understands the need for carrying enough to meet the needs of the agency
Service Delivery Setting	• Clinic • Home • Private space or office necessary
Implementation Costs	• Individualized costs depending on site • Bi-weekly/monthly supervision 6-12 months; at least 2 cases for trainee use for training. • Can be a full learning collaborative with workshop training, consultation, tape review, boosters, etc., but can also do separate estimate per service. • Flexible/individualized cost estimates/cost estimates vary depending on the size of the group. • Travel costs reimbursed. • Full training up to 32 hours. Trainings tailored to the agency.
Service Delivery Costs	• Twelve to 18 weeks – one hour per week - of treatment, Individual/Group/ or Family
Standard Training Protocol	• Can be varied • Pre-training assessment • Six hours of didactic • Consultation 6 to 18 hours • Three to 6 months follow-up • Review of tapes of sessions • Phone consultation calls/booster sessions available/advanced case review available
Proprietary	• Yes
Sustainability	• Manual available/Train the Trainers Model being put in place • Developing a certification process
Contact	kolkodj@upmc.edu Phone: 412-246-5888 Elizabeth 412-246-5886

Program	Child-Parent Psychotherapy
Population	Young children , infants to seven years old who have experienced a traumatic event and their care givers
Cultural Evidence	37% Latinas in one study and in another all of the participants (N=93) were immigrants from Mexico and Central America
Risk and Protective Factors	None noted
Level of Evidence	Supported
Outcomes	1. Significant improvement in maternal distress 2. Significant reductions in child behavior problems 3. Reductions in child trauma symptoms
Prevention: Universal/Selective	
Early Intervention	Families referred
Description	CPP-FV is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories into a dyadic treatment approach designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of domestic violence. Child-parent interactions are the focus of six intervention modalities aimed at restoring a sense of mastery, security, and growth and promoting congruence between bodily sensations, feelings, and thinking on the part of both child and parent and in their relationship with one another.

Program	Child-Parent Psychotherapy
Staffing Requirements	• Requires Master's level clinicians
Service Delivery Setting	• Can be delivered in home or at a clinic
Implementation Costs	Information not available at this time
Service Delivery Costs	• Intervention is delivered one time per week for 1 to 1.5 hours and the sessions occur over a period of 50 weeks.
Standard Training Protocol	Information not available at this time
Proprietary	• Yes
Sustainability	Information not available at this time
Contact	Patricia Van Horn, J.D., Ph.D. UC-San Francisco Patricia.vanhorn@ucsf.edu Phone: 415-205-5323

Program	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	
Population	School aged children 10-14 who have had substantial exposure to violence	
Cultural Evidence	The studies have involved recent Latino immigrant youth and middle school youth in East Los Angeles	
Risk and Protective Factors	Risk: • Victimization and exposure to violence • Mental health problem • Peer rejection • Family management problems	Protective: • Effective parenting • Good relationships with peers • Social competencies and problem solving • Perception of support from adults and peers
Level of Evidence	Supported	
Outcomes	1. Decreased symptoms of depression 2. Decreased trauma symptoms 3. Improved parental psychosocial functioning	
Prevention: Universal/Selective		
Early Intervention	Early Intervention – youth are referred	
Description	The CBITS program is a cognitive and behavioral therapy group intervention for reducing children's symptoms of posttraumatic stress disorder (PTSD) and depression caused by exposure to violence that has been used successfully in inner city schools with multicultural populations. CBITS has three main goals: to reduce symptoms related to trauma, to build resilience, and to increase peer and parent support. CBITS was designed for use in schools, for children aged 10-14 who have had substantial exposure to violence and who have symptoms of PTSD in the clinical range. The CBITS intervention incorporates Cognitive-Behavioral Therapy skills in a group format (5-8 students per group) to address symptoms of PTSD, anxiety, and depression related to exposure to violence. Treatment includes homework. The program format is 10 child group sessions, 1-3 individual child sessions, two parent education sessions, and a teacher informational meeting. A manual details step-by-step plans and provides scripts for implementing the program.	

Program	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
Staffing Requirements	• Clinicians do first round of training; mental health background recommended. • Masters level clinician
Service Delivery Setting	• Schools • Mental Health Clinics
Implementation Costs	• Minimum of two clinicians; two day training costs $3,000 • Follow-up consultation review of sessions • 200 Hours—PRN—Ongoing • Quality Assurance Review is APX $100 per hour • Costs vary depending on CBT experience in clinician being trained. • One trainer for every 15 clinicians per site; two-day training
Service Delivery Costs	• Ten group sessions; approx. 1 hour per week; once a week; 6 to 8 students in group • One to 3 individual sessions, 2 parent education sessions • One teacher education session
Standard Training Protocol	• No standard training protocol • Training depends on the background of the person being trained and the availability of an on-site CBT specialist • Common training approach is for trainees to read background materials, review the manual, watch a training video, attend a two day training, then receive ongoing supervision from a local clinician with CBT experience.
Proprietary	• CBITS Manual available from Sopris Publishers ($35) • Manual alone not sufficient training
Sustainability	• Fidelity assessment measure available; independent rater watch sessions video/audio tape and rate adherence • Regular supervision weekly/biweekly recommended with a CBT expert • Learning collaborative also recommended • Train the Trainer Mode, i.e. work with their trainers in trainings • CBIT works with a local LA community and is “fluid” regarding training
Contact	Sheryl Kataoka, MD/UCLA/NPI 10920 Wilshire Blvd. #300 Los Angeles, CA 90024 310 794-3727 310 794-3724 skataoka@ucla.edu

Program	Prolonged Exposure (PE) Therapy for Post Traumatic Stress Disorder	
Population	Adults 18 to 65+ who have experienced single or multiple traumas	
Cultural Evidence	Three studies reported data: 100% of the participants were female and 36%, 25% and 44% were African American females	
Risk and Protective Factors	Risk: • Mental health problem	Protective: • Social competencies and problem solving • Self-efficacy
Level of Evidence	Well-Supported	
Outcomes	1. Reduced severity of trauma symptoms 2. Significantly reduced symptoms of depression 3. Improved social adjustment 4. Reduced anxiety symptoms	
Prevention: Universal/Selective		
Early Intervention	Early Intervention	
Description	This is a cognitive-behavioral treatment program for adult men and women (ages 18-65+) who have experienced single or multiple/continuous traumas and have post-traumatic stress disorder (PTSD). The program consists of a course of individual therapy designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety. PE has three components: (1) post-trauma difficulties, (2) imaginal exposure (also called revisiting the trauma memory in imagination), repeated recounting of the trauma memory, and (3) in vivo exposure, gradually approaching trauma reminders that are feared and avoided despite being safe. Treatment is individualized and is conducted by social workers, psychologists, psychiatrists, and other therapists trained to use the PE manual, which specifies the agenda and treatment procedures for each session. Standard treatment consists of 8-15 sessions conducted once or twice weekly for 90-minutes each. The duration of treatment can be shortened or lengthened depending on the needs of the client and his or her rate of progress.	

Program	Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorder
Staffing Requirements	• Masters level and higher clinicians, preferred experience treating trauma victims
Service Delivery Setting	• Clinic based • Veterans centers • Private practice office • Inpatient units
Implementation Costs	• Four day clinician training $950 (in Philadelphia) • Follow up consultation for a fee • Video or audio recordings for supervision • Reading list • Some materials available for no cost • Train 30 people per training group
Service Delivery Costs	• Individual treatment • Nine to 12 sessions 1-2 times a week; 90 minutes (varies) • Therapist uses the manual
Standard Training Protocol	• Reading lists • Treatment manual • Complete 4-5 day workshop, training varies from ½ day; 2-day; 4-day, requires two clients in treatment for supervision
Proprietary	• Mix of public/proprietary
Sustainability	• Do have a train the trainer model
Contact	Center for the Treatment and Study of Anxiety Department of Psychiatry, University of Pennsylvania 3535 Market Street, 600 N. Philadelphia, pa 19104 ctsa@mail.med.upenn.edu Contact Person: Melissa aworly@mail. med.upenn.edu

Program	Psychological First Aid for Students and Teachers
Developer	Marlene Wong, PhD (Co-Developer)
Submitted by	Los Angeles Unified School District / University of California at Los Angeles / RAND Corp.
Description	• Training and nationally-published educational materials for teachers whose students have experienced a disaster, school crisis, or emergency
Population	• Teachers of pre-school-age children and older who have experienced any disaster, school crisis, or emergency
Cultural Evidence	• This model has been used nationally (endorsed by the US Department of Homeland Security and the US Department of Education) and internationally (i.e., in China after the 2008 Chengdu earthquake)
Risk and Protective Factors	• Increased coping skills for managing the emotional and behavioral sequelae of unanticipated trauma
Level of Evidence	• Emerging
Outcomes	• (anticipated) To stabilize the emotions and behaviors of students • (anticipated) To return students to an improved mental and emotional state after a crisis or disaster, ready to attend school and reengage in classroom learning
Prevention: Universal/Selective	• Selective

Program	Safe Dates	
Population	8th and 9th grade students	
Cultural Evidence	Data not reported	
Risk and Protective Factors	Risk: • Victimization and exposure to violence	Protective: • Conflict resolution skills
Level of Evidence	Supported	
Outcomes	1. Decrease in psychological abuse against a dating partner 2. Decrease in sexual abuse against a dating partner 3. Decrease in violence against a dating partner	
Prevention: Universal/Selective	Universal	
Early Intervention		
Description	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 program includes a curriculum with nine 50-minute sessions, a 45-minute play to be performed by students, and a poster contest. Safe Dates involves family members through its parent letter and parent brochure.	

Program	Safe Dates
Staffing Requirements	• Classroom teachers (Middle and high school) • Counselors • Prevention specialists
Service Delivery Setting	• Schools
Implementation Costs	• Curriculum materials - $215.00 • $2000-$3500 in training costs as well as reimbursed travel costs for the trainers
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Roxanne Schladweiler Executive Director of Sales Hazelden Publishing and Educational Services 15251 Pleasant Valley Road Center City, MN 55012 Phone: (800) 328-9000 Fax: (651) 213-4577 E-mail: rschladweiler@hazelden.org

Program	Seeking Safety	
Population	Adults and older adolescents with a history of trauma and substance abuse	
Cultural Evidence	Most of the research participants have been female, and the range of African American participants is from 11 to 42%	
Risk and Protective Factors	Risk: • Mental health problem	Protective: • Self-efficacy
Level of Evidence	Promising	
Outcomes	1. Reductions in substance use 2. Improvement in trauma symptoms 3. Improved psychosocial functioning	
Prevention: Universal/Selective		
Early Intervention	Early intervention – consumers are referred.	
Description	Seeking Safety is a present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential). Seeking Safety focuses on coping skills and psychoeducation and has five key principles: (1) safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions); (2) integrated treatment (working on both posttraumatic stress disorder (PTSD) and substance abuse at the same time); (3) a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; (4) four content areas: cognitive, behavioral, interpersonal, and case management; and (5) attention to clinician processes (helping clinicians work on counter-transference, self-care, and other issues).	

Program	Seeking Safety
Staffing Requirements	• Clinicians with experience treating trauma and/or substance abuse • Bachelors level • Masters level • Trainees • Case managers
Service Delivery Setting	• Outpatient clinic • Inpatient • Residential • Individual • Group
Implementation Costs	• Depends on the site • Individualized • Supervisions via review of taped sessions • Fidelity scale provided/manual costs $40 • 4.5 hours training video cost $250
Service Delivery Costs	• Clinician costs
Standard Training Protocol	• No specific training required by developers • Formal training is available through the developers • Books, video based training, on site training/phone consultation is available/intervention adherence part of the consultation
Proprietary	Yes
Sustainability	• Training offered periodically in various sites or can have trainers come to the site • No Train the Trainers Model available • Certification available after sufficient supervision
Contact	Lisa Najavits, Ph.D. 12 Colbourne Crescent Brookline Mass 02445 Phone 617-731-1501 Fax 617 701-1295 e-mail Lnajavits@hms.harvard.edu

Program	SITCAP-ART Structured sensory intervention for traumatized children, adolescents and parents
Population	Youth 12-17 with a history of trauma or loss
Cultural Evidence	85% of the research participants were Caucasian
Risk and Protective Factors	Risk: • Mental health problem Protective: • Problem-solving skills
Level of Evidence	Promising
Outcomes	1. Improvements in some trauma symptoms
Prevention: Universal/Selective	
Early Intervention	Early Intervention – Families are referred
Description	The *SITCAP-ART* program is a comprehensive trauma intervention program, modified from the original *Structured Sensory Intervention for Traumatized Children, Adolescents and Parents (SITCAP)* program initially researched in 2001. *SITCAP-ART* is designed specifically for at-risk and adjudicated youth. *SITCAP-ART* integrates cognitive strategies with sensory/implicit strategies. When memory cannot be linked linguistically in a contextual framework, it remains at the symbolic level for which there is no words to describe. To retrieve that memory so it can be encoded, given a language, and then integrated into consciousness, it must be retrieved and externalized in its symbolic perceptual (iconic) form (Steele, 2003). *SITCAP-ART*, which is followed by cognitive or explicit strategies, supports moving from victim to survivor thinking, allowing changes in negative behaviors (aggressive and rule-breaking behavior) and making adolescents more resilient to future traumas.

