A GUIDE TO EVIDENCE-BASED MENTAL HEALTH PRACTICES

for CHILDREN, ADOLESCENTS AND THEIR FAMILIES

SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

This report was produced with the support of the Saginaw County Community Mental Health Authority. It is dedicated to the children and families we are privileged to serve.

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Table of Contents

FORWARD

This is the second of a series of reports on evidence-based practices compiled for the Saginaw County Community Mental Health Authority (SCCMHA) in an endeavor to build a foundation of services and supports that are grounded in empirical evidence and offer optimal opportunities for consumer resilience and recovery. It is the result of an exhaustive review of relevant journal articles, expert consensus guidelines, algorithms, reports, manuals, monographs and text book chapters. Because children and adolescents often interface with various systems, literature from the fields of child welfare, public health, substance abuse treatment, education and juvenile justice was reviewed in addition to mental health. While many of these documents are available in the public domain, a number are not. However, no attempt was made to compose the report in accordance with established publication standards in order to enhance readability. All sources are listed in the reference section, but are not footnoted.

This report offers available information on how to best assist children and their families at home and in the community. While it is intended as a stand-alone document, a number of areas found in the report on adults with mental illness (e.g., family psychoeducation, integrated dual disorders treatment, assertive community treatment, polypharmacy, solution-focused brief therapy, working with faith-based organizations) are applicable, but not repeated here in order to keep the document as brief as possible. The reader is referred to the adult document where applicable.

The reader may not find all areas of personal interest nor as an in-depth rendering of various topics as might be desired. Limitations posed by resource availability and evolving science make it impossible to provide all information available. There are ample resources listed for the reader who wishes to pursue various areas in greater depth. In addition, each program description contains relevant web site as well cost information that is available. The web sites listed are in hypertext, which allows for direct access via the electronic version of the report.

This, as well as other summaries of scientific support for interventions, is really a work in progress. Research findings continuously change as evidence accumulates pursuant to the development and testing of new interventions, and refinements are made to current treatment options. Furthermore, the interventions included herein are not meant to imply that they serve as solutions to all problems and disorders, or that they epitomize ideal solutions. Finally, it should be noted that some of the programs and interventions reviewed are not evidence-based practices per se (e.g., family dependency treatment courts), but are included because they are of topical interest at federal, state, and/or local levels.

It is hoped this, and the companion reports on the various populations served by SCCMHA, will become part of the culture of the organization as it strives to implement services and supports with proven beneficial outcomes for consumers, families and other stakeholders of the public mental health system in Saginaw.

 The writer acknowledges with gratitude the support and sponsorship of SCCMHA in the production of this report. SCCMHA is to be commended for its efforts to provide state of the art services and supports to the community.

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EXECUTIVE SUMMARY

The information contained in this report is intended to serve as a reference guide and inform service delivery policy. It is designed to emphasize the science that is currently available on mental health services for children, adolescents and their families and draws primarily from research in mental health, education, juvenile justice, public health, substance abuse treatment, and child welfare systems. It aims to assist in the evaluation and selection of services and supports by offering a review of scientifically researched treatment options that have proven beneficial outcomes for consumers and their families. Although not all of the programs and services reviewed are evidence-based per se, they reflect national, state, and local priorities, trends and interests and show promise for promoting beneficial outcomes.

Most compendia on evidence-based interventions for children and adolescents are organized according to diagnosis or disorder. This report, however, is organized very differently as it takes into account issues related to family, culture, systems of care, types of interventions and modalities used. There are numerous interventions identified by various sources (e.g., Office of Juvenile Justice, Substance Abuse and Mental Health Services Administration) as model programs. Since they are too numerous to report on, examples were selected for inclusion based upon national recognition (e.g., Olweus Bullying Prevention Program) and relevance to public sector mental health practitioners.

The first section, following the introduction, acquaints the reader with salient concepts and issues specific to evidence-based practices in the child and adolescent mental health arena. The second section gives an overview of key pieces of legislation and policies that impact mental health service and support provision to children, adolescents and their families. The third section is comprised of cultural issues and their impact on help-seeking behavior and clinical presentation. Parameters for the delivery of culturally responsive services and supports are delineated. Two programs that have been culturally adapted are presented. The next section contains information on family-centered practice and provides descriptions of parent management programs and family therapies.

Prevention and early intervention issues, including risk and protective factors, as well as the concept of resiliency, are reviewed in the following section. Significant areas of risks are detailed including parental mental illness, divorce, child abuse/neglect, suicide, and violence. The zero-to-five age group is also covered in this section. Services and supports such as early intervention, mentoring, respite, and family strengthening programs, are reviewed.

The following section offers a foundation for collaborative efforts among key child-serving sectors. It covers education, child welfare, juvenile justice, and primary care and reviews of programs and services in the various areas. Systems of Care, wraparound, and models of therapeutic jurisprudence are highlighted.

The next section is comprised of a review of transition services and supports for adolescents and young adults. This is followed by a discussion related to various psychotherapeutic approaches not covered in previous sections, and a section on somatic interventions including medication and ECT. Crisis services and out-of-home settings such as therapeutic foster care are reviewed in the next section. Measurement tools and outcomes comprise the next two sections. The final sections consist of a recap of key findings and recommendations. The appendices include references, resources, a quick reference guide, and a matrix of programs with levels of evidence ratings.

INTRODUCTION

The recognition of childhood as a phase distinct from that of adulthood was articulated in the first book on pediatrics, *The Boke of Chyldren* by Thomas Phâtre, published in 1544. However, the concept of mental illness occurring during childhood did not arise until the later part of the nineteenth century. And, it was not until the early twentieth century that such illnesses were viewed as distinct from those manifested during adulthood. The first text on child psychiatry was published in 1935.

During the 1970s the World Health Organization encouraged a classification of clinical syndromes specific to childhood and the first multi-axial diagnostic scheme was developed in 1975. The third edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (D.S.M.), published in 1980, was the first to include a distinct section on child and adolescent disorders. Thus, the recognition that children and adolescents suffer from distinct mental disorders is a rather recent phenomenon. The development and promulgation of interventions, services and supports for such disorders is even newer.

Children's mental health care received little attention before the 1980s and the landmark publication of Knitzer and Olson's *Unclaimed Children* in 1982 in which they reported that three million children in the United States had significant mental health care needs and two-thirds received inappropriate services or no services at all. At that time less than half of the states had even one mental health professional devoted to providing services to children. The study raised public awareness and concern, and spurred an increase in research and policy development. The Congressional Joint Commission on the Mental Health of Children also brought the unmet mental health needs of children to national attention. The Joint Commission's report pointed out that many children suffered from significant mental health problems, but were unable to effectively access services, or were provided services within excessively restrictive settings. The report further indicated that children who have complex needs require coordinated services across multiple systems within the health care and social services sectors. In 1984 the Children and Adolescent Service System Project (CASSP) generated the concept of a System of Care (SOC) and spurred national efforts to create systems of care for children with mental health needs. Public agencies and providers adopted systems of care standards as a best practice (despite the absence of empirically validated outcomes research on systems of care).

Research in the field of child and adolescent mental health has been significantly expanded in recent years pursuant to the National Institute of Mental Health's release of a national plan to shape and encourage studies in 1989. The Surgeon General's 1999 report on mental health included a chapter on children and was followed by the Surgeon General's *Conference on Children's Mental Health: A National Action Agenda* published in 2000, and *Youth Violence: A Report of the Surgeon General* in 2001. The Surgeon General's *Conference on Children's Mental Health: A National Action Agenda* indicated that the gap between scientific knowledge and practice was widening in many public mental health systems across the country. Additionally, the Child Mental Health Foundations and Agencies Network issued *A Good Beginning* in 2000 which detailed the importance of the socio-emotional aspects of school readiness. *From Neurons to Neighborhoods: The Science of Early Childhood Development* was published in 2000 by the National Research Council and Institute of Medicine.

A number of the trends that have developed over the past two decades in the provision of services and supports for children and their families are addressed in this report. These include:

- The service array has enlarged much beyond traditional acute psychiatric hospital care, long-term residential placement, and traditional office-based,

individual therapy. Services now more typically include in-home services such as family preservation and support programs, school-based services, intensive case management, respite, mentoring, therapeutic group and foster family care, and a number of different types of crisis services.

- Treatment and interventions have moved away from long-term approaches based on psychoanalytic and psychodynamic theories to briefer cognitive-behavioral interventions based on ecological theories and models.
- The significance of culture in meeting the needs of children and families, and in the design and implementation services, has achieved prominence.
- Understanding the different systems involved with children and families beyond mental health (e.g., child welfare, education, health, juvenile justice, substance abuse), and designing a more integrated service delivery system have been emphasized.
- The flexibility to provide whatever a child or family needs to help the child remain in their home, school, and community, as exemplified in the wraparound model, has been broadly promulgated.
- The central role that families play in the treatment and support of their children has evolved to the point that they are viewed as full partners in the design, development, delivery and evaluation of services, supports, and systems of care.
- The need for individualized programs for special populations has been acknowledged (e.g., children in foster care and in adoptive families, adolescents who display sexual offender behaviors, children who have been sexually abused, children and families who are homeless, children exposed to harmful substances in utero or as infants, and children exposed to violence).
- Services are more frequently organized and financed using managed care principles and practices with greater emphasis on efficiency and accountability for outcomes.
- Professionals (e.g., psychiatrists, psychologists, social workers, nurses, and educators) perform a variety of roles that may differ from those for which they were originally trained. Practitioners may assume roles as advocates, consultants in assessment and treatment planning, administrators, evaluators, and trainers.
- Organizations have expanded their hiring of family members and neighborhood residents in paraprofessional roles, based on their life experiences rather than years of education, or completion of formal pre-service training. Case management and other services and supports may be provided by individuals who do not have formal professional training.

Today, the field of child and adolescent mental health is focused on empowerment-oriented, family-centered, strengths-based interventions within an ecological perspective provided within appropriate community, cultural, ethnic and racial contexts. Professionals are no longer viewed as the singular experts and leaders. Family members are no longer seen as the cause of problems and the mere recipients of services. The current paradigm values families for their expertise and involves them in policy development, decision-making, treatment planning, delivery, and evaluation of services and supports for their children.

The reader will note that many services and supports for children, adolescents and their families are not only categorized as preventive, they are also interventions. Many are partly educational in nature. Also, one needs to bear in mind that, age, cognitive level, environment, and, at times, multiple disorders are important considerations in the selection of appropriate services and supports.

Childhood is marked by developmental transition and change as well as reciprocal influences between children and their environments. Age-related changes, and the complex and dynamic interaction between the child, family and environment that accompany maturation, must be taken into account in the design of services and supports. Because of developmental changes, interventions that work for one developmental stage may not be effective for another. For instance, a practice that may be deemed effective for anxiety during the teenage years may prove ineffective or contraindicated for prepubescent children. Interventions thus need to take into consideration the developmental conditions that affect the permanence of outcomes.

The ways in which children and their families are embedded in sociocultural communities, as well as the transactions between systems that influence their experiences, is viewed within an ecological framework. Mental health services for children and adolescents are provided in a number of different venues. These include clinics, schools, mental health and health programs, the juvenile justice and child welfare systems. Each of these systems has specific rules and standards that regulate the provision of mental health services. Moreover, diagnoses in children and adolescents are more contextually bound. Because context is so critical, a variety of providers need to be involved in the provision of an evidence-based practice in order to assure success in implementation. These include school personnel, child welfare staff, primary health care professionals, and juvenile justice facility staff. Furthermore, parents may have different perceptions from their children regarding particular problems. It is incumbent upon the implementer of an evidence-based practice to recognize and focus on the family as a whole.

Finally, it should be noted that there is a lack of consensus in defining emotional and mental disorders in children. Current literature points to the lack of diagnostic categories that have been empirically validated for young children. Thresholds and boundaries for a number of disorders are still being debated (e.g., bipolar disorder). The significant degree of overlap between disorders makes their nosology (or classification) uncertain. The rapid pace of development characteristic of childhood adds significant complexity to manifestations of symptoms; they are not always consistent with categorical classifications of disorders. Children often experience co-occurring disorders, which adds to the complexity. Due to the high level of co-occurring disorders and lack of diagnostic specificity in standard diagnostics, many experts view symptoms as more relevant than diagnostic labels.

AN OVERVIEW OF EVIDENCE-BASED CONCEPTS

The research base on risks, effective prevention strategies, and interventions for children, adolescents and their families is rapidly developing. However, it lags well behind the base of empirical evidence related to interventions for adults with mental illnesses. Moreover, there is a significant gap between the knowledge base of effective interventions and what is actually practiced in everyday settings. The current challenge of transporting evidence-based practices to everyday clinical practice (i.e., moving science to services) has become a national focus along with adapting interventions for individual families and children, training clinicians, and maintaining fidelity to intervention protocols.

The impetus for implementing evidence-based practices is predicated on the conviction that children who have emotional and behavioral disorders should be able to access care that is based on the best scientific knowledge available and receive services and supports that meet their needs. Unfortunately, all too often children and their families are subjected to practices that are ineffective, outmoded, sometimes deleterious, and based on outcomes that are narrowly defined rather than those considered fundamental to quality of life. In other words, services and supports are frequently based on practices that constitute "what we have always done" rather than on a base of scientific evidence of proven effectiveness. Research indicates that children and adolescents who receive empirically supported interventions improve significantly and at faster rates than those who do not receive such interventions.

Evidence-based practices constitute interventions that have been scientifically researched, studied, successfully replicated by various investigators, and demonstrated to have measurable and sustained beneficial outcomes. They also have theoretical underpinnings that explain why they work, procedures to evaluate outcomes, standards for conducting and evaluating staff training, procedures for maintaining quality and fidelity to the model of treatment delivery, and written manuals that detail protocols for practitioners and clinical research replications.

In general, evidence-based practices in children's mental health refers to knowledge that is scientifically derived regarding the prevalence, incidence or risks for mental disorders, and the impact of treatments or services on these problems. However, while there has been increased focus on empirically supported interventions for children and adolescents, there is a lack of consensus on criteria to delineate evidence-based practices. Moreover, the same practices are rated differently by various consensus panels, organizations, and individual experts in the field. This lack of consensus and, in some cases, discrepant ratings for the same practice, makes determinations regarding which practices to adopt rather challenging. In addition, much of the research-based evidence centers on interventions for specific disorders, but many children and adolescents experience multiple difficulties.

Different levels of evidence, based upon the rigor of the research design (e.g., the number of controlled studies, randomization of participants in studies, number of single-case studies, etc.) have been posited. These range from evidence-based practices based on systematic randomized clinical trials[2], to evidence-informed practices derived from meta-analyses[3] of

[2] A large-scale, randomized, controlled field is considered the gold standard in ascertaining whether an intervention works as well, for whom, and under what conditions.

[3] The most commonly accepted approach to the evaluation of outcomes is a clinical trial in which the post-treatment change in a group of children who receive an intervention is compared with one or more control groups who did not receive the intervention. These clinical trials are often combined in a meta-analysis to determine the effect size (i.e.,

existing research studies, to evidence-suggested practices put forth by expert opinion and consensus groups. A number of national organizations and provider systems have created their own criteria and lists of evidence-based practices. All of these efforts represent attempts to identify services and supports that produce positive outcomes for children and their families and obtain maximum leverage in an era of shrinking resources.

Common to all proposed criteria for determining evidence is a focus on data-based empirical support (i.e., scientific validation) to ensure that scientific investigations include adequate research methodologies, sufficient power to detect meaningful differences, and statistically significant findings. Quality research entails a strong research design, based on sufficient quantitative data to verify effectiveness, as well as the use of an experimental design that entails random assignment, or a quasi-experimental design with matched control groups. Large enough sample sizes to afford statistical power to distinguish at least moderate effects, consistent administration and measures, as well as low attrition to ensure integrity of the randomization or matching process in order generalize findings are important components of a good design. It is also important to ascertain whether the effects of an intervention endure beyond treatment.

In 1995 the American Psychological Association's Task Force on the Promotion and Dissemination of Psychological Procedures issued a set of standards for the development, testing and dissemination of psychotherapy practices that are empirically grounded. Criteria for practices deemed well-established and those deemed probably efficacious were set forth and are as follows:

Well-Established Treatments
I. At least two good group design studies, conducted by different investigators, demonstrating efficacy in one or more of the following ways: **A. Superior to pill or placebo or to another treatment.** **B. Equivalent to an already established treatment in studies with adequate statistical power.** **OR** **II. A large series of single case design studies demonstrating efficacy. Theses studies must have:** **A. Used good experimental design and** **B. Compared the intervention to another treatment as in I. A.** **Further Criteria for Both I and II:** **III. Studies must be conducted with treatment manuals.** **IV. Characteristics of the consumer samples must be clearly specified.**

the indicator of the magnitude and trend of the effects of an intervention). The effect size is typically calculated as the difference between the post-treatment mean on an outcome measure for the intervention group compared to the corresponding control group mean. The difference is then divided by the standard deviation of the measure. A meta-analysis can compute a single mean effect size for each study and/or treatment group by averaging across the outcomes measures used. This leads to a calculation of an overall mean effect size for the entire group of studies reviewed, as well as a comparison of mean effect sizes across studies that differ in significant ways such as type of intervention used, target population (such as age and gender), target problem. Meta-analyses can also be used to indicate estimates of the impact that various consumer, clinician and intervention factors have on outcomes.

Probably Efficacious Treatments
I. Two studies showing the treatment is more effective than a waiting-list control group.
OR
II. Two studies otherwise meeting the well-established treatment criteria I, III, and IV, but both are conducted by the same investigator.
OR
One good study demonstrating effectiveness by these same well-established treatment criteria.
OR
III. At least two good studies demonstrating effectiveness but flawed by heterogeneity of the consumer samples.
OR
IV. A small series of single case design studies otherwise meeting the well-established treatment criteria II, III, and IV.

The Interdisciplinary Committee on Evidence-Based Youth Mental Health Care (with input from the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the American Psychological Association), consistent with the above-noted APA standards, suggested that a treatment can be deemed evidence-based if it has generated a body of research permitting meta-analyses to support its efficacy. In addition, the committee's criteria includes a minimum of two studies using a between-group design of at least thirty participants of the same age, who receive the same treatment, or a minimum of two studies using a within-group design or single-case design, or a combination of these designs. A majority of the studies must demonstrate support for the treatment. Adherence to a treatment manual must also be part of the protocol.

A further expansion to five levels of evidence has been proposed by Child and Adolescent Mental Health Division of the Hawaii Department of Health Task Force for Empirical Basis to Services (2004) to address efficacy:

Level 1: Best Support

I. At least two good between group design experiments demonstrating efficacy in one or more of the following ways:
   a. Superior to pill placebo, psychological placebo, or another treatment.
   b. Equivalent to an already established treatment in experiments with adequate statistical power (about 30 per group; cf. Kazdin and Bass, 1989).

OR

II. A large series of single case design experiments (n > 9) demonstrating efficacy. These experiments must have:
   a. Used good experimental designs
   b. Compared the intervention to another treatment as in I.a.

AND

Further criteria for both I and II:

III. Experiments must be conducted with treatment manuals.

IV. Characteristics of the client samples must be clearly specified.

V. Effects must have been demonstrated by at least two different investigators or teams of investigators.

Level 2: Good Support

I. Two experiments showing the treatment is (statistically significantly) superior to a waiting-list control group. *Manuals, specification of sample, and independent investigators are not required*.

OR

II. One between group design experiment with clear specification of group, use of manuals, and demonstrating efficacy by either:
   a. Superior to pill placebo, psychological placebo, or another treatment.
   b. Equivalent to an already established treatment in experiments with adequate statistical power (about 30 per group; cf. Kazdin and Bass, 1989).

OR

III. A small series of single case design experiments (n > 3) with clear specification of group, use of manuals, good experimental designs, and compared the intervention to pill or psychological placebo or to another treatment.

Level 3: Moderate Support

I. One between group design experiment with clear specification of group and treatment approach and demonstrating efficacy by either:
   a. Superior to pill placebo, psychological placebo, or another treatment.
   b. Equivalent to an already established treatment in experiments with adequate statistical power (about 30 per group; cf. Kazdin and Bass, 1989).

OR

II. A small series of single case design experiments (n > 3) with clear specification of group and treatment approach, good experimental designs, at least 2 different investigators or teams, and comparison of the intervention to pill, psychological placebo, or another treatment.

Level 4: Minimal Support

I. Treatment does not meet criteria for Level 1, 2, 3, or 5.

Level 5: Known Risks

I. At least one study or review demonstrating harmful effects of a treatment that would otherwise meet criteria for Level 4.

The Institute of Medicine recommends that interventions be developed in accordance with the following principles of experimental design:

- Investigate risk and resilience factors
- Use well-specified and theoretically driven hypotheses
- Reliable, clearly identified variables
- Randomization to manual-based specific replicable interventions
- Blind assessment of outcomes
- Follow-up for several years

The Substance Abuse Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP) has developed a comprehensive system to connect science-based mental health and substance abuse prevention and intervention programs with practice. The primary venue for this effort is the National Dissemination System (NDS) and the National Registry of Effective Programs (NREP) located on the web at www.modelprograms.samhsa.gov

The NREP uses an expert review process to identify three types of science-based programs:[4]

- **Promising programs** are those that have generally been well-implemented and evaluated, but results are not consistently positive across domains of measurement and/or replications.
- **Effective programs** are those that are well-implemented, well-evaluated and have demonstrated consistently positive outcomes across domains of measurement and/or replications.
- **Model programs** share the characteristics of effective programs but also include the stipulation that program developers work with CSAP to disseminate the program (i.e., supply materials, training, and technical assistance) to ensure replications/adaptations adhere to the model of change used in the program and are implemented with strong fidelity.

Evidence-based practices are not available for all needs and problems. Moreover, even when evidence-based practices are available, they do not always produce beneficial outcomes for all children and families. This has fostered the promulgation of emerging and promising practices as well as those that are culturally-driven or are adaptations of evidence-based practices that incorporate culture. In situations where services and supports do not meet the gold standard for

[4] A number of these programs that are of particular relevance to mental health service provision as well as some that are noteworthy are discussed in this report. However, space limitations preclude a review of all of them.

evidence-based practice (i.e., randomized, controlled studies in everyday practice settings), promising and emerging practices should be considered as alternatives.

The following criteria can be used to ascertain whether an intervention is promising:

- The intervention has a basis in established theory
- The model of treatment is well articulated
- The practice has the capacity to address multidimensional problems
- The intervention is based on quality evaluative research
- The practice has the potential to be replicated and/or implemented in everyday practice settings

It has been suggested that the above-noted criteria for determining levels of evidence do not address contextual issues that are unique to children including rapid developmental changes, familial relationships, and varied treatment settings, and are therefore not entirely relevant to children's mental health. Different treatment settings (e.g., school, home, office) can affect service delivery and thus, what constitutes an evidence-based practice in one setting, may not be such in another due to lack of transferability. In addition, controlled studies do not usually include so-called "nuisance factors" such as co-occurring conditions, parental mental illness and/or co-occurring substance use disorders, family stressors, and other variables. Thus, it cannot be assumed that interventions that have been demonstrated to be efficacious will be effective in routine community-based settings without modification to accommodate more heterogeneity in populations, higher case loads, staff training, and other factors previously noted. The largest portion of the base of evidence in children's mental health care is comprised of efficacy studies.

Two other concepts germane to evidence-based practices are manualization and fidelity. Treatment manuals are used to provide guidelines and instructions for conducting specific treatments. Manuals specify and standardize interventions. In other words, treatment manuals provide descriptions of interventions allowing for a determination of whether treatments are conducted as intended (i.e., have integrity; maintain fidelity to the model). The use of a manual also allows practitioners and researchers to know what a treatment consists of and, hence, what has been supported in efficacy trials. Because there are many interventions, and many variations of interventions, categorized as one type of psychotherapy (e.g., cognitive-behavioral therapy), manualization is especially important to clarify the types or variations of an intervention.

Fidelity is the degree to which a specific implementation of a program or practice resembles, adheres to, or is faithful to the evidence-based model on which it is based. Fidelity is formally assessed using rating scales of the major elements of an evidence-based model. A toolkit on how to develop and use fidelity instruments is available from the SAMHSA-funded Evaluation Technical Assistance Center at http://tecathsri.org/.

In sum, the evaluation of practices in the children's mental health arena must be done with the understanding that there is a lack of consensus around the very meaning of evidence-based practices, origins and factors associated with mental health disorders in children, and appropriate modalities of intervention. Moreover, due to the emergent nature of the field, many experts contend that it is virtually impossible to unequivocally state that a specific intervention has been determined to be a best practice[5] for very young children due the limited evaluative research relating to this population.

[5] Best practices are those that incorporate the best objective information currently available from recognized experts regarding effectiveness and acceptability. Best practices include, but are not limited to, evidence-based and promising approaches.

ENABLING LEGISLATION AND POLICY MANDATES

The following pieces of legislation are examples of those that impact the delivery of mental health services and supports for children, adolescents and their families.

EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (ESPDT)

Public Law 90-248, enacted in 1967, established Early Periodic Screening, Diagnosis, and Treatment (EPSDT) programs as part of Medicaid (Title XIX of the Social Security Act). It was designed to provide early identification and treatment for children from low-income families in order to prevent medical and developmental problems. Young children who are found to require physical or mental health intervention by a medical provider must receive treatment under this law. It also mandates that outreach and information are provided to eligible families regarding their children's entitlement to medical screenings to determine health conditions that need intervention. However, studies indicate that many children who are eligible for Medicaid do not receive mental health screenings or interventions to which they are entitled.

In 1997, the Children's Health Insurance Program (CHIP) was created in an effort to expand health insurance coverage to uninsured children. It mandates Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for all children covered under Medicaid and allocates funds for mental health services through community mental health centers. States that offer CHIPs through non-Medicaid coverage that include mental health services must comply with the Mental Health Parity Act (MHPA) of 1996.

It should be noted that many children with needs are not eligible for Medicaid because their parents' income is too high. Two federal programs under Medicaid allow otherwise ineligible children to access in-home and community-based services: the home and community-based waiver (see below), and the Katie Beckett option. Under federal law, states have the option to cover children with physical and mental disabilities in the community if they would be eligible for Medicaid institutional services but can be cared for at home. This option was authorized by the Tax Equity and Financial Responsibility Act of 1982 (TEFRA); it is sometimes called the Katie Beckett[6] option (named after the child whose situation inspired it). Neither program is mandatory, however; states may opt for them or seek a federal waiver.

HOME AND COMMUNITY BASED SERVICES WAIVER (HCBSW)

The Social Security Act authorizes multiple waivers and demonstrations to allow states flexibility in operating Medicaid programs. Section 1915(c) permits Home and Community-Based Services Waivers which set aside Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings. HCBSW provides a mechanism for providing services and supports to families with children who have been diagnosed with severe mental illnesses and are at risk for out-of-home placements.

The HCBS Waiver is designed to:

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[6] This waiver is part of Medicaid and reduces the financial eligibility criteria in order to allow Medicaid to fund medical services for children who have chronic disabilities and help families provide care for their children at home.

- Enable children to remain at home, or in the community, and reduce the need for institutional placement
- Utilize individualized service planning, delivery and evaluation
- Expand funding and service options available to children and adolescents diagnosed with serious emotional disturbances and their families
- Provide services that promote better outcomes and are cost-effective

Core Services of the HCBS Waiver:

- Individualized care coordination
- Intensive in-home services
- Respite care
- Family support services
- Crisis response services
- Skill building services

CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA)

The Child Abuse and Prevention and Treatment Act (CAPTA), P.L. 93-247, enacted in 1974, provided federal funding to states to prevent, identify, and treat child abuse and neglect. It created the National Center on Child Abuse and Neglect, developed standards for receiving and responding to reports of child maltreatment, and established a clearinghouse for the prevention and treatment of abuse and neglect. This act has been amended several times and was most recently amended and reauthorized as the Keeping Children and Families Safe Act of 2003 (P.L. 108-36).

CAPTA mandates minimum definitions for child abuse, defined as “any recent act, or failure to act, that results in imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse, or exploitation of a child by a parent or caretaker who is responsible for the child's welfare”. Suspected child abuse reporting is mandatory and penalties are imposed for failure to report. Relevant information regarding this legislation can be found on the web at http://www.acf.hhs.gov/acf_services.html#caan.

Each state has enacted a mandatory child abuse and neglect reporting law in order to qualify for funding under CAPTA. The Michigan Child Protection Law, P.A. 238, enacted in 1975, requires the reporting of child abuse and neglect by physicians, dentists, physician's assistants, registered dental hygienists, medical examiners, nurses, persons licensed to provide emergency medical care, audiologists, psychologists, marriage and family therapists, licensed professional counselors, social workers, school administrators, school counselors, teachers, law enforcement officers, members of the clergy, regulated child care providers and specific Department of Human Services staff. It also includes the legal requirements for reporting, investigating and responding to child abuse and neglect cases and permits reporting of child abuse and neglect by all persons. Information can be found at http://www.michigan.gov/dhs.

FAMILY PRESERVATION AND SUPPORT INITIATIVE

The Family Preservation and Support Initiative, P.L. 103-66, of 1993 earmarked federal funds for family support services and increased funding for family preservation services. The intent of this law is to assist communities in the construction of systems of family support services to help vulnerable children and families prevent child maltreatment. Family preservation services are designed to help families who are experiencing crises that might lead to the placement of their children in foster care. States use the funds to integrate preventive services into treatment-oriented child welfare programs, and improve service coordination within and across state

agencies as well as at the local level. The initiative, which is now called Promoting Safe and Stable Families, stipulates that planning processes include a broad range of stakeholders (e.g., parents, consumers of services, community-based service providers, professional and advocacy organizations, as well as child welfare agency personnel) in order to enhance child welfare systems' responsiveness to families and communities. Funds are used to safely maintain children in their own homes, prevent unnecessary separation of families, return children in care to their families sooner, and find permanent alternatives for children who cannot return home safely.

Michigan uses funding from the act for Strong Families/Safe Children (SF/SC) which focuses primarily on reducing of out-of-home placements by promoting child safety, permanency, and improved family functioning to strengthen families through four service categories:

- Family preservation
- Family support
- Time-limited family reunification
- Adoption promotion and support services

ADOPTION AND SAFE FAMILIES ACT (ASFA)

The Adoption and Safe Families Act (ASFA), P.L. 105-89, signed into law in 1997, was designed to promote safety and permanency for children in out-of-home placements due to abuse and/or neglect. It established expedited time fames for establishing permanent homes for children who have been placed into foster care settings. ASFA mandates that permanency hearings be held no later than twelve months after a child enters foster care (starting from the date of adjudication, or sixty days from the child's removal from their home, whichever is earlier). State child welfare agencies must review existing caseloads to ensure that termination of parental rights (TPR) proceedings are initiated for children who have been the responsibility of the state for fifteen out of the most recent twenty-two months.

In addition to preventing child abuse and neglect, and assisting families in crisis, ASFA provides supports for time-limited reunification services which may include:

- Individual, group, and family counseling
- Substance abuse treatment services
- Mental health services
- Assistance to address domestic violence
- Temporary child care and crisis nurseries

This law has some implications for mental health service delivery. To begin with, the challenges posed by the recovery from a chronic mental illness and/or substance use disorder may make it more difficult for parents to regain custody of their children prior to the end of the fifteen month time frame. The short time lines mandated by ASFA may not be adequate for the successful completion of a substance abuse treatment program. The potential for negative consequences for parents whose children are removed due to substance use by the parents is exacerbated by the lack of access to residential treatment that includes children.

The mandated termination of parental rights is also very significant for individuals of color. Research shows that children of color, especially children who are African American, are placed into foster care at significantly higher rates than children who are Caucasian. They also remain in foster care longer are adopted at lower rates (despite the higher level of African American family adoption rates).

JOHN H. CHAFFEE FOSTER CARE INDEPENDENCE PROGRAM (CFCIP)

The John H. Chafee Foster Care Independence Program (CFCIP), Title I of the Foster Care Independence Act of 1999 (P.L. 106-169), provides funds to states to assist adolescents, and young adults up to age twenty-one, in foster care make a successful transition to adulthood. This program replaces and expands Section 477 of the Social Security Act and allows states to use funds for a more comprehensive array of supports for youth who are aging out of the foster care system, including room and board, educational, vocational, and mental health services for adolescents in foster care, as well as young adults who have recently exited foster care. This act is of significance due to the lack of mental health funding dedicated to transition age youth and the vulnerability of youth aging out of foster to adverse outcomes as will be discussed subsequently.

PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT (PRWORA)

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 mandates parents of young children enter the work force following the expiration of time limits for receiving public assistance funds. The Temporary Assistance to Needy Families (TANF) program which supplanted the Aid to Families with Dependent Children (AFDC) program has restrictive time limits for receiving assistance. Concerns regarding the implications of this shift from child development to parental employment relate to its impact on childrearing and access to quality childcare services and supports. Current federal childcare subsidies have been found to be inadequate to cover the cost of high quality childcare centers that offer comprehensive services. Moreover, TANF work requirements do not consider the impact of mental illness on the ability to obtain employment. It places mothers who have a mental illness and receive public welfare support at a disadvantage since these mothers may require long term employment supports and child care to become gainfully employed. (More recent legislation such as the Ticket to Work and Work Incentives Improvement Act provide support to individuals who have a disability to become self-sufficient and work.)

INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)

Public Law 94-142, the Education for All Handicapped Children Act (EAHCA) enacted in 1975, mandated the provision of special education and related services to meet the needs of children with physical or mental disabilities. The Education of the Handicapped Act was amended several times and in 1990 was renamed the Individuals with Disabilities Education Act (IDEA). The act acknowledged the need for all children with a disability to have educational opportunities and gave parents the right to be involved in their child's Individualized Education Plan (IEP).

This law also increased access and funds for early childhood services for young children who have disabilities and their families. Part H of IDEA, the Infants and Toddlers with Disabilities Program, mandates that family-centered Early Intervention (EI) services are provided to toddlers (birth to age three) who have a disability, or who are at risk for developing a disability, and their families. Part H of the Individual with Disabilities Education Act (now Part C under the 1997 reauthorization) also mandates the development of an Individualized Family Service Plan (IFSP) by a multidisciplinary team and the child's parents. This represents a significant shift in emphasis to family-centered services and early intervention. (The following section, Early On, offers more details regarding this portion of the law.)

Children who display emotional and behavioral problems may be eligible for special education and related services under the Individuals with Disabilities Education Act (IDEA) if they are classified as having an emotional disturbance, or are under nine years of age and display a

delay in social or emotional development. Eligibility is not automatic; a determination of eligibility must be made by a multidisciplinary team. Studies indicate that only about one percent of the estimated nineteen percent of students who display symptoms of serious emotional disturbance are identified and referred for such support. According to national data, those students typically referred tend to be male, over age thirteen, from families with very low incomes, and African American.

IDEA does not limit services and supports to those provided by or through a school system. Parents can seek reimbursement for services obtained privately if a school does not offer adequate options as part of a student's IEP. IDEA can also be used to fund residential services if a child's IEP is not realistically designed to enable the child to receive educational benefits, and the proposed residential placement is demonstrated to be appropriate. Documentation of a child's serious school failure in a day program prior to residential placement and subsequent progress while in a residential setting has been used to litigate successfully for residential funding from schools. However, a finding of delinquency increases the possibility of denial of reimbursement for residential treatment under IDEA.

IDEA regulations stipulate that school districts provide extended school year (ESY) services when they are determined to be necessary for a student enrolled in special education. ESY has a stricter standard for qualification than does special education during the academic year, which means that services such as in-home behavior management, family therapy and recreation outside of school during summer, are often denied even when such services are provided during the school year. IDEA and its 1997 amendments (P.L. 105-17) also mandates youth who are enrolled in special education programs have transition plans starting at age fourteen.

It should be noted that children with emotional disturbances face significant barriers to accessing services under IDEA. Schools are under tremendous pressure to conserve resources and control expenses. This may cause schools to limit the provision of services to children with serious emotional disturbances for fear of being overwhelmed by demand. Public educators also may not view public education systems as having a role in the mental health arena. In addition, parents, teachers and students can be hesitant to accept a stigmatizing label such as emotional disturbance. In fact, national data indicate that approximately sixteen percent of children who receive special education services do so under a different label (e.g., learning disability).

EARLY ON

Early On targets infants and toddlers from birth through age thirty six months of age who require early intervention services due to developmental delays and/or diagnosed physical or mental conditions that have a high probability of resulting in developmental delays. Children from birth through thirty-six months of age who are at risk of developmental delay may also be eligible at a state's discretion. An evaluation is initiated if a child is suspected to have a developmental delay or a condition that could lead to such a delay. If the child is found eligible for Early On services, an Individualized Family Service Plan (IFSP) is developed to address the developmental needs of the child as well as the needs of the family in helping the child. An Early On Service Coordinator assists parents with the coordination of services outlined in the child's service and support plan.

Early On services are provided within the home and community. Services include assistive technology devices, audiology, family training, counseling, home visits, health care, nursing, nutrition, occupational therapy, physical therapy, psychological services, service coordination, social work services, special instruction, speech and language therapy, transportation and related costs, and vision services.

In Michigan, Early On is coordinated by the Michigan Department of Education in accordance with Part C of IDEA. Local communities receive funding through their local Intermediate School Districts (ISDs) to implement Early On. Each local ISD has an interagency coordinating council (comprised of individuals from human service agencies, parents, educators, and others) which develops memoranda of understanding between education, mental health, public health, and human services to guide implementation. Early On Coordinators are located in each county to help parents determine whether they want to utilize the Early On system. Information on Early On Michigan can be found on the web at: http://www.cenmi.org/pair/.

HEAD START

Public Law 88-452, enacted in 1964, established Head Start as part of the so-called "war on poverty." It represented the first national effort to provide early childhood education, health screening and referral, mental health services, nutrition and hot meals, social services, and education for children from families with low incomes and who are disadvantaged.

Head Start is a center-based preschool program that serves children from the ages of three to five. Children usually attend Head Start programs for half-day sessions for one school year, although some may attend for two years. Parental involvement in planning, administration and daily routines at local centers is a significant component of Head Start. The program has established standards in six areas which are adapted to local communities in accordance with need and resources:

- Early childhood education
- Health screening and referral
- Mental health services[7]
- Nutrition education and hot meals
- Social services for the child and family
- Parental involvement

In 1997 Head Start began FACES, a study of a random sample of national Head Start programs to document the characteristics, experiences, and outcomes for children and families served by Head Start. Findings indicate that the majority of children who enter Head Start have less developed early literacy skills than those of most of their cohorts. Children who participate in Head Start programs have been found to display significant gains in vocabulary and early writing. Younger children who spend a second year in Head Start demonstrate further increases in literacy levels, but show less or no gain with respect to national norms. Those who complete Head Start with more developed vocabulary and writing skills score higher on assessments of these skills at the end of kindergarten.[8] Other findings indicate that participation in Head Start also leads to improved social skills.

Early Head Start is a product of Head Start that was established in 1994. It is specifically targeted to families with infants, toddlers and pregnant women with low incomes. The program is designed to promote healthy prenatal outcomes, foster the development of very young children, and promote healthy family functioning. The program provides parent education, comprehensive health and mental health services, and home visits.

[7] Head Start has an explicit mandate to meet the mental health needs of the children it serves.

[8] The amount of benefit children derive from preschool has been shown to be directly proportional to the quantity and quality of language-related activities in the program. Children who receive less language stimulation at home gain more from literacy-related activities in preschool.

EVEN START

The Even Start Family Literacy Program, authorized by Title I, Part B, Subpart 3 of the Elementary and Secondary Education Act of 1965 (ESEA), was first authorized in 1988. The program became state-administered in 1992 and was reauthorized by the Literacy Involves Families Together (LIFT) Act of 2000 and the No Child Left Behind Act of 2001.

Even Start is an education program for families with low incomes that is designed to improve the academic achievement of young children and their parents, especially in the area of reading. It combines the four essential components of family literacy:

- Early childhood education
- Adult literacy (basic and secondary-level education and/or instruction for adults learning English)
- Parenting education
- Interactive literacy activities for parents and their children

The program supports family literacy services for parents who have low literacy skills or limited English proficiency, and their children from birth through age seven. It is designed to help parents improve their literacy or basic educational skills and become full partners in educating their children to maximize their children's opportunities for learning.

THE CULTURAL CONTEXT

There has been increasing awareness of the impact of cultural factors on mental illness in recent years. Individuals from different cultures may manifest symptoms in different ways, and may differ in coping styles, family and community supports, and willingness to seek and continue with treatment. In addition, practitioners may also be influenced by their own cultural values which may, in turn, impact diagnosis, treatment interventions, and service delivery decision-making. Current research indicates that treatment outcomes depend on practitioners' abilities to understand consumers' identities, social supports, self-esteem, and perception of stigma.

Although the prevalence of mental health problems appears to be of equal incidence across racial and ethnic groups, there are significant racial and ethnic disparities in access to care and health status between children from minority cultures and those from the majority population. Because of these factors, children and families from minority cultures bear a disproportionate burden from mental health problems. Lack of access to services, poorer treatment and outcomes pose significant difficulties for those from minority groups.

Children of color have been shown to be underserved by the mental health system. African American and Hispanic children are significantly less likely to receive specialty mental health care despite the fact that they are referred as often as other children. African American adolescents with mental health problems tend to be diagnosed with more severe disorders. Psychiatric hospitalization rates for African American adolescents are two to three times the rates for white youth. African American children and adolescents are also over represented among students in school who are classified as having more serious emotional disturbances. African American adolescents (particularly males) are more likely to be referred to the juvenile justice system rather than to the treatment system. Children of color are also disproportionately represented in the child welfare system. They constitute sixty-five percent of children in substitute care, which is almost twice their representation in the population nationally.

Children from minority groups who experience poverty and co-occurring disorders (i.e., substance use disorders and mental illness) are disproportionately represented in the juvenile justice system. Evidence suggests that children who are members of minority groups and families of lower socioeconomic status are placed into the juvenile justice system, while children who are white and from middle-class families are diverted into mental health care. This disproportionate representation increases at each stage in the system, from arrest through secure confinement.

Native American children experience more serious mental health problems than all other ethnic groups. They are considered to be the highest at-risk and most underserved population in this country. Native American communities have been afflicted with high rates of poverty, unemployment, domestic violence, alcoholism, child neglect, accidental death, and suicide. Despite these stressors and risk factors, Native peoples have historically received little to no mental health services. Limited access has been compounded by their fear and mistrust of non-Native service providers and western models of service delivery. However, despite centuries of genocide, oppression and impoverishment, Native Americans, the original inhabitants of North America, display resilience and creativity, and their traditional cultural methods of maintaining mental health have endured despite efforts to suppress them and acculturate them.

In addition to lack of access to child and adolescent mental health services, premature termination of treatment is a significant problem for the service delivery system. About forty to

sixty percent of families who begin treatment terminate it prematurely, and a majority of children who enter outpatient treatment attend for only one or two sessions. Children who are particularly vulnerable include those of single mothers, living in poverty, and from minority groups. Children who have serious problems are the most likely to drop out of treatment early, and least likely to remain in treatment beyond the first session. (Effective ways to reduce dropout from treatment and increase participation and retention include offering services in schools and primary health care settings, and using case management to engage families, which will be discussed subsequently.)

There is a paucity of information regarding the effects of ethnicity on outcomes for specific interventions. Interventions may not take into account child-rearing practices, expectations for parent and child behavior, language, customs, values and stressors and resources associated with various cultures. Additionally, the clinical setting is replete with cultural factors that can lead to misunderstandings between clinicians and families and premature termination from treatment. While the literature indicates a number of recommendations regarding interventions for specific ethnic groups,[9] there is a lack of empirical evidence to support many of them. Most rely on anecdotal or experiential reports. Moreover, there is a lack of science-based evidence for traditional interventions provided by faith-based healers and traditional therapies (e.g., folk/medicinal remedies, talking circles, curanderismo) despite reports from recipients of their effectiveness.

Research indicates that culture influences the manifestation of symptomatology in children. For instance, children of European decent who have depression evince more cognitive and affective complaints, whereas children from Native American cultures expressive somatic and interpersonal complaints. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) contains an Outline for Cultural Formulation in Appendix I that represents an attempt to apply standardized mental health diagnoses to other cultures. It includes diagnoses that are unique to specific cultures and suggestions for culturally sensitive diagnoses. But, it does not adequately address the cultural identity of caregivers, child-rearing practices, or changing manifestations of cultural adaptation.

Parents from minority groups are more likely to seek input regarding their children from family and community contacts. For example, in Hispanic/Latino families, important decisions related to health and mental health are often made by the entire family network rather than by individual members. Thus, family and group interventions that also include extended family members may be more culturally congruent for youth from certain minority cultures.

Cultural variation in child-rearing practices is receiving increased attention in the literature. For example, parents from various cultural backgrounds have been found to differ in the degree to which they identify child and adolescent behavioral and emotional problems. Differences have also been found across cultural groups in their beliefs about whether children's and adolescent's problems are likely to improve in the absence of professional support. Developmental tasks are experienced and perceived in specific ways in different ethnic groups. Patterns of parental noninterference, protectiveness, and vigilance are provided in varying ways depending upon the culture of the family.

Studies show that services and supports that are linked to community culture result in less premature termination of treatment than those provided in traditional programs. In other words,

[9] The Office of Juvenile Justice and Delinquency Prevention (OJJDP) which endorses Functional Family Therapy (FFT), and the Substance Abuse and Mental Health Service Administration's Center for Substance Abuse Prevention's (CSAP) National Registry of Effective Programs (NREP) include information related to efficacy by race and ethnicity.

service utilization is promoted when specialized cultural programming is provided. In addition, flexible adaptations including offering assistance at multiple locations, multiple hours of access (including evenings and weekends), and the availability of providers who are representative of diverse populations have been shown to reduce access barriers and reduce premature termination. The display of culturally relevant pictures and literature can also help demonstrate respect and can increase consumers' comfort with services.

In sum, cultural competence is based on awareness of and respect for values, beliefs, traditions, customs, language, and parenting styles. Programs that are culturally competent include multilingual, multicultural staff and provide community outreach activities. The most effective practices use parental cultural beliefs as a framework for service delivery. Effective services take into consideration the cultural norms and expectations that are specific to individual families and connected to a specific ethnocultural group. They recognize the ways in which culture is operating for the child an in the family. Two examples of culturally adapted programs are described below.

EFFECTIVE BLACK PARENTING PROGRAM (EBPP)

The Center for the Improvement of Child Caring's (CICC) Effective Black Parenting Program (EBPP) is a culturally adapted cognitive-behavioral program that was developed in the late 1970's to meet the specific needs of African American parents. It is designed to foster effective family communication, healthy African American identity, child growth and development, and healthy self-esteem. In addition, it promotes efforts to reduce child abuse, substance abuse, juvenile delinquency, gang violence, and emotional and behavior problems.

The program teaches parenting techniques and provides information that is applicable to African American families in all socioeconomic status levels. It is targeted to parents of children aged two to twelve, but has also been used successfully with teenage parents and their babies, as well as parents of adolescent children.

The program is taught in two formats. One is comprised of fifteen three-hour training classes that emphasize role playing and home behavior change projects. The other is a one- day seminar for large groups of (fifty to five hundred) parents that uses an abbreviated version of the parenting strategies and skills taught in the classes. Both versions involve African American educators and mental health professionals who educate parents about basic child management skills using African proverbs, African American linguistic forms, and emphasize African American achievement and competence. An interactive group process is employed that addresses the following topics:

Culturally-Specific Parenting Strategies
- Achievement Orientation to Parenting: The Pyramid of Success for Black Children
- Traditional Black Discipline vs. Modern Black Self-Discipline
- Pride in Blackness: Positive Communications about Heritage, Coping with Racism, Avoiding Black Self-Disparagement
- Finding Special Times for All of Our Children: Chit Chat Time

General Parenting Strategies
- Social Learning Ideas and Pinpointing and Counting Behavior
- The Thinking Parent's Approach
- Family Rules Are Like A Coin, and Family Rule Guidelines
- Children's Developing Abilities
- Children's Thinking Stages and the Development Swing between Belonging and Independence

Basic Parenting Skills Taught in a Culturally-Sensitive Manner, Using African American Language Expressions and African Proverbs

- Effective Praise
- Mild Social Disapproval
- Ignoring
- Time Out
- Special Incentives

Special Program Topics

- Single Parenting
- Preventing Drug Abuse

Classes are conducted using a manual that contains fully-scripted guidelines for each session and each of the program's parenting skills, techniques, and topics. The instructor demonstrates each skill and then has the parents practice it in class before using it at home with their children. Participants receive a Parent's Handbook that highlights each session and the activities to be practiced at home to apply skills learned. Each week parents describe their use of skills at home and receive feedback from the instructor and other participants.

Parents are encouraged to bring in members of their extended families to garner their support for the skills being learned. Toward the end of the program, the trainer encourages parents to continue to meet for mutual support and skill enhancement booster sessions as a Harrambee (Friendship) Club.

Outcomes studies have documented significant decreases in parental rejection, negative family communication, as well as increases in the quality of family relationships, reductions in child behavior problems, increases in parental involvement with children, use of limit-setting, and general psychological well-being of parents. Follow-up studies indicate that reductions in parental rejection and children's behavior problems are maintained well beyond completion of the program.

The program kit costs $413.00. All parents who enroll in the program purchase a $19.00 handbook. The one-day seminar version of the program requires the kit materials, a $33.00 seminar leader's guide, and an $11.00 parent guide. The five-day intensive instructor training workshop costs $925.00 per person including an Instructor's Kit. Information can be obtained on the web at http://www.ciccparenting.org/ciccebpp1112.asp.

FAMILY EFFECTIVENESS TRAINING (FET)

Family Effectiveness Training (FET) is a family-based program developed and used (exclusively) by Hispanics/Latinos for children aged six to twelve who are in the process of transitioning to adolescence, and whose families have difficulties with family functioning, parent-child conflicts, or cultural conflicts between children and parents. It includes both didactic lessons and participatory activities designed to assist parents in mastering effective family management skills, and planned family discussions in which the therapist/facilitator intervenes to correct ineffective/maladaptive interactions between or among family members.

The program consists of thirteen weekly one and a half to two-hour family sessions that are typically offered afternoons, evenings, and Saturdays in order to accommodate participation by the entire family. It can be conducted in a variety of settings including family agencies, schools, houses of worship, mental health offices, etc. FET is designed to help parents understand their children's cultural assimilation and seeks to improve parenting competence (i.e., understanding, knowledge, skills). Interventions include:

- Using bicultural skills to promote bicultural effectiveness
- Brief Strategic Family Therapy (BSFT), a short-term, problem-focused, direction-oriented, approach (described in the Family Therapy section)
- Educating parents regarding normal adolescent development

- Promoting effective parenting skills
- Promoting family communication, conflict resolution, and problem-solving skills
- Providing information on substance abuse to parents

FET is a SAMHSA model program that has shown to be effective in reducing conduct problems, associations with peers who engage in antisocial behaviors, and in improving family cohesion, cultural understanding, and self-concept.

Training is provided by the Center For Family Studies located on the web at http://www.cfs.med.miami.edu/. Instructor training is provided for three levels of competence. The beginner's level is a three-day workshop that costs $6,000.00 plus travel. The intensive intermediate three-day workshop costs $18,000.00 plus travel. The Certification level follows the intermediate level of training and is comprised of a two-day workshop, thirteen weeks of distance supervision with video recording reviews of FET sessions, and group telephone supervision. The cost is $17,000.00 plus travel. In order for instructors to become certified in FET, they must possess knowledge of BSFT.

WORKING WITH FAMILIES

"Mental healthcare is dispersed across multiple systems: schools, primary care, the juvenile justice system, child welfare and substance abuse treatment. But the first system is the family…" (Satcher 2000)

A family is defined by its members -- i.e., each family defines itself. Families can include biological or adoptive parents and their partners, siblings, extended family members, and friends who provide support to children and/or their primary caregivers. In this document a family member is defined as any primary caregiver or adult who has a significant and ongoing involvement in the life of a child who has an emotional, behavioral or mental disorder. This can include siblings, parents, grandparents, fictive kin, and clan members.

Families are central to children's well-being. Yet, in the not too distant past families were frequently blamed and stigmatized for their children's difficulties, not credited with having expertise regarding their children, or included in service planning and decision-making. Families have historically been viewed by professionals as troubled, or perhaps even more so than their children, and frequently identified as the source of their children's problems. Often therapeutic change was directed at parents, particularly mothers. The family's role in the provision of services and supports was relegated to one of informant, and providers often sought additional informants in order to confirm information. While much of this stigmatization and blame has dissipated, professional views of parental inadequacy still persist.

Knitzer's landmark 1982 publication previously mentioned was instrumental in calling attention to the need to include families in all facets of service and support planning and delivery. Families now serve in a number of roles and are viewed as crucial to the achievement of beneficial treatment outcomes for children and adolescents. Family-centered service delivery enhances awareness of cultural influences and promotes a community-based system of care. Research demonstrates that the more families participate in planning services, the more likely family members feel their children's needs are met. Studies show that family participation improves the process of service delivery and outcomes.

Parents should be assumed to know what is best for themselves and their children. Moreover, they have years of experience raising children who have serious emotional disturbances. Parents: (1) are the most important resource for their children; (2) are not to blame for the uniqueness of their children; (3) have the best knowledge of their children's problems and resources needed to help; and (4) will advocate for their children more than anyone else. Professionals need to regard families as capable and competent decision-makers when given relevant and comprehensible information. Their role is to provide services designed to support parents in their role as primary agents in facilitating the achievement of their child's goals.

Family-provider collaboration is characterized by the following elements:

- Recognition of the family as a primary resource
- A caring, non-blaming position in relation to the family and recognition of the family's limitations and other responsibilities
- Shared responsibility and power in provider-family relationships, including joint problem-solving and decision-making
- Clear and open information sharing (Providers should communicate and share complete, unbiased information with consumers and family members in a manner that is affirming and helpful.)

- Practical assistance to enhance the family's access to services and supports
- A readiness to change services and supports pursuant to feedback from family members

Current views see families as full participants and collaborators at all levels, including program design, evaluation, implementation and service delivery, within a paradigm of mutual respect and power-sharing that serve as a guide to the design of services and supports. The literature clearly indicates that the degree of family participation in service and support delivery is related to improvements in coordination and meeting the needs of children. They are the true decision-makers about the services their children receive.

Family participation is achieved through independent family organizations,[10] those who hold staff positions in organizations as trainers, educators, and therapists. Effective service models use parent-to-parent support from individuals who have received or are receiving services, work full or part time, and are paid for their services. The incorporation of family-to-family support into services reduces families' sense of isolation and stigmatization and increases available services and supports. Families can also function as co-trainers for staff and other families. Family advocates or family liaisons can attend meetings with family members and help them locate resources. They also can conduct courses to educate and empower families and work with clinical staff to ensure families are meeting the emotional, behavioral and academic needs of their children.

Research indicates that there are six roles families should have in the treatment process:

❶ Family members are the most critical component of a child's environment; improving family relationships and providing the most stable and supportive environment possible for the child should be a focus. Family members should seek external support from extended family members and community resources to reduce stressors related to rearing a child with emotional or behavioral problems.

❷ Family members are a critical element in the therapeutic process; interventions should focus on the health of the entire family with assessment of strengths and limitations of the family structure designed to promote the well-being of the parents and other family members. Parent training and education, coping skills development, stress management techniques, respite care, parent support groups, transportation, and financial assistance need to be available.

❸ Family members should function as equal partners in the identification of treatment goals, strategic planning and implementation of plans to attain those goals.

❹ Family members are often responsible for the provision of emotional support and information to their children, other family members, and for services not provided by the service delivery system (e.g., coordination of service delivery, transportation to appointments, scheduling meetings, ensuring follow-up appointments are kept, tracking prescribed medications, and monitoring successful and unsuccessful treatments).

[10] During the past two and a half decades family-run organizations have functioned as a strong voice for families raising children who have mental health needs. These organizations have been instrumental in the development of formal roles for family members including, but not limited to: support group facilitation, peer mentoring, respite care provision, service coordination, conference organization, policy documentation, grant writing, workshop leadership, keynote speaking, data collection, writing newsletters, brochures, and manuals, as well as advocacy, and research. They offer peer support to other families, and provide community-based services and supports for other families. The Federation of Families for Children's Mental Health has served as a national advocacy voice for families who have children with emotional and behavioral disorders.

❺ Family members function as their child's voice in the mental health system; they can become involved in various local and national organizations that provide education and support to parents and other family members.

❻ Families can participate in research and program evaluation activities; their opinions and feedback regarding the quality and effectiveness of services and interventions can be incorporated into quality improvement efforts.

When parents' strengths are respected and their needs are met, they are able to provide better care giving to their children on a consistent basis. They are more attentive to their children's development. Parental involvement in the treatment process has been associated with increases in parental feelings of self-efficacy which, in turn, correlates with increased investment in their children's treatment and outcomes. Parents report acquiring constructive problem-solving skills and becoming better advocates for their children. Parental self-esteem has also been shown to be enhanced which also has a positive impact on intervention. Finally, parental involvement has been shown to reduce lengths of stay in out-of-home treatment settings.

PARENT MANAGEMENT TRAINING PROGRAMS

Parent Management Training (PMT) programs teach parents to manage their children's behavior problems at home and in school. PMT stems from research indicating that ineffective/maladaptive parent-child interactions, especially in disciplinary practices, foster and maintain children's conduct problems. Parent training programs use operant principles of behavior change and instruct parents to monitor and track both prosocial and problem behaviors and reward those that are incompatible with deviant behaviors, while ignoring or punishing deviant behaviors. They are also taught to use rational limits and nonviolent means of discipline and provide encouragement on a daily basis. The most effective parent training programs employ a combination of written materials, verbal instruction in social learning principles and contingency management, modeling by the clinician, and behavioral rehearsals of specific skills. Parent management training has been implemented for youngsters of various ages and differing symptoms. However, formats vary and include recorded modeling of parenting skills, parent groups, and individual therapy with parents. Several manuals are available.

PMT is one of the most extensively studied interventions for children and has been shown to be effective in decreasing oppositional, aggressive, and antisocial behavior. It has been found to be more effective and enduring in reducing antisocial behavior and increasing prosocial behavior than other interventions (e.g., family therapy, play therapy, etc.). Beneficial effects are maintained for years following cessation of treatment and generalize to areas not focused on during treatment (e.g., sibling behavior, marital relationships). Moreover, parent management training has been shown to be a relatively low cost intervention with a rapid response rate; most studies show that improvements are made within three months. Several parent management training programs are described below.

PARENT MANAGEMENT TRAINING-OREGON MODEL (PMTO)

PMTO views parents as the primary agents of intervention. It targets all family members and subsystems within the family (e.g., siblings, parents/couples). The program teaches parents basic behavioral principles, how to define, track, and record rates of antisocial and prosocial behaviors, as well as how to design, role play, carry out, and refine behavior modification programs and assess the effectiveness of the interventions used. It is designed for children and adolescents who display serious behavior problems from preschool through adolescence. The model has been used effectively for difficulties such as overt antisocial behavior (e.g., aggression, defiance, hyperactivity, fighting), covert antisocial behavior (e.g., lying, stealing,

truancy, fire setting), internalizing problems (depressed mood, peer problems, deviant peer associations), delinquency, substance abuse, and academic failure. It is also used for families who have multiple difficulties, such as parents who have mental health problems, marital/couples conflicts, those undergoing divorce and membership changes (e.g., new marital partners and children), and those living in impoverished circumstances. PMTO synthesizes social learning principles and techniques, strategic family therapy, and applied behavioral analysis into an intervention designed to assist in the development of parenting skills.

During sessions the therapist is very active and starts with a brief overview of concepts, then models the techniques for parents, and coaches them in their implementation of the techniques. The techniques and interaction patterns practiced in the sessions are then used (in vivo) at home. Parents are taught to define, observe, and record behavior in order to define behaviors (e.g. fighting, engaging in tantrums) so they can use positive reinforcement (e.g., contingent delivery of attention, praise, points) and punishment techniques (e.g., time out from reinforcement, loss of privileges, and reprimands) contingent on the child's behavior. They learn to provide consequences consistently, attend to appropriate behaviors, ignore inappropriate behaviors, apply skills in prompting, shaping, and fading, and apply these techniques to manage future problems. PMTO seeks to alter coercive family process (i.e., the contingent use of aversive behaviors), and enhance behaviors that are desired. It teaches problem-solving skills and promotes positive involvement with the child.

Parents acquire the following effective parenting skills:

- Skill encouragement which entails teaching new behaviors with the application of positive contingencies
- Limit setting which entails discouraging deviant behavior through the use of negative non-corporal sanctions
- Monitoring/supervision by attending to children's behavior at home and away from home
- Family problem-solving skills consisting of interpersonal planning troubleshooting, contingency agreements
- Positive involvement by displaying interest, attention, and caring behaviors

At the outset parents apply new skills to relatively simple problems (e.g., compliance with requests, completion of chores, oppositional behaviors). As they become more proficient, more severe problem behaviors at home and in school are focused on (e.g., fighting, poor school performance, truancy, stealing, and fire setting). The therapist maintains telephone contact with the parents between sessions to problem-solve, encourage adherence to the program, support parents' use of skills, and offer parents the opportunity to ask questions.

Outcome studies have shown that PMTO results in decreases in non-status offenses, institutional placements, ineffective/maladaptive parent-child interactions, and antisocial behaviors. Improvements in parenting skills as well as the socioeconomic status of families have been demonstrated. PMTO is currently being disseminated in Michigan's public mental health system.

Fidelity to PMTO is monitored with the Fidelity of Implementation Rating System (FIMP), an observation-based measure that evaluates five dimensions of adherence to PMTO: knowledge, structure, teaching skill, clinical skill, and overall effectiveness as specified in the model. Information can be obtained from the Oregon Social Learning Center (OSLC) located on the web at http://www.oslc.org/.

PARENT-CHILD INTERACTION THERAPY (PCIT)

PCIT is a parent management training program for families of children between the ages of two and six who are experiencing emotional, behavioral or developmental difficulties and family problems. The program uses play therapy and in vivo teaching to give feedback regarding mother-child interactions. It is a short-term, manualized intervention that is comprised of two phases, Child-Directed Interaction (CDI), and Parent-Directed Interaction (PDI). The focus of the CDI phase is on enhancing parent-child attachment. This is the foundation for PDI, which focuses on using a structured and consistent approach to discipline. CDI is based on attachment theory. Parents are taught skills to promote positive, nurturing interaction in order to provide a secure attachment for the child. PDI is based on social learning theory and addresses ineffective/maladaptive parent-child interactions that can create and maintain behavioral problems.

The program consists of ten to sixteen one-hour sessions conducted on a weekly basis consisting of:

- A pretreatment initial assessment of child and family functioning
- Joint development of therapy goals by the clinician and parents
- Feedback, teaching, and coaching of parents in the CDI skills
- Teaching and coaching parents in the PDI skills
- Direct consultation and coaching for the child's teacher
- Teaching generalization skills
- Post treatment assessment
- Booster sessions over a twelve month period to maintain positive skills

Each phase of treatment entails a didactic session for parents during which interactional skills and their rationales are taught via modeling and role-plays. Then, parents and their children attend weekly coaching sessions together. They are given homework to practice skills between sessions on a daily basis for five to ten minutes per day. During CDI, parents are taught to use PRIDE (praise, reflection, imitation, description, enthusiasm) skills while avoiding questions, commands, and criticism when playing with their children. During PDI, parents are taught to impart clear, developmentally appropriate, direct commands and confer consistent consequences for both compliance and noncompliance. Praise is used for compliance and time-outs are used for noncompliance.

Research indicates PCIT is effective in reducing children's behavior problems at home and school, and results in improved parental interactional styles. Parents report gains in confidence in their parenting abilities and reductions in personal distress. The beneficial effects of PCIT have been shown to generalize to other family members (i.e., siblings who have not undergone treatment). Studies that have included culturally diverse families have also found these positive outcomes. PCIT has been shown to be most effective if it is used continuously in the home and other significant environments.

A comprehensive treatment manual, test outline of the program, and implementation recommendations are available. However, there are several training models and these are of varying levels of intensity. Information on PCIT can be found on the web at http://www.pcit.org/.