Program	SITCAP-ART Structured sensory intervention for traumatized children, adolescents and parents
Staffing Requirements	• Prefer Master's level clinician with experience working with adjudicated youth.
Service Delivery Setting	• Community agencies; mental health clinics; residential care facilities and schools.
Implementation Costs	• Manual and required 3-5 day training
Service Delivery Costs	• Group treatment • One hour per week for 8-10 weeks
Standard Training Protocol	Information not available at this time
Proprietary	• Yes
Sustainability	Information not available at this time
Contact	Caelean Kuban, LMSW ckuban@tlcinst.org (877) 306-5256 www.tlcinst.org

Program	Trauma Focused Cognitive Behavioral Therapy	
Population	3-18 year olds who have been trauma exposed and their caregivers	
Cultural Evidence	Data not reported	
Risk and Protective Factors	Risk: • Victimization • Exposure to violence • Mental heath problem • Life stressors • Family violence • Maternal depression • Family transitions	Protective: • Effective parenting • Social competencies and problem solving • Self-efficacy
Level of Evidence	Well supported	
Outcomes	1. Decreased child behavior problems 2. Decreased trauma symptoms 3. Decreased depression 4. Improved social competence	
Prevention: Universal/Selective		
Early Intervention	Early intervention – families are referred	
Description	TF-CBT is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles. Sessions are conducted once a week. Each session is 30-45-minutes for the child (ages 3-18); 30-45 minutes for the parent. The program also includes conjoint child-parent sessions toward the end of treatment that last approximately 30-45 minutes. Treatment lasts 12-18 sessions. Can be provided in groups of 6-10 children and their caregivers. Homework is a component of treatment. Delivery sites include community agency and outpatient clinic.	

Program	Trauma Focused Cognitive Behavioral Therapy
Staffing Requirements	• Clinical staff-Masters degree of higher • Supervisors trained in TF-CBT
Service Delivery Setting	• Outpatient • Foster homes • Residential Treatment Centers • Long term inpatient units • Schools • Community settings
Implementation Costs	• CIMH Community Development Team Training Protocol - $16,000 for Team (1 Administrator, 1 Supervisor, 4 Clinicians)
Service Delivery Costs	• One hour sessions weekly for child and parent • Primary adult • Approximately 12-15 sessions
Standard Training Protocol	CIMH Community Development Team Training Protocol • Pre-implementation Planning Calls • Completion of Web-Based Training Course • Initial Clinical Training 2-3 days • Two Booster Training 1-2 days each • Twenty one hour team based phone consultation calls • Twelve Administrator Calls • One audiotape review per clinician • Outcome evaluation protocols with measures, data base and twice yearly dashboard reports
Proprietary	• Public
Sustainability	• Use of the TF CBT Fidelity Checklist is suggested to sustain fidelity to the model • Trained Site Supervisors • Replacement Training to address attrition of staff • Routine collection of evaluation protocol
Contact	Todd Sosna, Ph.D. Senior Associate California Institute for Mental Health 2125 19th St. tmq@verizon.net (916) 549-5506

Program	Trauma Recovery and Empowerment (TREM)
Population	Adult women, 18-55 with histories of exposure to physical and sexual abuse
Cultural Evidence	Three studies have been conducted. The range of African American participants is from 18 to 82% and for Latinas from 16 to 31%
Risk and Protective Factors	**Risk:** • Victimization • Mental heath problem • Life stressors • Family violence • Maternal depression • Family transitions **Protective:** • Self-efficacy
Level of Evidence	Promising
Outcomes	1. Decreases in drug addiction severity 2. Reduction in trauma symptoms 3. Slight improvements in overall health
Prevention: Universal/Selective	
Early Intervention	Early intervention – consumers are referred
Description	TREM is a fully manualized group-based intervention designed to facilitate trauma recovery among women with histories of exposure to sexual and physical abuse. Drawing on cognitive restructuring, psychoeducational, and skills-training techniques, the gender-specific 24-29 session group emphasizes the development of coping skills and social support. It addresses both short and long-term consequences of violent victimization, including mental health symptoms, especially posttraumatic stress disorder (PTSD) and depression, and substance abuse. TREM has been successfully implemented in a wide range of service settings (mental health, substance abuse, criminal justice) and among diverse racial and ethnic populations.

Program	Trauma Recovery and Empowerment (TREM)
Staffing Requirements	• Master's level clinicians
Service Delivery Setting	• Criminal justice settings, substance abuse settings, residential care facilities and community mental health
Implementation Costs	• On site training available • Curriculum materials approximately $1500
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Rebecca W. Berley, M.S.W. Director of Trauma Education Community Connections 801 Pennsylvania Avenue, SE, Suite 201 Washington, DC 20003 Phone: (202) 608-4735 Fax: (202) 608-4286 E-mail: rwolfson@ccdc1.org www.ccdc1.org

Program	American Indian Life Skills	
Population	13-17 year old Native American Youth at risk for suicide and school failure	
Cultural Evidence	100% of the study participants were Native American Youth	
Risk and Protective Factors	Risk: • Life stressors • Mental health problems • Family history of suicide and/or depression • Peer rejection • Poor school bonding	Protective: • Social competencies and problem-solving skills • Strong school motivation • Good relationships with peers • Presence and involvement of caring, supportive adults
Level of Evidence	Promising	
Outcomes	1. Decrease in hopelessness 2. Improvement in suicide prevention skills	
Prevention: Universal/Selective	Universal for Native American Youth	
Early Intervention		
Description	This program is a curriculum that is school-based, culturally tailored, suicide prevention for American Indian adolescents (11-19 years old). Tailored to American Indian norms, values, beliefs, and attitudes, the curriculum is designed to build self-esteem; identify emotions and stress; increase communication and problem-solving skills; and recognize and eliminate self-destructive behavior, including substance abuse. The curriculum provides American Indian adolescents with information on suicide and suicide-intervention training and helps them set personal and community goals. Each lesson in the curriculum contains standard skills training techniques for providing information about the helpful or harmful effects of certain behaviors, modeling of target skills, experimental activities, behavior rehearsal for skill acquisition, and feedback for skills refinement. The curriculum can be delivered three times a week over 30 weeks, during the school year or as an after-school program.	

Program	American Indian Life Skills
Staffing Requirements	• Team teaching using teachers • Community resource leaders • Local social service agencies
Service Delivery Setting	• School • Community settings rural and/or frontier • Tribal • Urban
Implementation Costs	• Manual costs $30.00 training for school staff costs approx. 3,000 for 3- day training plus travel expenses
Service Delivery Costs	• 3 times a week • 30 weeks
Standard Training Protocol	• Training resources are available • Intervention fidelity tool • Training effectiveness tools
Proprietary	• Mix of public/proprietary
Sustainability	• No information available at this time
Contact	Teresa Lafromboise, Ph.D. Stanford University 485 Lasuen Mall Stanford, CA 94305 650-723-2109 650-725-7412 Lafrom@stanford.edu Griefnet.org/library/review/Americanindian

Program	Asian American Family Enrichment Network (AAFEN) Program	
Developer	Terry Gock, PhD, MPA	
Submitted by	Asian Pacific Family Center-East	
Description	• Bicultural 12-week skill-based parenting program for Asian immigrants • Outreach, engagement, and support activities also part of curriculum	
Population	• Asian immigrant parents and/or primary caregivers of teenage children	
Cultural Evidence	• Curriculum has been evaluated with over 350 immigrant parents of Chinese, Korean, and Vietnamese origin • Evaluation measures used were specifically developed for and tested with Asian immigrant population	
Risk and Protective Factors	• Increased bicultural parenting skills • Improved parent/child relationships • Decreased family conflict	
Level of Evidence	• Emerging	
Outcomes	• Improved family functioning • Improved family relationships and attitudes	
Prevention: Universal/Selective	• Selective	
Program	Bicultural Competence Skills Approach	
Population	Native American adolescents	
Cultural Evidence	100% of the study participants are Native American adolescents	
Risk and Protective Factors	Risk: • Negative attitude toward school • Low school bonding • Poorly organized and functioning school	Protective: • Presence and involvement of caring, supportive adults • Social competencies and problem solving skills
Level of Evidence	Supported	
Outcomes	1. Increases in knowledge about substance use 2. Improved problem-solving and refusal skills 3. Decreased substance use	
Prevention: Universal/Selective	Universal for Native American youth	
Early Intervention		
Description	This approach is an intervention designed to prevent the abuse of tobacco, alcohol, and other drugs by Native American adolescents (ages 12-18) by teaching them social skills in a way that blends the adaptive values and roles of both the Native American and popular American cultures. The intervention groups are led by Native American counselors. Through cognitive and behavioral methods, participants are instructed in and practice communication, coping, and discrimination skills. Communication skills are introduced with biculturally relevant examples of verbal and nonverbal influences on substance use. For instance, leaders model how subjects could turn down offers of tobacco, alcohol, and other drugs from their peers without offending their Native American and non-Native American friends. While the participants practice communication skills, leaders offer coaching, feedback, and praise. Coping skills include self-instruction and relaxation to help subjects deal with pressure and avoid substance use situations. Leaders suggest alternatives to using tobacco, alcohol, and other drugs and teach subjects to reward themselves for positive decisions and actions. Substance abuse awareness is also brought	

	into the community.

Program	Asian Mentoring and Advocacy Support to Enhance Resiliency in Youth (MASTERY): A Mentoring Program
Developer	Terry Gock, PhD, MPA
Submitted by	Asian Pacific Family Center-East
Description	• Bicultural, community-based program for middle-school Asian immigrant youth; intensive one-to-one mentoring and 42-week Life Skills curriculum focused on self-awareness & identity, cultural identity, goal setting, communication, anger management, selection of prosocial peer group, and refusal skills for alcohol, tobacco, and other drugs
Population	• Middle-school age Asian immigrant youths at high risk of substance abuse and other delinquent behaviors
Cultural Evidence	• Curriculum has been implemented with Asian immigrant youth • Evaluation measures used were specifically developed for and tested with Asian immigrant population
Risk and Protective Factors	• Enhanced self-awareness and cultural identity • Enhanced relationships with significant adults and prosocial peers • Increased school bonding • Increased knowledge and use of prosocial skills
Level of Evidence	• Promising
Outcomes	• Decreased substance use • Decreased association with substance-using peers • Decreased risk of using alcohol, tobacco, or other drugs
Prevention: Universal/Selective	• Selective

Program	Bicultural Competence Skills Approach
Staffing Requirements	• Two Native American counselors
Service Delivery Setting	• Public schools • Tribal schools • Tribal community centers • Student retreats
Implementation Costs	• Program packet for $240, users guide for $18 • Original Instrument: Follow-Instrument (PDF) $2.88 • Original Instrument: Pre/Post Test Instrument (PDF) $3.24
Service Delivery Costs	• Information not available at this time
Standard Training Protocol	• Information not available at this time
Proprietary	• Yes
Sustainability	• Information not available at this time
Contact	Steven P. Schinke **Columbia University School of Social Work** **622 West 113th Street** **New York, NY 10025** **Phone: (212) 851-2276** **Fax: (212) 854-1570** **E-mail: schinke@columbia.edu** Technical Assistance Provider: Editor **Sociometrics** **170 State Street, Suite 260** **Los Altos, CA 94022** **Phone: (415) 949-3282** **E-mail: editor@socio.com** **Web site: www.socio.com/srch/summary/ysappa/ysa01.htm**

Program	Brief Strategic Family Therapy
Population	Families with children and adolescents (ages 6-18) with behavioral and substance abuse problems
Cultural Evidence	Studies primarily on Latino youth Developed to enhance bicultural skills and problems associated with minority status and/or migration-related stresses
Risk and Protective Factors	**Risk:** • Anti-social behavior • Early onset of aggression and/or violence • Favorable attitudes toward drug use/early drug or alcohol use • Family management problems/poor parental supervision and/or monitoring • Pattern of high family conflict • Poor family attachment • Sibling antisocial behavior **Protective:** • Perception of social support from adults and peers • Self-efficacy, social competences and problem-solving skills • Effective parenting • Good relationships with parents/bonding • Involvement with positive peer group activities
Level of Evidence	Supported
Outcomes	1. Reductions in conduct and emotional problems 2. Association with antisocial peers 3. Drug use improvements in self-concept 4. Family functioning 5. Engagement into family therapy
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	BSFT is designed to (1) prevent, reduce, and/or treat adolescent behavior problems such as drug use, conduct problems, delinquency, sexually risky behavior, aggressive/violent behavior, and association with antisocial peers; (2) improve prosocial behaviors such as school attendance and performance; and (3) improve family functioning, including effective parental leadership and management, positive parenting, and parental involvement with the child and his or her peers and school. BSFT is typically delivered in 12-16 family sessions but may be delivered in as few as 8 or as many as 24 sessions, depending on the severity of the communication and management problems within the family. Sessions are conducted at locations that are convenient to the family, including the family's home in some cases. Hispanic families have been the principal recipients of BSFT, but African American families have also participated in the intervention.

Program	Brief Strategic Family Therapy
Staffing Requirements	• Licensed staff preferred • Non-licensed staff (case manager/B.A. Level) possible if a part of a treatment team
Service Delivery Setting	• Office • Home • Community setting
Implementation Costs	• $50,000 - $60,000 Per cohort for first year of implementation • Five therapists per cohort • Total cost of 3 year implementation depends on which out year components are selected and number and length of consultation sessions. • Particular skills area deficiencies can be addressed on an individual basis.
Service Delivery Costs	• Interventions are 12-15 sessions of 60-90 minutes over a period of three months. The entire team is expected to participate.
Standard Training Protocol	• A 2-day on-site consultation with program leadership to determine if BSFT is a good programmatic fit • Training consists of four 3-day sessions with 4 to 6 months of telephone supervisions
Proprietary	• Yes
Sustainability	• In addition to the telephone supervision, best results are achieved if there is an in-house supervisor who has gone through separate supervisor curriculum training • Monthly clinical tapes are submitted for critique and to asses the adherence to the model with up to 40 individually identified skills rated. (Nine to 12 months post training)
Contact	Olva Hervis Family Therapy Training Institute of Miami 1221 Brickell Ave. 9TH Floor Miami, FL 33133 888-527-3828 ohervis@bsft-av.com TA PROVIDER Kathleen Shea 305-668-0850 kshea@bsft-av.com

Program	Caring for Our Family (CFOF)
Developer	Special Service for Groups – Asian Pacific Counseling and Treatment Centers
Submitted by	Special Service for Groups – Asian Pacific Counseling and Treatment Centers
Description	• Culturally appropriate adaptation of national "Family Connections" model • Includes community outreach, family assessment, individually tailored program of counseling, referrals and linkages • Direct services provided for minimum of six months, minimum one hour weekly
Population	• Los Angeles County Cambodian and Korean immigrant and refugee families with children between the ages of 5-11
Cultural Evidence	• Monolingual and bilingual services provided • Independent evaluation of adapted model conducted by external third party
Risk and Protective Factors	• Increased social support • Enhanced parenting competence • Decreased parent depression, anxiety, and stress
Level of Evidence	• Promising
Outcomes	• Improved child well-being
Prevention: Universal/Selective	• Selective

Program	Circus Arts for Homeless Youth
Developer	Philip Solomon
Submitted by	My Friend's Place
Description	• In partnership with Cirque du Monde (the social outreach arm of Cirque du Soleil), an outreach model to serve as a non-threatening gateway for transition age homeless youth to access more traditional services that may be of benefit
Population	• Homeless transition age youth (15-25) and their children
Cultural Evidence	• This model is being used with a primarily ethnic minority homeless TAY population in Los Angeles County
Risk and Protective Factors	• Homelessness • Histories of trauma • Untreated psychiatric symptoms • Substance use/abuse
Level of Evidence	• Promising
Outcomes	• Increased access to and engagement in traditional case management services, health programs, and employment programs
Prevention: Universal/Selective	• Selective

Program	Cognitive Behavioral Therapy (CBT) for Anxiety
Population	African American adolescents (ages 14-17), low-income, urban school setting
Cultural Evidence	Modified group CBT for African American adolescents
Risk and Protective Factors	**Risk:** • Neighborhood crime and violence • Issues related to stepparents, siblings, and dating • Drug use • Financial hardship **Protective:** • School-based support
Level of Evidence	Supported
Outcomes	1. Decrease in overall anxiety (both self-report levels and clinician ratings)
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	Cognitive-behavioral therapy is an action-oriented form of psychosocial therapy that assumes that maladaptive, or faulty, thinking patterns cause maladaptive behavior and "negative" emotions. (Maladaptive behavior is behavior that is counter-productive or interferes with everyday living.) The treatment focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Culturally tailored to fit the needs of African American youth.

Program	Cognitive Behavioral Therapy (CBT) for Anxiety
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Information not available at this time

Program	Cognitive Behavioral Therapy (CBT) for Depression (with antidepressant medication)
Population	Low-income women
Cultural Evidence	Evidence for Latina immigrants and African American women; modified to be sensitive to low-income women and cultural adaptations
Risk and Protective Factors	None reported
Level of Evidence	Supported
Outcomes	1. Decreased depressive symptoms and improved functioning
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	Low income women (African American, White and Latina) diagnosed with Major Depressive Disorder. Intervention is antidepressant medication for 6 months; cognitive behavioral therapy (CBT) for 8 weeks (weekly group or individual sessions; followed by 8 further sessions for non-improvers; participant and therapist manuals adapted from a program specifically for low income English and Spanish speakers), or referral to a community provider.

Program	Cognitive Behavioral Therapy (CBT) for Depression (with antidepressant medication)
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Information not available at this time

Program	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
Population	Ethnic minority and immigrant youth (ages 10-14) with symptoms of posttraumatic stress disorder and depression (due to exposure to violence). Inner-city schools
Cultural Evidence	Evidence for Mexican and Central American youth; also for African American and Native American youth
Risk and Protective Factors	**Risk:** • Mental health problem • Victimization and exposure to violence • Child victimization and maltreatment • Family management/poor poor parental supervision and/or monitoring • Poor family attachment • Peer rejection **Protective:** • Perception of social support from adults and peers • Resilient temperament • Social competencies and problem-solving skills • Effective parenting • Good relationship with parents/bonding • Good relationship with peers
Level of Evidence	Supported
Outcomes	1. Decrease in posttraumatic stress and depressive symptoms 2. Parents of children in treatment showed less psychosocial dysfunction
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	The CBITS program is a cognitive and behavioral therapy group intervention for reducing children's symptoms of post-traumatic stress disorder (PTSD) and depression caused by exposure to violence that has been used successfully in inner city schools with multicultural populations. CBITS has three main goals: to reduce symptoms related to trauma, to build resilience, and to increase peer and parent support. CBITS was designed for use in schools, for children aged 10-14 who have had substantial exposure to violence and who have symptoms of PTSD in the clinical range. The CBITS intervention incorporates Cognitive-Behavioral Therapy skills in a group format (5-8 students per group) to address symptoms of PTSD, anxiety, and depression related to exposure to violence. Treatment includes homework. The program format is 10 child group sessions, 1-3 individual child sessions, two parent education sessions, and a teacher informational meeting. A manual details step-by-step plans and provides scripts for implementing the program.

Program	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
Staffing Requirements	• Clinicians do first round of training; mental health background recommended. • Masters level clinician
Service Delivery Setting	• Schools • Mental Health Clinics
Implementation Costs	• Minimum of two clinicians; two day training costs $3,000 • Follow-up consultation review of sessions • 200 Hours—PRN—Ongoing • Quality Assurance Review is APX $100 per hour • Costs vary depending on CBT experience in clinician being trained. • One trainer for every 15 clinicians per site; two-day training
Service Delivery Costs	• Ten group sessions; approx. 1 hour per week; once a week; 6 to 8 students in group • One to 3 individual sessions, 2 parent education sessions • One teacher education session
Standard Training Protocol	• No standard training protocol • Training depends on the background of the person being trained and the availability of an on-site CBT specialist • Common training approach is for trainees to read background materials, review the manual, watch a training video, attend a two day training, then receive ongoing supervision from a local clinician with CBT experience.
Proprietary	• CBITS Manual available from Sopris Publishers ($35) • Manual alone not sufficient training
Sustainability	• Fidelity assessment measure available; independent rater watch sessions video/audio tape and rate adherence • Regular supervision weekly/biweekly recommended with a CBT expert • Learning collaborative also recommended • Train the Trainer Mode, i.e. work with their trainers in trainings • CBIT works with a local LA community and is “fluid” regarding training
Contact	Sheryl Kataoka, MD/UCLA/NPI 10920 Wilshire Blvd. #300 Los Angeles, CA 90024 310 794-3727 310 794-3724 skataoka@ucla.edu

Program	Coping Power Program
Population	Pre-adolescent children (ages 9-11) with aggression and their parents Low income, urban communities
Cultural Evidence	Studies with large percentage of African American youth
Risk and Protective Factors	**Risk:** • Anti-social behavior • Cognitive and neurological deficits/low IQ/hyperactivity • Life stressors • Mental health problem • Poor refusal skills • Family management problems/poor parental supervision and/or monitoring • Poor family bonding • Low academic achievement • Negative attitude toward school • Association with delinquent and/or aggressive peers **Protective:** • High and positive expectations • Social competencies and problem-solving skills • Good relationships with parents/bonding • High expectations • High expectations of students • Presence and involvement of caring • Supportive parents • Rewards for pro-social school involvement • Strong school motivation • Student bonding • Good relationships with peers
Level of Evidence	Well-Supported
Outcomes	1. Decrease in aggression 2. Peer rejection 3. Parent-rated substance use 4. Behavioral improvement in school (teacher rated)
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	See Coping Power Program description under Juvenile Justice for program description.

Program	Coping Power Program
Staffing Requirements	• Masters/Doctorate in psychology or social work • School guidance counselor
Service Delivery Setting	• Schools in group setting
Implementation Costs	• Includes a 2-3 day initial trainings session • Two days if only the child component is selected and 3 if the parental component is selected • Costs are $1,500 per trainer per day (roughly one trainer per 25 trainees) • Trainings occur onsite or there are 2 residential sessions at the university annually
Service Delivery Costs	• There are 34 sessions for the child and 16 for the parents
Standard Training Protocol	• The curriculum is manualized and there are fidelity measures
Proprietary	• Yes
Sustainability	• There is group phone supervision (10-12 trainees per call) bi-weekly for 1 year costing $100 per hour • Additionally, review of taped sessions is available for evaluation of skill learning and model adherence • The cost for the latter is in the range of $4,000-$5,000 annually depending on the number of sessions chosen
Contact	John Lochman Department of Psychology University of Alabama 383 Gordon Palmer Hall P.O. BOX 870348 Tuscaloosa, AL 35487 205-348-7678 jlocjman@gp.as.us.edu

Program	Coping with Depression
Population	Adults (age 45+) at risk for depression due to ailing health
Cultural Evidence	Adapted for Native Americans with chronic health problems Adapted skills-based curriculum for increased cultural relevance
Risk and Protective Factors	Not reported
Level of Evidence	Promising
Outcomes	1. Decreased depressive symptoms 2. Increased involvement in pleasant events
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	Developed for Native American adults at risk for depressive symptomatology as a result of deteriorating health. Comprised of 16 weekly 2-hr sessions, the adapted curriculum emphasizes skills training toward progress in four areas: rehearsed relaxation, increased pleasurable activity, improved patterns of thinking, and cultivated social skills. In order to decrease the potential stigma of an intervention related to "mental health," the program was offered though a local tribal college for adult education credit. Participants received tuition remission in the amount of $10 per each session attended. Curricular resources included lectures, class activities, homework assignments, a textbook, and local community members who were trained as instructors. Curricular materials were modified slightly for increased cultural relevance.