THE INCREDIBLE YEARS

The Incredible Years is a parent training program that uses a comprehensive curriculum for children aged two to eight, their parents, and teachers. It is a prevention and intervention model that is designed to enhance emotional and social competence as well as ameliorate behavioral

and emotional problems. The program is comprised of three components, a parent training program, child training program, and teacher training program:

❶ Parent training:

- The Basic Parent-Training module consists of twelve to fourteen two-hour sessions held once a week that focuses on parenting skills designed to foster children's social competence and reduce behavioral problems. It teaches parents how to play with children, help children learn, give effective praise and incentives, use limit-setting, and deal with misbehavior.
- The Advance module is an eight to ten-session program that focuses on parental communication skill building (e.g., effective communication, anger management, problem-solving between adults), and ways to give and receive support.
- The School module is comprised of three to four two-hour sessions that focus on parenting techniques designed to foster children's academic skills. These include reading skills enhancement, establishing homework routines, and establishing collaborative relationships with teachers.

❷ Child training:

The child-training component uses the Dina Dinosaur Curriculum, an intervention program for small groups of children who exhibit conduct problems (e.g., aggressive, defiant, oppositional, and compulsive behaviors). It focuses on communicating feelings, empathy for others, friendship development, anger management, interpersonal problem-solving, and obedience to school rules and regulations. It is conducted in groups of five to six children in weekly two-hour sessions for eighteen to twenty weeks. The Dina Dinosaur character is used to teach emotional literacy, empathy and perspective taking, friendship development, anger management, impersonal problem-solving (e.g., waiting, taking turns), and following school rules (e.g., being quiet, raising one's hand to speak, listening to the teacher).

❸ Teacher training:

The teacher-training component is comprised of a six-day, forty-two hour workshop that focuses on classroom management skills development. These include effective use of attention given to children, praise and encouragement, incentives for difficult behavior problems, proactive teaching techniques, and ways to manage inappropriate classroom behavior and enhance positive relationships with students. The program encourages teachers to be sensitive to children's individual developmental differences (e.g., variations in attention spans and activity levels, heightened interest in novel situations), and teaches them how to respond to these differences in a positive, accepting, and consistent manner. Teachers are also taught how to prevent peer rejection by teaching children who display aggression appropriate problem-solving strategies and helping their peers respond appropriately to aggression. Teachers, parents, and group facilitators jointly develop transition plans that detail classroom strategies found to be effective for each child, goals achieved and those remaining, and the child's characteristics, interests, as well as motivators for children who display conduct problems.

Studies have shown that The Incredible Years produces beneficial outcomes including decreases in the frequency of problem behaviors (including noncompliance/failure to respond and aggression toward peers), negative behaviors, and increases in behaviors that are more prosocial such as social problem-solving (e.g., positive response to hypothetical conflict situations). In addition, parents use less corporal punishment (spanking).

Trained facilitators devote five hours per week to a two-hour parent group and provide workshops and weekly meetings for teacher training. The costs for program are as follows: $1300.00 for the Basic component, $775.00 for the Advance component, $995.00 for the School component, $1250.00 for the teacher training, and $975.00 for the child training program. Training and technical assistance costs are charged on daily rate. The certification fee for facilitators is $350.00. Information about the program is available on the web at http://www.incrdiblyears.com/.

PARENTING WISELY (PW)

Parenting Wisely is a SAMHSA model program that is based on Functional Family Therapy (see description below). It is designed for at-risk families with low incomes who have children with mild to serious behavior problems. Parenting Wisely is a self-administered, interactive computer-based program that teaches parents and their nine to eighteen-year-old children skills designed to ameliorate risk factors for substance use and abuse and other high risk behaviors (e.g., stealing, vandalism, defiance of authority, bullying, and poor hygiene), and reduce family conflict. The program teaches parents and children effective communication skills (active listening and using "I" messages), assertive discipline (contracting, praise, and setting consequences), and supervision (working with teachers, monitoring homework and friends).

Parenting Wisely can be used alone, in groups, or with a practitioner in a variety of settings (e.g., public agencies, schools, libraries, home, juvenile courts and detention centers, human services, health, mental health, and child protective services agencies, schools, libraries, and adult literacy/education locations, community centers, homeless shelters, and public housing). It can be made accessible to parents with low levels of literacy by using the option to have the computer read all the text aloud. The printed portions of the program are written at the fifth-grade level. The program is also available in Spanish and there is a version for parents of children aged three to nine.

The program consists of nine case studies, each of which opens with a video of a common family problem, followed by three positive responses. Parents choose a response, and then view a video depicting how their choice would work and receive feedback on their choice. After choosing the best response, parents answer questions about the ideas and skills presented in the case. Each family is given a workbook with practice exercises and implementation tips to promote practice of skills.

Parenting Wisely can be used variety of ways, including:

- Agencies can refer parents to a private room where they use the program on a computer and take the workbook home for reference and skill practice
- Case managers, practitioners, or volunteers can take the program to the families' homes for use by several family members
- Parents can use the program in groups led by a facilitator
- Parents can be loaned the CD-ROM or video series to use at on their own at home
- Families can use the program before, during, or after family therapy to complement the treatment

Two to three three-hour sessions are usually needed for parents to work through the computer program's nine case studies. In a group format, six to ten one-hour sessions for six to ten weeks are needed to complete it. The program can also be conducted as a one-day workshop using a non-interactive video version for a large number of participants. If the program is used

conjunction with clinical work with families, one to two family scenarios are used during each session for four to six sessions.

Beneficial outcomes are seen within a week of implementation and tend to increase over time. The program has been shown to lead to reductions in children's aggressive and disruptive behaviors, improvements in parenting skills, enhancement of family communication and cohesion, increases in parental supervision and appropriate discipline of their children, reductions in maternal depression, increased knowledge and use of effective parenting skills and less use of corporal punishment, as well as reductions in spousal and child physical abuse, improved problem-solving skills, setting clear expectations for child behavior, increased peer and school activities supervision of children, and improved academic performance by children.

The cost of the program is $1,001– 5,000 including the CD-ROM program kit, provider guide, parent workbooks and other materials. It typically takes about three to six weeks to install the program and familiarize staff with it. The program is upgraded periodically, based on ongoing research. Information can be found on the web at: www.parentingwisely.com/.

HELPING THE NON-COMPLIANT CHILD

Helping the Noncompliant Child is a SAMHSA model, manualized, parental skills training program designed to reduce conduct problems, prevent subsequent delinquency, and teach parents to help their children comply with parental directives. The program targets parents and their three to eight year-old children.

Sessions are typically conducted in a therapeutic playroom. Five to fifteen, sixty to ninety-minute sessions are held with individual families once or twice a week. The average number of session is ten. The program consists of a series of parenting skills designed to help parents interrupt their coercive cycles of interaction with their children by increasing positive attention for appropriate behavior, ignoring minor inappropriate behaviors, providing clear instructions, and appropriate consequences for compliance (positive attention) and noncompliance (time out). Skills are taught to parents using extensive demonstration, role plays, and direct practice with their children in clinical settings and at home. Progression from one skill to the next is based upon demonstrated proficiency.

Parents report high levels of satisfaction with the program. Outcomes studies indicate it is effective in altering the behaviors of parents and children and that changes generalize across time (in fifteen years of follow up data), settings (office/clinic to home), siblings, and behaviors (i.e., beyond behaviors that are noncompliant). Parent attitudes regarding their children also become more affirming. More information on this program can be found on the web at http://www.strengtheningfamilies.org/html/programs_1999/02_HNCC.html.

FAMILY THERAPIES

Family therapy has a long research history with a range of studies, of varying quality, documenting its efficacy. A series of meta-analyses found family therapy to be effective alone or as part of a multimodal approach for children with conduct problems, enuresis, eating disorders, mood and psychotic disorders. A number of treatment manuals are available for the various family therapies. This section offers an overview of some models of family therapy.

FAMILY THERAPIES
■ **Structural:** A family therapy designed to restore family boundaries and equilibrium
■ **Strategic:** A family therapy that reframes perceived problems to provide new perspectives
■ **Milan Systemic:** A family therapy that positively connotes family relationships to alter interactions
■ **Narrative:** A family therapy in which families are taught to construct new stories and ways of interpreting events
■ **Psychoeducational[11]:** A family intervention that employs a combination of behavioral and structural techniques to teach relatives about the causes and courses of a family member's mental illness and helpful ways to respond. The aim is to decrease expressed emotion (EE). Relatives' groups and family sessions are used.
■ **Behavioral:** A family therapy that uses operant conditioning, contingency contracting, communication training, and problem-solving skill development techniques
■ **Brief Solution-Focused:** A family intervention that promotes increases in a family's focus on solution patterns and decreases their focus on problems

BRIEF STRATEGIC FAMILY THERAPY (BFST)

Brief Strategic Family Therapy is a short-term, problem-focused intervention with an emphasis on modifying maladaptive patterns of interaction that was developed in 1975 at the Spanish Family Guidance Center of the Center for Family Studies, University of Miami. It uses a structural family systems framework to improve family interactions that are presumed to be directly related to children's behavior problems. It is designed for families with children and adolescents aged six to seventeen who are displaying, or at risk for developing, behavior problems including conduct problems, relationships with peers who engage in antisocial behavior, early substance use, and problematic family relations. BSFT has been adapted for African American and Hispanic/Latino families living in inner cities. (Therapists are trained to assess and facilitate healthy family interactions based on cultural norms of the family being helped.)

BSFT fosters the development of parental leadership, appropriate parental involvement, mutual support among adult care givers, family communication, problem-solving skills, clear rules and consequences, and shared responsibility for family problems. In addition, outreach strategies are used to bring families into therapy. The therapy is based on each family's unique characteristics that surface when family members interact, and the manner in which the family system influences all members of a family. (Such repetitive interactions [i.e., the manner in which family members interact and behave with regard to one another] can be either effective or unproductive.) BSFT targets interactional patterns that are directly related to children's behavior problems and helps families develop more effective patterns of interaction.

[11] Individuals who have schizophrenia have been shown to benefit significantly (e.g., reductions in risk of relapse) from psychoeducational family interventions. There is a robust research base to support this intervention, which is discussed at length in *A Guide to Evidence-Based Practices for Adults with Mental Illness* located on the SCCMHA website at http://sccmha.org/quality.html. The SAMHSA toolkit on Family Psychoeducation (FPE) is available on the web at http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/family/.

BSFT is usually provided over the course of three months for twelve to fifteen sixty to ninety-minute sessions. The three primary components of the intervention are:

- *Joining*: engaging and entering the family system, understanding resistance and engaging the family in therapy
- *Diagnosis*: identifying ineffective/maladaptive interactions, family strengths, and the interactional patterns that promote problematic behavior
- *Restructuring*: transforming ineffective/maladaptive interactions, developing a specific plan to help change maladaptive family interaction patterns by working in the present, reframing, and dealing with alliances and boundaries

Outcome studies indicate significant reductions in symptoms of conduct disorder, aggressive behaviors, offender recidivism, and improved family relationships. Training is provided by The Center for Family Studies in Miami and costs $18,000.00 plus travel. Information on BSFT can be found on the web at http://www.strengtheningfamilies.org/html/programs_1999/09_BSFT.html.

BEHAVIORAL FAMILY SYSTEMS THERAPY (BFST) FOR ANOREXIA NERVOSA

Anorexia Nervosa is the third most common chronic condition experienced by adolescent females. Chronic anorexia nervosa is associated with a number of acute and chronic medical problems, including growth retardation, osteoporosis, bradycardia, orthostatic hypotension, and infertility. Depression and anxiety disorders are often co-occurring conditions. Mortality rates for anorexia nervosa range from six to ten percent. There is a range of interventions including nutritional counseling, family, individual, supportive, analytic and cognitive-behavior therapies, of which family therapy is the most supported. For example, Minuchin's structural family therapy has a strong research base for the treatment of anorexia nervosa, especially for females whose illness is of a shorter duration. Those whose illness is three years or longer have poorer outcomes. The most robust evidence supports a specific type of family-based treatment for adolescents with anorexia nervosa developed at the Maudsley Hospital in England and used since 1987. This approach has consistently demonstrated efficacy in approximately two-thirds of those who received the intervention, with five-year follow-up rates indicating continued benefits relative to other interventions.

The Maudsley Method is a family-centered treatment that enlists the family as the primary player on the recovery team. It consists of three phases in which power shifts from the consumer to family and back to the consumer after she/he reaches an acceptable weight.

❶ The first phase (sessions one through ten) focuses on empowerment and eating, placing the parents in charge of their adolescent's eating behavior, and making food the medicine to be administered. The parents thus function as doctors who administer the remedy. They must form an alliance around re-feeding and agree to consistently enforce unvarying rules related to food. The first two sessions entail engaging the family in order to determine their eating habits and compile a depiction of the impact of the illness on all family members. A family meal is conducted that allows the therapist to observe familial interaction patterns around eating. The clinician externalizes the illness by presenting the eating disorder as controlling the consumer in order to liberate the parents and consumer from blame. The therapist then encourages the parents to find their own method to control the adolescent's eating behaviors through a system of techniques that include functional rewards (e.g., not allowing the adolescent to obtain a driver's license until they regain their strength) rather than force or punishment. The consumer is encouraged to form an alliance with siblings for support.

❷ The second phase (sessions eleven through sixteen) entails shifting the locus of control of the feeding process back to the adolescent, and addresses related family problems. It begins when the consumer complies with the parents' food guidelines and makes steady weight gains. During this phase parents help their child assume increased responsibility for eating.

❸ The third and final phase of the treatment focuses on encouraging the processes of adolescent development that unfold as the anorexia nervosa abates, and establishing new family relationships extricated from the eating disorder. According to the Maudsley model, once the consumer maintains a stable weight of approximately ninety-five percent of his or her ideal weight without substantial parental supervision, individual therapy should be started to focus on issues and anxieties surrounding adolescence, a life phase that has been avoided by having an eating disorder. At this point in recovery, issues of identity, independence, and development of appropriate family boundaries can be explored.

This intervention is appropriate only for minors living at home where some degree of parental control is assumed. It is contraindicated for parents who are abusive. Data from studies indicate the program is less effective for older adolescents, those who have chronic illness, and those who binge and purge. In addition, some families may not be able to devote the significant time and effort required to supervise meals and resolve conflicts regarding food. Another factor that may impinge on the impact of the intervention is that the highly involved parental roles in the Maudsley Method may exacerbate enmeshed interactional patterns so often found in parents and their adolescents who have eating disorders. Adolescents may also experience more difficulty in gaining a sense of autonomy following treatment. Despite these possible drawbacks, the Maudsley Method is now being used and evaluated at the University of Chicago, University of Michigan, Columbia University, and Stanford University.

FUNCTIONAL FAMILY THERAPY (FFT)

Functional Family Therapy is a manualized, family-based, multisystemic prevention and intervention model for children and adolescents aged eleven to eighteen, and their younger siblings who are at risk for, or are, displaying delinquent behaviors, violent behaviors, substance use/abuse, conduct disorder, oppositional defiant disorder, or disruptive behavior disorder. It is a short-term intervention that is provided for eight to twelve one-hour sessions for mild situations, and twenty-six to thirty hours for more difficult situations, for three months. It can be conducted in clinical settings, juvenile courts, and during transitions from institutional settings, or as a home-based intervention by one clinician or a two-person team.

Functional Family Therapy is comprised of problem-solving skills training, parent management training, cognitive-behavior therapy, and contingency management. It is designed to teach parents and children skills for conflict resolution and foster supportive communication and prosocial activities. While similar to Problem-solving Skills Training (see page 105 for a discussion), it is provided to the family as a unit rather than to parents and children separately.

FFT is designed to enhance communication and mutual problem-solving by specifying clear rules and consequences for breaking them; developing clear and contingent parent-child contracts that link desirable behavior to specified rewards; using social reinforcement such as praise; and instituting a token economy (the exchange of privileges for desired behaviors). It employs cognitively based interventions in a three-stage intervention plan (known as the Phase Task Analysis). The phases consist of:

- *Engagement* which is designed to emphasize factors that prevent premature termination of treatment

- *Motivation* which is designed to change ineffective/maladaptive emotional reactions and beliefs, and increase alliance, trust, hope, and motivation for enduring change
- *Assessment* which is designed to clarify individual, family system, and larger system relationships, especially the interpersonal functions of behavior and how they relate to change techniques
- *Behavior Change* which consists of communication training, specific tasks and technical aids, basic parenting skills, contracting, and response-cost techniques
- *Generalization* during which family case management is driven by the family's individualized functional needs, environmental constraints and resources, and their alliance with the FFT therapist/Family Case Manager

FFT is supported by thirty years of clinical research conducted since its inception in 1971. It has a robust evidence base and has been shown to be effective for youth from ethnically diverse backgrounds who display antisocial behavior and abuse substances. It has been found to prevent the need to use of more restrictive, higher cost services, reduce the use of other social services, and prevent adolescents from becoming involved in the adult criminal justice system. FFT has been found to effective in decreasing juvenile offender recidivism by twenty-five to sixty percent. Furthermore, it has been found to be effective in preventing younger children in participant families from entering systems of care. Outcome studies indicate that it also results in enhanced psychosocial functioning and decreased out-of-home placements (including incarceration) by as much as fifty percent. It also leads to lower total treatment needs at far less cost than out-of-home alternatives. Functional Family therapy has been shown to reduce felonies by twenty-seven percent and save taxpayers and crime victims $14,149 to $59,067 per participant.[12]

FFT has intensive training requirements. The first year consists of a three-day on-site clinical training for a team of three to eight staff and an externship for the clinical team leader. In addition, it entails three two-day follow-up visits per year and four hours of phone consultation per month. The first year start-up costs average about $20,000.00, excluding travel, for one group to attain certification as a provider of FFT. An annual fee is required to maintain certification thereafter.

Fidelity to the FFT model is monitored via the use of a specific training model and consumer assessment, tracking, and monitoring system (the FFT-CSS) that provides for specific clinical assessment and outcome accountability. The FFT Practice Research Network (FFT-PRN) permits clinical sites to participate in the development and dissemination of FFT model information.

FFT has been adapted for the treatment of child/adolescent depression in a model called Systematic-Behavioral Family Therapy (SBFT). Information on FFT can be found on the web at http://www.fftinc.com/.

HOME-BASED BEHAVIORAL SYSTEMS FAMILY THERAPY

Home-Based Behavioral Systems Family Therapy is designed for families whose children have committed, or are at risk for committing, juvenile offenses and engaging in substance abuse, and are between the ages of six and eighteen. It is based on Functional Family Therapy and

[12] According to the Washington State Institute for Public Policy, the cost of FFT averages approximately $2161.00 per program participant compared to $14,149 in potential criminal justice expenditures resulting in a savings of $11,988. In addition, the Institute estimated that up to $59,067.00 in crime victim costs could be offset for each participant. Thus, the cost-benefit ratio is $28.81 for each dollar spent for FFT.

aims to reduce family conflict, increase family cohesion, improve communication, parental monitoring, discipline, support of appropriate child behavior, as well as problem-solving abilities, parent-school communication, school attendance and grades, child adjustment, and reduce child involvement in the juvenile justice system, delinquent behaviors, teen pregnancy, and placement in special classes. It also seeks to increase rates of graduation and employment.

Modifications to the program have been made for families in Appalachia and African American families residing in inner cities. It has been effectively used with children and adolescents who have histories of committing multiple offenses, those residing in institutions, and families with lower educational levels and significant levels of difficulty.

Home-Based Behavioral Systems Family Therapy is a brief structured model conducted in five phases by paraprofessionals and professionals in participants' homes. During the early phases, therapists are less directive and more supportive and empathic than in the later phases, when the family's level of cooperation is increased and resistance is reduced and hence more conducive to increased therapist directiveness. The five stages are:

- Introduction/Credibility (therapist-family contact time = five percent)
- Assessment (therapist-family contact time = fifteen percent)
- Therapy (therapist-family contact time = forty-five percent)
- Education (therapist-family contact time = twenty-five percent)
- Generalization/Termination (therapist-family contact time = ten percent)

The intervention is psychoeducational in nature and is supplemented with the Parenting Wisely (PW) program (see previous discussion) before or during treatment. Families who at moderate to lower risk can use the PW program to prevent escalation of family problems that would lead to referral for family therapy. Both individual and group administration of the PW program allows more families the opportunity to receive services and can reduce their need for family therapy. This combination program approach also creates a continuum of care from least to most intensive intervention.

Outcomes studies indicate that the program leads to reductions in involvement in the juvenile justice system, self-reported delinquent behaviors, teen pregnancy, special class placement, as well as increased graduation rates and employment. Decreases in family conflict, increases in family cohesion, and improvements in communication, parental monitoring, discipline, and support of appropriate child behavior, problem-solving abilities, parent-school communication, school attendance, grades, and child adjustment have been noted. Outcome studies also indicate significant reductions in recidivism and out-of-home placements.

The program uses two therapist manuals that cost $11.50 per trainee and can be copied. Parent workbooks for the Parenting Wisely program are given to each family. These workbooks, which are used in the education phase, cost $9.00 each. A set of three parenting skill training videos and the Parenting Wisely video series, which can be used repeatedly, cost $250.00. Parenting Wisely CD-ROM kits are $659.00 each (i.e., American Teen and Young Children's Version, both of which are also available in Spanish). Information can be obtained from familyworks@familyworksinc.com.

MULTISYSTEMIC THERAPY (MST)

Multisystemic Therapy (MST) is an intensive community-based family intervention for children and adolescents who have a history of committing chronic offenses, display violent behavior, and abuse substances. It focuses on the components of serous antisocial behavior that underlie juvenile delinquency and addresses individual child, family, peer group, school, neighborhood and community supports. MST is based on the premise that behavioral problems of children and

adolescents are maintained through problematic interactions within, or between, one or more of these systems.

MST is designed to empower parents and endow them with the skills and resources required to independently address difficulties that occur in raising teenagers, as well as empower youth to cope with family, peer, school, and neighborhood problems. Intervention strategies are integrated into a social ecological context and include strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavior therapies.

MST is provided using a home-based model of service delivery in order to surmount barriers to service access, increase family retention in treatment, offer the opportunity for the provision of intensive services, and enhance the maintenance of treatment gains. Family members are considered to be full collaborators in the treatment planning and delivery process, with treatment goals driven primarily by parents. MST emphasizes the development of extended family and informal support networks for the family. The clinician is held accountable for engaging the family in treatment and placing developmentally appropriate demands on the adolescent and family for responsible behavior.

MST is provided by teams of master's prepared therapists who receive supervision from an on-site doctoral level clinician. Teams should reflect the ethnic makeup of the population being served. The average caseload is four to six families per clinician. Each clinician works with about fifteen families per year. Treatment is usually four months in duration per family.

MST TREATMENT PRINCIPLES

- The primary purpose of the assessment is to understand the "fit' between the identified problems and their broader systemic context.
- Therapeutic contacts should emphasize the positive and should use systemic strengths as levers for change.
- Interventions should be designed to promote responsible behavior and decrease irresponsible behavior among family members.
- Interventions should be present-focused and action-oriented, targeting specific and well-defined problems.
- Interventions should target sequences of behavior within and between multiple systems that maintain the identified problem.
- Interventions should be developmentally appropriate and fit the developmental needs of the youth.
- Interventions should be designed to require daily or weekly effort by family members
- Intervention efficacy is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.
- Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple system contexts

MST is a SAMHSA model program with demonstrably beneficial outcomes including reductions in re-arrests, out-of home placements, mental health problems, long-term criminal offender behavior, and significant improvements in family functioning. Moreover, it has been shown to be very cost effective. The costs have been estimated to be approximately $8000.00 per family, which represents a significant cost savings when compared to $20,000 for institutional care, and an estimated $31,661 to $131,918 in savings to taxpayers for each participant.

The intervention is manualized and has a fidelity measurement tool. All materials and instruments are only available through MST Services, Medical University of South Carolina (MST Institute: http://www.mstinstitute.org/). MST Services, Inc. owns the model and has a licensing agreement for dissemination of the model. Training, consultation and supervision are available.

PREVENTION AND EARLY INTERVENTION

Mental health problems during childhood are common and impose a significant burden on children and their families. It is estimated that one in ten children and adolescents in the United States suffers from a mental illness that is serious enough to cause significant functional impairment. Childhood mental disorders can lead to more serious mental disorders if appropriate intervention and treatment are not provided. They are also precursors of other future problems such as increased potential for involvement in the juvenile justice system, dropping out of school, parental loss of custody, and placement outside the home.

Prevention programs focus on addressing the needs of children who are at risk for adverse social and academic outcomes. They are designed to alleviate problem behaviors, enhance social competence, and facilitate social skill development. Prevention for young children focuses on quality child care environments, facilitating optimal social and emotional development, and preventing or intervening early in challenging behavior.

The public health field places prevention efforts into three categories. Primary prevention is aimed at intervening prior to the onset of an illness or disorder. Secondary prevention incorporates screening in order to detect an illness or disorder prior to it becoming symptomatic. Detection is followed up by measures designed to halt progression or eradicate the illness or disorder. Tertiary prevention focuses on the prevention of complications of an illness or disorder, and is aimed at individuals who are known to have an illness or disorder. Disease management protocols constitute tertiary prevention efforts.

The Institute of Medicine's model of prevention is comprised of a three-tiered approach. Universal prevention is applied to everyone in the population. Universal prevention programs provide general awareness education and information to an entire community. Selective prevention is targeted to individuals who are at risk for a given condition. Selective prevention targets high risk groups in a community via screening, assessment, and training of gatekeepers in the health and mental health treatment systems. Indicated prevention is used for individuals who are at high risk for developing a given condition. Indicated prevention targets individual children and adolescents who are known to be at high risk in order to provide services and supports.

Research indicates the following are effective methods for providing prevention and early intervention:

- The provision of mental health consultation in child care and early learning programs (e.g., giving child care providers increased access to mental health consultants and clinical supervision)
- The inclusion of mental health components in home visiting programs
- The provision of mental health consultation in pediatric and obstetric health care settings

The literature points to the following conclusions regarding prevention and early intervention efforts:

- Multi-component programs offer the most effective prevention and early intervention opportunities.
- Multiyear programs are more likely than those of a short-term duration to have sustained benefits.

- Ongoing intervention during early childhood, specifically the preschool years, may help to prevent serious conduct problems.
- Prevention efforts should be targeted to reducing risk factors and promoting protective factors, rather than concentrating on the elimination of negative behaviors.
- Effective programs focus on fostering positive changes in home and school domains rather than on the child alone.
- Prevention programs should be integrated with treatment programs and other community care systems. Educational settings may be the most opportune for developing integrated models of community-based systems of care.
- Center-based early education programs that are effective use low teacher to child ratios and enriched programming.
- Effective prevention programs are comprehensive and implemented prenatally. They include prenatal counseling for mothers and focus on parenting, care giving, and health care and incorporate periodic health screenings to monitor the growth and development of children and parent-child interactions.
- Effective programs use culturally relevant individualized plans of service and support that are developed and implemented in partnership with families, and include components for both children and their families.

Prevention and early intervention services and supports are designed to enhance resilience and mitigate risk by augmenting protective factors. Interventions aimed at prevention are a natural outgrowth of research on resilience as they expand upon the notion that it is much better to increase capacities to do well despite adversity than it is to provide treatment subsequent to the development of problems. While prevention has historically been designed to decrease risk, more recent research has demonstrated that the most effective strategies are those that focus on risk and promote protection.

RISK, PROTECTIVE FACTORS AND RESILIENCY

Risk refers to a characteristic of children (biological risk) or a characteristic in the environment (environmental risk, including family and community) that research has demonstrated to be associated with unfavorable developmental outcomes for children, such as behavioral problems or developmental delays. A risk factor is not causative; its presence indicates a probability for a negative outcome. In other words, risk factors do not invariably lead to problems in the lives of children, but rather increase the probability that such problems will arise. For example, low birth weight or irritable temperament during infancy when combined with caregiver stress, and deficits in attention and low frustration tolerance in the school setting, can lead to negative outcomes such as learning difficulties and peer relationship problems.

The combination of ineffective parenting practices, attachment difficulties, vulnerable child characteristics and social/environmental risks have the highest predictive value in the development of behavioral and emotional problems in young children. The quality of the care giving environment during the second year of life seems to play an especially significant role in the development of subsequent conduct problems. Poverty, in particular, is a major risk factor for developing psychological problems. Research indicates that the experience of poverty during the early years of life has more adverse consequences than its experience in later years. Children raised in poverty are at increased risk for experiencing developmental, behavioral, social and academic difficulties. However, child and family-focused interventions have been shown to improve well-being and mitigate the effects of this risk factor.

Risk Factors

Child	Family Characteristics	Family/Experiential
Fetal drug/alcohol effects	Poverty	Poor infant attachment to mother
Premature birth or complications	Large family; 4 or more children living in overcrowded space	Long term absence of caregiver in infancy
"Difficult" temperament	Siblings born within 2 years of the child	Witness to extreme conflict, violence
Shy temperament	Parental mental illness, especially maternal depression	Substantiated neglect
Neurological impairment	Parental substance abuse	Separation/divorce/single parent
Low IQ (IQ <80)	Parental criminal behavior	Negative parent-child relationship
Chronic medical disorder		Sexual abuse
Psychiatric disorder		Physical abuse
Repeated aggression		Removal from home
Substance abuse		Frequent family moves
Delinquency		Teen pregnancy
Significant levels of truancy and school retention challenges		
Poor academic performance		

The impact of risk factors on young children endures. For example, research on children whose mothers have a depressive disorder indicates they perform poorly on school readiness and behavioral indicators at age three and may be ejected from early childhood programs. Cumulative risk factors contribute to adjustment difficulties and mental disorders such as conduct problems, high-risk sexual behavior, depression and substance abuse. Malleable risk factors include: family communication, parenting style, exposure to domestic discord, violence, child abuse, and family arrests and treatment of parental mental illnesses and substance use disorders, and medical conditions.

Protective, or opportunity, factors consist of those characteristics of a child or their environment that may offer protection from negative outcomes, or act as a buffer from the adversities of risk factors, and enhance the ability to thrive. For instance, early risk factors and neurobehavioral vulnerabilities may be ameliorated by sensitive and responsive care giving, and building an infant's tolerance for frustration in order to foster the ability to stay on task, act in a cooperative manner with others, and gain competence in adapting to change and managing stressors.

Resilience is the process of healthy adaptation in the face of adversity. It denotes the ability to adapt and thrive, even in the face of adversity. Resilience allows an individual to withstand challenges (e.g., tragedy, high levels of stress, etc.) and bounce back or recover from such circumstances. Individuals who display a pattern of good adaptation despite risk demonstrate resilience. The ability to overcome developmental risks and adversities without apparently harmful outcomes is characteristic of resilience. Resilience is dynamic rather than static; individuals may show resilience at one point in their lives but poor adaptation at another. Recovery from an emotional and/or behavioral disorder transpires when a child is able to master challenges appropriate to his or her developmental stage.

Protective Factors

Child	Family Characteristics	Social Support From Outside The Family
Positive, "easy" temperament type	Living at home	Adult mentor for the child outside immediate family
Autonomy and independence as a toddler	Secure mother-infant attachment	Extra adult help for caretaker(s) of family
High hopes and expectations for the future	Warm relationship with a parent	Support for the child from friends
Internal locus of control as a teenager	Inductive, consistent discipline by parents	Support for the child from a mentor at school
Interpersonally engaging, "likable"	Perception that parents care	Support for the family from faith-based organizations
Sense of humor	Established routines in the home	Support for the family from work place
Empathy	Family cohesion	
Perceived competencies	Clear, open communication among family members	
Above average intelligence (IQ>100)	Spirituality/faith	
Good reading skills		
Gets along with others		
Problem-solving skills during school-age years		

The concept of resilience emerged from investigations of risk and misgivings regarding deficit models of psychosocial functioning. The latter led a shift from a focus on problems to one on strengths and, hence, resilience. This focus on resilience has engendered hope and optimism, consumer empowerment, and the application of strength-based assessments, goals, and prevention and intervention strategies that capitalize on all children's and adolescent's natural assets and capacities.

Research has suggested that many children have sufficient resilience to cope with environmental and interpersonal stress and adapt despite the experience of adversity. Studies point to positive social orientation and a warm, supportive home environment as protective factors. The four major types of interventions designed to foster resilience are: improving academic achievement, enhancing social skills, improving self-esteem, and strengthening families and social supports. Interventions strengthen positive parent-child relationships and support effective parenting in an effort to provide children with successful role models. They offer opportunities for children to experience competence, mastery, and an increased sense of self-efficacy.