Program	Coping with Depression
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Information not available at this time

Program	Culturally Adapted Parent Management Training for Latinos	
Population	Latino middle-school-aged youth at risk of problem behaviors	
Cultural Evidence	Adapted for Latino youth (U.S. and foreign born)	
Risk and Protective Factors	Risk: • Acculturation issues for parents, children, and parent-child relations	Protective: • Positive behavioral interactions at home, school and with peers
Level of Evidence	Supported	
Outcomes	1. Improvements in parenting outcomes (overall effective parenting) 2. Parents of U.S.-born youth had better outcomes 3. Decreased child aggression, externalizing behaviors, likelihood of alcohol and drug use	
Prevention: Universal/Selective	Selected	
Early Intervention	Early Intervention	
Description	Parent management training (PMT) refers to programs that train parents to manage their child's behavioral problems in the home and at school. PMT has emanated from two lines of work. First, maladaptive parent-child interactions, particularly in relation to discipline practices, have been shown to foster and to sustain conduct problems among children. Second, social learning techniques, relying heavily on principles of operant conditioning, have been extremely useful in altering parent and child behavior. In PMT, parent-child interactions are modified in ways that are designed to promote prosocial child behavior and to decrease antisocial or oppositional behavior. Treatment sessions include instruction in social learning principles and techniques. The therapist provides a brief overview of underlying concepts, models the techniques for the parents, and coaches parents in implementing the procedures. Procedures and interaction patterns practiced in the sessions are then used in the home. Parents usually are taught how to define, observe, and record behavior at the beginning of treatment because once behaviors (e.g. fighting, engaging in tantrums) are defined concretely, reinforcement and punishment techniques can be applied. The PMT therapist details the concepts and procedures derived from positive reinforcement (e.g., contingent delivery of attention, praise, points) and punishment (e.g., time out from reinforcement, loss of privileges, and reprimands). Reinforcement for prosocial and non-deviant behavior is central to treatment. Parents are taught how to use reinforcement and punishment techniques contingent on the child's behavior, to provide consequences consistently, to attend to appropriate behaviors and to ignore inappropriate behaviors, to apply skills in prompting, shaping, and fading, and to use these techniques to manage future problems. There is an extensive amount of practice and shaping of parent behavior within the sessions to develop skills in carrying out the procedures.	

Program	Culturally Adapted Parent Management Training for Latinos
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Information not available at this time

Program	Culturally-Modified Trauma-Focused Treatment (CM-TFT)	
Population	Children and adolescents (ages 4-18) with trauma related to sexual or physical abuse	
Cultural Evidence	Developed for Latino children and adolescents (primarily of Mexican descent); cultural experiences addressed in treatment	
Risk and Protective Factors	Risk: • Barriers (poverty, recent immigrants)	Protective: • Cultural values of *familismo, respeto,* etc.
Level of Evidence	Well-supported for Trauma Focused CBT – Adaptions being evaluated	
Outcomes	(Pilot testing in progress)	
Prevention: Universal/Selective	Selected	
Early Intervention	Early Intervention	
Description	Based on Cognitive-Behavior Therapy; key components include: psycho-education, emotional regulation skills, coping skills training, distinguishing thoughts, feelings, and behaviors, including trauma-related, gradual exposure (trauma narrative), cognitive and affective processing of trauma experiences, parallel parent treatment, risk reduction skills. Average length of sessions is 12-16. Aspects of culture or group experiences that are addressed: spirituality, gender roles, familismo, personalismo, respeto, sympatia, fatalismo, folk beliefs. Trauma type addressed: sexual abuse and physical abuse. This intervention was developed for use with Latino children and is based on Trauma-Focused Cognitive Behavior Therapy, with the addition of modules integrating cultural concepts throughout treatment.	

Program	Culturally Modified Trauma-Focused Treatment (COPE)
Staffing Requirements	• Case management model • Clinicians must know PCIT or TF-CBT or other CBT treatment • Clinicians do community training • Case managers should have mental health background • Masters level clinicians/ Case managers
Service Delivery Setting	• Home • School • Community based treatment
Implementation Costs	• Requires weekly review of taped sessions. Need consultation from clinicians trained in CB treatments. • Cost to be determined on individual basis
Service Delivery Costs	• Staff/Travel costs (service delivery in the community) • Program includes child, parent and joint sessions
Standard Training Protocol	• Intensive case management model; weekly supervision of taped sessions • Reading supervision (2-3 hours of group and/or individual)
Proprietary	• Case load of 6 to 10—intensive CM model/supervision Twelve to 20 sessions, 1-2 sessions per week from 45-90 minutes. (Varies depending on the case)
Sustainability	• Pre-requisites are training in CBT techniques • Certification available • Training is through reading, treatment manuals • Supervision (2-3hours GRP and/or individual supervision for case load of 6)
Contact	A. deArellano, Ph.D. Medical University of South Carolina, Institute of Psychiatry 165 Cannon street PO box 250852 Charleston SC 29425 843-792-2945 dearelma@musc.edu/Michael

Program	Effective Black Parenting
Population	African American Families at risk for Child Maltreatment
Cultural Evidence	100% of research participants were African American
Risk and Protective Factors	Risk: • Parental substance abuse • Parental mental health problems
Level of Evidence	Promising
Outcomes	1. Enhanced family relationships 2. Decreased parental rejection 3. Decreased child behavior problems
Prevention: Universal/Selective	Selective
Early Intervention	
Description	The EBPP was originally developed for parents of African American children aged 2 to 12. Most of its evaluation studies have been conducted with this population. However, since beginning the national dissemination of the program in 1988, the program has been successfully used with teenage African American parents and their babies, and with African American parents of adolescent children. Thus, its widespread usage has been with parents whose children range from 0 to 18. Format: the complete EBPP consists of 14 3-hour training sessions and a graduation ceremony. It has been delivered in a variety of settings: schools, Head Start agencies, churches, mental health clinics, substance abuse agencies, hospitals, counseling centers, etc.. The complete program is usually taught for small groups of parents (8 to 20) and the parents are recruited from the populations that the sponsoring institutions serve. The vast majority of EBPP's are conducted by individuals who completed a CICC-sponsored 5-day instructor training workshop, where, in addition to learning how to deliver the complete program, they learned a variety of recruitment and parent attendance incentive strategies. Recently, a briefer version of the EBPP was created (a one-day seminar version) which is taught with large numbers of parents (50 to 500). Program content is culturally tailored to the African American community.

Program	Effective Black Parenting
Staffing Requirements	• Doctorate, Master, Bachelor and paraprofessional staff have delivered this practice.
Service Delivery Setting	• Birth Family Home • Community Agency • Foster Home • Outpatient Clinic
Implementation Costs	• Parent Handbook, ($19), an overhead projector and screen, and space for 8-12 parents with enough room to break into dyads for skill practice • The current fee per workshop participant is $975 which covers the cost of the 5 days of professional training and the complete Instructor's Kit of training materials • The price of the Kit is currently $413 • Other program costs vary depending upon which institution sponsors the delivery of the class or seminar, as each institution incurs different costs for marketing and advertising, space, refreshments, transportation, child care, and instructor fees.
Service Delivery Costs	• Recommended intensity: Weekly three-hour sessions or one-day 6.5 hours abbreviated seminar version • Recommended duration: 15 weeks total including a session for graduation and testifying or just one-day for the abbreviated seminar version
Standard Training Protocol	• Five 6.5 hour days • Training is obtained from regularly scheduled workshops in different cities or the workshop can be brought to a specific location on a contractual basis
Proprietary	Information not available at this time
Sustainability	• Booster sessions
Contact	Gary Oltman Center for the Improvement of Child Caring E-mail: gary@ciccparenting.org Phone: 818-980-0903 Website: /www.ciccparenting.org

Program	Family Coping Skills Program (FCSP)
Population	Low-income Latina mothers at risk of depression
Cultural Evidence	Developed for Latina mothers Group-based intervention involving family sessions; culturally relevant content
Risk and Protective Factors	Risk: • Stressors related to child rearing, other stressors • Financial • Acculturation Protective: • Problem-solving/coping skills • Family functioning/competencies
Level of Evidence	Emerging
Outcomes	1. Decreased depressive symptoms
Prevention: Universal/Selective	Selected
Early Intervention	
Description	Developed by E.V. Cardemil, S. Kim, T.M. Pinedo, and I.W. Miller FCSP is a novel depression prevention program developed specifically for low income Latina mothers. The culturally tailored approach enhances recruitment and retention of participants.

Program	Family Coping Skills Program (FCSP)
Staffing Requirements	• Bilingual clinicians trained in Cognitive Behavioral Therapy
Service Delivery Setting	• A variety of community based settings including clinics, family resource centers, public health clinics
Implementation Costs	Information not available at this time
Service Delivery Costs	• Intervention consists if 6 group sessions and 2 family sessions. In addition the costs of on site child care and transportation are included.
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Esteban Cardemil, PhD Associate Professor of Psychology, Clark University ecardemil@clarku.edu (508) 793-7738

Program	Family Effectiveness Training
Population	Children and adolescents (ages 6-12) with behavioral problems and at risk of drug use
Cultural Evidence	Developed for Latino families of preadolescents (primarily males and Cuban)
Risk and Protective Factors	**Risk:** • Anti-social behavior • Early onset of aggression and/or violence • Favorable attitudes toward drugs and alcohol and/or use • Management problems and/or poor parental supervision or monitoring • Harsh punishment • Pattern of high family conflict **Protective:** • Healthy beliefs and clear standards • High expectations • Perception of social support from adults and peers • Social competencies and problem-solving skills • Effective parenting • Good relationships with parents/bonding
Level of Evidence	Supported
Outcomes	1. Improved structural family functioning 2. Decreased problem behaviors reported by parents 3. Increased self-concept of child
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	FET is a family-based program for Hispanics that targets family factors known to place children at risk. FET helps Hispanic immigrant families with children ages 6-12, particularly when the child is exhibiting behavior problems, associating with deviant peers, or experiencing parent-child communication problems. The program consists of three components: Family Development, Bicultural Effectiveness Training, and Brief Strategic Family Therapy. FET uses two primary strategies to initiate change: (1) didactic lessons and participatory activities that help parents master effective family management skills, and (2) organized discussions in which the therapist/facilitator intervenes to correct dysfunctional communications between or among family members. The training sessions last for 13 weeks, are 1 ½ to 2 hours long, and are tailored to each individual family.

Program	Family Effectiveness Training
Staffing Requirements	• Therapist/facilitator • Basic knowledge of how family systems operate • 3 years of clinical experience with children and families. • The ideal candidate has a Master's degree in social work or marriage or family therapy. However, individuals with a Bachelor's degree and experience working with families may qualify
Service Delivery Setting	• Community • Social services agencies • Schools • Mental health clinics • Faith communities • Community youth centers
Implementation Costs	• Videotape equipment, visual teaching aids and handouts for families
Service Delivery Costs	• The program consists of three components: Family Development, Bicultural Effectiveness Training, and Brief Strategic Family Therapy. FET uses two primary strategies to initiate change: 1) didactic lessons and participatory activities that help parents master effective family management skills and 2) organized discussions in which the therapist/facilitator intervenes to correct dysfunctional communications between or among family members. The training sessions last for 13 weeks, are 1½ to 2 hours long, and are tailored to each individual family. • One full-time counselor can provide FET to 15 to 20 families per week, depending on experience and maturity of counselor
Standard Training Protocol	• Agencies should allow 6 months to hire and train counselors, develop referral resources from the community, and recruit and screen participant families.
Proprietary	• Yes
Sustainability	• Video supervision
Contact	Lila Smith, M.D. **University of Miami School of Medicine** **1425 Northwest 10th Avenue, Third Floor** **Center for Family Studies** **Miami, FL 33136** **Phone: (305) 243-7585** **Fax: (305) 243-2320** **E-mail: lsmith@med.miami.edu** **Web site: www.cfs.med.miami.edu**

Program	Family Health Promotion
Population	Latino children 3-8 who live in poverty, have been maltreated and/or who have substance abusing parents
Cultural Evidence	Study participants were drawn from barrio housing projects in Tucson, AZ
Risk and Protective Factors	**Risk:** • Early onset of aggression • Victim of or exposed to violence • Family violence • Parental use of harsh physical punishment • Low academic achievement • Economic deprivation **Protective:** • Effective parenting • Opportunities for prosocial school involvement
Level of Evidence	Promising
Outcomes	1. Increased school readiness for preschoolers 2. Decreased parental stress 3. Decreased parental drug use 4. Increased resource utilization
Prevention: Universal/Selective	Selective
Early Intervention	
Description	The FHP program is a primary prevention program that offers a variety of interventions to children ages 3-8 and to their families. Based on research in risk, resiliency, and protective factors, FHP seeks to reduce risk factors in the child and family domains. The program offers children developmentally appropriate activities in childcare, school, and recreation to help develop resiliency skills. Parents are encouraged to become involved in activities that enable them to increase protective factors. Participants requiring treatment services will receive them onsite. The central feature of the FHP is the family services team that serves as the integrating force of the program. Specific program activities include: • Training in resiliency and protective factors provided to parents through home visitation. The visits occur once a month during year 1, twice a month during year 2, and as needed during year 3. • Parent advisory council meetings • The S.T.E.P. Curriculum workshop series • Support groups • Family weekend activities • Training of school personnel on the Building Me program and cultural competence • Implementation of the Building Me curriculum • Transportation to the program • Art Therapy sessions

Program	Family Health Promotion
Staffing Requirements	Information not available at this time
Service Delivery Setting	• Childcare sites school • Recreation sites
Implementation Costs	• Staff must be trained in step program
Service Delivery Costs	• Visits 1 time per month first year • Visits 2 times a month second year • As needed the third year • 20 hours of intensive In-Home Service • 10 hours of Parent Advisory Council, and Parenting Workshops • 8 hours of Family ATID-Free Weekend activities • 4 hours involving referrals
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Dr. Linda Arzoumanian Codac Behavioral Health Services, Inc. 3100 North First Avenue Tucson, AZ 85719 Amy Graves, M.A. Codac Behavioral Health Services, Inc. 3100 Northfirst Avenue Tucson, AZ 85719 520-327-4505 Fax: 972-401-8801

Program	GLTB CHAMPS: Comprehensive HIV & At-Risk Mental Health Services
Developer	Jack Barbour, MD and William Cunningham, MD, MPH
Submitted by	South Central Health and Rehabilitation Programs, UCLA
Description	• A comprehensive package of interventions that includes: (1) Assertive Community Treatment (ACT) in conjunction with SAMHSA's Treatment Intervention Protocol (TIP); (2) an enhanced case management and outreach intervention (MOHOP); (3) mobile van HIV testing; and, (4) a CDC evidence-based social skills intervention for enhancing risk reduction education and decreasing stigma among HIV+ African American females (SISTA)
Population	• African American GLBT transition age youth (ages 15-25) who are (1) at-risk for or HIV+, and/or (2) at-risk for or experiencing early onset comorbid mental health problems and/or frequent substance abuse [some of whom are probationers or parolees]
Cultural Evidence	• Culturally appropriate for target population • Outcomes achieved with Los Angeles County (SPA 6) target population
Risk and Protective Factors	• Increased education • Decreased stigma • Decreased engagement in risky behaviors • Decreased isolation, depression, anxiety, and other mental health symptoms
Level of Evidence	• Varies by intervention component: Emerging to Promising
Outcomes	• Improved medication management • Improved engagement in medical and mental health care • Improved mental health status • Improved housing and employment stability
Prevention: Universal/Selective	• Selective

Program	Group Cognitive Behavioral Therapy (CBT) of Major Depression	
Population	Adults with major depression	
Cultural Evidence	English and Spanish manuals used with diverse populations: various ethnic groups, primarily low-income adults and low-income minority women	
Risk and Protective Factors	Risk: • Stressors (poverty, legal issues, discrimination, etc.)	Protective: • Positive internal and external thought processes
Level of Evidence	Well-Supported	
Outcomes	1. Decreased depressive symptoms; increased functioning	
Prevention: Universal/Selective	Selected	
Early Intervention	Early Intervention	
Description	Cognitive-behavioral therapy is an action-oriented form of psychosocial therapy that assumes that maladaptive, or faulty, thinking patterns cause maladaptive behavior and "negative" emotions. (Maladaptive behavior is behavior that is counter-productive or interferes with everyday living.) The treatment focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Cultural tailoring and case management show increased effectiveness for low income Latino and African American adults.	

Program	Group Cognitive Behavioral Therapy (CBT) of Major Depression
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Information not available at this time

Program	IMPACT! (Inspire & Mobilize People to Achieve Change Together): A Youth Development and Leadership Program
Developer	Terry Gock, PhD, MPA
Submitted by	Asian Pacific Family Center-East
Description	• Bicultural, school-based, 26-week skill-based curriculum focused on increasing pro-social skills and preventing externalizing behavior problems in Asian immigrant adolescent youth
Population	• High-school age Asian immigrant youths at high risk of behavioral problems
Cultural Evidence	• Curriculum has been implemented with 169 Asian immigrant youth • Evaluation measures used were specifically developed for and tested with Asian immigrant population
Risk and Protective Factors	• Increased self-efficacy • Increased pro-social peer interactions • Increased pro-social connections in school and with family • Decreased substance abuse • Decreased engagement in risky sexual activities • Decreased engagement in delinquent behaviors
Level of Evidence	• Promising
Outcomes	• Increased knowledge of healthy and pro-social behaviors • Increased pro-social attitudes • Increased pro-social behaviors
Prevention: Universal/Selective	• Selective

Program	Incredible Years Parenting Program
Population	Families with children (ages 2-10) with conduct problems; To promote parenting competencies
Cultural Evidence	Evidence for low-income, ethnically diverse families; insignificant differences in outcomes between ethnic groups. Integrates cultural values/practices into parenting program
Risk and Protective Factors	**Risk:** • Cognitive and neurological deficits/ low IQ • Hyperactivity • Mental health problem • Family management problems/poor supervision and/or monitoring • Maternal depression • Pattern of high family conflict • Negative attitude toward school **Protective:** • Effective parenting • Good relationships with parents/bonding • Opportunities for pro-social school involvement • Supportive adults • Involvement with positive peer group activities
Level of Evidence	Well-Supported
Outcomes	1. Improved parenting 2. Fewer behavioral problems in children
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	See previous Incredible Years description in Children/Youth At Risk for School Failure section for details of program. Cultural modifications have been made and implemented with success.

Program	Incredible Years Parenting Program
Staffing Requirements	• Teachers • Parents
Service Delivery Setting	• Home • School • Community
Implementation Costs	• One-time start-up costs include $400-$500 per leader for leader training and $1,500 per series for program materials (the cost for the child program is slightly higher due to the price of puppets) • Ongoing costs include $500 annually for each leader to receive consultation, $476 for each parent in parent groups, $775 for each child in child treatment groups, $15 for each child receiving the Dinosaur curriculum in school, and $30 for each teacher receiving the teacher training.
Service Delivery Costs	• For detailed cost information associated with each program component see the Incredible Year web site
Standard Training Protocol	• Three day on site training for parenting and 2 day on site for the child curriculum. Certification takes place after group leaders complete two group cycles and have video tapes reviewed by the developer.
Proprietary	• Mix of public and proprietary
Sustainability	• Mentor who functions as a trainer in the local context.
Contact	Lisa St. George Administrative Director Incredible Years 1411 Eighth Avenue, West Seattle, WA 98119 Phone: (888) 506-3562 Fax: (888) 506-3562 E-mail: lisastgeorge@comcast.net Carolyn Webster-Stratton, Ph.D. Professor and Director of Parenting Clinic, University of Washington Developer and Director, Incredible Years 1411 Eighth Avenue, West Seattle, WA 98119 Phone: (888) 506-3562 Fax: (888) 506-3562 E-mail: cwebsterstratton@comcast.net www.incredibleyears.com

Program	Incredible Years Parenting Program Used with Korean American Mothers
Population	Korean American mothers and their children (ages 3-8) with behavioral problems
Cultural Evidence	Evidence for Korean American mothers Translation of vignettes into Korean
Risk and Protective Factors	(See above, "Incredible Years Parenting Program")
Level of Evidence	Supported
Outcomes	1. Use of more positive discipline 2. Fewer behavioral problems in children 3. Greater social competency of children as perceived by mothers
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	See Incredible Years for general description. Service delivery carried out by community based group leaders who spoke Korean and materials are available in Korean.

Program	Incredible Years Parenting Program Used with Korean American Mothers
Staffing Requirements	• Teachers • Parents
Service Delivery Setting	• Home • School • Community
Implementation Costs	• One-time start-up costs include $400-$500 per leader for leader training and $1,500 per series for program materials (the cost for the child program is slightly higher due to the price of puppets) • Ongoing costs include $500 annually for each leader to receive consultation, $476 for each parent in parent groups, $775 for each child in child treatment groups, $15 for each child receiving the Dinosaur curriculum in school, and $30 for each teacher receiving the teacher training. • For detailed cost information associated with each program component see the Incredible Year web site
Service Delivery Costs	Information not available at this time
Standard Training Protocol	• Three day on site training for parenting and 2 day on site for the child curriculum. Certification takes place after group leaders complete two group cycles and have video tapes reviewed by the developer.
Proprietary	• Mix of public and proprietary
Sustainability	• Mentor who functions as a trainer in the local context.
Contact	Lisa St. George Administrative Director Incredible Years 1411 Eighth Avenue, West Seattle, WA 98119 Phone: (888) 506-3562 Fax: (888) 506-3562 E-mail: lisastgeorge@comcast.net Carolyn Webster-Stratton, Ph.D. Professor and Director of Parenting Clinic, University of Washington Developer and Director, Incredible Years 1411 Eighth Avenue, West Seattle, WA 98119 Phone: (888) 506-3562 Fax: (888) 506-3562 E-mail: cwebsterstratton@comcast.net www.incredibleyears.com

Program	Interpersonal Psychotherapy (IPT) for Depression	
Population	Adolescents (ages 12-18) with depression	
Cultural Evidence	Adapted IPT for Latino adolescents (individual and group); studies on primarily Puerto Rican youth	
Risk and Protective Factors	Risk: • Interpersonal conflict with parents • Acculturation stress • Financial stress	Protective: • Social supports in family, among peers, in school and community
Level of Evidence	Well-Supported	
Outcomes	1. Decrease in depressive symptoms 2. Improvements in family outcomes	
Prevention: Universal/Selective	Selected	
Early Intervention	Early Intervention	
Description	IPT was developed for the treatment of ambulatory depressed, nonpsychotic, nonbipolar patients. It has been demonstrated to successfully treat patients with depression, and has been modified to treat other psychiatric disorders (substance abuse, dysthymia, bulimia) and patient populations (adolescents, late-life, primary medical care). It has primarily been utilized as a short term (approximately 16 week) therapy, but has also been modified for use as a maintenance therapy for patients with recurrent depression. It includes specific strategies such as assessing the symptoms of depression, relating the onset of the depressive inventory and selecting a focus for the treatment for the following problem areas: delayed/incomplete grief, role transitions, role disputes or interpersonal deficit. These tasks are usually accomplished in the first three sessions. The middle phase (sessions 4-13) is devoted to work on the specific problem area with the goal of alleviating the symptoms of depression and improving interpersonal relationships. In the termination phase (sessions 14-16) the course of treatment is reviewed, progress reinforced, feelings about ending the therapy addressed and future problems anticipated.	