Research on resilience in and of itself does not indicate a specific type of intervention that will be of benefit. Rather it indicates practices that include instilling hope and enhancing strengths (e.g., optimism, interpersonal skills, future-mindedness, finding a purpose) that function as buffers from adversity are elements in beneficial interventions.

MITIGATION OF RISK & ENHANCEMENT OF PROTECTIVE FACTORS: DEALING WITH PARENTAL MENTAL ILLNESS, DIVORCE, CHILD MALTREATMENT, SUICIDE AND VIOLENCE

THE IMPACT OF PARENTAL MENTAL ILLNESS

Research indicates that children who have a parent with a mental illness are at considerable risk for developing psychosocial difficulties (e.g., developmental delays, lower academic performance, and problems with social relationships), with some studies showing that about thirty to fifty percent of these children (compared to twenty percent of the general population of children) have a diagnosable psychiatric condition.[13] However, in spite of these risks, many children display resilience and seem to circumvent significant difficulties. In other words, having a parent with a mental illness does not assure adverse outcomes.

Children whose parents suffer from affective disorders (e.g., depression) are at greater risk for developing psychiatric disorders than their counterparts who reside in homes with parents who do not suffer from such disorders. Meta-analytic studies show that sixty-one percent of children whose parents have a major depressive disorder develop a psychiatric disorder during childhood or adolescence. Such children are at greater risk for developing internalizing and externalizing problems, and are four times more likely to develop affective disorders. However, these youngsters are rarely seen or treated by mental health professionals.

Depression in mothers is associated with the occurrence of developmental problems in their young children, including impaired cognitive functioning, depression, and behavioral problems. Depression may also affect mothers' confidence and parenting skills. Addressing maternal depressive symptoms has been shown to improve behavioral outcomes for both mothers and children, and recent guidelines emphasize pediatricians' roles in screening for depression.

Although there is a paucity of data on the parental status of public mental health consumers, there is evidence that this seemingly invisible population of men and women who are parents constitutes a growing proportion of persons receiving public mental health services. Current research[14] indicates that adults with mental illnesses have children at about the same rate as other adults, and that a significant proportion of these parents lose custody of their children. The literature indicates that these parents share the following characteristics:

- Women with a mental illness experience a high percentage of unplanned pregnancies.
- Mothers who have schizophrenia experience higher rates of reproductive losses from miscarriages, stillbirths, and induced abortions.
- Parents who have a mental illness are vulnerable to custody loss, with some studies indicating rates as high as seventy to eighty percent. Fear of loss of custody may stop parents from seeking services. Separation from children and loss of custody may undermine motivation for recovery and be a factor in decompensation.

[13] It should be noted that most of the studies in this area have focused on middle class, Caucasian families in which the mother has an affective disorder. Thus, there is a paucity of information about ethnocultural differences and parental mental illness and child outcomes.

[14] The majority of information accumulated on the experiences of parents who have a mental illness is based on research that includes only small samples of mothers who receive services in the public sector, have a severe mental illness, and experience multiple stressors (e.g., poverty, ethnic minority status).

- Successful parenting may be compromised by symptoms of trauma that are a consequence of the victimization many individuals with mental illness experience.
- Parents who have a mental illness are more likely to live without their partners.
- Parents who have a mental illness often feel responsible or blamed for their children's difficulties.
- Family members may be regarded as either a resource or as a source of stress.
- Parents who have a mental illness have been found to have a tendency to attribute everyday childrearing stressors and challenges to their illnesses.
- Parents who have a mental illness describe their relationships with their children as fulfilling and important. Parenthood is identified as a significant contributor to recovery.
- Parents may prioritize their children's needs and neglect their own. Women may stop taking psychotropic medication during pregnancy due to fears of fetal harm. They may worry about the impact of their illness on their children.

The significance of the stigma associated with mental illness is profound and acts as a barrier to successful functioning of families living with a mental illness. Children live with the secondary stigma of having a parent with a mental illness. Parents who have mental illnesses often avoid seeking mental health services for fear of losing custody of their children. Yet, raising children while managing a mental illness means that, at times, parents may require additional supports. The needs of families in which a parent suffers from a mental illness are not typically addressed by providers, which increases risk for adverse outcomes. The responsibility for care-giving is often left to healthy spouses or parents, extended family members (e.g., grandparents), siblings (usually sisters) and other relatives adding additional family stress.

Increased awareness and knowledge regarding parents with mental illnesses requires including parenting in treatment planning and asking consumers whether they are parents. Family unity is a critical element of treatment planning for both children and parents; it can accelerate recovery and improve outcomes for both children and parents. An individual with a mental illness should be allowed to parent his or her children, unless demonstrable evidence indicates the potential for harm.

Core elements and principles of effective services for families in which a parent has a mental illness include:

- Services need to be available on an ongoing basis (not provided with time or age limits)
- The entire family must be the focus of services and supports, not just the adults or children; extended family members should also be involved
- Interventions should focus on the development of natural supports
- Services and supports need to consider the impact of stigma associated with mental illness, particularly the prejudices faced by parents with mental illnesses and their children who also face rejection and discrimination from peers and other parents
- The prevention of loss of custody (or, in the event it cannot be prevented, dealing with loss of custody, visitation and placement)
- Family case management that is designed to coordinate services and supports for families as a unit, as well as for individual members of the family
- Access to a comprehensive array of services and supports including twenty-four crisis intervention, housing, employment, parenting skills training, marital and family counseling, reproductive decision-making, perinatal health care,

assistance with school related issues, benefits and entitlement counseling, peer support, medication management, and advance directives planning and support.

Family-centered, strengths-based approaches to working with parents with mental illness and fostering positive relationships between providers and consumers are crucial to effective service and support provision as exemplified in the following programs.

THE INVISIBLE CHILDREN'S PROJECT (ICP)

The Invisible Children's Project (ICP) is a promising program for parents aged eighteen and older who have a serious mental illness and their children. The program focuses on empowering parents and assisting them in the creation of a safe and nurturing environment for their children within an intact family unit. ICP is premised on parenthood as a significant and oftentimes therapeutic role for adults with mental illness and their desire to be effective parents.

The program offers a variety of services and supports including twenty-four hour family case management services with referrals and linkages to community resources for family crisis planning and services, advocacy, respite, child care, parenting skill development, pregnancy and post-partum education, access to financial assistance, supported education and employment, as well as supported housing services. A twenty-four hour helpline, compeer services, and consumer run support groups, are also provided along with in-home interventions, and transportation to appointments (e.g., doctor visits, meetings with child welfare staff and school personnel). Flexible funds are available for special needs (e.g., toys, camps, birthday parties, and education).

The average duration of services is two to three years. The intensity of services (i.e., number of family contacts) depends on a family's needs. Most families are seen once a week with telephone contacts from case managers between visits. The intensity of contact usually decreases over time, but families can continue to receive services as long as needed and minor children reside in the home.

Outcomes studies indicate parents display increased ability to maintain jobs and secure stable housing. Reductions in the need for public assistance, hospitalizations, and numbers of children placed in out-of-home settings (e.g., foster care) have also been found. Other benefits include improvements in the capacity to develop natural supports, parenting skills, and an enhanced sense of autonomy. Their children display increased school attendance, improved academic performance, behavioral control, and communication skills.

THRESHOLD'S MOTHER'S PROJECT

The Thresholds Mother's Project in Chicago, established in 1976, is a comprehensive program for mothers who have a serious mental illness and their children from the age of zero to five. Parents and children attend a therapeutic nursery that is staffed by child developmental specialists who work with the children and provide coaching to the mothers regarding appropriate play and child development issues. While parents attend the program, their children participate in therapeutic classrooms. Some families may reside in agency operated residences that provide supervision and childcare. Crisis beds are also available. A Parenting Assessment Team provides ongoing evaluation of parenting capacity to promote recovery.

The program focuses on teaching independent living and parenting skills as well as supporting recovery to assist mothers meet the challenges of parenthood and includes:

- Parenting skills training
- Individual and group therapy
- Educational services
- Independent living skills training
- Housing
- Employment services

- At-home monitoring
- Case management
- Substance abuse treatment
- Drop-in center services
- Therapeutic nursery

Evaluations of the Thresholds Mother's Project indicate it leads to reductions in hospitalizations for the mothers and improvements in their children's cognitive skills. A five-year study of the program demonstrated that both mothers and children showed improvement over time. Children evidenced increases in developmental intelligence, intelligence quotient, social competence and adaptive skills. Mothers showed enhanced attention skills, social adjustment, and adjustment to work and parenting roles. (However, no significant differences were found in child or maternal outcomes for a comparison of Thresholds' participants and those in a much less comprehensive home-based aftercare program where participants received weekly visits from a psychiatric nurse or social worker.)

THE IMPACT OF DIVORCE

While the effects of a troubled marriage have been demonstrated to have a greater impact on children than a divorce itself or post divorce conflict, children who are raised in families of divorce have been found to be at increased risk for emotional problems, including depression and suicide. Parents who are in the process of a divorce may use their children to manipulate and/or control each other around a variety of personal, social, and financial issues. These tactics add to the stress and anxiety children of divorce typically experience and can increase their risk for behavior problems, depression, delinquency, substance use, and teen pregnancy. These issues point to the value of preventive and early intervention programs to help families cope with divorce. Two such programs are described below.

CHILDREN IN THE MIDDLE

Children in the Middle is a skills-based video program designed to help parents and children deal with children's reactions to divorce, school failure, and suicide. It aims to alleviate children's problems such as loss of concentration and attention, declining grades and behavior problems at school, withdrawal from friends, emotional outbursts, health problems, serious anger with one or both parents, delinquency, and substance use.

A parent video is used to teach parents skills to avoid placing children in the middle of their conflicts. A child video helps children understand why parents divorce and dispels common myths that children have about divorce (e.g., it is their fault; they can reunite their parents) and teaches stress management, anger management, and problem-solving skills. The parent video is available in open-captioned and Spanish language formats.

Children in the Middle is a SAMHSA model program that has been shown to reduce parental anger toward ex-spouses, the use of children as go-between messengers, and children's exposure to parental conflict and stress. Improvements in parents' communication skills and support for children's relationships with their other parent have also been documented. Information can be found on the web at http://www.childreninthemiddle.com/.

CHILDREN OF DIVORCE INTERVENTION PROGRAM (CODIP)

Children of Divorce Intervention Program (CODIP) is a school-based small group preventive intervention that aims to decrease stressful family transitions and foster children's resilience and adjustment to changes in family structure. This SAMHSA model program consists of twelve to fifteen sessions co-led by mental health professionals. Four different CODIP curricula, the Daring Dinosaurs Board Game, and the Feeling Faces poster are available for children from

kindergarten through eighth grade and are tailored to the developmental needs of children based on grade level. School staff members use these to conduct peer support groups during which children share their experiences of divorce or separation with each other. They learn how to identify and express feelings, share experiences, form prosocial bonds with peers to enhance positive perceptions of self and family, and develop the capacity to cope with challenging changes associated with divorce.

The program has been demonstrated to be effective for children residing in urban, suburban, and rural settings. Participants display improvements in overall school adjustment, reductions in anxiety, and improvements in their ability to be appropriately assertive, follow rules, get along well with peers, and tolerate frustration. Longitudinal studies indicate that improvements are maintained years after participation. Information about the program is available on the web at http://www.childrensinstitute.net/programs/CODIP/.

CHILD MALTREATMENT

Child abuse was viewed as a rare occurrence until the 1960s and received little attention. However, research indicates that child abuse occurs in all socioeconomic levels, although it is highly associated with poverty, lower levels of parental education, underemployment, inadequate housing, reliance on public assistance, and single parenting. Child maltreatment has been found to occur more frequently in multi-problem families, including those who experience social isolation, domestic violence, parental mental illness, and parental substance abuse (especially alcoholism). Additional risk factors for children include prematurity, and physical and cognitive disabilities.

The literature indicates a combination of primary, secondary and tertiary prevention services including public awareness activities, parent education programs, skills-based curricula for children, and home visitation programs are needed to prevent maltreatment.

Primary prevention efforts include:

- Public awareness campaigns that educate citizens regarding where and how to report suspected child abuse and neglect
- Public service announcements that encourage parents to use nonviolent forms of discipline

These types of programs are particularly popular during April, which is designated by presidential proclamation as Child Abuse Prevention Month. It should be noted that there is a paucity of information available on the efficacy of such prevention efforts. Other primary prevention efforts focus on support services available to the general population, such as pediatric care for all children, childcare, and parent education classes.

Secondary prevention activities focus efforts and resources on children and families known to be at higher risk for maltreatment. Services may be provided in communities or neighborhoods that have a high incidence of one or several risk factors mentioned above that are associated with child maltreatment. Examples of secondary prevention programs include:

- Parent education programs for teen mothers provided in high schools
- Substance abuse treatment programs for parents with young children
- Respite care for families who have children with special needs
- Family resource centers offering information and referral services to families living in low-income neighborhoods

Family support activities that are available to individuals identified as at-risk or community members in a high-risk neighborhood also are considered secondary prevention. For example,

local hospitals or community organizations may offer prenatal care and parenting classes to new or expectant parents. Local agencies may provide home visitation services for at-risk families with infants and young children. Family support services are intended to assist parents in creating safe home environments and fostering the development of healthy children. Home visiting programs have been shown to lead to improvements in family functioning which can mitigate risk. Research indicates that parent education programs can successfully impart information and alter behavior, but there is little evidence to conclude that such programs actually prevent abuse.

Tertiary prevention efforts target families in which maltreatment has already occurred to prevent it from recurring and reduce its negative consequences (e.g., social and emotional problems in children, lower academic achievement, family problems). Such prevention programs include:

- Intensive family preservation services with trained mental health counselors available to families on a twenty-four hour a day basis for several weeks
- Parent mentoring programs that use stable, non-abusive families who function as role models and provide support to families experiencing crises
- Mental health services for children and families affected by maltreatment to improve family communication and functioning

Parent education intervention programs focus on enhancing parental competencies and promoting healthy parenting practices and typically target teenaged parents and those under significant stress. Some of these programs are led by professionals or paraprofessionals, while others are facilitated by parents who provide mutual support and discuss personal experiences. These programs address issues such as:

- Developing and practicing positive discipline techniques
- Learning age-appropriate child development skills and milestones
- Promoting positive play between parents and children
- Locating and accessing community services and supports

Parent education programs are designed and structured differently, depending on the curriculum being used and the target audience. Programs may be short-term (i.e., those offering once weekly classes for six to twelve sessions) or they may be more intensive (i.e., those offering services more than once a week for up to one year).

Two interventions for sexual abuse can be found in the section on psychotherapy.

FAMILY SUPPORT SERVICES

PARENTS ANONYMOUS

Parents Anonymous provides mutual support and resources to families who are overwhelmed by everyday stressors. It is rated as a promising approach for prevention, education and as an intervention for child maltreatment. It consists of weekly parent meetings lead by a professionally trained facilitator and co-led by a parent group leader. Participants determine the agenda for each meeting which includes topics related to basic parenting skills, such as communication and discipline. Group members offer twenty-four hour support for parents experiencing a crisis or stress. A complementary children's program includes activities to assist with the acquisition of skills such as conflict resolution, appropriate peer interactions, identification and communication of thoughts and feelings.

Outcome studies have found Parents Anonymous to be a cost effective means of reducing the frequency of child abuse, enhancing parents' feelings of competency and their ability to manage

stress effectively. Research indicates that benefits accrue proportionality in relation to the length of participation with longer term involvement leading to increased self-esteem, decreased social isolation, and increased knowledge regarding child development and behavior.

Parents Anonymous, Inc. offers training, publications and technical assistance free of charge. Information on the program can be found at http://www.parentsanonymous.org/.

RESPITE SERVICES

Raising a child who has a serious emotional disturbance can be very stressful. Adult family members need occasional relief from stressors, or a change of pace, in order to maintain their own physical and mental health. Such relief should be available to all members of the family, including caregivers as well as siblings, and be provided in a manner that is in accordance with their specific needs.

Respite is defined as temporary relief provided to primary caregivers in order to reduce stress, support family stability, prevent abuse and neglect, and minimize the need for out-of-home placements. Families receiving respite can include intact families, foster and adoptive families, kinship families, and other caregivers. Respite is an important component in the prevention of child abuse and neglect. The Community-Based Family Resource and Support (CBFRS) program, established by Title II of the Child Abuse Prevention and Treatment Act (CAPTA) Amendments of 1996, includes respite as a mandated service. Therapeutic respite offers parents time for themselves so they can be the best parents possible, and provides relief from stress during crises as a means of preventing child abuse.

Respite services can be utilized within the home or outside of the home. In-home respite can include a sitter or companion for a child, siblings, or homemaker, or be comprised of an informal network of assistance. Out-of-home respite models include services offered in respite providers' homes, foster homes, group daycare centers, residential treatment centers, crisis and emergency facilities, and parent cooperatives where parents volunteer to care for each other's children on a planned or emergency basis.

Respite settings include:

- Agencies
- Families' homes
- Day care centers
- Recreational facilities
- Hospitals
- Family resource/support centers
- Providers' homes
- Residential facilities
- Camps
- Schools
- Faith-based organizations
- Therapeutic child development programs

Planned respite services are scheduled, whereas crisis respite services are provided on an emergency basis. Crisis respite provides a safe haven for children and families experiencing challenges such as financial, housing, and social stressors, substance abuse, mental illness, inadequate parenting skills, and domestic violence. Crisis nurseries are an example of out-of-home crisis respite care. Crisis nurseries are designed to prevent abuse and neglect by providing temporary child care for young children who are at-risk, while offering an array of support services to the families and caregivers of these children.

Planned and crisis respite care can help prevent child abuse by reducing the stress of working parents, increasing the ability of parents to cope with the pressures of child care, enhancing parent-child communication, decreasing family isolation, improving access to health care and other services, and offering families relief from the demands of daily child care. It can also help reduce disrupted foster care placements. Studies of families of children who are at risk for

abuse and/or neglect have found significant decreases in reports of child maltreatment as well as levels of stress in families using crisis respite services. The provision of respite care for families of children with emotional disturbances has been shown to result in reductions of out-of-home placements.

MENTORING

The literature clearly points to the positive impact that adult role models can have on the development and socialization of children and adolescents who are at risk for delinquent and aggressive behaviors. Mentors, with proper clinical supervision, can play an important role in working with children who have multiple risks for difficulties. Research consistently points to a warm relationship with a caring adult outside of the family for support and guidance in the development of resiliency. A warm trusting relationship with such an adult who can offer help with child rearing, respite, and social support provides significant protective factors. A sustained relationship with a mentor can help a child gain conflict resolution skills, problem-solving skills, and the ability to interact positively with others. Studies indicate that supportive relationships with adults outside of the family are associated with beneficial outcomes, particularly for youth whose families are not supportive.

Mentors often assist children and their families by providing them with linkages to mental health services and supports. They can help ensure medication regimens are adhered to and provide transportation to appointments and support groups. Family support mentors assist with child care, and household functioning through the enhancement of positive attachments, parental training in appropriate discipline, and developing and maintaining household routines.

Outcomes of studies on mentoring have shown reductions in aggressive behaviors, substance use and improved school, peer, and family functioning. Mentoring programs such Big Brothers Big Sisters and the Quantum Opportunities Program (QOP) have found that positive relationships with non-parental adults influence prosocial behavior in children and adolescents and compensate for inadequate family relationships. Both programs use relationships with adult volunteer mentors as their primary intervention. QOP includes other community interventions (primarily remedial education and career preparation).

BIG BROTHERS/BIG SISTERS OF AMERICA (BBBSA)

Big Brothers/Big Sisters of America, founded in 1904, is a community-based mentoring program that is targeted to children and adolescents who are between the ages of six and eighteen living in single parent homes. Services are provided by adult volunteers (Big Brothers and Big Sisters) to children/adolescents (Little Brothers and Little sisters) in one-on-one relationships. Volunteers are screened by case managers who then match them with children and monitor the relationship from the onset until termination (which is due to a voluntary decision or lack of meeting eligibility criteria). The program is designed to enhance prosocial behaviors, academic achievement, and family and peer relationships.

BBBSA's published standards and requirements include the following components:

- Screening of all volunteers that includes a written application, background investigation, extensive interview, and a home assessment to screen out individuals who lack the capacity to form a caring bond with a child, may cause harm to a child, or are unlikely to honor their time commitments.
- An orientation to the program is required for all volunteers.
- An assessment of each child/adolescent that entails a written application, interviews with the child and the parent, a home assessment designed to help

the case manager become acquainted with the child in order to make the best possible match, and secure parental permission.

- Matches are made based on the needs of the children/adolescents, abilities of volunteers, preferences of parents, and capacity of program staff.
- Supervision is provided starting with an initial contact with parents, children/adolescents, and volunteers within two weeks of the match. Monthly telephone contact is maintained with volunteers, parents and/or children/adolescents during the first year. Quarterly contact is maintained with all parties thereafter for the duration of the match.

Outcome studies indicate that participants are less likely to initiate substance use, strike another person, and demonstrate positive academic behavior, attitudes, and performance. They are more likely to have more positive relationships with their parents/guardians and peers. The average cost of creating and supporting a match relationship is $1,000 per year. Information can be obtained from the BBSA web site http://www.bbbsa.org.

QUANTUM OPPORTUNITIES PROGRAM (QOP)

The Quantum Opportunities Program (QOP) is an intensive, multi-component intervention for high school aged teens from fourteen to eighteen who are from disadvantaged circumstances and whose families receive public assistance. The four-year program, which originated in 1989, aims to increase graduation rates, and decrease teen pregnancy rates and violent behavior.

Participants are involved during all four years of high school for two hundred fifty hours per year in three areas: (1) educational support, (2) community service activities, and (3) developmental activities.

Component	Provider	Duration	Description
Education-related activities (tutoring, computer-assisted instruction, homework assistance)	Adult counselors	250 hours/year after school	Different settings: community agencies, public schools, homes, group activities
Development activities (acquiring life and family skills; planning for college and jobs)	Adult counselors	250 hours/year after school	Different settings: community agencies, public schools, homes, group activities
Service activities (community service projects, helping with public events, holding regular jobs)	Adult counselors	250 hours/year after school	Different settings: community agencies, public schools, homes, group activities
Hourly stipends and bonuses for completing each segment of the program			

The program operates year-round and combines features of case management, mentoring, computer-assisted academic assistance and instruction, work experience, community service, and financial incentives. A counselor is assigned to a small group of students and commits to stay with the group for all four years of high school and beyond.

The original demonstration program enrolled twenty five students in five different sites around the country: San Antonio, Philadelphia, Milwaukee, Oklahoma City, and Saginaw, Michigan. QOP has also been replicated on a larger scale in seven more cities, with a total of six hundred multiethnic participants (Hispanic/Latino, Asian, and Caucasian). Outcomes studies clearly demonstrate that participants are less likely to drop out of high school and more likely to graduate, attend post-secondary school, receive an honor or award, and are less likely to become teen parents or be arrested. The cost for four years is $10,600.00 per participant, or $2,650.00 per year.

SUICIDE PREVENTION

Suicide prevention has become a public health agency priority. The Surgeon General's *Call to Action to Prevent Suicide* published in 1999 identified suicide as a major public health problem and indicated the need for a public health approach to address it. The Department of Health and Human Services' *Healthy People 2010 Objectives* set a goal for a reduction in suicides overall and a reduction in injurious suicide attempts among youth in grades nine to twelve. The Health Resources and Services Administration's Maternal and Child Health Bureau has made reduction in the rate of youth suicide a priority for state Maternal and Child Health (MCH) agencies. It is now one of the core performance measures that states must address in their annual block grant applications.

Suicide[15] is the third leading cause of death among children and adolescents aged fifteen to nineteen and in many states ranks as the second leading cause of death in this population. The incidence of suicide attempts is greatest during the mid teen years. The 2003 Michigan Youth Risk Behavior Survey data indicated that eighteen percent of ninth through twelfth grade students give serious consideration to suicide, and one of ten makes an actual attempt.

Males under the age of twenty-five are much more likely than their female counterparts to complete suicide. The incidence of suicide varies by race and gender with youth from Native American groups having the highest rate, followed by Caucasians, African Americans and Asians. It has been widely reported that youth who are gay and lesbian are two to three times more likely to commit suicide than other youth, and thirty percent of all attempted or completed youth suicides are related to issues of sexual identity. While empirical data on completed suicides to support these assertions is lacking, there is increasing concern about an association between suicide risk and bisexuality or homosexuality for youth, particularly among males.

Approximately half of all suicides are associated with depression. Evidence also points to a lack of social connectedness and increased risk due to interpersonal loss and conflict (e.g., parental divorce, loss of a romantic interest). Many teenage suicides are reported to occur in clusters of a temporal and geographic nature, thus indicating some may be the result of imitative behavior. Risk factors for suicide include:

- A previous suicide attempt (which is more predictive and common for males than females with a ratio of three to one in prepubescent children, and approximately five and a half to one in the fifteen to twenty-four year old age group)
- Mental illnesses, especially mood disorders[16]
- Substance abuse (which significantly increases risk for suicide for the sixteen and older age group)
- Co-occurring mental illness and substance use disorders

[15] The term *gesture* is often used denote a non-lethal, self-destructive behavior that is judged to be a cry for help or indicative of a manipulative behavior lacking serious intent. This is a misleading label; it minimizes the potential risk for future suicidal behavior. Future suicidal behavior cannot be determined.

[16] Research indicates that ninety percent of children who commit suicide have a mental disorder. The presence of a mood disorder significantly increases the risk for suicide. Adolescents who have a depressive disorder are five times more likely to attempt suicide compared to their cohorts who do not have a depressive disorder. Panic attacks are a risk for suicidal ideation and attempts in females, while aggressiveness is a risk factor for males. Depression is the greatest risk factor, but ADHD, and bipolar disorder are also risk factors. Disruptive disorders increase the risk of suicidal ideation in children aged twelve and younger.

- A family history of suicide
- An age of sixteen and older
- A sense of hopelessness
- A propensity for impulsive and/or aggressive behavior
- Barriers to accessing mental health services
- A physical illness
- Ease of access to lethal methods, especially firearms
- Cultural and religious beliefs that view suicide as a noble act
- The contagious influence of local epidemics of suicide
- Feelings of isolation
- Influential role models who have died by suicide (e.g., family, peers, celebrities)[17]
- Inadequate parental communication and severe family problems

It should be noted that official suicide rates often do not represent the full extent of the problem. Misclassifications and underreporting of suicide completions and attempts may occur due to lack of adequate training for individuals completing death certificates, the absence of national standards for identifying or coding suicide attempts in medical records, and the social stigma associated with suicide.

Suicide Methods, United States, 2002

Method	No.	Rate	% of total
Firearms	17,108	5.9	54.0
Suffocation/Hanging	6,462	2.2	20.4
Poisoning	5,486	1.9	17.3
Falls	740	0.3	2.3
Cutting/Piercing	566	0.2	1.8
Drowning	368	0.1	1.2
Fire/burning	150	0.1	0.5
All others	775	0.3	2.5
Total	30,622		100.0

The following protective factors have been identified to mitigate suicide risk:

- Ongoing supportive relationships with mental health and medical health care providers
- Problem-solving, conflict resolution skills and nonviolent ways of dealing with disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation
- Effective care for mental, physical and substance use disorders
- Effortless access to support and interventions
- Restricted access to lethal methods of suicide
- Family and community support

There are two central components of successful suicide prevention programs: (1) case-finding, which involves efforts to find children and adolescents who are at risk, referring them for services, and ensuring they receive appropriate care; and (2) risk reduction or primary

[17] Research indicates that the deaths of celebrities by suicide are more likely to lead to imitation. In addition, research has shown that the use of the word *suicide* in headlines or references to the cause of death as self-inflicted increases the likelihood of contagion.

prevention aimed at reducing the risks for suicide and suicidal behavior by, for example, restricting access to lethal means. Youth suicide prevention activities should include suicide survivors, educators, social service agencies, faith-based community organizations, state cooperative extension (4-H) programs, school psychologists, child psychiatrists, parent-teacher associations, substance abuse treatment professionals, the juvenile justice system, primary care, and the mental health service system. Strategies to prevent suicide include:

- Training primary care providers to recognize suicide risk and treat depression, substance abuse and other mental illnesses associated with an increased risk for suicide
- Training mental health, health, substance abuse and human service professionals including clergy, teachers and corrections officers to conduct suicide risk assessments and make referrals for intervention as appropriate
- Encouraging family members of those deemed at risk to obtain assistance
- Providing prevention programs in educational settings that incorporate peer support
- Providing intervention for mental illnesses and substance use disorders to mitigate risk
- Restricting access to lethal methods of suicide
- Intervening with the family as whole

Research indicates that broad-based suicide awareness efforts and excessively inclusive screening may actually promote suicide as a potential solution to everyday distress or imply that suicidal ideation and/or behavior is a normal response to stress. Evaluations of suicide awareness curricula provided in schools indicate that they are not effective and are contraindicated. Inappropriate approaches to prevention can unintentionally increase the risk for suicide in youth who are vulnerable. Other kinds of school-based prevention programs involving skill development (e.g., assertiveness training, conflict resolution) appear to be more promising.

Research supports the effectiveness of providing training to hospital emergency department staff to intervene in all suicide attempts and emphasize to family members the dangers of ignoring suicide attempts, as well as the benefits of follow-up treatment to decrease recurrence of suicide attempts. Inpatient admission is warranted when an adolescent expresses a persistent wish to die and/or is displaying symptoms of a severe mental illness/disorder. Discharge from an inpatient setting is warranted only when there is sufficient assurance suicidality has been stabilized, adequate supervision in the community is available, the environment is free of all potentially lethal items such as guns or medications, and follow-up therapy has been arranged.

Only two medications have been associated with reduced suicide: clozapine and lithium. SSRIs (selective serotonin reuptake inhibitors) are used to treat depression to mitigate risk. (Tricyclic antidepressants are contraindicated as a first-line treatment due to their potential for toxicity.) It is critical for medication to be monitored for proper ingestion, side effects, and behavioral changes. Interpersonal Psychotherapy for Adolescents (IPT-A), cognitive-behavioral interventions, and Dialectical Behavior Therapy for Adolescents (DBT-A) have been shown to be effective. The sections on psychotherapy and somatic therapy discuss the use of medications and therapies in more detail.

VIOLENCE PREVENTION

Youth violence has been identified as a significant national problem as evidenced by reports of school shootings, inner city violence related to drugs and gangs, and the increasing use of violence to solve disputes. Children and adolescents aged ten to seventeen commit the majority of violent acts.

Youth who are at risk for violent behavior are distinguished by their poor school performance, limited family support, delinquent behavior, and influential relationships with peers who engage in antisocial behaviors. They are also over represented in juvenile and family courts, foster and residential care, and mental health programs.

A number of risk factors for juvenile violence have been identified:

- Low socioeconomic status
- Inadequate parental supervision
- Harsh and erratic discipline
- Delinquent peer group associations
- Child abuse and neglect
- Substance abuse
- Early sexual involvement
- Conflict
- Aggression

The identification of effective programs to prevent violence has been a national priority for more than a decade. The Blueprints for Violence Prevention is an initiative that has identified model and promising programs for both prevention and intervention based on rigorous standards for determining their level of evidence. The website is www.colorado/blueprints/. The program matrix can be found in Appendix C.

Research has demonstrated the effectiveness of a number of interventions in the prevention or reduction of violence in at-risk adolescents. A review of these programs indicates there are common elements that lead to beneficial outcomes. These elements are:

- **Anger management and problem-solving skills training** provided either through educational or modeling approaches.

  Anger management programs are comprised of teaching the difference between anger and aggression, how to express anger appropriately, resisting taunts, responding to other's anger without using aggression, and appropriately giving and accepting negative feedback. Awareness of triggers, body sensations associated with anger, and resources for self control, assertiveness, and relaxation techniques are used in some of the programs.

  Problem-solving programs are comprised of enhancing decision-making skills by identifying options, resisting peer pressure, and developing alternatives to violent responses. Cognitive interventions that focus on improving moral reasoning, such as guided discussions of examples of moral dilemmas, (e.g., witnessing shoplifting), modeling openness, acceptance, and respect for other's views, listening, and communication skills training are used. Cognitive mediation is used to increase awareness of the consequence of violence, refute beliefs that support the use of violence, and improve social problem-solving by helping participants question their perception of others' hostility, search for further information about

the situation, generate alternative solutions, identify consequences of violent solutions, and prioritize solutions according to their effectiveness in achieving the desired outcome or goal. Dissemination methods are primarily cognitive-behavioral and educational, using role-plays and multimedia examples. Some programs use peers to teach and model improved anger management.