Program	Interpersonal Psychotherapy (IPT) for Depression
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Information not available at this time

Program	LIFE (Loving Intervention for Family Enrichment) Program
Developer	Special Service for Groups – Occupational Therapy Training Program
Submitted by	Special Service for Groups – Occupational Therapy Training Program
Description	• Adaptation of Parent Project® national model (22-week skills based curriculum for parents of children at risk of or involved with the juvenile justice system) and multi-family group therapy
Population	• Low income Latino families with monolingual (Spanish) parents of children ages 10-17 at high-risk of delinquency and/or school failure
Cultural Evidence	• Outcomes achieved with Los Angeles County target population
Risk and Protective Factors	• Poor school attendance and performance • Poor relationships with peers, parents, and other authority figures • Antisocial behavior • Substance use/abuse • Parental stress • Inadequate parenting skills
Level of Evidence	• Promising
Outcomes	• Decreases in youth aggressive behaviors and social problems • Improved youth self-efficacy • Improved parenting skills and parenting competence
Prevention: Universal/Selective	• Selective

Program	Maternal Wellness Center
Developer	Emily C. Dossett
Submitted by	LAC+USC Medical Center
Description	• Culturally appropriate, evidence-based prevention and early intervention for perinatal depression through co-location of psychiatric services and perinatal care; includes screening, assessment, individual and/or group therapy, and medication management and support through six months postpartum (employs validated measures and cognitive-behavioral therapy).
Population	• Low income, ethnic minority, high-risk women and infants served in prenatal clinics
Cultural Evidence	• Educational materials for patients and training materials for providers are available in English and Spanish
Risk and Protective Factors	• Untreated depression • Financial stress • Poor social support • Chronic illness or disease (e.g., diabetes, hypertension, HIV) • Increased education regarding perinatal depression • Decreased stigma
Level of Evidence	• Emerging
Outcomes	• Increased identification of perinatal depressive symptoms and disorders • Increased access to care • Increased engagement in care
Prevention: Universal/Selective	• Selective

Program	Mindful Parenting Groups
Developer	Diane Reynolds and Wendy Denham
Submitted by	Center for Mindful Parenting
Description	• Twelve week parenting program for parents and caregivers of infant, toddler and preschool children at risk to mental health problems and disrupted adoptions. Weekly sessions are sequenced to include parental engagement and skill building.
Population	• Children and youth in stressed families. Includes families with child neglect and children at risk to disrupted adoptions.
Cultural Evidence	• Bilingual-Bicultural clinicians offer this service to monolingual Spanish speaking parents. In addition, the groups have been successful with gay and lesbian parents and bi-racial couples. The intervention is tailored to the parenting traditions and cultures of the parents in the group. In addition, discrimination (particularly as it relates to non traditional families) is explored as an additional parenting stressor
Risk and Protective Factors	•
Level of Evidence	• Promising
Outcomes	• Increased secure attachment
Prevention: Universal/Selective	• Selective

Program	The Mothers and Babies Course "Mamas y Bebes" (Reality Management Approach and Relaxation Methods for Managing Stress)
Population	Pregnant women, mothers and their babies for prevention of postpartum depression
Cultural Evidence	Spanish course available for Relaxation Methods for Managing Stress Course
Risk and Protective Factors	**Risk:** • Stressors (financial, work, emotional, physical, etc.) **Protective:** • Positive thoughts • Coping and problem-solving skills
Level of Evidence	Promising
Outcomes	1. Fewer major depressive episodes for intervention in pilot trial
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	Mamás y Bebés is a prenatal intervention designed to prevent the onset of major depressive episodes (MDEs) during pregnancy and postpartum. The Mamás y Bebés/Mothers and Babies Course is an intervention developed in Spanish and English that uses a cognitive-behavioral mood management framework, and incorporates social learning concepts, attachment theory, and socio-cultural issues. Methods have been adapted from existing psychological treatment approaches, such as interpersonal psychotherapy and cognitive-behavioral therapy. The program consists of a 12-week mood management course and four booster sessions conducted at approximately 1, 2, 6, and 12 months postpartum. The explicit goal of the intervention is to help participants create a healthy physical, social, and psychological environment for themselves and their infants. The program is specifically designed to be culturally sensitive and linguistically appropriate for immigrant, low-income Latinas. The program seeks to 1. Reinforce values such as collectivism 2. Foster new outlets of support in a foreign context, including using the class as an additional outlet of support 3. Validate Latinas' values and beliefs regarding pregnancy, childrearing practices, and motherhood 4. Address Latinas' attitudes toward mental illness and seeking mental health services 5. Adhere to common cultural verbal and nonverbal communication norms 6. Validate the role of religion and spirituality in the health and healing of Latinas 7. Allow them to relate their frustrations and painful experiences of discrimination and racism 8. Expand Latinas' knowledge without devaluing their cultural beliefs

Program	The Mothers and Babies Course “Mamas y Bebes” (Reality Management Approach and Relaxation Methods for Managing Stress)
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	

Program	Multidimensional Family Therapy (MDFT)	
Population	Families with adolescents (ages 11-18) with substance abuse and behavioral problems; youth on juvenile probation	
Cultural Evidence	Studies on MDFT have included ethnic minority youth (primarily males) and youth in inner cities: African American, Latino and other ethnicities	
Risk and Protective Factors	Risk: • Antisocial behavior and alienation/drug dealing • Early sexual involvement • Favorable attitudes toward drug use/early use of drugs or alcohol • Family management problems/poor parental supervision and/or monitoring • Parental use of physical punishment/harsh and/or erratic discipline • Pattern of high family conflict • Negative attitude toward school/low school bonding • Association with antisocial peers • Gang involvement • Peer alcohol, tobacco, and/or other drug use	Protective: • Healthy/conventional beliefs and clear standards • Self-efficacy • Social competencies and problem-solving skills • Effective parenting • Good relationships with parents/bonding • Opportunities for pro-social school involvement • Involvement with positive peer group activities
Level of Evidence	Supported	
Outcomes	1. Decrease in cannabis and alcohol use 2. Decrease in problem behaviors	
Prevention: Universal/Selective	Selected	
Early Intervention	Early Intervention	
Description	See MDFT description under Juvenile Justice for details of program.	

Program	Multidimensional Family Therapy (MDFT)
Staffing Requirements	• One team consists of: 2 -3 full time therapists (Masters level) • 1 therapist assistant (high school/Bachelor's level) • On-site clinical supervision
Service Delivery Setting	• Home • Clinic
Implementation Costs	• Training for the 6-month certification is between $25,000-$30,000 per team. This includes all training costs.
Service Delivery Costs	• One MDFT Team (2 therapists, 1 therapist assistant) carry 10-16 families on its caseload. • Each family receives 3-5 visits a week for 3-6 mos.
Standard Training Protocol	• 6-month intensive process leading to certification for 1 year, annual re-certification thereafter
Proprietary	• Yes
Sustainability	• Certified teams need annual re-certification and additional training to address attrition/expansion - $3,000.
Contact	Center for Treatment Research on Adolescent Drug Abuse, University of Miami, Miller School of Medicine www.miami.edu/ctrada Gayle Dakof, Ph.D. (305) 243-3656 gdakof@med.miami.edu

Program	Multisystemic Therapy (MST)
Population	Youth (ages 12-17) with criminal behavior, substance use and emotional disturbance; youth on juvenile probation
Cultural Evidence	Studies on MST have included African American
Risk and Protective Factors	**Risk:** • Anti-social behavior and alienation • Early onset of aggression and/or violence • Favorable attitudes toward drug use/early use of drugs or alcohol • Mental health problem • History of problem behavior/parent criminality • Poor family attachment • Low academic achievement • Association with delinquent and/or aggressive peers **Protective:** • Perception of social support from adults and peers • Effective parenting • Good relationships with parents/bonding • School bonding • Good relationships with peers • Involvement with positive peer group activities
Level of Evidence	Well-Supported
Outcomes	1. Decrease in delinquency, arrests, and incarceration 2. Decrease in suicide attempts 3. Decrease in alcohol and substance use self-report (decreases not sustained in follow-up studies)
Prevention: Universal/Selective	Selected
Early Intervention	Early Intervention
Description	See MST description under Juvenile Justice for details of program.

Program	Multisystemic Therapy
Staffing Requirements	• Masters level therapists • In some case Bachelor level with supervision
Service Delivery Setting	• Public mental health or private providers • Home based model
Implementation Costs	• Five days regular training supervisors/staff stakeholders from other agencies • Weekly MST consultation • Regular booster trainings • Track progress/outcomes by completing specific forms • Participate in weekly supervision • Quarterly on site booster sessions • Master License $4000 • Team License $2500 • Program development and start up fees: $10,000—includes on site 5 day orientation for up to 4 teams Booster Training • Single Team $26,000 (5,000) GA services • Two teams jointly $20,000 per year • Three or more $17,000 • Replacement staff 5 day on site $8,000 plus travel costs • If staff goes to Charleston, $750 per day
Service Delivery Costs	• Provide on an as needed basis and regular appointments • Caseload is 4/6 families/ range of treatment is 4-6 months • Estimated cost savings juvenile justice system, crime victim & tax payers: $31,661 – $131,918 (Aos, et al., 2001)
Standard Training Protocol	• Yes—manualized training and program
Proprietary	• Yes •
Sustainability	• New staff must receive the 5-day training either in Charleston or new training on site
Contact	MST SERVICES 710 J. Dodds Blvd. Suite 200 Mt. Pleasant, SC 29464 Keller.Strother@mstservices.com 843-856-8226 FAX 843-856-8227 CIMH 2125 19TH ST. Sacramento, CA 95818 Bill Carter, LCSW bcarter@cimh.org Tel. 916-556-3480 X 130 Fax 916-446-4519

Program	Parent-Child Interaction Therapy (PCIT): "Honoring Children, Making Relatives"	
Population	Native American families with child-parent relational problems	
Cultural Evidence	Adapted for Native American children and their parents	
Risk and Protective Factors	Risk: • De-valuing children and their relationships with adults	Protective: • Strength of relationships • Embracing Native concepts of parenting • Honoring children
Level of Evidence	Well Supported for PCIT – Adaptations not yet evaluated	
Outcomes	1. Treatment goals to enhance relationship between child and parent, enhance parenting skills	
Prevention: Universal/Selective	Selected	
Early Intervention	Early Intervention	
Description	Honoring Children, Making Relatives incorporates American Indian philosophies into the basic concepts of Parent-Child Interaction Therapy. Included in the curriculum are the issues of implementation and dissemination of evidence-based interventions in rural and/or isolated tribal communities with limited licensed professionals. Procedures are in place for assisting, measuring and monitoring the skills acquisition and treatment fidelity for rural/isolated or reservation based therapist-trainees. Online video consultation is used in the live remote real time coaching sessions to overcome the issue of distance and time constraints. The treatment is appropriate for children between the ages of 3-7.	

Program	Parent-Child Interactive Therapy (PCIT) "Honoring Children, Making Relatives"
Staffing Requirements	• Masters level clinicians trained in PCIT
Service Delivery Setting	• Tribal organizations • Tribes
Implementation Costs	• $4000 per person for six months
Service Delivery Costs	• 12-16 sessions
Standard Training Protocol	• Information not available at this time
Proprietary	• Mixed
Sustainability	Information not available at this time
Contact	Dolores Subia BigFoot, Ph.D CHO-38-3406 P.O. Box 26901 OKC, OK 73190 405-271-8858

Program	Parent-Child Interaction Therapy (PCIT): "*Guiando a Niños Activos* (GANA) Program"	
Population	Children (ages 3-6) with behavioral problems and their families	
Cultural Evidence	Mexican American children, parents and extended family Public health approach to mental health services	
Risk and Protective Factors	Risk: • Financial, cultural, attitudinal barriers to seeking and maintaining services	Protective: • *Familismo* and other Latino cultural values
Level of Evidence	Promising	
Outcomes	1. Decreases in conduct problems for children in GANA Program	
Prevention: Universal/Selective	Selected	
Early Intervention	Early Intervention	
Description	Culturally modified PCIT for Mexican American families by including culturally significant practice and understanding into the model's protocol.	

Program	Parent Child Interaction Therapy (PCIT): "*Guiando a Niños Activos* (GANA) Program"
Staffing Requirements	• Teachers • Therapists • Researchers • Masters degree or better
Service Delivery Setting	• Twelve to twenty sessions
Implementation Costs	• Forty hours of direct training with ongoing supervision • Consultation for 4 to 6 months via conference calls, videotapes, distance learning • $3,000 per person (5 day workshop)
Service Delivery Costs	• Clinic based • Community based • Home based
Standard Training Protocol	• Yes • Assessment instruments • Scoring forms • Step by step clinician guide • Manualized training, coding of sessions and handouts.
Proprietary	• Yes
Sustainability	• There is a Train the trainer protocol.
Contact	Erical Pearl/Erna Olafson, Ph.D, Psy.D Trauma Treatment Training Center Cincinnati Children's Hospital 3333 Burnett Avenue MLC 3008 Cincinnati, Ohio www.OhioCanDo4kids.org CAARE Diagnostic and Treatment Center UC Davis Health Systems 3300 Stockton Blvd. Sacramento, CA 95820 800-770-6992 chinh.pham@ucdmc.ucdavis.edu

Program	Positive Directions
Developer	Special Service for Groups – HOPICS Family Center
Submitted by	Special Service for Groups – HOPICS Family Center
Description	• A comprehensive package of three national evidence-based interventions for the prevention and early intervention of substance use/abuse and delinquency including: (1) SAMHSA's Anger Management curriculum; (2) Cannabis Youth Treatment (CYT), based on motivational interviewing and cognitive-behavioral techniques; and, (3) a Life Skills for Teens curriculum. Youth participate for 9-12 months and receive individual case management in addition to the three 12-week, group-based, consecutively delivered interventions.
Population	• Low income, ethnically diverse youth ages 10-17 with substance use/abuse problems at risk of or involved with the juvenile justice system
Cultural Evidence	• Delivered in English and Spanish
Risk and Protective Factors	• Substance abuse • Community violence • Poor school attendance
Level of Evidence	• Promising
Outcomes	• Decreased substance abuse • Increased pro-social behavior • Increased knowledge of and skill use in anger management and conflict resolution • Increased knowledge of and skill use in problem solving, goal setting and communication skills • Increased utilization of community support system, particularly around relapse prevention
Prevention: Universal/Selective	• Selective

Program	Prevention and Early Treatment of Depression in Primary Care
Developer	Isabel T. Lagomasino, MD, MSHS
Submitted by	LAC+USC Medical Center
Description	• Culturally appropriate evidence-based collaborative care model that includes screening, prevention, and early intervention for depressive symptoms and disorders (employs validated measures and cognitive behavioral therapy)
Population	• Low income, ethnic minority, primary care patients (adults and older adults)
Cultural Evidence	• Treatment manuals are available in English and Spanish • Curriculum/intervention does not rely on client/consumer literacy
Risk and Protective Factors	• Increased education regarding symptoms and appropriate care • Decreased stigma • Increased access to evidence-based screening, assessment, and intervention
Level of Evidence	• Promising
Outcomes	• Improved access to care for depressive symptoms and depressive disorders • Improved engagement in care for depressive symptoms and disorders • Decreased depressive symptoms
Prevention: Universal/Selective	• Selective

Program	*Promotores de salud para nuestra tercera edud* (Health Promoters for our Third Age or Community Health Workers for Latino Older Adults)
Developer	Behavioral Health Services, Inc.
Submitted by	Behavioral Health Services, Inc.
Description	• Volunteer community members are trained in outreach and education activities specific to common physical health conditions in older Latino adults and their associated mental health conditions (e.g., diabetes and depression) • Volunteers are trained to conduct basic physical health status assessments and to follow-up with participants who have evidence of chronic health conditions (including knowledge of local referrals)
Population	• Latino older adults (55+) in Los Angeles County
Cultural Evidence	• All older adults served are/have been Latinos in Los Angeles communities • All materials are in English & Spanish
Risk and Protective Factors	• Increased positive health behaviors, presumed to mediate depression and anxiety, which are common to older adults with chronic health conditions • Increased knowledge of and access to appropriate health services
Level of Evidence	• Emerging
Outcomes	• Increased engagement in positive health behaviors, specifically those related to diabetes and hypertension • Improved communication with health providers
Prevention: Universal/Selective	• Selective

Program	Resilience and Effectiveness of Asian Adolescents in Countering Hostility (REAACH) Program
Developer	Terry Gock, PhD, MPA
Submitted by	Asian Pacific Family Center-East
Description	• Bicultural, school-based, 14-week skill-based curriculum focused on increasing pro-social conflict-management skills in Asian immigrant middle-school youth
Population	• Intermediate-school age Asian immigrant youths at high risk of aggression and behavioral problems
Cultural Evidence	• Curriculum has been implemented with 75 Asian immigrant youth • Evaluation measures used were specifically developed for and tested with Asian immigrant population
Risk and Protective Factors	• Reductions in immigrant-specific stress • Enhanced extended family support • Enhanced connections with school • Increased bicultural competence
Level of Evidence	• Promising
Outcomes	• Decreased engagement in violent and aggressive behaviors when dealing with conflict
Prevention: Universal/Selective	• Selective

Program	School, Community and Law Enforcement Program
Developer	Terry Gock, PhD, MPA
Submitted by	Asian Pacific Family Center
Description	• Comprehensive intervention designed for Asian immigrant adolescents and their families at risk to school failure and or juvenile justice involvement. Core components include: a) Holistic Family Needs Assessment b) Individualized Life Skills Mentoring and Counseling c) Family Case Management Service Linkage d) Community Education and Consultation
Population	• Asian immigrant youth (adolescents) and their families at risk to school failure and juvenile justice involvement
Cultural Evidence	• The program was developed with input from local Asian community stakeholders. It was designed to specifically capitalize on those Asian cultural values and traditions associated with "extended family."
Risk and Protective Factors	•
Level of Evidence	• Promising
Outcomes	• Decreases in school disciplinary actions • Decreases in missed homework assignments • Improvements in school attendance • Decreased risk for delinquent behavior
Prevention: Universal/Selective	• Early intervention

Program	Strengthening Bonds of Chicano Youth and Families	
Population	9 to 16 year old Latino youth at risk to substance abuse	
Cultural Evidence	80% of the research participants were Latino	
Risk and Protective Factors	Risk: • Favorable attitudes toward drug use • Family management problems • Family history of substance abuse • Peer alcohol, tobacco or other drug use	Protective: • Self-efficacy • Effective parenting • Opportunities for prosocial family involvement • Presence and involvement of caring and supportive adults
Level of Evidence	Promising	
Outcomes	1. Improved family communication and bonding 2. Increase in awareness of substance abuse issues and decreased substance abuse	
Prevention: Universal/Selective	Selective	
Early Intervention		
Description	Strengthening the Bonds of Chicano Youth (*El Proyecto de Nuestra Juventud*) is a comprehensive, multilevel, community-based, and culturally appropriate program designed to meet the prevention needs of rural Chicano youth in Central Arizona who demonstrate high-risk characteristics of substance abuse. The program is rooted in a family-oriented approach that is based on Mexican-American culture, values, and principles. The project was conceived and implemented by the Pinal Hispanic Council, a minority nonprofit organization based in Eloy, Ariz. The target population served by the project included 450 high-risk youth (323 female, 127 male) in three age groups (9–11 years old, 12–14 years old, and 15–16 years old), who were residents of low-income housing and students at the elementary, junior, and senior high schools. Availability of alcohol and drugs, attitudes favorable to drug use, negative peer influences, and poor family management were the risk factors used for referral to the project interventions. During the project, 330 families and 60 service providers were reached.	

Program	Strengthening Bonds of Chicano Youth and Families
Staffing Requirements	Information not available at this time
Service Delivery Setting	Information not available at this time
Implementation Costs	Information not available at this time
Service Delivery Costs	Information not available at this time
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Ralph Varela, C.M.S.W. Pinal Hispanic Council 712 North Main Street Eloy, AZ 85231–2037 Phone: (520) 466-7765 E-mail: warriors@cgmailbox.com

Program	Supporting Adolescents with Guidance and Employment
Population	Violence prevention program for African American adolescents
Cultural Evidence	100% of the research participants were African American males (12-16 year olds)
Risk and Protective Factors	**Risk:** • Early onset of aggression • Early sexual involvement • Gun possession • Life stressors • Mental health problems • Victimization and exposure to violence • Low academic achievement • Association with delinquent peers **Protective:** • Positive expectations • Self-efficacy • Social competencies and problem-solving skills • Involvement with positive peer group activities
Level of Evidence	Emerging
Outcomes	1. Reduced reports for carrying a gun, selling illegal drugs and injuring others with a weapon
Prevention: Universal/Selective	Selective
Early Intervention	
Description	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.

Program	Supporting Adolescents with Guidance and Employment
Staffing Requirements	• Public health professional • County government officials • Local businessmen—African American Mentor Program
Service Delivery Setting	• Community-based
Implementation Costs	Information not available at this time
Service Delivery Costs	• Eight month program (adult mentoring/African American history and culture) • Manhood • Conflict resolution • Six week summer employment • 12 week entrepreneurial component
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Arnold Dennis North Carolina Central University 1801 Fayetteville Street Durham, NC 27707 919-560-7092 Bob Flewelling Pacific Institute for Research and Evaluation 1515 Chapel Hill , NC 27514-3307 919-265-2621 fax 919-265 -2659

Program	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): "Honoring Children, Mending the Circle"	
Population	Native American child trauma victims	
Cultural Evidence	Adapted for Native American children	
Risk and Protective Factors	Risk: • Problems in cognition, relationships and family	Protective: • Embracing Native cultural practices • Strong sense of resiliency through native concepts of well-being and healing • Family strengths
Level of Evidence	Trauma Focused CBT – Well Supported – Adaptations not yet evaluated	
Outcomes	1. Treatment goals to improve spiritual, mental, physical, emotional, and relational well-being	
Prevention: Universal/Selective	Selected	
Early Intervention	Early Intervention	
Description	Based on TF-CBT (see previous entries for details). Traditional aspects of healing with American Indians and Alaskan Natives from their world view are included.	

Program	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): "Honoring Children, Mending the Circle"
Staffing Requirements	• Need background in CB treatment • Training in Trauma Focused Cognitive Behavioral Therapy • Limited to clinicians working in tribal organizations or with tribes
Service Delivery Setting	• TF-treatment adapted to be culturally appropriate for American Indians/indigenous people
Implementation Costs	• Training is $4,000 per person for 6-month training
Service Delivery Costs	• 12-16 sessions
Standard Training Protocol	Information not available at this time
Proprietary	Information not available at this time
Sustainability	Information not available at this time
Contact	Dolores Subia Bigfoot, Ph.D. CHO-38,3406 PO Box 26901 OKC,OK 73190 405-271-8858 dee-bigfoot@ouhsc.edu

Program	Un Paso Mas
Developer	Feliza Perez
Submitted by	Mental Health of America Los Angeles
Description	• Outreach and engagement intervention for Latinos in Service Area 7 of Los Angeles County. Service components include: a) Community leadership outreach and development regarding understanding the manifestation of mental health problems b) Individual and family outreach to potential consumers "referred" by community partners. Includes group psychoeducation c) Community outreach. Includes information provided in church bulletins, community organizations, and events such as fiestas
Population	• Latino families and individuals at risk to mental health problems living in service area 7 of Los Angeles County
Cultural Evidence	• All materials provided are in Spanish and English. Providers of psychoeducation are bilingual and bicultural. Outreach efforts are conducted with input from traditional leaders in the Latino community including the clergy.
Risk and Protective Factors	•
Level of Evidence	• Emerging
Outcomes	• Increases in community collaboration • Increases in psychoeducation classes • Increases in access to mental health services
Prevention: Universal/Selective	• Universal for Latinos living in Service Area 7 of Los Angeles County

Program	Ventanas
Developer	SPIRITT Family Services
Submitted by	SPIRITT Family Services
Description	• Seven week family communication skills curriculum developed for adolescent youth and their families at risk to school failure and juvenile justice involvement. Skills taught are based upon known risk factors for involvement in delinquent behavior and school failure
Population	• Latino adolescents and their families at risk to school failure and juvenile justice involvement.
Cultural Evidence	• The program has been adapted to serve Latino families. Cultural themes and metaphors are incorporated into the intervention. • Bilingual/bicultural facilitators help parents bridge the parenting practices learned in their country of origin to those more acceptable in the U.S.
Risk and Protective Factors	•
Level of Evidence	• Promising
Outcomes	• Increased family communication skills • Increased problem solving skills • Decreased adolescent aggression • Satisfaction with services for Latino parents
Prevention: Universal/Selective	• Early intervention

Program	Why Try? Program
Developer	Martha Marquez, LCSW
Submitted by	Los Angeles Unified School District Student Health and Human Services – School Mental Health Services
Description	• National, evidence-based 10-week group curriculum (45 mins each) designed to prevent delinquency and school failure
Population	• Low income, minority students (2nd thru 12th grade) at risk of school failure, dropping out of school, substance use/abuse, and/or juvenile justice involvement
Cultural Evidence	• This model is being used with low income, minority youth in Los Angeles County
Risk and Protective Factors	• Increased social skills • Increased conflict resolution skills • Increased coping skills
Level of Evidence	• Promising
Outcomes	• Increases in indicators of student resiliency
Prevention: Universal/Selective	• Selective

Program	Winners
Developer	Darnell Bell
Submitted by	Avalon Carver Community Center
Description	• The Winners program is a school based classroom and after school activities program for African American elementary age students who are trauma exposed and at risk to school failure. The curriculum focuses on developing or enhancing positive ethnic identity which is protective against school failure, problem behavior and substance use abuse.
Population	• African American elementary aged students who are trauma exposed and at risk to substance abuse and school failure. The service is delivered in Service Area 6 of Los Angeles County
Cultural Evidence	• The curriculum was developed specifically for African American children and youth utilizing Afrocentric concepts from family psychology.
Risk and Protective Factors	•
Level of Evidence	• Emerging
Outcomes	• Increases in positive ethnic identity • Increases in participation in positive school activities
Prevention: Universal/Selective	• Selective for African American elementary school children

APPENDICES

Appendix A: Evidence-Based Practices Rating System

Rating	Criteria
Well-Supported	1. There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits. 2. More than one rigorous randomized controlled trial has been conducted, using valid outcome measures, and has obtained consistent outcomes (positive effects with statistically significant results) in more than one setting and/or with more than one population. 3. The practice can be replicated. 4. Fidelity measures exist or can be developed from available information.
Supported	1. There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits. 2. At least one rigorous randomized controlled trial has been conducted, using valid outcome measures, and has identified positive effects with statistically significant results. 3. The practice can be replicated. 4. Fidelity measures exist or can be developed from available information.
Promising	1. There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits. 2. A less rigorous research and evaluation design or quasi-experimental design, using valid outcome measures and some form of control, has been conducted with evidence of positive effects.
Emerging	1. There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits. 2. The practice has sound theoretical rationale and has shown to be related to positive change through a minimum of a pre/post evaluation using valid outcome measures.