- **Gender-specific programming** is recommended since female aggression has been found to be different from that of males. Females use more indirect methods of aggression, such as exclusion and telling false stories about others. Educational approaches that incorporate discussion of different examples, problem-solving skills development, and refuting beliefs supporting the aggressive behavior have been found to be of benefit.
- **Social skills training** and choosing prosocial peer relationships. However, social skills training alone has not proven effective in changing behavior. It is therefore used as part of a multimodal approach.
- **Family interventions** (e.g., Multisystemic Therapy and Functional Family Therapy) that are designed to improve relationships and parenting skills have been found to be effective. These interventions stress the importance of parenting skills that include clear descriptions of expectations, specific consequences, open discussions, contracting between parents and children/adolescents, and flexibility based on ultimate goals (rather than rigid rules and consequences). Improved parental monitoring of peer relationships that indirectly affect aggressive behavior through the influence of peers who engage in antisocial behavior is also an important component.
- **Therapeutic foster care** has been shown to be effective in modifying aggressive behaviors in adolescents. Specific limit setting and enforcement of consequences, particularly when the level of structure is balanced with emotional support, are associated with improved behavior. (A discussion of therapeutic foster care can be found in the section on crisis intervention and out-of-home settings.)
- **Bullying prevention programs** that use limit setting in schools to alter bullying behavior and responses by victims through the use of increased monitoring and enforcement of consequences for bullying behavior have proven effective. (A discussion of bullying prevention in schools can be found on pages 83-84.)
- **A strengths-based focus** on resiliency to help at-risk teens and their families discover and use existing skills and capacities which are found in models such as Functional Family Therapy, Multisystemic Therapy, and Multidimensional Treatment Foster Care.
- **Interventions that target multiple domains** (e.g., individual, family, peers, community relationships) are more effective, especially when these interventions are coordinated in a collaborative manner with all relevant service sectors.

The interventions with the most robust evidence of effectiveness for reducing violent behavior are intensive case management, cognitive-behavioral therapy and skills training, Integrated Dual Disorders Treatment (IDDT) and family therapies, such as Functional Family Therapy (FFT) and Multisystemic Therapy (MST).

PREVENTION OF SEX OFFENDER BEHAVIOR

Sexual assault is one of the fastest growing violent crimes in the United States. Approximately one out of three women and one out of every seven men will be sexually victimized before age eighteen. Studies of adult sex offenders indicate that most report the onset of sexual offending

behavior began prior to age eighteen. The majority of adolescents commit their first sexual offenses before age fifteen and many do so prior to age twelve. Youth under the age of eighteen commit about twenty percent of all rapes and thirty to fifty percent of child molestations. Most are males between the ages of thirteen and seventeen, although there are a number of studies indicating females and prepubescent children also engage in sexual offender behavior. It should be noted that juvenile sex offender behavior is not more prevalent in any specific ethnocultural group.

It has been estimated that up to eighty percent of juveniles who have committed sex offenses have a diagnosable psychiatric disorder. Fifty to eighty percent have learning problems, repeated a grade in school, and/or have been enrolled in special education classes. Sixty to ninety percent have co-occurring conduct, attention deficit/hyperactivity, and mood, anxiety, and substance use disorders. A higher number of co-occurring disorders is correlated with a younger age of the first sexual offense. Twenty to fifty percent have histories of physical abuse and forty to eighty percent have histories of sexual abuse.

Controlled outcome studies are lacking due to ethical issues and funding problems. Therefore, the literature can only point to promising practices. These usually combine intensive, multimodal approaches and support early intervention. Cognitive-behavioral interventions typically focus on taking responsibility for one's sexual behavior, victim empathy development, and skill building to prevent future offending. The literature identifies the following essential components of intervention for juveniles who commit sex offenses:

- Impulse control and coping skills to successfully manage sexual and aggressive impulses
- Assertiveness and conflict resolution skills to manage anger and resolve interpersonal disputes
- Enhancement of social skills to promote increased self-confidence and social competency
- Empathy enhancement and improved appreciation of the negative impact of sexual abuse on victims and their families
- Relapse prevention including: (1) teaching understanding of the cycle of thoughts, feelings, and events that are antecedent to the behavior; (2) identifying environmental circumstances and thinking patterns that should be avoided due to increased risk of reoffending; and (3) identifying and practicing coping and self-control skills for the management of behaviors
- Clarifying and teaching values related to respect for self and others as well as a commitment to cease interpersonal violence, including the promotion of a healthy identity, mutual respect in male-female relationships, and respect for cultural diversity
- Sex education to achieve an understanding of healthy sexual behavior and correct distorted or erroneous beliefs about sexual behavior

Multisystemic Therapy and cognitive-behavior therapy (CBT) are most effective interventions. For a complete discussion of CBT techniques refer to *A Guide to Evidence-Based Practices for Adults with Mental Illness* available on-line at http://sccmha.org/quality.html.

FIRE SETTING PREVENTION

Juveniles are arrested more often for crimes of arson than any other age group in the United States and account for fifty percent of all arrestees. Most are male (eighty percent), Caucasian, and members of the middle class. A home environment characterized by lax discipline, supervision and monitoring, as well as lack of parental involvement, and family conflict, with one

or no biological parents present, are common risk factors.[18] Many of these children/adolescents display poor academic performance and may also have histories of truancy, disruptive or hyperactive behavior, poor peer relationships, a history of sexual abuse, and display an inability to form close friendships. Many also experience problems with aggression and conduct as well as attention deficit/hyperactivity disorder.

Early intervention to preclude the escalation in number and intensity of fires for children who have set fires or display an unusual interest in fire is recommended since children do not usually outgrow the behavior. Furthermore, the intensity and scale tends to rise with age ("the bigger the child, the bigger the fire"). Cognitive-behavioral therapy, parent management training and fire safety awareness education have been shown to reduce fire setting and playing with matches for up to one year following intervention. Fire safety education is considered integral and should include information regarding the nature of fire, how quickly it spreads, potential for destruction, how to maintain a fire safe environment, using escape plans and practicing them, and the appropriate use of fire. To date, no treatment approach has been found to be universally effective for the treatment of fire setting behavior.

[18] A home with a significant number of family problems is the single strongest predictive factor in recidivism.

ZERO TO FIVE: EARLY INTERVENTION

Limited research and innovation have long characterized services for very young children and their families. The changes in children's mental health services over the last fifteen years have largely ignored the needs of young children and most programs have not adequately addressed the needs of infants, toddlers, and preschoolers. However, in recent years this population has been identified as a priority group within the children's mental health arena.

Early intervention is supported by research demonstrating that childhood is a critical developmental period. Studies show significant associations between maternal deprivation, stress, and children's well-being. Research on the environment of care giving indicates that severe environments (e.g., those with abuse and neglect) may affect brain development in terms of cell survival, neuronal density, neurochemical functioning, and behavioral response to stress.

Early brain plasticity[19] can contribute positively to optimizing brain development. Behavioral changes such as improved regulation of attention and affect, impulse control and task focus during the preschool years are associated with biological changes such as neurogenesis, myelination, dendritic and axonal arborization, synaptic stabilization and sculpting of neural circuits. These transformations constitute the foundation for academic achievement, empathy, and cooperation in social relationships. Research as shown that poor nutrition, physical or emotional abuse, neglect, substance abuse, and lack of an environment that stimulates active participation have deleterious effects on brain cell survival, normal growth of brain circuitry, cerebral vascularization, and neuron density. Data indicate that behavioral correlates of these anatomical and physiological changes exist and that psychological harm in early life can be reversed if it is dealt with during critical time periods.

The early years offer a unique opportunity for positively influencing development and enhancing support from families to maximize the opportunity to achieve positive outcomes for children and their families. Early diagnosis and intervention has been shown to result in beneficial outcomes for children. In fact, intervention that is begun very early may be even more effective because of its potential to prevent the development of cumulative deficits. For example, programs that focus on enhancing the quality of parent-child interactions and strengthen the competence and problem-solving capacities of families have been demonstrated to be successful in preventing declines in assessed cognitive development that can occur over time for children with low birth weights and prematurity.

Early experiences set the stage for peer relationships, child-adult relationships, emotional self regulation, self-concept, and academic performance. Research demonstrates that promoting the emotional well-being of young children and fostering warm, secure relationships with their parents and other caregivers are central to healthy early development and subsequent success in school. Children's early physical and mental health are important determinants of their later readiness for school and school success. Nurturing relationships seem to be a critical factor in emotional development which itself is related to school success.

Preschool children rarely receive mental health care. Infants and young children (birth to age five) may experience serious emotional and/or behavioral disturbances but these are often ignored or are inadequately addressed. Studies have documented that young children utilize mental health services at rates that are lower than the projected need based on incidence of problems. It is estimated that only about one to two percent of preschoolers access mental

[19] The plasticity of the brain begins to decline after the age of ten.

health services and supports, compared to the six to eight percent of six to eleven year olds and eight to nine percent of twelve to seventeen years olds that do.

The importance of ensuring early identification and intervention for children who are at risk for, or have delays in, social and emotional development and exhibit problem behaviors are an increasing national focus. Along with this is recognition of the need to include health, mental health, child welfare, and early education[20] in service planning. Communities tend to deliver services for young children and families in a fragmented and patchwork fashion which creates barriers to access. The effectiveness of a no wrong door entrance policy and providing services in natural settings to enhance access are being recognized. A large number of young children spend time in out-of-home settings such as day care and preschool. Such settings offer significant opportunities to identify children with challenging behaviors, offer intervention, and referral.

Programs aimed at the zero-to-five age group are based on research that demonstrates that interventions provided during the first five years of life can help reduce subsequent developmental challenges. Such programs incorporate mental health into prevention efforts, anticipate and promote children's well-being, rather than merely respond to identified problems. In addition, these programs are based on the principle that parents and other caregivers are essential to the enhancement of the mental health of children, especially those who have recognized difficulties. They incorporate a strong outreach component to children who are identified as being at risk for developing behavioral and/or emotional problems and focus on maximizing nurturing environments and relationships to promote healthy development.

Essential Services and Supports for Young Children

- **Health care** (e.g., immunizations, pediatric care, diagnosis and follow-up for special health care needs)
- **Screening** for developmental delays and age appropriate developmental services (e.g., behavioral interventions, speech and language services)
- **Parent education** (e.g., modeling healthy parent-child interactions)
- **Basic supports** for families such (e.g., child care subsidies, housing, food stamps)
- **Specialized supports** for families (e.g., substance abuse intervention, mental health care)

The goal of early childhood mental health services is to improve the social and emotional well-being of young children and families by strengthening relationships with caregivers and fostering age-appropriate social and emotional skills. Mental health services and supports for very young children can be of significant benefit to children who experience difficulty developing age-appropriate social and behavioral skills as well as their families.

The underpinnings of effective interventions are based on social learning theory (which emphasizes role models and their impact on the development of children) and behavior modification. Research indicates that the development of good social relationships is based upon infants' interactions over a period of time with someone who is familiar and sensitive. Thus, the importance of a biological tie is less important than the nature of the relationship itself. In other words, the most important context is the care-taking environment.

[20] Michigan's Great Start Collaborative, initiated in 2005, is designed to create a coordinated system of community resources and supports to assist families with children from birth to age five to ensure the health, welfare and preparation of children entering kindergarten. Grants are provided to Intermediate School Districts to promote physical health, social and emotional health, family support, basic needs, parenting education, early education and child care and incorporate physical health, social-emotional health, family support, basic needs, economic stability and safety, parenting education, early education and child care.

HOME VISITATION AND FAMILY STRENGTHENING PROGRAMS

Nurse home visitation models are predicated on the importance of: (1) reducing children's neurodevelopmental deficits (affective and behavioral dysregulation and cognitive impairments) by enhancing prenatal health related behaviors; (2) reducing care giving that compromises health and development; and (3) improving parental economic self sufficiency through future pregnancy planning, finding employment, and ultimately reducing dependence on public assistance.

Home visitation program models offer a variety of family-focused services to pregnant mothers and families with new babies and young children. Services typically include structured visits in the family's home, informal visits, and telephone contacts. Common components include addressing the following areas:

- Positive parenting practices and nonviolent discipline techniques
- Education regarding child development
- Availability and accessibility of community resources
- Establishment of natural social supports
- Advocacy for parents, children, and families
- Maternal and child health issues
- Prevention of accidental childhood injuries by ensuring a safe home environment

There is sufficient evidence in the literature to indicate that home visitation models improve parent-child interactions and health. In addition, they offer the opportunity for early intervention to ameliorate the sequelae of cognitive and developmental delays. Some caveats are worth mentioning, however. Most home visiting programs have not demonstrated consistently positive outcomes. They are fraught with challenges of engaging families, lack of fidelity to models, and staff training and qualifications issues which strongly impact quality. Most of the research conclusions indicate that home visiting cannot be relied upon as a singular service strategy. Outcome data are mixed and studies have relied on parental self-report. This lack of direct assessment reduces the scientific validity of the studies.

No single model of family strengthening stands out as universally effective. Research indicates that these service models produce slightly positive outcomes for children and their parents, but families may require differing interventions depending upon their circumstances. The most promising models combine parental involvement with high quality care for their children. The literature points to the following conclusions:

- Only modest effects on outcomes can be attained from home visiting programs alone. Moreover, these effects are only found in those families where parents are highly engaged in the program
- Families who are at higher risk usually need more intensive services with more intensive home visits and immediate rescheduling of failed appointments
- The best results are achieved when home visiting is combined with comprehensive services (e.g., high quality child care, education[21])

[21] Research on home visiting literacy programs indicate older toddlers (eighteen to twenty-five months) acquire larger vocabularies, while no difference for younger toddlers (thirteen to seventeen months) has been found in studies. Studies suggest that home visiting family literacy programs need four components to be effective: high levels of family participation, skilled staff, an appropriate curriculum, and adequate funding. However, various programs differ significantly in the number of home visits; they range from zero to one hundred fifty per annum. Additionally, while children in experimental groups whose parents were highly engaged in studies made significant improvements in vocabulary and other indicators of school readiness, children in control groups typically catch up by the end of the

- Family engagement is critical to producing beneficial outcomes
- Fidelity to the model of the parent/family strengthening program is critical to achieving intended results
- Interventions should be delivered by professional staff

NURSE-FAMILY PARTNERSHIP PROGRAM (NFP)

Originally called the Elmira Prenatal/Early Infancy Project, this SAMHSA model program targets families who are young, single-parent, and socioeconomically challenged. The program was established by the National Center for Children and Families and Communities (NCCFC) and provides home visits by public health nurses to enhance maternal, prenatal and early childhood health, mental health, family and peer supports, parental roles, and well-being of first-time mothers who have limited incomes. Issues such as pregnancy planning, education, and employment are addressed. The program uses the Nurse-Family Partnership Home Visit Guidelines which detail the structure of each visit and tools to use in working with mothers. The mother's health, quality of care giving for the child and their own development are addressed with resources that match the developmental needs of the child and family.

Outcome studies indicate that nurse home visits both during and subsequent to pregnancy lead to improved birth outcomes through reductions of pre-term and low birth weight babies, decreased quickly recurring and unintended pregnancies, incidents of child abuse, and behavioral problems. In addition, participants become more involved with their children, and report reductions in incidents of arrests, convictions, alcohol consumption, and lifetime sexual partners. Children display reductions in conduct disorders, involvement in crime, and delinquent behaviors. The costs of the program have been found to be more than offset by the higher taxes the women pay through increased participation in the workforce, and by projected savings on community-based interventions. The original program saved four dollars for every dollar invested due to reduced need for welfare benefits, fewer arrests, and lower health care (especially emergency room) costs. A fifteen-year follow-up of the original Elmira New York participants found significant reductions in child abuse and neglect, maternal behavioral problems due to use of alcohol and drugs, fewer arrests among the mothers, as well as fewer arrests, convictions, sexual partners, cigarettes smoked, and days of alcohol consumption alcohol among their fifteen year old children.

It should be noted that efforts to replicate the nurse home visitation program have met with limited success when paraprofessionals are used. Fidelity to the original model is therefore integral to its success. The NCCFC provides consultation and training to assist communities in establishing the program. Each local program then participates in a national program quality and performance evaluation to identify factors that contribute most significantly to the program's success or failure in a variety of settings. Information is available on the web at http://www.nccfc.org/.

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second grade. Children whose parents are not highly engaged do not demonstrate significant differences from those in other early childhood programs.

TODDLER-PARENT PSYCHOTHERAPY (TPP)

TPP is a preventive intervention designed to promote secure attachments[22] in the offspring of mothers with depression. It is also an intensive intervention that addresses difficulties with attachment that has been shown to be helpful in improving children's cognitive functioning. The program is based on the premise that caregivers tend to repeat insecure early childhood attachments and parenting behaviors they experienced with their own caregivers. It is designed to modify caregivers' inappropriate perceptions regarding their infant's/toddler's developing mental health by changing care giving behavior. Caregivers are helped to connect their past experiences to current behavioral interactions with their infants/toddlers, as well as recognize and integrate previously unresolved negative experiences to enhance their parenting abilities. Interactive guidance using videos of the current caregiver and infant/toddler during play sessions are employed.

TPP is typically provided for ten to twenty sessions over a period of two to six months as a home-based or office-based intervention. The latter may be in either a group or individual dyadic format. Home-based service delivery is recommended for families that are challenging to engage in services.

Outcome studies indicate TPP leads to the achievement of increased maternal empathy (which has been linked to reduced avoidant and angry behavior in children), enhanced care giving attachments, and improvements in the quality of the dyadic relationship. However, it should be noted that studies lack randomized control trials.

PARENTS AS TEACHERS (PAT)

Parents As Teachers is predicated on the concept that parents are children's first and most influential teachers. This promising program is designed to develop and enhance parenting skills to promote the development of children from birth to age three. PAT provides intensive, targeted education and support from the third trimester of pregnancy through the child's third year of life with follow-up through age five. The program offers age-appropriate information on development and provides guidance to parents in fostering their child's social and intellectual development. The two components of the program are parent education, which is comprised of four home visits and four group sessions per year, and periodic behavioral and health developmental screenings.

Outcomes studies indicate improvements in children's school-readiness as evidenced by math and reading scores on standardized tests. Parent participants have been found to be more knowledgeable about developmental issues, including the importance of physical stimuli in their children's development, effective discipline, and child development in general. Findings from research indicate that the gains children make are directly proportional to the amount of parental involvement and participation in the program. However, studies have methodological flaws and contain relatively small sample sizes.

[22] TPP is used to treat reactive attachment disorder (RAD). However, although reactive attachment disorder is listed in the DSM-IV, studies documenting the reliability or validity of this diagnosis or its treatment are lacking. Evidence-based practices are used to address essential behavioral components of RAD. Three modalities are used to help children and their caregivers attune to each other and interact more positively: working through the caregiver, working with the caregiver-child dyad (and/or family) together, and/or working with the child alone. None of these has been specifically evaluated for RAD. Infant-parent therapies, such as TPP, focus on the caregiver and child's experience of one another and alter the patterns of emotional communication between them.

There is a standardized PAT training program which requires thirty-two hours of pre-service and continuing in-service training. While there is no preset curriculum, materials are available for guidance and the program is tailored to the strengths and needs of families who participate. It can be implemented by nurses, teachers, social workers and trained parent educators. Information about the Born to Learn Curriculum which details personal visit plans, activities for parents to engage in with their children, information on child development, and materials for professionals can be found at the PAT National Center on the web at http://www.patnc.org/.

HEALTHY FAMILIES AMERICA (HFA)

Healthy Families America (HFA) is a national program begun in 1992 by Prevent Child Abuse America (formerly the National Committee to Prevent Child Abuse) in partnership with the Ronald McDonald House, and is modeled after Hawaii's Healthy Start program. It is a home visiting program that is designed to promote positive parenting skills development, healthy pregnancy practices, use of social system resources, child health and development, and prevent negative birth outcomes (e.g., low birth weight), child abuse/neglect, substance abuse, and criminal activities. Expectant and new mothers are linked to community resources (e.g., primary care, housing assistance, substance abuse treatment programs) by trained staff who provide home visits and referrals. Children's Charter is the designee for Healthy Families America work in Michigan. It is located on the web at http://www.childcrt.org/.

HFA is designed for families with children aged zero to five who are deemed at-risk. The program is of comprised assessments and home visits beginning prenatally or shortly after birth. A family support worker (FSW) initiates visits on an at least once weekly basis at the outset; visit frequency decreases over a course of three to five years. The FSW offers information, education, and referrals to community resources as well as assistance with the development of support systems and problem-solving skills training to promote positive parent-child interaction.

Studies indicate that benefits for participants accrue in the areas of parent-child interaction and parenting skill capacities. Most families who have received services have been found to be better able to care for their children, access and effectively use health care services, avoid reports of child abuse or neglect, and resolve many personal and familial problems associated with families that are economically challenged and single-parent. However, many of these findings have emerged from the quasi-experimental designs, rather than from randomized trials. Information can be found on the web site at http://www.healthyfamiliesamerica.org.

MELD

MELD is a family strengthening, parent education program developed in 1973 that uses peer support groups to develop parenting skills. It is designed to strengthen families by: (1) reducing family isolation that can lead to child maltreatment, (2) increasing parents' knowledge of child development, (3) increasing parents' problem-solving skills, decision-making capabilities, and ability to manage family life, and (4) fostering parental personal growth.

MELD targets parents of preschool aged children and has been adapted to meet the needs of first-time adult parents, parents of children with special needs, young, single mothers, and single fathers, Hispanic/Latino and Southeast Asian parents, and parents who have hearing impairments. The curriculum is accessible to parents who do not have high levels of literacy, and it addresses concerns of parents with financial challenges.

MELD parent education groups usually meet twice per month (or as often as once a week). The groups are facilitated by community volunteers who use a standardized curriculum and are provided ongoing support and supervision from a local certified MELD professional. The curriculum addresses the following topics:

- Health
- Child development
- Child guidance
- Family management
- Use of community resources
- Home and community safety
- Balancing work and family
- Other issues related to the parenting needs of the specific group

MELD is a SAMHSA model program with demonstrable benefits that include: (1) parents gaining more appropriate expectations of children's abilities and increased knowledge of child development; (2) increased empathic awareness of children's needs and appropriate responses; (3) decreased belief in the value of corporal punishment; (4) reduced social isolation and parental depression; (4) increased awareness that parents' purpose is to respond to the needs of their children (and that children do not exist to please and love their parents).

HOMEBUILDERS PROGRAM

HOMEBUILDERS is an intensive, short-term family preservation program for families with newborns to teenagers first established in Tacoma, Washington, as an outgrowth of efforts to prevent of out-of-home placements. The program utilizes professionals, parent advocates, and aides who maintain small caseloads and have frequent group supervision. It is designed to prevent the need for foster care, residential, and other out-of-home placements, and strengthen the family. Its goals include improving family functioning, social support, parenting skills, school and job attendance and performance, household living conditions, daily household routines, and self-esteem. It focuses on helping consumers become self-sufficient, enhancing their motivation for change, and reducing family violence.

HOMEBUILDERS is comprised of four to six weeks of intensive in-home services for children and families. A practitioner provides counseling and other services, spending an average of eight to ten hours per week in direct contact with the family. The practitioner is on call twenty-fours hours per day, seven days a week for crisis intervention. Skill building, behavioral interventions, motivational interviewing, relapse prevention, rational emotive therapy, and other cognitive-behavioral strategies are the primary interventions used to teach effective parenting skills.

The program has been evaluated both formally and informally since it began in 1974. Studies have indicated positive results including out-of-home placement prevention and improvements in child and family functioning. While the model has been used throughout the country for family preservation, it has not always been replicated with fidelity to the original model resulting in less than optimal outcomes.

DARE TO BE YOU (DTBY)

DARE To Be You is designed to improve the parenting skills of parents of young children aged two to five. The program is comprised of components for children, parents, child care providers, and child serving agency staff who work with families. DARE To Be You is designed to build skills in:

D **D**ecision making/problem-solving
A **A**ssertiveness/communication/social skills
R **R**esponsibility/**R**ole modeling
E **E**steem for self and others/**E**mpathy development

The program has been found to be most effective when provided in two-hour long sessions over a ten to twelve week course. Each workshop for parents, children, and siblings includes ten to twenty-five participants. Sessions start with a joint activity for parents and children and continue with separate activities for each based on age. Each session has a defined objective with the majority focused on enhancing parenting skills. These objectives include: improving the parents' self esteem; increasing the parents' recognition that consequences are the result of their actions rather than fate or a "Powerful Other" (thus changing the locus of control of consequences from an external source to an internal one); enhancing decision-making skills through effective reasoning; increasing parent-child communication skills to improve childrens' self esteem, decision-making and problem-solving skills; learning effective stress management techniques; learning about normative child development to reduce unrealistic expectations; strengthening peer support and reducing social isolation.

Families can also participate in yearly two-hour long refresher and skill-building workshops as well as ongoing weekly support groups and parent potlucks for formal and informal discussion of child development issues. Additional training for other caregivers, including teens and family service agencies, is offered for up to twenty hours of training on working with preschool children.

Outcome studies indicate that the program results in increased parental self-esteem and self confidence in child rearing skills, more effective parent-child communication and discipline, less harsh punishment, increased internal locus of control, and satisfaction with peer and social supports. Children display increases in developmental and age-appropriate behaviors and reductions in oppositional behaviors (e.g., engaging in frequent and irrational arguments).

The program is documented in various manuals that can be used for replication. Information is available on the web at http://www.colostate.edu/Depts/CoopExt/DTBY/ and materials are available in English and Spanish.

PERRY PRESCHOOL PROJECT

The Perry Preschool Project was started in 1962 in Ypsilanti, Michigan to promote the social and cognitive development of African American preschoolers who are at risk for school failure. Its Resource Mothers program links older experienced mothers with teenage girls during pregnancy to nurture trusting relationships and offer education and skills for parenting, health, nutrition, child development, and community resources throughout the first years of childrearing. The Perry Preschool places an emphasis on active learning in which children learn through self-directed and self-initiated activities. It exemplifies combined early education and family support.

Core components include sessions on social relations, decision-making, problem-solving, dealing with conflict, expressing one's feelings, group participation, and sensitivity to the needs and feeling of others. The program includes weekly home visits for one and one half hours by classroom teachers. The teacher to student ratio is approximately one to six students. Children attend the preschool Monday through Friday for two and one half hours per day over a two-year period. Parents participate in monthly small group meetings with other parents that are facilitated by program staff. An ongoing, continuous home-school relationship is maintained to promote socialization and involve parents early in their children's educational process.

Outcomes data indicate that beneficial effects of participation endure into the adult years for participants who demonstrated increased rates of high school graduation, college attendance, and employment, and lower rates of criminal behaviors, arrest and juvenile court petitions, teen pregnancy and reliance on welfare benefits. A cost-benefit analysis indicated a savings of more than seven times the initial investment per child, with a return of $7.16 for every dollar spent on the program and a taxpayer return of $88,433.00 per child in savings from reduced use of welfare assistance (prior to welfare reform), special education, involvement in the criminal

justice system, crime victim losses, and increased tax revenue from higher earnings. Information on the program can be found on the web at http://www.highscope.org/.

STRENGTHENING FAMILIES PROGRAM (SFP)

The Strengthening Families Program (SFP) is a family-skills training program that uses family systems and cognitive behavioral elements and is designed to ameliorate risk factors for problem behaviors (e.g., behavioral, emotional, social and academic problems and substance use) in children. There are three versions of the program for children from age three to fourteen. Two models are reviewed here.

SFP focuses on enhancing family relationships, parenting skills, and improving children's social and life skills. It is used in elementary schools, faith-based organizations, protective services agencies, public housing communities, mental health programs, jails, homeless shelters, and child/family service agencies The program is designed for families with elementary school aged children from six to ten. It has been modified for African American, Asian, Pacific Islander, Latino/Hispanic, and Native American families, as well as families living in rural areas. It is also accessible to families with a variety of education levels.

SFP includes three separate courses: Parent Training, Children's Skills Training, and Family Life Skills Training. During the first part of the sessions parents meet separately with two group leaders for an hour to learn to increase desired behaviors in children by increasing attention and rewards for positive behaviors. They also learn about clear communication, effective discipline, substance use, problem-solving, and limit setting. Children meet separately with two children's trainers for an hour to learn how to understand feelings, control anger, resist peer pressure, comply with parental rules, solve problems, improve social skills, and communicate effectively. During the second hour of the sessions, families engage in structured family activities, practice therapeutic child play, conduct family meetings, learn communication skills, practice effective discipline, learn to reinforce positive behaviors, and plan family activities together.

Supportive services such as transportation, child care, and family meals are provided in order to retain families in treatment. Incentives for attendance, desired behavior in children, and homework completion are offered to increase program recruitment and participation. Booster sessions and ongoing family support groups for SFP graduates are used to increase generalization and the use of skills learned.

Beneficial outcomes have been found in a number of independent program evaluations. Parents report significant decreases in drug use, depression, and use of corporal punishment, as well as increased parental efficacy. Children display reductions in behavior problems (e.g., aggression, impulsivity, conduct disorders) and improved social skills (e.g., communication, problem-solving, peer pressure resistance, and anger control). Reductions in substance abuse have also been found in both parents and their children. These results have been shown to endure in five-year follow up studies; ninety-two percent of participant families continuing to use the parenting skills learned, and sixty-eight percent continuing to hold regular family meetings. Information is available on line at http://www.strengtheningfamiliesprogram.org/.

STRENGTHENING FAMILIES PROGRAM FOR PARENTS AND YOUTH 10–14 (SFP 10–14)

The Strengthening Families Program for Parents and Youth 10–14 (SFP 10–14) is a video-based intervention designed to reduce problematic behaviors in children aged ten to fourteen. The program is conducted in parent, youth, and family sessions using narrated videos that portray families in typical situations. This curriculum-based, manualized program is comprised of seven week two-hour sessions with four booster sessions (provided three months to one year after the first seven sessions) for parents and children. Separate skill building sessions are held

for parents and children during the first hour. The second hour is comprised of supervised family activities. These sessions include discussion, activities designed for skill building, videos that demonstrate modeling of positive behaviors, and games to enhance positive family interactions. It is a SAMHSA model program.

Sessions are usually held on weekday evenings or Saturdays in public schools, faith-based organizations, community centers, and family serving agencies and include eight to thirteen families. The teaching manual and videos are available in Spanish using a culturally adapted version called Familias Fuertes. A nonvideo version is available in English for other ethnic groups who may not relate to the program's videos.

Sessions are highly interactive and include role playing, discussions, educational games, and family projects that are designed to improve parenting skills, build life skills in youth, and strengthen family bonds. Session topics are as follows:

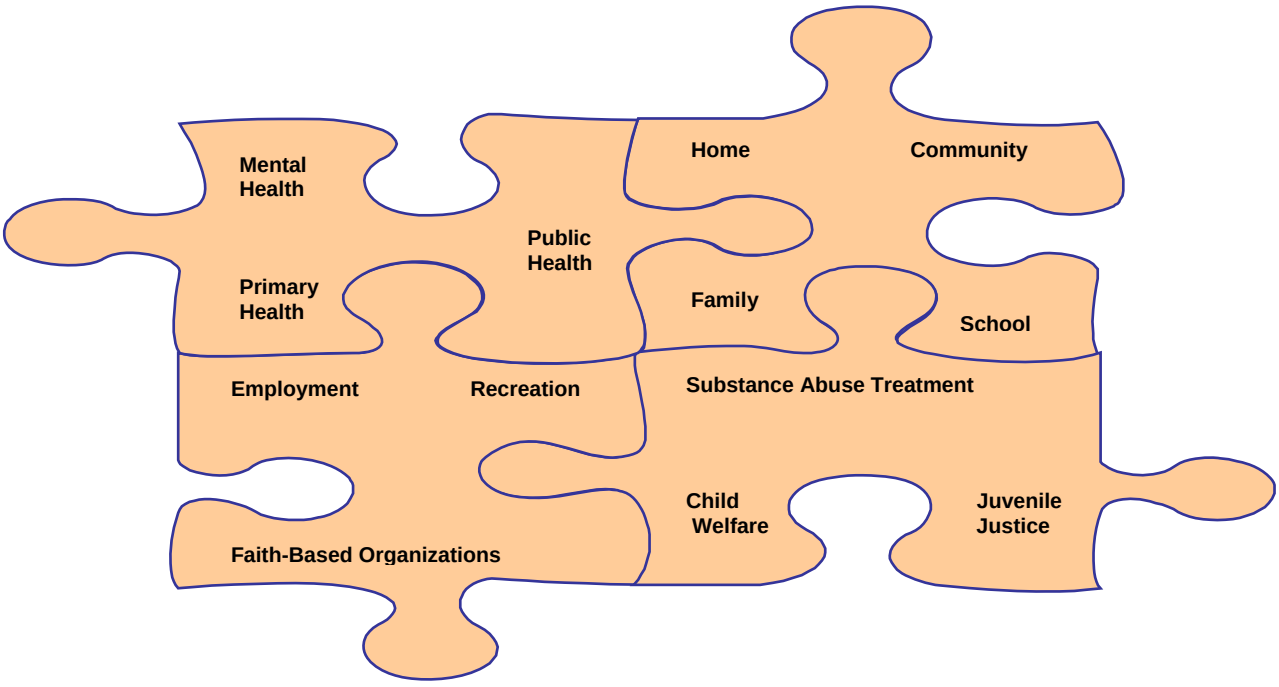
Primary Sessions	Booster Sessions
Parent	
Using Love and Limits	Handling Stress
Making House Rules	Communicating When You
Encouraging Good Behavior	Don't Agree
Using Consequences	Reviewing Love and Limits
Building Bridges	Skills
Protecting Against Substance	Reviewing How To Help
Abuse	With Peer Pressure
Getting Help for Special Family	
Needs	
Youth	
Having goals and Dreams	Handling Conflict
Appreciating Parents	Making Good Friends
Dealing With Stress	Getting the Message Across
Following Rules	
Handling Peer Pressure I	
Handling Peer Pressure II	
Reaching Out to Others	
Family	
Supporting goals and Dreams	Understanding Each Other
Appreciating Family Members	Listening To Each Other
Using Family Meetings	Understanding Family Rules
Understanding Family Values	Using Family Strengths
Building Family Communication	
Reaching Goals	
Putting It All Together and	
Graduation	

Results of studies indicate that children who participate in the program display fewer conduct problems (e.g., aggressive behavior, minor theft, property damage, truancy, cheating at school, substance use), are more resistant to peer pressure and affiliating with peers who display antisocial behavior. These beneficial effects have been shown to endure for two and a half years post intervention. Parents who participate demonstrate improved parenting skills, including displaying more affection and support, as well as setting appropriate limits for their children. The cost for implementation is estimated to be about $5,001 to $10,000 including training and materials. Information about this program can be found on-line at http://www.extension.iastate.edu/sfp/.

SYSTEMS COLLABORATION

In order to address the needs of children and adolescents who experience severe emotional disturbances and their families in a comprehensive manner it is essential for various agencies and service systems to work together. No single organization or service system has the resources or capabilities to deal with their needs alone. However, the systems (e.g., mental health, schools, child welfare, etc.) that are responsible for the provision of mental health services and supports are fragmented and entrenched in models of service delivery that do not adequately meet the needs of children and their families.

Services for children and adolescents have traditionally been delivered in a categorical fashion by individual agencies with differing funding and eligibility criteria. In other words, services and supports have been agency-driven rather than family-driven. This has resulted in a patchwork of services which are costly and frequently not accessible to those who are most in need of them.



Research indicates that collaboration at all levels in service delivery can improve access and service monitoring, as well as expand available resources through cooperative planning, information sharing and joint training, shared facilities and personnel. It also offers the opportunity to incorporate a variety of perspectives on children and their families and alleviate the burden on single agencies or the tendency to place blame on them when results are not optimal. In addition, collaboration can lead to more positive community perceptions due to improvements in outcomes, consumer satisfaction and cost reductions through elimination of unnecessary service duplication.

CHILD AND ADOLESCENT SERVICE SYSTEM PROGRAM (CASSP)

A federal initiative to create partnerships among mental health, juvenile justice, physical health, education, child welfare, substance abuse treatment and families was spurred by Knitzer's *Unclaimed Children* in 1982 and congressional testimony from service recipients. Children with emotional disturbances were, in Knitzer's view unclaimed by the very public agencies responsible for providing services and supports to them. She found that two-thirds of all children with severe emotional disturbances were not receiving appropriate services and there was little coordination among the various child-serving systems. Congressional testimony revealed that children who have serious emotional disturbances and lack appropriate services and supports drop out of school, are needlessly removed from their families, placed into long-term residential settings for unnecessarily protracted periods of time, and encounter legal difficulties due to socially unacceptable, unlawful behaviors. In addition, testimony revealed that often services for these children were not available, or, when available, were not appropriate, fragmented, and difficult to access.

In 1984 Congress authorized the National Institute of Mental Health to develop the Child and Adolescent Service System Program (CASSP) to improve services for children who have a serious emotional disturbance and their families. It provided support for family organizing and collaborative efforts. Grants were provided to all fifty states to develop systems of care to alleviate the fragmentation in service delivery systems. CASSP was the precursor to the 1992 Comprehensive Community Mental Health Services for Children and Their Families Program (or Children's Services Program) and was designed to promote a system of care approach to service delivery.

SYSTEMS OF CARE (SOC)

As noted above, the responsibility for children's mental health is dispersed across multiple systems: primary care, education, juvenile justice, public health, child welfare, the substance abuse treatment system and mental health. Agencies that serve children have discrepant organizational structures, cultures and imperatives. Their hours of operation, professional language and constituencies differ. Children and their families often encounter many challenges and barriers in trying to gain access to the services and supports they need due to fragmentation of the service systems and gaps they face in trying navigate them. A system of care offers a means of alleviating these difficulties.

Stroul and Friedman described the ideal system of care in their seminal 1986 publication (titled *Systems of Care)* as "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of severely emotionally disturbed children and adolescents." SOC depicts a set of core values and principles rather than a prescription for specific components of care that need to be in place. Thus, systems of care concepts define a model for what quality services should look like, but not what those services should be.

The system-of-care model promotes maintenance of children in their communities, coordination of services and supports, involvement of families in the planning and delivery of services and the cultural relevance of services and supports. It is designed to coordinate points of entry into services for all of the organizations and service systems (e.g., schools, child welfare, juvenile corrections, families, primary health/pediatric care) that are involved in the provision of services and supports.

Three key principles of a System of Care are:

- **Child and Family-Centered:** The needs of the child and family dictate the types and mix of services and supports provided; services are adapted to the child and family rather than expecting the child and family to conform to preexisting service and support configurations.
- **Individualized:** A unique service plan is developed for each child and family which assesses their strengths and needs, prioritizes their needs in each life domain, and is responsive to the family's cultural, racial, and ethnic identity.
- **Community-Based:** Services are provided within or close to the child's home community in the least restrictive setting feasible, and are coordinated and delivered via connections between providers.

GUIDING PRINCIPLES OF SOC

- A broad array of services and supports is provided in an individualized, flexible, coordinated manner with an emphasis on treatment in the least restrictive, most appropriate setting.
- Children who have a serious emotional disturbance should have access to a comprehensive array of services that addresses their individual physical, emotional, social, and educational needs.
- The family's participation in service planning and delivery is essential. Family involvement is integrated into all aspects of service planning and delivery.
- The mental health service system is driven by the needs and preferences of the child and family, using a strengths-based perspective.
- The locus and management of services are built on multi-agency collaboration and grounded in a strong community base. Services should be integrated and coordinated between child-serving agencies.
- Case management is fundamental to ensure service coordination, integration, and system navigation.
- The early identification of, and intervention for, needs should be promoted in order to maximize the prospect for positive outcomes.
- A smooth transition to the adult service system should be planned when necessary.
- The rights of children who have a serious emotional disturbance should be protected.
- The services offered, agencies participating, and programs generated, are responsive to the cultural context and characteristics of the populations served. Children who have a serious emotional disturbance receive services irrespective of gender, ethnicity, race, income status, physical disability, and other characteristics.

A multi-agency advisory team provides oversight for a system of care. It is comprised of representatives from families and partner agencies who engage in planning and decision-making. The team monitors the development and maintenance of interagency collaborations and seeks to improve the overall effectiveness of the partnerships. The advisory team also helps to maintain open communication and decision-making across stakeholders.

Interagency collaboration between child-serving agencies can improve service delivery and cost effectiveness. Agency partnerships can be used to blend funding streams and leverage scarce resources in order to maximize and expand services. Reinvested savings can be used to develop and implement prevention and early intervention programs to increase access to services, mitigate risk and enhance protective factors.

Successful practices within a System of Care framework have been identified:

Engagement	• **Meeting families' basic/practical needs (food, clothing, housing, schoolbooks)** • **Establishing partnerships with e families/parents**
Clinical Services[23]	• **Establishing effective relationships with families through access to providers** • **Families' perceptions of providers as caring and committed** • **Individualized services; families' needs are addressed in accordance with *their* priorities** • **Collateral clinical services (crisis intervention, follow-up care, therapeutic foster care, substance abuse treatment, respite care, home-based intensive case management, mentoring, tutoring)** • **Medication (used in combination with therapy)** • **Maintenance of continued commitments to families** • **Services and supports that address the needs of the *entire* family and promote empowerment and skill acquisition to foster independent problem-solving**
Structure	• **Flexible funding** • **Flexible services and supports; nontraditional approaches to service provision are offered** • **Community-based locations for service delivery** • **Services and supports that enhance the family's connection with their community** • **Continuity of care** • **Twenty-four hour provider availability** • **Advocacy** • **Coordination of care (a single point of contact across services and systems)** • **Training and education** • **Natural and community supports** • **Service design that is based on the family's strengths and needs, rather than on a fixed menu of services** • **Service design that is based upon the *family's* criteria for success** • **Providers' persistence and creativity in meeting families' needs** • **Providers demonstration of genuine concern and regard for families**

Research has shown that systems of care result in reductions in the use of residential settings and improvements in functional behavior. Parents indicate greater levels of satisfaction with services provided within systems of care than those provided in more traditional service delivery systems. However, it should be noted that there is a paucity of evidence to substantiate that systems of care result in improved clinical outcomes when compared to more traditional service delivery systems. In fact, studies have shown that system coordination of services in and itself does not lead to more improved clinical outcomes (e.g., reduced impairment or symptoms, enhanced functioning) than usual services. Moreover, in some studies the cost of the SOC approach has been found to be significantly higher.[24]

[23] Non-clinical services include those that provide assistance to children and families, including transportation, those that help make environments safer, and enhance aspects of living that impact quality of life.

[24] The Fort Bragg program is one of the most notable studies of an SOC. While the program improved access to a rich array of services and supports, it was also more expensive than traditional service delivery with a cost of $7777.00 per child versus $4904.00 for each child in a community comparison site. Outcomes were not improved by the increased access and services received. In sum, while the Fort Bragg children and their families received more interventions at a higher cost, outcomes were not found to better as a result of this intensity. Thus, an array of conventional services and supports does not produce improved outcomes no matter how they are coordinated and organized.

Due to the above-noted findings, focus shifted from systemness to clinical effectiveness[25] within systems of care and the transportability of efficacious interventions and practices into mental health service delivery systems. An emphasis on fidelity to implementation of systems of care at the practice level has also been stressed. However, the implementation of systems of care has not resulted in standardized language and the concept has been applied in a variety of ways.

SERVICE DELIVERY WITHIN A SYSTEM OF CARE

WRAPAROUND

Wraparound is a family-centered process for the identification, selection and provision of a unique set of services and supports to children and families based upon their strengths and needs, and woven seamlessly into an individualized plan of care; it is not a program, model, or service. The wraparound process involves teams working together to operationalize Systems of Care at the child and family level. It is based upon the premise that all children should have the chance to have their mental health needs met within their home and community. Wraparound processes are organized around all key life domains (home, school, and community living). Some services may be delivered through formal agency procedures, while others may be delivered through informal arrangements in the community.

VALUES OF WRAPAROUND

- Voice and choice for the child and family
  - Access – parents and children have valid options in the decision-making process
  - Voice – parents and children are heard and listened to during all planning stages
  - Ownership – parents and children agree with and are committed to plans made
- Integration of services and systems
- Compassion for children and families
- Flexible approaches to funding, service provision and working with families
- A focus on safety, success, and permanency in home, school, community
- Care that is:
  - Unconditional
  - Individualized
  - Strengths-based
  - Family-centered
  - Culturally competent
  - Community-based (with services close to home in natural settings)
- A relationship with the child and family characterized by:
  - A lack of blame
  - A lack of shame
  - Dignity
  - Respect
  - Empathy
  - Listening
  - Support
  - Meaningful options
  - Self-determination

Wraparound represents the antithesis of the traditional provider-consumer relationship wherein the professional is the authority, and the parents are the problem and, when their children

[25] Evidence-based practices and a system of care approach are complementary endeavors. An SOC focuses on improving access, developing a broad array of services, and ensuring coordination, thus providing a context for the delivery of evidence-based practices.

experience difficulties, they become the property of the provider agency and may be removed from home and community so they and their parents can be fixed. Wraparound, on the other hand, places families in decision-making positions as core members of the team. Services and supports are individualized and tailored to meet the needs identified by children and their families rather than placing them into sets of services that are on the current menu of particular agencies. Care is based on needs, not on programs that are available. For instance, if a child requires half-day school attendance to maintain behavioral control, then the child attends school for half days irrespective of traditional attendance requirements.

The wraparound process provides services and supports in places that children and their families identify as their community. An inherent element of the process is the belief that children will not acquire the skills needed to succeed in their natural environments unless they remain within the community in the least restrictive setting feasible; opportunities for teachable moments are more likely to occur in natural environments.

Steps of the wraparound process:

Step 1: Engagement of the Child and Family
Step 2: Immediate Crisis Stabilization and Safety Planning
Step 3: Strengths, Needs, and Culture Discovery
Step 4: Child and Family Team Formation and Nurturing
Step 5: Creating the Child and Family Team Plan

Preparing for the Meeting
Facilitating the Meeting
The Wraparound Plan

Step 6: Ongoing Crisis and Safety Planning
Step 7: Tracking and Adapting (the Wraparound Plan)
Step 8: Transition (Out of Formal Services)

Wraparound is conducive to managed care models, particularly in the capacity to provide flexible funding rather than having to rely on billing under categorical fee-for-service mechanisms that may not match the needs or desires of children and families. It is compatible with the goal of managed care to ensure that the right services are delivered in the right amount at the right time. Wraparound offers the opportunity to maximize flexibility in the allocation of resources effectively and efficiently. Funds that are saved due to diversions from more expensive residential or hospital care can be reinvested in the system of care to increase service capacity.

Wraparound teams monitor progress in all targeted life domains and focus on ensuring services are of high quality. The outcomes of wraparound that are tracked can include changes in school attendance, incidence of juvenile justice charges and adjudications, restrictiveness of living situation, and behavioral functioning measured by the Child Behavior Checklist (CBCL), Child and Adolescents Functional Assessment Scale (CAFAS), and others. System outcomes can include tracking of costs. However, it should be noted that while traditional mental health services often measure outcomes using standardized assessment instruments listed above, scores on such instruments may not always reflect what families want or identify as their needs.

CORE ELEMENTS OF WRAPAROUND

- **Community-based** services and supports**.** Wraparound is based on the premise that children belong in their natural environments.
- **Individualized and strength-focused** planning for services and supports in all life domains. These should fit the child (as opposed to fitting the child into some pre-existing program), focus on positives and build on strengths rather than problems, diagnoses or deficits.
- **Culturally competent services/supports** that demonstrate respect for unique family cultures in demonstrable recognition that every family has its own culture.
- **Family-driven** Families are full and active partners at every level of the process and responsible for decisions and allocation of resources (with input from the professionals on the team), rather than passive consumers of care. Family choices are adhered to and prioritized in accordance with needs because families have the best knowledge regarding how services and supports should enter into their lives. The process is structured to give families voice, choice and ownership. Success is defined from the perspectives of the *family* and provider.
- **Team-based** involving the child, family, natural supports, agencies, and community services. Team members are selected on the basis of their connection or attachment to the family rather than their roles. Teams include professionals (e.g., social workers, teachers) and natural supports (e.g., friends, coworkers, family) who are equal partners in the planning process. Teams change over time with respect to roles and membership. The ideal composition of a team includes less than fifty percent professional membership.[26]
- **Flexible funded** with access to monies that can be used to meet the basic needs (e.g., medical, financial, requirements for safety and comfort) of children and their families. Access to non-categorical funding is essential. Often, several child-serving agencies create pooled funding streams to support children who have multiple agency involvement. The dollars follow the child and family, instead of being tied to specific programs and services. Flexible funds can be used for service and support activities that are outside traditional funding streams and are non-reimbursable by state and federal funding streams.[27]
- **Balanced between conventional and natural supports** Natural supports are a source of culturally relevant caring and support for families. Ideally, conventional clinical services are gradually replaced with natural ones (e.g., extended family members, friends, neighbors, members of the faith-based community, volunteers, local service organizations, teachers, and coaches). Many families who enter into a wraparound process have experienced rejection by extended family members or isolation due to their difficulties. Thus, natural supports are absent from their lives and wraparound teams need to work to rebuild such supports. Self-sustaining, culturally relevant, nurturing natural supports endure long after professional relationships end.
- **Unconditionally committed** A "no reject, no eject" policy and a mindset of doing whatever it takes to meet the needs of the child and family is maintained. When difficulties arise, services and supports are changed, but never eliminated. An attitude of *doing whatever it takes* to meet the needs of children and their families and overcoming barriers and obstacles is adopted.
- **Collaborative** Interagency/community/neighborhood collaboration is used to develop individualized support and service plans. The approach is "how can we as a group get this accomplished and funded?"
- **Accountability for outcomes** that are based on family, child and team priorities. Outcomes are identified, documented, and progress is measured. Goals often include achieving success, safety, and permanence in the home, school and community.

[26] The involvement of a parent advocate early in the process is helpful due to perceptions of shared experiences which enhance the development of supportive relationships. Parent advocates offer nonjudgmental emotional support during crises, assist with problem-solving and navigating service delivery systems. Family resource developers (who are paid staff members whose children have received or are receiving services) can also be of assistance in identifying natural supports within the community and advocate for garnering resources.

[27] Ideally, funds are pooled from a variety of agencies (e.g., mental health, social services, juvenile justice, and education) and can be readily accessed and used flexibly. This means that funds are not restricted to specific services and supports. For example, funds that might be typically used to support residential care might be reallocated to provide home and community-based services and supports..

Continuous unmet needs of families results in a significant depletion of the capacity to meet emotional, social and behavioral challenges. Flexible funds may be used for sport equipment, bus passes, car repairs, personal care items, camp fees, alternative activities for children, nutritional counseling, behavioral reward programs (e.g., earning points that can redeemed for items), clothing, childcare, school supplies, etc. that result in positive consequences far beyond the solution of an immediate problem. The provision of funds up front also eliminates extensive inter and intra-agency negotiations and stipulations and enhances families' control over the use of the funds. It has been found that when families are placed in charge of a budget, they demand provider accountability which in turn can result in improved quality. Research indicates, contrary to concerns regarding budgetary constraints, flexible funding expenditures are comparable to, or less than, funds expended for traditional services and supports. Annual savings have been consistently found in numerous reviews of flexible funding arrangements.

In Michigan statewide Wraparound Quality Assurance (QA) Tools have been developed. The state of Michigan introduced four mandatory Quality Assurance tools for counties that have a DHS/FIA contract for Wraparound. These tools are designed to identify needed county outcomes as well as state outcomes. Wraparound standards were set forth in the *Information Advisory for Multi-Purpose Collaborative Bodies* which has been distributed to child mental health service providers.

Beneficial outcomes from the wraparound process have been shown to be enhanced by competent respite providers, mentors, one-on-one aides, quality summer programming and in-home behavioral support providers. It has been found that inexperienced one-on-one aides, untrained mentors, and less than competent therapists can seriously harm the wraparound process. Staffing issues are not uncommon due to shortages in many communities. This has been addressed in some localities by forming interagency recruitment-retention committees comprised of staff from agencies that share responsibilities.

Outcomes studies indicate that wraparound produces a number of beneficial outcomes including less restrictive living situations, decreased costs for care, and improvements in school, community and social functioning for participants. Studies show that children who have serious emotional disturbances demonstrate improvements in behavior, social and familial relationships, academic performance, and are less likely to require out-of–home placement. The wraparound process has been found to be more acceptable and empowering to families. Research also indicates that children's perceptions of their wraparound teams as unconditionally committed directly correlates to reductions in the severity of acting-out behaviors, depression, self-injurious behaviors, and increases in overall satisfaction with services.

Fidelity to the wraparound process as well as oversight have been found to vary by location. There are published criteria with common key components and implementation manuals to measure fidelity (see resource section in Appendix B).

The duration of service is usually one to three years. A five-year study in Kentucky indicated that the average cost during the first year is $1224.00 per child and $2455.00 during the fifth year.

CASE MANAGEMENT

Although research and experience indicate that case management is both beneficial and prevalent in children's mental health service delivery, a set of consistent standards for case management models is lacking. However, all models include the following functions:

- **Assessment** to determine needs or problems
- **Planning** to identify specific goals and the services and supports needed to attain them
- **Linking** to connect consumers to appropriate services and supports
- **Monitoring** to ensure services and supports are being delivered and are appropriate to need as well as ongoing evaluation of progress
- **Advocacy** to ensure consumers obtain services and entitlements

INTENSIVE CASE MANAGEMENT (ICM)

Intensive case management services are targeted to children and adolescents who have serious emotional disturbances and their families in order to reduce the need for more intensive levels of care (i.e., hospitalization) by providing assistance in accessing needed services and supports, monitoring service delivery, and helping with problem resolution. Caseloads are small, with a one to twelve case manager to consumer ratio. Services are available on a twenty-four

hour basis, seven days a week and provided for as long as necessary. The wraparound process can be used to achieve comprehensive care coordination with the case manager assuming a lead role in assuring care coordination.

Core Functions:

- Assessment
- Service Planning
- Service Plan Implementation
- Service Coordination
- Monitoring and Evaluation
- Advocacy
- Providing Clinical Services
- Role Modeling
- Case Identification or Outreach

Services provided:

- Individualized Service Plans
- Home Visits
- Assistance with obtaining and maintaining basic living needs and skills, such as housing, food, medical care, recreation, education and employment
- Twenty-four-hour availability
- Linkages with community resources and natural supports
- Assistance arranging transportation to and from appointments

Research indicates that ICM results in significant behavioral improvements and decreases in unmet medical, recreational and educational needs, and decreased use of inpatient hospital and residential services. The use of flexible service dollars to provide services and supports that are not part of standard service packages has been found to be beneficial.

COLLABORATION WITH SCHOOLS

Schools are the primary providers of mental health services for children. In fact, seventy to eighty percent of children who receive mental health treatment do so in a school setting. The reasons for this include the fact that schools provide an ideal setting for both early identification of children who are at risk for serious emotional disturbances as well as effective delivery of services and supports. School locations are usually convenient for children and families. There are fewer stigmas associated with school than there are with other social service agencies. Students spend the largest portion of their day in school in both formal and extra curricular school-related activities. Thus, schools play a significant role in lives of children and the structure of their day-to-day lives. Moreover, schools are natural settings for the provision and coordination of services.

Schools are a critical point of entry into mental health services. Students who are identified as being in need of mental health services and supports have been shown to be more likely to actually receive them when they are provided within the school setting than when they are provided within the community. Moreover, schools offer the opportunity to reach more children in need of services since education is an entitlement and all children have contact with schools.

While more children who have serious emotional and behavioral disorders have been included in mainstream educational settings, they are still at risk for extrusion due to difficulties in functioning both within and outside of school and many have fallen through the cracks failing to

receive needed education and supports. Many teachers and other school personnel are typically not prepared for dealing with students who have emotional and behavioral challenges. They also may not receive supports to help them with this population of students. Teachers may have lower expectations for their performance and view them as making teaching difficult and challenging, thus reinforcing their poor academic performance.

Students who have an emotional disturbance have been found to:

- Fail more classes
- Miss more days of school
- Get lower grades
- Be retained at the same grade level more often than other students who have a disability
- Drop out of school more often than any other group of students (Fifty-six percent of children who have serious emotional disturbances drop out of school and seventy-three percent of them are arrested within three to five years after leaving school.)

Pejorative school experiences (e.g., punitive discipline, academic failure, isolation, rejection by peers, public humiliation) can lead to, or exacerbate, emotional and behavioral problems. Children who display poor academic performance are at greater risk for becoming involved in delinquent acts. Educational experiences that are affirmative, on the other hand, have been shown to help create a foundation that promotes healthy growth and development and aides in the prevention of emotional and behavioral difficulties.

Research indicates that school-based interventions that alter the social context of schools and the school experiences of children can decrease and prevent delinquent behaviors in children under age thirteen. Evidence-based approaches include:

- Classroom and school-wide behavior management programs (e.g., targeted classroom based contingency management to decrease the incidence of disruptive behaviors exhibited by children who have attention deficit/hyperactivity disorder and conduct problems)
- Social competency enhancement programs
- Conflict resolution and violence prevention curricula
- Bullying prevention programs
- Multi-component classroom-based programs designed to assist teachers and parents with management, socialization, and education of students as well as enhance their cognitive, social and emotional skills
- Community-based after school recreational and mentoring programs
- Preventive programs that: (1) identify children who are at risk for emotional or behavior problems (e.g., group-based cognitive therapies for adolescents who exhibit depressive ideation); (2) social problem-solving skills for children in elementary school who are at risk for depression; and (3) reduce risk for conduct problems with interventions provided at home, in school and peer-based settings.

Research strongly supports the integration of mental health professionals (e.g., psychologists, behavior specialists, social workers) into schools to work with students, families, faculty and administrative staff. They enable schools to more effectively identify students who are at-risk and provide early intervention to prevent additional emotional and behavioral difficulties.

A number of models have been developed for the delivery of school-based mental health services. One model extends the role of school counselors and psychologists to deliver mental health services to students. Another model uses mobile mental health teams comprised of

social workers, nurses, counselors, psychiatrists, psychologists, and parent advocates that go into school settings to enhance access and services. Program components include: outreach, in-service training for school personnel, in-home assessment/intervention, and services for children who are at risk of school suspension or expulsion and/or removal from their homes.

SCHOOL-BASED MENTAL HEALTH SERVICES

Research indicates that integrating mental health services into schools produces improvements in social and academic performance for children who receive ongoing service and support. School-based mental health services typically include screening and evaluation, case management, classroom consultation, education, individual and group counseling, family counseling, crisis intervention, vocational planning, and therapeutic recreation. Mental health practitioners in school settings provide short-term counseling and linkages to additional services and supports for children and families. They also provide consultation and training for teachers and other school staff on behavioral management issues, techniques for crisis intervention and referral.

School-based mental health professionals can identify children who have special needs by providing services to them, participating in IEPs, and conducting community education programs on mental health. As advocates for families, they supply information, accompany families to meetings, conduct home visits and help families understand how the various service systems work. They can assist teachers in adapting instruction methods to the needs of students with emotional or behavioral problems through short-term co-teaching, consultation, modeling appropriate student-teacher interactions and progress monitoring. Their presence also offers schools the opportunity to implement school-wide prevention and early intervention programs.

Case managers can provide a more intensive level of mental health support. The placement of case managers in school settings has been found to be a highly effective strategy. School-based case managers are responsible for five core services: assisting in the determination of needs, identifying goals and resources required to attain them, linking children and families to services and supports, advocating for needed changes. Case managers also participate in IEP meetings and can assist with transitions between schools and during summer breaks. A more intensive level of case management support can be used to work with parents and school personnel to create behavioral management programs and set academic goals thereby allowing children who may otherwise be suspended or placed in other settings to remain in the classroom.

Research indicates that school-based wraparound has been found to be beneficial for students with emotional and behavioral challenges. Wraparound services typically include the provision of assistance in getting children to school, after school care, and promoting successful transitions between educational settings. Wraparound teams can also prepare families for the natural transition at the end of each school year and link families with community agencies for students who require services and supports during the summer.

Services can be coordinated by teams that are comprised of family members, school-based clinical staff, and practitioners from community mental health organizations. The wraparound team can assist in dealing with behaviors that can lead to suspension and expulsion from school, procure in-school respite (e.g., using paid extended family members) which offers more flexibility than traditional special education where a designated teacher's aide is categorically assigned to a group of students. Care coordinators in schools can function as liaisons between students and school personnel by assisting wraparound teams focus on students' and families' immediate needs and access resources to meet those needs. School-based wraparound

services have been found to increase the participation and performance of students deemed at-risk in school and reduce suspensions and expulsions.

Some schools incorporate mental health services into school-based health centers that provide comprehensive preventive and primary care services. Such centers are specific areas reserved to provide students with a place to go to meet with clinical staff when they feel they need emotional, academic or behavioral support and services. Studies indicate that developing centers within schools that provide support to children with behavioral and emotional needs can be an effective strategy.

THERAPEUTIC RECREATION: SUMMER CAMPS AND AFTER SCHOOL PROGRAMS

Therapeutic recreation is viewed as an important component in the continuum of services and supports for children, adolescents and their families. Recreational opportunities are beneficial for participants and offer families respite from the demands of caring for children who display emotional and behavioral challenges.

Extracurricular activities, such as summer camps and after-school programs, provide opportunities for enhanced support to improve the academic and social achievement of children who have serious emotional disturbances (and who might not otherwise be allowed to participate because of their behaviors). Such activities can be therapeutic, enjoyable, enhance peer relationships, and provide opportunities for education and socialization in less formal environments. Extracurricular programs can also be used to reinforce behavioral techniques utilized in classrooms and school-based mental health programs.

Summer camps can provide children with opportunities to learn and interact in less structured environments than schools provide. Moreover, summer camps give children the opportunity to internalize behaviors that can generalize into the classroom. Some summer camps provide extracurricular activities for children who might otherwise be excluded from field trips and other activities due to disruptive behaviors.

After-school programs consist of structured activities that are offered on a regular basis during the hours after school to assist children learn new skills and help them achieve developmental capacities. Activities may include reading, math, science and arts. Programs may also offer experiences such as community service, internships, tutoring, and mentoring opportunities. Many after-school programs function as a place for students to complete homework assignments with help from staff and peers, and participate in extracurricular activities (e.g., art, music, sports) in a supervised setting. The inclusion of mental health staff in programs provides additional opportunities for intervention since behavior is monitored and any problems displayed can be addressed.

The immediate after-school hours are a critical time for youth. These are the peak times for engaging in criminal activities and other high-risk behaviors (e.g., alcohol and drug use). Youth are at highest risk for being a victim of violence between 2:00 p.m. and 6:00 p.m. And, the peak hour for crimes committed by youth is from 3:00 p.m. to 4:00 p.m., the first hour most students are released from school. After-school programs can contribute to safety, help improve academic achievement, and offer relief from the stresses working families often experience. They can also provide prevention and intervention programs for youth who have a propensity to engage in violent or other problematic behaviors. Unfortunately, most youth do not have access to after-school programs.

Research indicates that after-school program participation contributes to violence prevention and increased social and academic achievement. Students who participate in after-school programs have been shown to exhibit fewer behavioral problems, enhanced ability to handle

conflicts, and increased self-confidence. Studies have demonstrated that after-school programs benefit students from elementary to high school. Students in middle and high school often benefit the most from these programs.

SCHOOL-BASED PREVENTION AND INTERVENTION PROGRAMS

The following interventions are examples of programs used in school settings including a number that involve mental health professionals.

PROMOTING ALTERNATIVE THINKING STRATEGIES (PATHS)

PATHS is a SAMHSA model program designed to promote emotional and social competencies and reduce aggressive and acting-out behaviors in elementary school aged children. It is a multiyear, curriculum-based, prevention program for kindergarten through sixth grade (ages five to twelve) that is used by educators and counselors.

PATHS is taught three times per week for a minimum of twenty to thirty minutes per day. The curriculum contains developmentally-based lessons on emotional literacy, self-control, social competence, positive peer relations, and interpersonal problem-solving skills. It is designed to be taught by classroom teachers and integrated into the standard curriculum. Strategies and information are provided for teachers and parents to promote generalization of the skills by using them throughout the school day and at home to promote generalization.