Appendix B:
Los Angeles County Department of Mental Health MHSA Prevention and Early Intervention Technical Work Group

Name	Title	Organization
Maria Aranda, Ph.D.	Associate Professor	University of Southern California, School of Social Work
William Beardslee, M.D.	Academic Chair, Department of Psychiatry	Children's Hospital Boston, Department of Psychiatry, Center for Behavioral Science
Michele Berk, Ph.D.	Director, Adolescent CBT and DBT Programs Assistant Professor	UCLA School of Medicine, Harbor—UCLA Medical Center, Psychology Division
John Briere, Ph.D.	Associate Professor of Psychiatry and Psychology Director, Psychological Trauma Program, LAC-USC Medical Center Co-Director, MCAVIC-USC Child and Adolescent Trauma Program, National Child Traumatic Stress Network, SAMHSA	Keck School of Medicine, University of Southern California
Steven Forness, Ed.D.	Retired	Retired- UCLA Neuropsychiatric Institute
Sheryl Kataoka, MPH, M.D.	Assistant Professor, Department of Psychiatry and Biobehavioral Sciences	UCLA NPI, Department of Child Psychiatry, Health Services Research Center
Bob Knight, Ph.D.	Merle H. Bensinger Professor of Gerontology, Professor of Psychology	University of Southern California, Davis School of Gerontology, Ethel Percy Andrus Gerontology Center
John Landsverk, Ph.D.	Director, Child and Adolescent Services Research Center	Rady Children's Hospital San Diego, Child and Adolescent Services Research Center
Kurt Organista, Ph.D.	Associate Professor	University of California, Berkeley, School of Social Welfare
Eric Trupin, Ph.D.	Professor and Vice Chair, Department of Psychiatry and Behavioral Sciences Director, Division of Public Behavioral Health and Justice Policy	University of Washington School of Medicine, Department of Psychiatry & Behavioral Sciences, Division of Public Behavioral Health and Justice Policy
Nolan Zane	Professor of Psychology and Asian American Studies Director, Asian American Studies Program Director, Asian American Center on Disparities Research (AACDR)	University of California, Davis, Department of Psychology

Appendix C:
Los Angeles County Department of Mental Health Ad Hoc Prevention and Early Intervention Advisory Group-Technical Subcommittee

Name	Organization
Michael Alba	DMH/SEIU
Bonnie Burstein	LA Community College District
Heather Carmichael	My Friend's Place
Rocco Cheng	Pacific Clinics
Carmen Diaz	DMH/United Advocates for Children and Families
Cheryl Garcia	LA Care Health Plan
Rene Gonzalez	LAUSD
Cynthia Jackson	Heritage Clinic
Helen Kleinberg	LAC Commission on Children and Families
Louse McCarthy	Community Clinic Association
Tara Pir	IMCES
Joanne Rotstein	Los Angeles County Public Defenders Office
Wendy Wang	ACHSA

Appendix D:
Los Angeles County Department of Mental Health Mental Health Services Act Prevention and Early Intervention Community-defined Evidence (CDE) Models Guidelines 2.0

County of Los Angeles Department of Mental Health
Mental Health Services Act Prevention and Early Intervention

Community-defined Evidence (CDE) Models
Guidelines 2.0

Los Angeles County Department of Mental Health (DMH), as part of its Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) program planning, developed resource guides of PEI interventions from which individual practices could be selected for inclusion in DMH's PEI component. These resource guides included the *Evidence-based Practices and Promising Practices Resource Guide for Los Angeles County (v. 1.0, 2009)* and the *Prevention and Early Intervention (PEI) Community-defined Evidence (CDE) Models (v.1.1 2009).* All practices in the resource guides are organized by their appropriateness and effectiveness in serving PEI priority populations and promoting achievement of PEI outcomes, across each of the four age groupings (child, transition age youth, adult, older adult). The resource guides contain practices that can be used for prevention and early intervention in mental health, in accordance with State Guidelines for PEI. These resource guides will be combined in a revised guide to be issued in 2010. Only practices that target PEI priority populations and outcomes will be included in the *Prevention and Early Intervention (PEI) Evidence-based Practices, Promising Practices, and Community-defined Evidence (CDE) Models Resource Guide (2010).*

Inclusion in the Resource Guide does not guarantee that a practice will be selected and funded for implementation. Inclusion in the Resource Guide only means that the practice could be suitable for a PEI project if the practice is selected as the best match for the project's target population and the intended outcomes for that population. The target population, intended outcomes for a project, and practice selection were determined through the PEI planning process.

Once a practice is selected for a PEI project, DMH will enter into an agreement with the specific CDE developer to train local agencies to provide the practice and access to their CDE materials. The local agencies that provide the practice will be selected through a Request for Services (RFS) process, and the practice developer will then train the selected agencies to provide the practice. This means that the developer may or may not be selected to provide the practice, however in either case, the developer would provide the practice training. To be clear: A solicitation for CDE practices to be included in the Resource Guide ***is not*** an RFS process, and no funding will be released to CDE developers to provide the practice merely upon acceptance of their practice into the Resource Guide.

The California State Department of Mental Health (SDMH) describes CDEs as follow:

> *"Community-defined evidence validates practices that have a community-defined evidence base for effectiveness in achieving mental health outcomes for underserved communities. It also defines a process underway to nationally develop specific*

criteria by which practices' effectiveness may be documented using community-defined evidence that eventually will allow the procedure to have an equal standing with evidence-based practices currently defined in the peer reviewed literature. (PEI Resource Materials. SDMH, 2007. Retrieved October 7, 2009 from http://www.dmh.ca.gov/DMHDocs/docs/notices07/07_19_Enclosure6.pdf)."

In order for DMH or one of its contractors to implement a CDE practice, the practice must be sufficiently well developed and described, teachable to other agencies, and delivered in a consistent manner. As indicated by SDMH's description above, a CDE must have some level of demonstrated effectiveness. If a developer cannot clearly say what the core components of the practice are, what the results of the practice are, how they know those results (and how those results relate to MHSA PEI), and/or if they can't teach others to do the practice (so they do the practice and get the same results as the developer), then the practice is not yet ready for inclusion in the Resource Guide. Specifically, CDE practices that will be included in the Resource Guide should be able to clearly specify the following characteristics.

Target Population

Target population refers to a well-defined group of individuals for whom the practice is intended. All CDE practices included in the Resource Guide must have a clearly defined target population that fits in at least one of the MHSA PEI priority populations.

The target group for the practice also needs to be defined in terms of one or more of the following:

1) Does this practice focus on a particular cultural group or sub-group? If yes, which group or sub-group is it?
2) Is this practice intended to be provided in a language other than English? If so, which language?
3) Does this practice focus on a particular age group? If yes, which age group?
4) Does this practice focus only on males or females? If so, which?
5) Does this practice focus on people with a specific need or risk? If so, which need or risk?
6) Does this practice focus on people in a particular area or setting? If so, which area or setting does this practice focus on?

Each CDE practice should describe the intended participants in terms of all relevant criteria for determining when the practice is appropriate to use, answering the question: ***Who is this practice intended to serve?***

Goals

Goals are one or more intended results that can be achieved by the practice. The goals need to correspond to MHSA prevention and early intervention outcomes, and may include:

If the practice is a preventative mental health service,

1) any specific mental illness (or illnesses) and/or mental health problems that are prevented by the practice
2) any mental health protective factors that are enhanced
3) any risk factors for mental illness that are reduced
4) any other mental health prevention goals achieved by this practice (for example, increasing mental health awareness, outreach and engagement, etc.)

If the practice is an early intervention,

1) any mental illness that this practice addresses early
2) improvements in mood or emotional state, thought or cognitive process, behavior, and/or skills that result from the early intervention

Each CDE model should describe the specific intervention goals, answering the question: ***What is the goal of this practice?***

Core Components

Core Components should clearly describe features that define the practice so that it can be copied (provided) by others.

A description of the core components may include, but is not limited to:

1 The essential components of the practice (activities, steps, stages, procedures, things that must happen for it to work).
2 The reason for these essential components - how the practice works and why.
3 The way that a new practitioner learns how to do this practice. Training may involve a training manual, a curriculum that must be followed, a specific set of skills that must be learned, an apprenticeship or an internship. Copies of any training materials can be included in the description of the practice.
4 Number of sessions to complete the practice.
5 How often sessions occur.
6 How long a session lasts.
7 For how long are services provided to consumers, family members and/or significant others.

Specifically, each CDE practice should describe its distinguishing features, answering the question: ***What is provided?***

Practitioners

The staff needed to provide the practice.

Practice developers should be able to describe:

1) The minimum number of people/practitioners needed to provide the practice.
2) Whether the practitioner needs to be bicultural and/or bilingual. If so, in which languages and cultures.

3) The key roles or responsibilities of each person/practitioner needed to provide the practice.
4) The minimum requirements for each practitioner to be able to provide the practice in terms of educational attainment, training, work or personal experience.
5) The number of people a practitioner can work with at a time (caseload).

Each CDE practice should be able to specify practice staffing, answering the question: ***Who are the core practitioners?***

Practice Setting

Practice setting refers to where the practice is provided.

Settings may include, but are not limited to, homes, schools, community settings, mental health clinics, health care centers, resource centers, and faith-based or civic organizations. Some practices may be appropriate for more than one type of setting.

Each CDE practice should indicate any required service delivery settings, answering the question: ***Where is the practice provided?***

Cultural Relevance

How the practice meets the cultural needs of the population served.

Each CDE developer should describe any indicators that the practice is culturally relevant to the population targeted by the practice, including but not limited to:

1 How the practice provides outreach to the population it serves - specific engagement strategies that are part of the practice.
2 How the traditions, customs and belief systems of the population the practice serves are incorporated into the practice.
3 How the practice includes elements that are easily recognizable by the specific population served as important for mental health and well-being.
4 Whether the community targeted by this practice trusts the practice and how the developer knows.
5 How the practice was developed, where it comes from, and what is the history of the practice in the population served.

Specifically, each CDE practice should describe indicators of cultural relevance, answering the question***: How does this practice meet the needs of the specific cultural population served?***

Indications of Effectiveness

One or more indications that the practice successfully does what it is intended to do.

Developers should be able to describe how they know the practice works. Types of evidence that the practice works may include, but is not limited to, any or all of the following quantitative and qualitative methods: (1) experimental evaluation, (2) quasi-experimental evaluation, (3) informal

evaluation that includes comparison of pre- and post-measures, (4) case studies, (5) informal evaluation that includes post measures only, (6) anecdotal reports, or (7) testimonials.

Each CDE model should describe evidence that supports its effectiveness, answering the question: ***How do we know that the practice is working?***

This question may be answered by describing any and all levels of available quantitative and qualitative evidence of effectiveness from testimonials through experimental evaluation.

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