PATHS lessons include instruction on identifying and labeling feelings, expressing feelings, assessing the intensity of feelings, managing feelings, understanding the difference between feelings and behaviors, delaying gratification, controlling impulses, reducing stress, self-talk, reading and interpreting social cues, understanding the perspectives of others, using steps for problem-solving and decision-making, maintaining a positive attitude, self-awareness, and nonverbal and verbal communication skills.

The PATHS curriculum is contained in six volumes that cover four conceptual units:

- Readiness and Self-Control "Turtle" Unit (one volume) fosters the development of self-control and the ability to identify problems.
- Feelings and Relationships Unit (three volumes) teaches students to recognize a wide variety of affective states and enhance empathy.
- Problem-solving Unit (one volume) teaches students to follow a series of steps to seek solutions to problems.
- Supplementary Lessons (one volume) includes optional lessons, review, and extensions of previous lessons. Topics include teasing and fair/unfair treatment.

The PATHS curriculum has been found to be effective for students from a variety of cultural backgrounds (e.g., African American, Hispanic/Latino, Asian American, Pacific Islander, Native American, and Caucasian) as well as those who have hearing impairments, learning challenges, and emotional disturbances. Outcome studies have demonstrated improvements in self-control, understanding and recognition of emotions, ability to tolerate frustration, use of more effective conflict-resolution strategies, improved thinking and planning skills, and reductions in symptoms of anxiety, depression, and conduct problems.

Teachers receive training in a two to three-day workshop and in bi-weekly meetings with a curriculum consultant. Program costs over a three-year period have been estimated to range from $15.00 to $45.00 per student per year. The lower cost option entails using current staff, while the higher cost option adds an on-site coordinator. The cost of training and materials is estimated to be about $10,000.

FAST TRACK

Fast Track is a promising multi-year, school-based prevention program designed to ameliorate serious conduct problems in children and families from various ethnic groups, social classes, and with varied family compositions in rural and urban school settings. It is targeted to children who have been identified during kindergarten as displaying disruptive behavior and difficulties with peer relationships. The program is provided from first through sixth grade and emphasizes key periods of entry to school (first grade) and the transition from grade school to middle school. It is comprised of the following components:

- Parent training, which takes place during first grade and focuses on fostering children's academic performance, communicating with the school, controlling anger, and using effective discipline
- Home visitation, which occurs on a biweekly basis and is designed to reinforce parenting skills, promote parents' feelings of efficacy and empowerment, and foster problem-solving skills
- Social skills training to enhance children's social-cognitive and problem-solving skills, peer relations, anger control, and friendship maintenance.
- Academic tutoring, which is offered three times a week in order to enhance children's reading skills
- Classroom intervention, which utilizes the PATHS curriculum (see discussion above)

Outcome studies demonstrate reductions in the number of children placed into special education and improvements in aggression and disruptive behaviors at home and in school. Moreover, children show improvements in cognitive, academic, and social skills and their parents use significantly less harsh discipline at home and are more involved with their children and in school activities.

ANGER COPING PROGRAM

Anger Coping is a cognitive-behavioral individual or group intervention that can be used in schools as well as mental health settings. The group format is comprised of five to seven children and is the preferred method of dissemination. The program is designed to reduce anger, aggression, conduct problems, and delinquency, etc. in children aged eight to fourteen. This intervention focuses on cognitive distortions and cognitive deficits often found in children who display aggressive behaviors.

Group sessions with four to six students are conducted by two co-leaders who alternate between monitoring behaviors and leading group activities. The program is manualized and consists of eighteen sessions conducted on a weekly basis for sixty to ninety minutes. Lessons are designed to improve children's perspective-taking skills, affect recognition, self-control (through inhibitory and coping self-statements), social problem-solving, and social skills strategies for managing conflicts. Reinforcement and feedback are used to support skill acquisition. Participants engage in discussion, role plays, viewing videos, and goal setting. The role plays and videos are used to simulate real life situations so skills can be learned and practiced in commonly occurring scenarios. Students establish a weekly goal that relates to the skills they have been practicing in the group sessions. Teachers monitor students' progress and provide positive reinforcement when a goal is accomplished. Improvements in targeted skills are tracked using weekly goal sheets. Booster sessions can be used to solidify gains made during the program.

The sessions are as follows:

Session 1:	Introduction and Group Rules
Session 2:	Understanding and Writing Goals
Session 3:	Anger Management: Puppet Self-Control Task
Session 4:	Using Self-Instruction
Session 5:	Perspective Taking
Session 6:	Looking at Anger
Session 7:	What Does Anger Feel Like?
Session 8:	Steps for Problem-Solving
Session 9:	Problem-Solving in Action
Sessions 10-18:	Video Productions I-VIII and Review

Outcome studies indicate participants display reductions in aggressive and disruptive behaviors and increases in on-task academic behaviors in school. Increases in self-esteem and problem-solving skills, and reductions in rates of substance use and abuse, have been demonstrated in longitudinal studies of the program.

The two co-leaders participate in a two-day training conducted by the staff of the Anger Coping Program. After the training, co-leaders can establish a hotline with the trainers should questions arise during the program. A twenty page manual is available to aid the co-leaders. Information is regarding this program can be found on the web at www.prevention.psu.edu.

COPING POWER

Coping Power is an extension of the Anger Coping Program. It is a SAMHSA model program for moderate to high-risk late elementary school and early middle school aged children in third to seventh grade. The program lasts from fifteen to eighteen months and includes child and parental components. The program employs cognitive-behavioral group and individual interventions for children who display aggression and behavioral parent training groups for their parents. It has also been used with a teacher in-service training component.

The program focuses on social competence, behavioral and emotional self regulation, school bonding, and positive parental involvement. The child component consists of thirty-three group sessions and periodic individual sessions, conducted in school-based settings. The parent component (for parents or primary caretakers) consists of sixteen group sessions and periodic home visits and individual contacts.

Studies indicate that the program reduces children's disruptive and aggressive behavior and prevents substance use. Participants display improved social skills, fewer aggressive behaviors, anger in response social problems, and proactive aggression. Outcome research has been primarily conducted with African-American and Caucasian children and families.

THE GOOD BEHAVIOR GAME (GBG)

The Good Behavior Game is a SAMHSA model program that promotes social task performance. It is a classroom management strategy to reduce aggressive/disruptive classroom behavior and prevent later criminal behaviors. It is implemented during early elementary school to provide children with skills to respond to later, possibly negative, life experiences and societal influences. GBG utilizes a group-based approach in which students are assigned reading units and cannot advance until a majority of the class has mastered previous sets of learning objectives. The program allows students to work in teams in which each individual is accountable to the rest of the group.

The Good Behavior Game is a behavior modification program that is designed to enhance the ability of teachers to set rules, use discipline, and define tasks. Students are divided into teams that compete to earn rewards for refraining from disruptive, inattentive, or aggressive behavior.

At the outset, teachers clearly specify disruptive behaviors (e.g., verbal and physical disruptions, noncompliance, etc.) which, if displayed, will result in a team's receiving a checkmark on the board. By the end of the game, teams that have not exceeded the maximum number of marks are given rewards; teams that exceed the standard do not receive rewards. Eventually, the teacher begins the game with no warning and at different periods during the day so that students are always monitoring their behavior and conforming to expectations.

The Good Behavior Game has been shown to decrease aggressive and disruptive behavior. It has been found to be most effective for children (particularly boys) in elementary school who display significant levels of aggression. Evaluations of the program indicate that participants display fewer aggressive and shy behaviors at the end of first grade, and reduced levels of aggression at the end of sixth grade.

I CAN PROBLEM SOLVE (ICPS) PROGRAM

I Can Problem Solve is a promising school-based intervention that teaches children to generate a variety of solutions to interpersonal problems, consider the consequences of those solutions, and recognize thoughts, feelings, and motives that engender problem situations. The program seeks to alter cognitive styles by teaching children how to think (rather than what to think). It is designed to enhance social adjustment, promote prosocial behavior, and reduce impulsivity and disinhibition in nursery and kindergarten school aged children (four to five) living in impoverished urban settings who may be at risk for behavioral and interpersonal difficulties. It has also been found to be beneficial for children in the fifth and sixth grades.

The program is comprised of ten to twelve lessons on basic problem-solving skills and nomenclature provided in groups of six to ten children who receive instruction for approximately three months. Children learn word concepts such as *not* (e.g., acting or not acting); *some/all* (solutions may be effective with one person but not all people); *or* (finding alternative solutions); *if...then* (learning consequences of actions); and *same/different* (thinking of multiple solutions). Pictures, role playing, puppets, and group interaction are used to help students develop thinking skills. Children's own lives and problems are used as examples when teachers demonstrate problem-solving techniques. The first twenty lessons focus on identifying one's own feelings and becoming sensitive to others' emotions. They are designed to help children recognize people's feelings in problem situations and realize that they can influence others' responses. The last fifteen lessons utilize role-playing games and dialogue to promote problem-solving skills. Students generate solutions to hypothetical problem situations and consider the possible consequences of their decisions.

Outcome studies indicate that children display reductions in impulsive and inhibited classroom behavior, improved problem-solving skills, increased prosocial behavior, healthier peer relationships, and problem-solving skills that endure three to four years post intervention.

FAMILIES AND SCHOOLS TOGETHER (FAST)

Families and Schools Together (FAST) is a SAMHSA model program. It consists of multifamily group interventions designed to assist children aged four to twelve and their parents achieve enhanced family functioning, prevent school failure and substance abuse, and reduce stress engendered from daily life situations.

Entire families participate in program activities that are designed to build parental respect in children, improve family cohesion, and enhance family-school relationships. Parents are taught parenting skills in order to function as the primary agents of prevention for their children.

Program components include:

- Outreach to recruit families to attend eight weekly multifamily support groups and monthly multifamily meetings. This is accomplished through face-to-face visits conducted at times and places convenient for parents.
- Multifamily support groups of five to twenty-five families held weekly for eight to twelve weeks, depending on the age the children. Family support group meeting activities are sequential and each session includes:
    - A family meal and family communication games
    - A self-help parent support group held while children are engaged in supervised play and organized activities
    - One-on-one parent-mediated play therapy
    - A family lottery (that is fixed so that every family wins once)
    - Opening and closing routines, which model the effectiveness of family rituals
- Multifamily meetings held monthly after families graduate from the program. (Parents develop an agenda to maintain FAST family networks that have been developed.)

Outcome studies show reductions in children's aggression and anxiety, increases in academic competence, attention span and social skills, at one and two-year follow up. Parental benefits include self-referral to substance abuse or mental health treatment, pursuit of adult education, and the development of ongoing friendships (i.e., natural supports). FAST has been used effectively families with low and middle-incomes, those living in rural and urban areas, as well those from various cultures (African American, Asian American, Hawaiian, Hispanic/Latino, Native American, and Caucasian). Program adaptations and results have also been replicated with preschool children and with teen mothers in Baby FAST. Information can be obtained on-line at http://www.wcer.wisc.edu/FAST/.

SCHOOL TRANSITIONAL ENVIRONMENTAL PROGRAM (STEP)

STEP targets students aged twelve to eighteen during transitions from elementary and middle school who are at risk for behavioral problems in urban, suburban, and rural junior high and high schools. Students are assigned to student cohort groups, each of which has a homeroom teacher. Cohort classrooms are grouped together within larger schools in an effort to create a feeling of community, foster the development of stable peer groups, enhance familiarity with the school, and reduce the likelihood of engaging in conflicts with older students. They remain together for homeroom as well as in core classes. Homeroom teachers are assigned twenty to thirty STEP students and serve as the primary link between home, student, and school. These teachers provide academic and personal problem counseling and assist with class scheduling. They also explain the program to parents, notify them of student absences, and follow up with them to enhance communication between families and the school. They meet with other homeroom teachers to discuss potential student problems and students who may require counseling or extra attention.

Outcomes studies indicate that participants display reduced absenteeism, increased grade point averages, and more favorable feelings regarding the school environment. Long-term follow-up studies indicate that participants have lower dropout rates, higher grades, and fewer school absences. Students in junior high who are deemed at lower risk benefit the most with significantly lower levels of school transition stress and better adjustment on measures of school, family, general self-esteem, depression, anxiety, and delinquent behavior, and higher levels of academic expectations. Teachers report the students display improved classroom adjustment behavior and fewer problem behaviors.

SCHOOL-BASED BULLYING PREVENTION

Bullying behavior among children has historically been often dismissed as a normal part of growing up and its negative effects received little attention until recent years. The prevention of bullying has become a priority for schools across the country.

It has been estimated that almost thirty percent of adolescents are involved in bullying, either as a target of bullying or as a bully, or both. Bullying occurs more frequently in males and appears to be more common among younger adolescents. Girls tend to use more subtle forms of aggression such as excluding other girls from activities and information sharing, and spreading gossip. Teenagers who engage in bullying are more likely to display antisocial and delinquent behaviors (e.g., vandalism, shoplifting, truancy, drug use) during adulthood. They are four times more likely to be convicted of a crime by the age of twenty-four. Sixty percent of those who have engaged in bullying have at least one criminal conviction. Research has found that adults who behaved as bullies as teenagers have higher levels of depression and poorer self-esteem. Thus, the effects of bullying are long-lasting and linger well after the behavior has ceased.

Those who bear witness to bullying can have feelings of guilt or helplessness for not standing up to a bully on behalf of a classmate or friend, or not reporting incidents to someone who can assist. The risk factors that have been identified for bullying include:

- Insufficient parental support
- Lack of parental monitoring of children's activities
- Lack of parental involvement in children's lives
- Extremely harsh or permissive parental discipline

Bullying has been found to occur where there is a lack of adult supervision in schools during breaks and where students and teachers exhibit indifference to bullying or find the behavior acceptable. In addition, it is more likely to occur in settings where rules that prohibit the behavior are not consistently enforced. Approaches to crack down on bullies are rarely effective. School-wide commitment to bullying prevention and intervention efforts, on the other hand, has been shown to lead to reductions in bullying behavior by up to fifty percent. The following program exemplifies such an approach.

OLWEUS BULLYING PREVENTION PROGRAM

The Olweus Bullying Prevention Program is a school-based program designed to prevent or reduce bullying in elementary, middle, and junior high schools, and is targeted to children aged six to fifteen. The program focuses on changing bullying behavior through behavior modification and by altering the structure of the school environment to reduce occasions and reinforcements for bullying behaviors through school staff who work to improve peer relations and make school a constructive and safe environment for students. The program also addresses victims' suffering and thwarts bullying tendencies of students who display or have the potential for aggressive and antisocial behavior (which are risk factors for substance abuse and other problem behaviors). The Olweus Bullying Prevention Program is a SAMHSA model program.

The program is maintained throughout the school year. A Teacher's Handbook is used to provide instructions about holding school-wide and classroom-level meetings with parents about bullying. A questionnaire about bullying is administered to all the students (who answer it anonymously), and results are analyzed. A Bullying Prevention Coordinating Committee is formed and trained. School rules against bullying are developed, along with a coordinated system of supervision during break periods. Regular, ongoing staff discussions are held to keep staff motivated, stimulate rapid implementation, as well as share and learn from each other's experiences.

Interventions include individual life and social skills training, family task-oriented education sessions to improve family interactions (e.g., parental involvement in program homework assignments, etc.), peer-resistance education, classroom-based skills development, as well as comprehensive school programs to increase parental involvement, change classroom management and/or instructional style, and improve student participation and school bonding. Parents attend school-wide and classroom-level meetings where they are taught about bullying from the perspective of both the victim and the bully as well as ways the school is being organized to combat the behavior. Six to twelve teachers and staff participate in regular, ongoing staff discussion groups. School counselors hold individual sessions with victims, children who engage in bullying, and their parents. Parents are provided with an information packet about bullying. Students participate in a series of regular classroom meetings about bullying and peer relations. Video and classroom discussions are used to teach students how to identify bullying and how to mitigate its effects in school.

Outcomes include reductions in student reports of general antisocial behaviors (e.g., vandalism, fighting, theft, and truancy), improvements in classroom orderliness and discipline, and more positive attitudes toward schoolwork and school. Studies document a thirty to seventy percent decrease in student, peer and teacher reports of being bullied and bullying others, reductions in existing bullying/victim problems, prevention of the development of new instances of bullying behavior, and improved peer relations at school. The cost of the program is estimated to be $1,001– 5,000 for training and materials. More information is available on-line at http://www.clemson.edu/olweus/contact.html.

COLLABORATION WITH CHILD WELFARE

The child welfare system (protective services, foster care, and adoption) often functions as a gateway to the mental health system, especially for children who have been placed into foster care. Research shows that, relative to other children, children in foster care utilize significantly more mental health services. Higher mental health utilization has been linked to a number of factors including age (i.e., older children), males, placement in non-relative foster care, and being removed from the home due to physical or sexual abuse.

There is evidence that gender and ethnicity play a role in access and utilization of mental health services for this population. For example, medication tends to be used more often for boys. Ethnic groups (African American, Latino/Hispanic and Asian) use less mental health services than Caucasian youth in foster care. African American youth receive fewer services for low to moderate levels of problems and Latino/Hispanic youth receive the least amount of services for any level of difficulty and are referred only when they display more symptoms.

Children in foster care are at higher risk for mental health problems (especially the zero-to-five age group) due to the abuse and neglect they suffered which led to placement. Data from the child welfare system indicate that one-half to two-thirds of children entering foster care display behavior problems that are serious enough to warrant mental health intervention. It is estimated that some thirty-five to eighty-five percent of youth in foster care have significant mental health problems including emotional, behavioral and developmental difficulties. The prevalence of mental health problems is three to six times greater than for children in the community. Their exposure to trauma and other risk factors make them more prone to eternalizing behavior disorders (e.g., disruptive behaviors, delinquency, hyperactivity, and aggression) than internalizing disorders (e.g., anxiety, low self-esteem, fear, depression, and sadness). [28]

[28] These children do not, contrary to conventional wisdom, experience higher levels of attachment disorders; attachment disorders do not explain the disruptive behaviors often seen in this population.

These problems negatively impact options for permanency and long-term social adjustment. Children who experience mental health problems have a decreased likelihood of family reunification and adoption. Children who display externalizing disorders and have developmental delays (as well as those who are age twelve and older and non-Caucasian) have been found to be the least likely to exit foster care.

Foster parents may not be prepared to meet the challenges of caring for children with serious emotional and behavioral disturbances, which can lead to placement breakdowns and unplanned terminations by foster parents. Hence, foster parent training has become a significant factor in successful foster care placement outcomes. Foster care training programs typically fall into one of two categories: (1) skill-based training that includes providing information regarding the developmental needs of children and cognitive-behaviorally based child management techniques; and (2) providing information and support to foster families to help them understand their roles and responsibilities, preparing for anticipated problems, and support in dealing with issues encountered. Wraparound foster care, described below, has been found to be effective in helping foster families and children maintain stable placements. Models of therapeutic foster care are discussed in the section on crisis intervention and out-of-home settings.

FOSTERING INDIVIDUALIZED ASSISTANCE PROGRAM (FIAP)

The Fostering Individualized Assistance Program provides wraparound services and support to children, aged seven to twelve years of age, in foster care who have emotional and/or behavioral disorders and their families (biological, adoptive, and foster). The program is designed to improve permanency outcomes for foster children.

FIAP contains four components:

- A strength-based child and family assessment to address individualized needs
- Service planning for each life domain to support and enhance permanency plans
- Case management of wraparound service plans
- Follow-along supports and services to maintain permanency and improve overall adjustment

Outcomes indicate that wraparound foster care is beneficial in helping maintain foster care placements and reducing emotional and behavioral symptoms (e.g., delinquency, externalizing behaviors). In addition, children with histories of running away and incarceration have been found to spend fewer days out-of-home.

COLLABORATION WITH PRIMARY CARE

Primary care settings offer opportunities for early identification of difficulties and the provision of interventions for both parents and children. Primary care providers, rather than mental health, providers, see the most children who have mental health difficulties. Parents may prioritize their children's health care needs and bring them for well care visits and acute care. This is particularly true for preschool children whose primary care visits may constitute their only contact with a delivery system. Families in which parents are living with a mental illness may seek services through primary health care providers. Primary care providers thus have the opportunity to intervene and engage parents in seeking appropriate services and supports in a setting that is not seen as stigmatizing.

Primary pediatric care often functions to identify, screen, refer, and facilitate access to services for young children with challenging behavior. However, only a small portion (with estimates ranging from seventeen to forty percent) of young children with challenging behavior are appropriately identified and addressed. Medicaid mandates screening and identification for all eligible young children, yet studies show that less than a third of eligible children receive a full EPSDT screening and even fewer receive a screen that includes behavioral health. Pediatricians rarely use routine developmental and psychosocial assessments or standardized instruments for young children and their families. They do not routinely screen for maternal depression or other significant risk factors. Linkages with mental health providers are often problematical and present barriers to making referrals. Efforts to enhance mental health and primary care linkages include consultation-liaison services, co-location of services, and integration of behavioral health providers into the primary pediatric care team.

Many children who experience chronic health problems are at greater risk for depression and other difficulties. It has been found that chronic health problems such as asthma and otitis media (ear infection) can affect school readiness and academic performance. Additionally, nutritional status (e.g., general malnutrition, iron deficiencies leading to anemia), dental health, and environmental factors (e.g., lead poisoning) can affect brain development, cognitive and behavioral functioning, and school readiness. Primary care settings need to address these issues and link children and their families with appropriate mental health and other supports and services.

The best pediatric primary care practices related to the promotion of health include:

- **Nutrition:** Referrals to programs such as WIC (Women, Infants and Children) supplemental food program, Food Stamps, the Child and Adult Care Food Program (or CACFP) which provides services to licensed non-profit child care facilities or those that maintain twenty-five percent Title XX enrollment to ensure access to adequate nutrition).
- **Early and periodic screenings:** Early identification of health and developmental difficulties along with referral to appropriate services and supports is an important component of improved health status for children. The importance of age-appropriate screenings and periodic well-child visits with follow-up are critical components.
- **Required immunizations**
- **Consultation and assistance to parents:** Early and continuous prenatal care has been shown to improve pregnancy outcomes. Nurse home visiting programs can lead to beneficial outcomes.

- **Consultation and technical assistance to child care providers:** Continuing education, training and consultation have been shown to be of benefit.
- **Injury prevention for infants and toddlers:** This includes child vehicle restraints, playground safety, proper supervision, poison control and first aid training for parents and teachers.
- **Access to age-appropriate health care services:** Regular preventive care and medical treatment including dental care.[29]

COLLABORATION WITH JUVENILE JUSTICE

According to national data, it is estimated that between sixty and eighty percent of youth involved in the juvenile justice system experience significant mental health challenges, many of which can be classified as serious emotional disorders. Studies show that one-quarter to one-third of youth who are incarcerated experience anxiety or mood disorders. In addition, up to two-thirds have co-occurring mental illnesses and substance use disorders. The incidence of suicide in juvenile detention centers is estimated to be more than four times greater than that of the general population. Involvement in the juvenile justice system has also been shown to be predictive of the development of future mental health issues. Despite these obvious needs for mental health services, most juvenile correctional facilities do not typically conduct assessments or have the resources to provide mental health services.

Most of the research on interventions for children who have behavioral problems in the juvenile justice system has focused on males. However, a number of prevalence studies done in state juvenile justice systems suggest that females have higher rates of mental health problems than their male counterparts. Issues that affect females include depression, sexually transmitted diseases, sexual abuse, pregnancy and parenting responsibilities, and neglect and abuse. Adolescent girls who come into contact with the juvenile justice system report extraordinarily high levels of abuse and trauma. Posttraumatic stress disorder has been found to be prevalent among adolescent girls in the juvenile justice system; almost fifty percent meet diagnostic criteria for the disorder. And many who enter the juvenile justice system are pregnant or already are parents and their separation from young children may result in substantial emotional and practical difficulties for them.

A growing research base indicates that gender-specific intervention models are more successful with females. Such models address health care, education, mental health treatment, co-occurring disorder substance use and psychiatric disorders, mutual support and mentoring opportunities, prenatal care and parenting skills, substance abuse prevention and treatment, job training, relationship issues, parenting, domestic violence, victim empathy, coping strategies, and family support/strengthening services.

Incarceration is not only costly, but may produce long-term negative outcomes for youth and increased rates of adult incarceration. Alternatives have typically involved placement in group homes or residential treatment settings with peers who have histories of comparable delinquent acts. However, there is a lack of data to support the effectiveness of group residential treatment for these young people. Moreover, there is strong evidence that peer group residential treatment models can lead to adverse outcomes by facilitating affiliation, bonding, and identification with peers who engage in delinquent behavior which leads to an escalation of aggressive and delinquent behavior over time. Research has clearly demonstrated that associations between

[29] Dental disease (i.e., dental caries) is the most common childhood disease.

peers who display delinquent behaviors is strongly predictive of involvement in violent and delinquent behavior.

There is little evidence to support harsher sanctions to reduce rates of juvenile delinquency. Rather, effective intervention hinges on the provision of interventions that have been demonstrated to decrease persistently disruptive and delinquent behaviors. Research indicates that early intervention leads to the most beneficial outcomes. One promising program of early intervention for children who have committed juvenile offenses is the Michigan Early Offender Program (EOP). It was established in 1985 in the Oakland County Probate Court and provides specialized and intensive in-home interventions for children aged thirteen and younger who have had two or more prior contacts with the police. Services are begun at the time of the first adjudication.

The program is comprised of individualized treatment planning, group therapy, school preparation assistance and short-term detention for up to ten days. A caseworker is assigned to each youth in the program to develop a plan and work with parents to model appropriate parenting techniques. Participants can receive psychological assessments and participate in individual, group, or family counseling services. Other program components include restitution and community service programs, academic exercises, and group events. Caseworkers are involved with twelve to fifteen children and other staff in the program monitor them on weekends and evenings and provide transportation to treatment sessions. Youth may be placed in short-term detention as a negative consequence for inappropriate behavior. The program has resulted in reduced recidivism and out of home placements, improved peer and family relations, school performance and conduct.

It should be noted that no single system can effectively address delinquency. Coordination and collaboration between juvenile justice, education, mental health and child welfare is needed. In addition, systematic screening for emotional and behavioral problems upon entrance into the juvenile justice system can help law enforcement personnel (police, judges, probation officers) make informed decisions and divert children into appropriate services.

The recidivism rate for juvenile offenders transitioning back into the community following secure confinement in a correctional facility is high. Intensive aftercare case management can be used to coordinate planning, service and support provision, and monitoring of juvenile offenders transitioning into the community from highly structured and regimented settings. Collaborative efforts between mental health, substance abuse treatment, employment and training programs, faith-based institutions and others is needed to provide effective transitional supports and aftercare services to reduce recidivism.

THERAPEUTIC JURISPRUDENCE

Collaborative justice efforts are designed to divert youth with mental illnesses and emotional disorders into treatment, rather than incarceration, while maintaining public safety. One model involves the placement of mental health staff in juvenile court offices to liaise with juvenile justice staff to divert youth into mental health treatment where appropriate. The placement of mental health staff in court offices has been shown to facilitate access to services and prevent unneeded hearings. Another model entails mental health staff working with probation officers to identify children who would benefit from mental health services, diverting them from adjudication into treatment when appropriate, and assisting them and their parents in accessing other services and supports. A third model involves mental health collaboration with police officers for crisis intervention and connecting families to services. In addition, a number of problem-solving court models have also been developed to address the mental health needs of children,

adolescents and their families. This section offers a review of models of therapeutic jurisprudence and opportunities for diversion and intervention.

BALANCED AND RESTORATIVE JUSTICE (BARJ)

Since 1977 the Office of Juvenile Justice and Delinquency Prevention (OJJDP) has supported development of juvenile restitution programs based on research showing that properly structured restitution programs can reduce recidivism. Balanced and restorative justice is predicated on the belief that juvenile justice is best served when the victim, youth, and community are viewed as equal clients of the juvenile justice system, receive fair and balanced consideration, are actively involved in the justice process, and gain tangible benefits from their interactions with the juvenile justice system. BARJ emphasizes the importance of the victim (individual or community) in the juvenile justice process and requires the offender to actively pursue restoration of the victim by paying restitution, performing community service, or both. The BARJ model also restructures juvenile justice staff roles from office-based functions to community-based work and supervision of offenders in their development of competencies and in victim-offender mediation as part of the restoration process.

Community Justice Principles and Core Values
Community Justice Principles • The community (including victims as well as those who commit offenses) is the ultimate customer as well as partner of the justice system. • The justice system and citizens, actively working together, share a common goal of maintaining a safe, peaceful community. • The justice system confronts crime by addressing social disorder, criminal activities and behavior, and restoring victims and communities to the fullest extent possible. • Justice system components collaborate in appropriate, just, and necessary actions to preserve community safety and well-being.
Core Values of Community Justice The justice system benefits the community by: • Promoting community protection and service. • Preventing crime and its harmful effects. • Repairing the damage caused by crime to individual victims and communities. • Promoting universal justice and fairness through proactive, problem-solving practices focused on creating and maintaining safe, secure, and just communities.

BARJ is not a treatment program, but rather a model for systems that embraces the following principles:

- Community safety
  - Zero offenses committed by youth while under supervision
  - Reductions in levels of fear in the community and in victims
  - An increased level of community understanding regarding juvenile justice
  - Increases in social competency, victim empathy, and internal control for juvenile offenders who are under supervision
  - Enhanced connections to conventional, law-abiding members of the community
  - An increased sense of belonging to the community
  - Reductions in school violence and increases in school and community-based conflict resolution
  - Increased community involvement and ownership in the regulation of the behavior of all youth in the community
- Offender accountability
  - Repayment of material losses to victims
  - Making observable contributions to the community

- A sense of acknowledgement of the harm and some degree of repair to the victim
- Increased awareness of the impact of one's behavior on others

➢ Competency development

- Increased capacity to contribute productively to the community
- Increased capacity of the community to accept and integrate youth who have a history of committing delinquent acts
- Measurable increases in educational, occupational, social, and decision-making abilities of youth with a history of offenses
- Increased bonding with adult community members
- Improved self and public images of youth who commit delinquent acts
- Clear demonstration of skills valued by the community
- Increased involvement of community members in the juvenile justice system

PEER COURTS

Peer courts, which can be located in schools, juvenile courts, probation departments and community agencies, are designed to provide education, motivation and empower youth while holding them accountable for their actions through restorative (rather than punitive) justice. These courts are staffed and managed by youth who function as defense attorneys, prosecutors, judges, juries, bailiffs and, at times, judges. Youth are thus held accountable for their actions by peers who do not condone delinquent behaviors. They acquire knowledge regarding the judicial and legal systems as well as how to resolve conflicts through the use of problem-solving skills. Moreover, they learn about the impact of their behavior on themselves, family, peers and community. Sentences involve community-based restorative actions that aim to repair harm inflicted rather than incarceration. Restorative actions can include community service, letters of apology to victims, and others. In addition, youth are provided with linkages to mental health, primary health, educational, vocational, recreational, and other resources to address issues that may have led to their involvement in the juvenile justice system. Charges are usually dismissed upon successful completion of the peer court's sentence.

Studies of peer courts have shown they are cost-effective and result in significant reductions of recidivism.

JUVENILE MENTAL HEALTH COURTS

While there is still much debate[30] regarding whether juvenile mental health courts are the best response to the needs of young people with emotional disturbances who have committed offenses, and outcome studies are sparse, they do offer opportunities for diversion and intervention.

Juvenile mental health courts are based on adult mental health courts. While most are a product of collaboration between the mental health and juvenile justice systems, some adult mental health courts accept young offenders, following the lead of the first juvenile mental health court established in Santa Clara County, California in 2001. Several juvenile courts have been established in various jurisdictions around the country that deal exclusively with juvenile cases.

In these courts judges, attorneys, and staff collaborate to develop treatment regimens. Probation officers ensure the sentences of medication and counseling are carried out. Attorneys are often encouraged to use the term client instead of defendant in reference to the minor.

[30] Many argue for effective community-based intervention to obviate the need for such courts.

Some of these courts only accept misdemeanor cases, typically nonviolent crimes (e.g., drug violations, shoplifting, trespassing, disorderly conduct), while others accept a broader range of all cases. Participation is voluntary and may involve the provision of psychiatric services, wraparound services, medication, outpatient psychotherapy, coordination with special education programs, and other services. Judges, defense attorneys, assistant district attorneys, mental health professionals, probation officers, social workers, and others jointly develop a service and support plan. If conditions set forth in the plan are violated, the juvenile may or may not be returned to the juvenile court system depending on the nature of violation. Upon successful completion of the program, the youth may be released from the court's jurisdiction with no record of conviction.

While each court has unique operating procedures, all current models share common elements:

- Screenings conducted by mental health professionals, probation officers, district attorneys, and defense attorneys
- Multidisciplinary teams operating under a System of Care framework to develop a treatment plan
- Implementation of treatment plans that include probation conditions and mental health services
- Judicial reviews of the minor's progress conducted regularly (usually every ninety days)
- Probation supervision provided via face-to-face contacts
- Community-based aftercare services and supports
- Court reviews conducted with regularity (every two weeks to every ninety days)
- Reviews/revisions made to treatment plans as needed
- Graduated justice interventions or increases in mental health treatment for probation violations
- Dismissal of cases following consistent participation and compliance with terms and conditions of probation, and adherence to treatment recommendations (e.g., medication, counseling, etc.)

While rigorous, empirical evaluations of juvenile mental health courts are lacking, it has been noted that they have resulted in reductions in recidivism and unnecessary detentions, as well as expedited processing of courts' caseloads and increased involvement of families (who are also connected to appropriate services and supports).

The MAYSI-2 is used to screen potential participants in these courts.

MASSACHUSETTS YOUTH SCREENING INSTRUMENT (MAYSI-2)

The MAYSI-2 is a standardized, validated, fifty two-item, true-false, paper-and-pencil instrument used to screen youth aged twelve to seventeen for potential mental health problems in need of immediate attention. It requires a fifth grade reading level, takes about ten minutes to administer, and can be used by non-clinical staff at intake, probation, pretrial detention admission, and reception. It is intended for use at any point in the juvenile justice system. Youth circle yes or no on each item to indicate whether it has applied to them within the past few months. Scoring of MAYSI scales takes about three minutes.

MAYSI-2 Scales

Alcohol/Drug Use	Frequent use of alcohol/drugs
	Risk of substance abuse
Angry-Irritable	Experiences frustration, lasting anger, moodiness
	Risk of angry reaction, fighting, aggressive behavior
Depressed-Anxious	Experiences depressed and anxious feelings
	Risk of depression or anxiety disorders
Somatic Complaints	Experiences bodily aches/pains associated with distress
	Risk of psychological distress not otherwise evident
Suicide Ideation	Thoughts and intentions to harm oneself
	Risk of suicide attempts or gestures
Thought Disturbance	(Boys only) unusual beliefs and perceptions
	Risk of thought disorder
Traumatic Experiences	Questions refer youths to "ever in the past," not "in the past few months"
	Lifetime exposure to traumatic experiences (e.g., abuse, rape, observed murder)

The instrument, answer and scoring forms can be duplicated after purchasing the MAYSI-2 User's Manual and Technical Report from Professional Resource Press and receipt of authorization from The National Youth Screening Assistance Project (NYSAP) to use the instrument. The MAYSI-2 is copyrighted by Professional Resource Press (PRP). The manual costs $60.00. Information is on the web available at http://www.umassmed.edu/nysap/MAYSI2/ and MAYSI-2 products. MAYSIWARE is the electronic version of the MAYSI-2 and can be found on the MAYSIWARE website at www.MAYSIWARE.com. The price of the software is $125.00 per CD and each facility must purchase its own CD and register to use MAYSIWARE.

FAMILY DEPENDENCY TREATMENT COURTS (FDTC)

Substance abuse has been estimated to be a factor in seventy-five percent of all foster care placements. Children whose parents abuse substances are almost three times more likely to be abused and more than four times likely to be neglected than children of parents who do not abuse substances. Family dependency treatment courts have been developed as a means of assisting parents who have substance use disorders and are at risk of losing their children due to child abuse and/or neglect. Their purpose is to protect the safety and welfare of children while offering parents the skills they need to become sober, responsible caregivers. In order to accomplish this, an interdisciplinary team (with ample cross-system training) works collaboratively to assess families' situations and formulate comprehensive plans that address the needs of both the parents and their children. Teams meet regularly (typically on a weekly basis) to share information regarding the parents' and children's progress, attendance at hearings, and participation in treatment.

The first family dependency treatment court opened in 1994 in Reno, Nevada and a number of such courts are now operating across the country. These courts are the result of collaboration between the judicial, child protection, and mental health fields. Inspired by adult drug courts, FDTCs are a collaborative approach to therapeutic jurisprudence, with teams that include judges, substance abuse treatment providers, child welfare specialists, attorneys (including the prosecution as well as those representing protection agencies, parents, and children), mental health practitioners, and others.

FDTCs have the following characteristics:

- Most FDTCs accept individuals who have civil cases, while some accept those who have both civil and criminal cases.
- FDTCs can function under the jurisdiction of family, juvenile or general jurisdiction courts.

- In some FDTCs all pending cases involving any member of the family are placed under the oversight of an FDTC judge, while others use multiple judges from the dependency court, the FTDC, and other criminal and civil courts in which family members have matters pending.
- Some FDTCs are fully integrated within a dependency court while others complement the dependency court case process and intervene at a specific point in the process to review parental compliance with court orders.
- Some programs have a particular focus (e.g., mothers of infants exposed to drugs), while others have a broader focus and consider any dependency case in which parental substance use contributes to the abuse or neglect of children.
- Frequent judicial review of cases is conducted.
- A graduated system of sanctions and incentives are used to maintain parental accountability. (Sanctions function as a consequence for parents who test positive for drugs, miss a treatment session, miss a hearing date, or are otherwise nonadherent. Such sanctions might include verbal admonitions from the judge, therapeutic essay writing, community service, fines, and increased frequency of drug testing. Some judges use jail as a sanction for serious nonadherence issues. For example, a judge may order an offender to jail for two days, a week, or longer. However, when considering a jail sentence for a parent, the first consideration is how such a sanction might affect the safety and welfare of the children and every effort is made to avoid adverse effects. [It is recommended that jail time not conflict with a parent's time with their child, even if the child is in foster care.] Incentives reward parents who achieve program objectives or succeed in a program. Sanctions and incentives have been found to have a therapeutic impact on parents and assist them in accepting responsibility for their behaviors.)
- Team meetings (or staffings) are held on a regular (usually weekly) basis.
- Aftercare planning begins when a family first enters the program. Parents often need access to self-help groups, counseling sessions, and other resources such as alumni events, support groups, and social functions. Aftercare plans also include services for children who may have experienced maltreatment.

The primary role of the judge in abuse and neglect cases is to ensure the child's safety, permanency, and well-being. The judge, who serves as a role model and authority figure, functions as the team leader and oversees the family members' progress in treatment. An FDTC coordinator maintains the ongoing operation of program activities including overall monitoring services, ongoing scheduling of cases, maintenance of files, identifying and allocating resources, budgeting, and performance evaluation. A substance abuse treatment professional determines the appropriate substance abuse treatment for the parents, educates the team on relevant issues regarding treatment options, issues (e.g., relapse), and substances of abuse specific to the jurisdiction. Treatment providers attend and participate in staffings and court sessions to offer information about the progress of participants. Child protective services, probation and parole officers, and case managers are responsible for linking parents with community supervision, treatment, and law enforcement services. A child welfare representative is responsible for protecting children's health and safety, advocating on behalf of the children's best interests, and ensuring that they and their parents receive necessary services. A parent attorney ensures that parents' interests are considered while protecting the safety and welfare of their children. This attorney informs parents about court procedures, makes parents aware of the benefits of the program, encourages their participation, and handles any related criminal charges against the parents. The prosecuting attorney identifies cases eligible for participation in the FDTC, is responsible for bringing cases forward, files motions and petitions necessary to

initiate the parents' involvement in the FDTC, attends and participates in team meetings and court hearings to ensure ASFA (Adoption and Safe Families Act) timelines are met and the safety and best interests of the child are maintained. Family members are included to ensure that parents have opportunities to advocate for services to meet the needs of their children. Children have a voice through their social worker, parents, or representatives, or may speak directly to the court regarding their own safety, well-being, and permanency.

Family dependency treatment courts incorporate the needs of both children and parents; the entire family is viewed as the client. While decisions are always made in the best interest of the child, a parallel focus on the interests of the parent is maintained. Family reunification is contingent upon parents' demonstrated ability to provide for their children's health, safety, and well-being within the timelines mandated by ASFA.[31] The goals of these courts are to ensure the safe return of children to their families, or find permanent placements for those who cannot return home.

COLLABORATION WITH LAW ENFORCEMENT

Police officers are typically the first professionals to arrive when violence occurs in the home or community. The manner in which police respond to the situation leaves an often indelible impression on children who witness, or are victims of, violence. Such first contacts with authority figures shape children's responses and attitudes toward police, the event, and violence in general. However, police training typically does not include dealing with children's reactions to trauma. As a result, police officers may not recognize the potential impact of their behavior on children in such situations, especially in instances where force is used. Police training also does not include information regarding age-appropriate responses to children's distress even when officers are sensitive to child development issues. As a result, children may view the actions of police as harmful and violent which can contribute to long-term negative attitudes and behaviors towards authority figures in general, and police in particular.

Police officers can provide immediate support to families and communities and ensure that communities receive needed assistance to reduce violence. The Child Development Community Policing Program (CD-CP) is an example of a community-based collaborative effort that includes regular ongoing meetings and cross training efforts to help police respond to children. It is a national model of collaboration between law enforcement, juvenile justice, child welfare, schools, and domestic violence, medical and mental health professionals, as well as other community agencies. The program also has been expanded to include juvenile probation officers and detention center staff who work with children and adolescents whose exposure to violence places them at risk for becoming involved in delinquent activities and provides assessments and interventions for these at-risk youth.

It was started in 1991 as a partnership between the Yale Child Study Center, New Haven police department and the city of New Haven and has been replicated in a number of communities across the country. The program places primary emphasis on the child's perspective and is designed to mitigate the affects of chronic exposure to violence on children and families.

The program provides training for both clinicians and police officers incorporates the following interventions to assist children exposed to violence:

[31] Because relapse is common for individuals with a substance use disorder, the long-term timeframes required for recovery may not mesh with the shorter timelines mandated by ASFA or those set by child welfare agencies to make child placement decisions. These mandated shortened timeframes mean that parents with substance use disorders have significantly less time to enroll and participate in treatment and establish their capacity to provide a safe home for their children. Thus, a child's needs for a permanent, safe home may conflict with their parents' needs for extended treatment.

- Mental health consultation
- Domestic violence intervention
- School crisis prevention and response
- A death notification protocol
- Community Outreach Through Police in Schools (COPS)
- Juvenile delinquency interventions
- Collaboration with schools

Police and mental health practitioners' provide intervention for children and families who are victims, witnesses, or perpetrators of violent crimes. The program also has a twenty-hour consultation service that allows police officers to make referrals and obtain immediate clinical guidance. Police officers and clinicians meet on a weekly basis to discuss challenging situations and cases.

TRANSITION SERVICES: PREPARING FOR ADULTHOOD

The literature offers ample evidence that young people who experience serious emotional disturbances as they enter adulthood struggle to meet the expectations of society to attain life goals (e.g., complete high school, obtain employment, move out of the family home, etc.). Longitudinal studies indicate that adolescents who are served by mental health systems or in special education programs are often unable to function adequately when confronted with the tasks of young adulthood. Public mental health systems typically lack services and supports geared to meet their unique needs, and there is a lack of coordination between children's mental health, child welfare, educational, adult mental health, substance abuse treatment, and other service sectors on their behalf.

Many young adults with emotional and/or behavioral problems are at risk of falling through gaps in the public mental health system and can end up in the criminal or juvenile justice systems, unemployed, and/or homeless. Studies demonstrate that youth and young adults who experience emotional and behavioral difficulties have some of the most adverse outcomes of any population with a disability. More than fifty percent are incarcerated. They also have higher rates of homelessness with up to one third experiencing at least one period of homelessness. They are less likely than their cohorts to reside with their families. They are more likely to experience pregnancy. More than half of these young people never complete their high school educations; some drop out, while others are expelled from school.

In general, there is a lack of funding dedicated to transitional services and few public mental health systems are able to direct resources to this population due to funding constraints. In fact, to date, no state has implemented a fully coordinated system of transition services and supports that continue into adulthood. Categorical funding streams often hinder the development of coordinated transition support services since categorical funds are linked to services rather than to individuals. Lack of funding is a serious impediment to developing age-specific services and supports.

A number of service access barriers have been shown to exist due to gaps between the children's and the adult mental health service systems[32] which are not typically designed to mesh with one another. These include age limits, diagnosis limits, and other eligibility criteria. The two systems provide services and supports to significantly different populations. Differences in eligibility requirements between the adult and children's mental health service systems are based upon the distinction between serious emotional disturbances for children and serious and persistent mental illness for adults. Children's mental health services are based on a broader definition and include a wider range of diagnoses than those for adults which tend to be narrower in terms of both diagnosis and severity of functional impairment. Youth who experience disruptive behaviors, affective and anxiety disorders are the primary focus of the children's system, while individuals who have serious mental illnesses typify those served in the adult service system. The latter are not usually manifest prior to late adolescence or early adulthood. In addition, many clinicians who work with children are reluctant to apply more serious diagnoses to youth due to fears regarding stigma and other negative consequences. This lack of an applicable diagnosis can result in difficulty in accessing the adult service system. Thus, a significant portion of adolescents who age out of the children's mental health system do not meet criteria for services in the adult system. Subsequent to age sixteen, and especially

[32] Approximately one third to one half of children who receive public mental health services transition to the adult mental health system.

subsequent to eighteen, youth who have received services and supports stop receiving them. However, many young adults who do not meet the diagnostic criteria for adult mental health services continue to require services and supports. And, while many express the desire to continue to receive services and supports, they are unable to procure them.

Children's mental health service systems are the only system with a specific mandate to provide services and supports for children and adolescents who have serious emotional disturbances and other mental health needs. These systems typically bear the most responsibility for transition age youth since they are already being served in these systems (although schools and child welfare systems have a long history of providing transition services).

Adolescents and young adults who experience emotional and behavioral challenges need a variety of services and supports during the stage of transition. These can include: enhanced family relationship building, treatment for co-occurring mental illness and substance use disorders, housing, education, career planning, job training, and life and social skills development. Despite these needs, however, research shows that very few services targeted to this population are made available during the transition phase.

Effective transition services and supports encompass the following elements:

- Interagency collaboration that includes the adult mental health system
- Procedures that link youth with the adult mental health service system
- An array of transition services that start when the youth is still eligible for children's services that continue to be provided into adulthood
- Transition supports for young adults who do not qualify for services in the adult mental health service system
- Removal of inflexible categorical funding requirements (that too often result in turf battles), and blending or pooling funds with other agencies with responsibilities for the transition age population. (EPSDT funds, for example have been used as a source of such funding.)
- According transition services a high level of priority
- Involving adolescents, young adults and other stakeholders in service planning

Potential Transition Supports
Housing
Mental health and substance use disorder treatment
Independent Living Skills and Supports
Balancing the need for independence with the need for family support
Vocational Supports (Supported Employment)
Educational supports for completion of high school/GED and post-secondary education/Career Planning
Assertive Community Treatment (ACT)
Service Coordination/Case Management
Child Care (for young parents)
Peer Leadership/Mentor Supports
Primary Health Care
Legal assistance for those involved in the justice system

A relatively inexpensive way to provide transition supports is through a shared case management approach wherein some case managers develop expertise regarding the unique needs of the transition age population and provide services to young adult consumers throughout the transition period from adolescence through young adulthood. Cross training staff from both the children's and the adult service systems is one approach since each system has developed expertise that can be shared to assist in addressing transition issues. For example, the adult system has expertise in housing and supported employment. The children's system has expertise in incorporating the larger context of the family and community in unique ways.

Another approach is to modify the traditional wraparound process to ensure it is developmentally appropriate for the transition age population. This entails a shift from partnering with parents to partnering with adolescents in order to accommodate evolving independence and legal status. The wraparound process needs to incorporate transition planning and acquisition of adult functioning skills (e.g., preparing a resume, job interviewing skills, developing a budget, balancing a checkbook, making doctor's appointments, etc.). Community teams should include supported employment services, adult mental health and substance abuse treatment services as needed and use transition specialists who have expertise in working with this population. When necessary, transition coordinators can assist consumers in developing longer range mental health service plans and linkages with appropriate services and supports within the adult mental health system, schools and other resources, including natural supports. Because the wraparound process emphasizes an individualized approach, changes in services and strategies can be made at developmentally appropriate points for each consumer.

The most effective transition services adhere to the systems of care approach to provide comprehensive, coordinated services and supports that meet the needs of the population. Early identification and prevention have the potential to make the transition from adolescence to adulthood smoother rather than allowing mental health problems to worsen unaddressed. The adult mental health system will eventually provide services to many transition age youth if their conditions are left untreated or are inadequately treated. Moreover, the social costs in terms of homelessness, crime and other problems will ultimately need to be borne if appropriate services and supports are not provided.

Outcomes research indicates that transition services that address major domains of life (employment, mental health, education[33], substance use treatment, and medical health) result in increased rates of employment, high school/GED completion,[34] and stable housing, as well as decreased use of mental health services, and involvement in the corrections and juvenile justice systems.

TRANSITION TO INDEPENDENCE PROCESS (TIP)

The Transition to Independence Process is a manualized program that is consistent with the principles of SOC. The TIP system is designed to engage youth and young adults in their own future planning processes, provide developmentally appropriate services and supports, and involve them and their families and other informal supporters in facilitating preparation for greater self sufficiency and achievement of goals related to each of the transition domains (employment, career planning, education, living situation, personal effectiveness and quality of life, community functioning).

Transition facilitators (also called transition specialists, resource coordinators, mentors, transition coaches, TIP facilitators, service coordinators or life coaches) assist in implementing process. They work with the youth, family members, formal and informal community supports.

The TIP system is operationalized through the following guidelines that provide a framework for service and supports:

- Engage adolescents and young adults via relationship development, person-centered planning, and a focus on the future

[33] Michigan requires community mental health programs to collaborate with schools on school-to-work transition endeavors using an individualized, interdisciplinary, person-centered planning process.

[34] A discussion of Supported Education (SEd) can be found in *A Guide to Evidence-Based Practices for Adults with Mental Illness* located at http://sccmha.org/quality.html

- Tailor services and supports to be accessible, coordinated, developmentally-appropriate; promote strengths to enable the pursuit of individual goals across all transition domains
- Support personal choice and social responsibility
- Establish a safety net of informal and formal supports by involving parents, family members, and others
- Promote self sufficiency skill development

Self-determination is inherent in the TIP process; it fosters setting goals that are likely to improve quality of life, generating alternative strategies, choosing among the strategies to find the most viable ones for achieving each goal, implementing the selected strategies, and evaluating progress toward achieving those goals. While the TIP system is designed to promote independence, interdependence is a central element in which independent functioning (e.g., budgeting money, maintaining a job) is sustained within a framework of reciprocal roles of providing and receiving support from others within the context of a social support network.

Outcome studies indicate that TIP leads to increased completion of education, employment and decreased involvement in the criminal justice system, use of intensive mental health/substance services and reliance on public assistance. Information on TIP can be found on the web at http://tip.fmhi.usf.edu/.

PSYCHOTHERAPY

AGGRESSION REPLACEMENT TRAINING (ART)

Aggression Replacement Training (ART) is a short-term multimodal psychoeducational intervention for adolescents who display difficulties with the management of aggressive behavior that can be used in a variety of settings including schools, mental health, residential, and inpatient programs. Parent and family modules are also available.

ART has three main components:

- A skillstreaming curriculum that is implemented with small groups of adolescents via **modeling**, **role-playing** with opportunities to practice and rehearse behaviors, performance **feedback** using praise and reinstruction, and **transfer training** to increase the use of skills learned in vivo.
  The curriculum is comprised of:
  - Beginning social skills (e.g., starting a conversation, introducing yourself, giving a compliment).
  - Advanced social skills (e.g., asking for help, apologizing, giving instructions).
  - Skills for dealing with feelings (e.g., dealing with another person's anger, expressing affection, dealing with fear).
  - Alternatives to aggression (e.g., responding to teasing, negotiation, helping others).
  - Skills for dealing with stress (e.g., being left out of activities, accusations, preparation for a stressful conversation).
  - Planning skills (e.g., goal setting, decision making, setting priorities for solving problems).
- **Anger Control Training (ACT)**, which is a ten-week component that teaches a various ways to manage anger. Each participant is required to bring a description of a recent anger-arousing experience (a hassle), which is recorded in a hassle log. Participants receive training in responding to hassles with a chain of behaviors that include:
  - Identification of triggers (i.e., external events and internal self-statements that provoke anger).
  - Identification of cues (i.e., individual physical responses, such as tightened muscles, flushed faces, and clenched fists, which indicate the emotion the adolescent is experiencing is anger).
  - Use of reminders (i.e., self-statements, such as *stay calm, chill out, cool down*, or non-hostile explanations of others' behavior).
  - Use of reducers to lower the level of anger (e.g., deep breathing, counting backward, imagining a peaceful scene, imagining the long-term consequences of one's behavior).
  - Use of self-evaluation (i.e., considering how effectively the hassle was responded to by identifying triggers and cues, using reminders and reducers, followed by self praise for effective performance).
- **Moral Education**, a group intervention conducted with twelve adolescents that is comprised of a set of procedures designed to increase one's sense of fairness, justice, and concern with the needs and rights of others (i.e., moral reasoning).

The group is presented with fictional moral dilemmas to facilitate discussion of concepts such as justice, concern for others, personal rights and responsibilities.

Outcomes studies suggest ART promotes skills acquisition and performance, improves anger control, decreases the frequency of acting-out behaviors, and increases the frequency of constructive, prosocial behaviors. ART has been found to lead to reductions in re-arrests when the youths' parents and siblings) participate simultaneously in their own ART groups.

COPING CAT

Coping Cat is a manualized, short-term cognitive-behavioral intervention for the treatment of childhood anxiety. It includes the Coping Cat Workbook and Notebook with charts and other materials. The program consists of eight training sessions followed by eight practice or exposure sessions. The coping skills taught include:

- Recognition of anxious feelings and physical responses to anxiety
- Clarification of cognitions in anxiety-provoking situations and an assessment of unrealistic or negative expectations and/or attributions
- Formulation of a plan to help deal with the anxiety provoking situation(s), altering anxious self-talk to promote positive self-talk, and determining which actions might be beneficial
- Evaluating the success of the coping strategies implemented, and administering self-reinforcement as appropriate

The Coping Cat Program is comprised of the following elements:

- **Psychoeducation** to assist the child and family understand the manner in which abnormal levels of anxiety are learned, maintained and treated. Children maintain a diary and use learning techniques from the Coping Cat Workbook.
- **Somatic management techniques** which entails teaching relaxation techniques to calm the fight or flight response to external stimuli that are perceived as threatening or fearful.
- **Cognitive restructuring** to investigate, uncover and challenge anxiety-provoking thoughts in order learn new ways to deal with feared situations. The following techniques are incorporated into this component: identification of automatic thoughts (ATs), gathering evidence to dispute negative ATs, and keeping a diary to monitor daily thoughts. The **Fear Plan** is a four step acronym that incorporates the use of behavioral experiments that challenge ATs that create anxiety and fear in very young children.
    - **F** - "**F**eeling frightened?" Children note the physical symptoms they are experiencing in response to this question.
    - **E** - "**E**xpecting bad things to happen?" Children note their self-talk, and the consequences or outcomes they fear in response to this question.
    - **A** - "What **A**ctions and **A**ttitude will help?" Children generate a list of different cognitions and behaviors that can help in response to this question. They then select and implement a coping strategy.
    - **R** - "What are the **R**esults of my coping actions?" and "How can I **R**eward myself for trying to cope with this situation?" Children realistically evaluate their chosen solution, and reinforce themselves for coping in response to these questions.

- **Problem-solving** training to teach the child to identify real life problems, then list and evaluate actions for resolving a specific problem.
- **Graduated Exposure** involves gradual and systematic exposure to a feared stimulus or situation. It can involve **guided imagery** (a step-by-step visual imagery of confronting the feared situation) through **symbolism** (the use of pictures or props), **simulation** (role-playing a feared situation), or **in vivo** exposure.
- **Response prevention**[35] includes interventions that obstruct escape from the feared object or situation. The participant is encouraged to confront anxiety provoking thoughts, situations or objects in order to demonstrate that their connections with danger are unrealistic.
- **Relapse prevention** entails follow-up to maintain treatment gains and can include maintaining a diary of ongoing progress and challenging stress-provoking thoughts.

The Coping Cat program has been found to be highly effective for children with anxiety. Moreover, benefits endure for years post intervention.

The C.A.T. Project is an adaptation for adolescents. Coping Koala, an Australian adaptation, is a cognitive-behavioral group intervention comprised of contingency management in combination with self-control techniques. The FRIENDS program is also an Australian adaptation that has been expanded into two parallel age groups, FRIENDS for Children 7–11 years, and FRIENDS for Youth 12–16 years, as an early intervention and prevention model.

FRIENDS

FRIENDS is a community-oriented cognitive-behavioral intervention that addresses cognitive, physiological and behavioral processes involved in the development, maintenance and experience of anxiety. The program can be used as both an intervention and as a school-based prevention course. It is comprised of two parallel programs for children aged seven to eleven and those aged twelve to sixteen.

FRIENDS is designed to help children gain skills in dealing with difficult situations, recognize the signs of anxiety, use relaxation techniques, positive thinking, problem-solving, peer support, and conflict resolution skills, as well as develop emotional resilience.

The program name **FRIENDS** is an acronym for the strategies taught:

F - Feeling Worried?
R - Relax and feel good
I - Inner thoughts
E - Explore plans
N - Nice work so reward yourself
D - Don't forget to practice
S - Stay cool and calm because you now know how to cope

FRIENDS consists of ten one-hour sessions held weekly, as well as two one-hour booster sessions held at one and three month intervals following completion of the initial ten sessions. A family skills module is comprised of four and a half hour-long sessions conducted in a group

[35] Response (ritual) prevention is also an important component of treating obsessive compulsive disorder in children. A decrease in the urge to engage in ritualistic behavior occurs when children are exposed to obsessional cues but are prevented from engaging in the ritual. Anxiety and discomfort are reduced over time as children learn that nothing bad will happen if the ritual is not performed.

format for a total of six hours. The six hours can be altered so that time frames fit with community, school or office-based delivery needs.

A group leader's manual describes the activities therapists implement during each session. Children use their own personalized workbooks which detail strategies discussed during each session. Lessons include learning how to practice relaxation exercises, thinking helpful thoughts, changing negative thoughts to positive thoughts, graded exposure to difficult situations, problem-solving strategies, recognizing feelings in oneself, recognizing feelings in others, and helping both oneself and others feel good. The manuals allow flexible implementation for cultural individuality to meet the needs of any specific group.

Outcome studies indicate that this program is effective in helping children and adolescents from culturally diverse groups learn skills to manage anxiety, and helps parents encourage their children's coping and problem-solving capacities. Information about the program is available on the web at http://www.friendsinfo.net/introtofriends.html.

COPING WITH DEPRESSION (CWD)

Coping With Depression is a manualized, group-based, cognitive-behavioral intervention designed for adolescents. It focuses on the identification and modification of depressive cognitions and the development of coping skills, social interaction, and positive activity selection skills. The program consists of fourteen two-hour group sessions with a separate component for parents. It can be used in a variety of settings including hospitals, schools and mental health programs.

In this program adolescents are taught skills for overcoming depression. The areas covered are relaxation, pleasant events, irrational and negative thoughts, social skills, communication, and problem-solving. Several different methods of instruction are employed: lectures by a group leader, discussions, role-playing exercises, and homework assignments. The chart below depicts the skills taught and timeframes for sessions.

Figure 1: Timeline of Skills and Sessions

Specific Skill	Session															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Mood Monitoring																
Social Skills																
Pleasant Activities																
Relaxation																
Constructive Thinking																
Communication																
Negotiation and Problem Solving																
Maintaining Gains																

Key

_____ = Skill is taught

_____ = Skill is discussed as part of home practice

Outcomes research has demonstrated that more than seventy percent of participants experience significant improvements one month after completion of the program, and gains are maintained up to a year after the termination of treatment. Manuals for adolescents and practitioners are available for download from the web at http://www.kpchr.org/public/acwd/acwd.html

PRIMARY AND SECONDARY CONTROL ENHANCEMENT TRAINING (PASCET)

This manualized program is designed for children/adolescents aged eight to fifteen with symptoms of depression that can be used in mental health programs, schools and other settings. It consists of ten structured individual sessions followed by five individually tailored sessions conducted with the children/adolescents. The individual sessions are supplemented with parent, family and school contacts. Homework assignments are given in accordance with an ACT & Think Practice Book. Conjoint parent/family sessions are conducted after each session with the child to review the session, homework assignment, and develop plans for parent-child collaboration on the practice assignment. During each session parents are given a handout that summarizes the information from the session and practice homework assignment. Separate parent sessions are also conducted to discuss the program, obtain parental feedback on their child's behavior and mood at home, assist parents in locating resources to help them with parenting skills and any marital or mental health problems they have. One home visit is made by the clinician to gather information regarding the home environment. The clinician also makes one visit to the child's school for observation and to solicit information regarding the child from school staff.

The skills that are taught in the program are summarized in an ACT & Think Chart. These skills are as follows:

ACT Skills:

- *Activities that solve problems*. This entails the use of systematic problem-solving using **STEPS** (**S**ay what the problem is. **T**hink of solutions. **E**xamine each one. **P**ick one and try it out. **S**ee if it worked.).
- *Activities I enjoy*. This entails the development of a menu of activities that enhance mood and are easily accessed without adult assistance.
- *Calm*. Progressive muscle relaxation is taught along with the use mental imagery and diaphragmatic breathing exercises and that can be used covertly in public.
- *…And Confident*. A positive self-image is taught through role-playing and in vivo exercises.
- *Talents*. Youth identify skills (e.g., academic, social, artistic, athletic) they want to enhance to promote increased self-esteem and then implement a skill-building practice schedule.

THINK Skills:

- *Think Positive*. This entails focusing on identifying and changing distorted and negative cognitions using role playing, vignettes, and videos to help the youth recognize and restructure cognitions.
- *Help from a friend*. The clinician and the youth create a list of people that the youth can reach out to and solicit differing perspectives in troublesome situations.
- *No replaying bad thoughts*. This entails the identification of distracting activities that can be engaged in to short-circuit the tendency to ruminate on negative incidents.
- *Keep thinking* – Don't give up. This is designed to help with the development and practice of multi-step coping skills sequential plans.

The final five sessions of the program are used to identify a few of the skills that appear to be most helpful. These are then practiced through role playing and in vivo homework assignments. Skills are linked so that they can be used in sequence as noted in the last of the Think skills above.

PASCET has been found to reduce depression, particularly with the inclusion of parents. On self-report measures, children/adolescents indicate reduced rates of depressive behaviors, feelings, and thoughts at both immediate post-evaluation and nine months after the termination of treatment.

PROBLEM-SOLVING SKILLS TRAINING (PSST)

PSST entails the use of modeling and reinforcement to help children and adolescents develop and use appropriate cognitive problem-solving skills. It focuses on altering the cognitive processes that underlie interpersonal behavior by targeting cognitive distortions and impulse control problems that are common in youth who display aggression. Children and adolescents are helped to develop skills that reduce the extent to which they attribute hostile intent to the actions of others and develop non-aggressive responses to perceived provocations by peers. PSST can be used in groups of three to five children for eighteen to twenty-two sessions. The therapist provides coaching and modeling for the skills taught through role plays of social situations so that skills are practiced with the therapist providing cues, feedback and praise. Homework tasks are assigned between sessions and include active parental involvement. A parent component teaches problem-solving skills to families to manage interpersonal situations through practice, modeling, and role playing, corrective feedback, and the use of social and token reinforcements.

Outcome studies with adolescents have demonstrated significant reductions in aggressive and antisocial behavior at home, school and the community. PSST has been found to be effective in ameliorating depression and self-injurious behaviors, social isolation, aggression, and increasing effective problem-solving and interpersonal skills. However, some evidence indicates that adolescents who display higher levels of difficulty in all domains (i.e., academic delays, lower reading ability, and severe parental and family problems) do not respond as well. PSST has been found to be more effective with older children (eleven to thirteen year olds) than younger children (five to seven year olds). Research indicates that the combination of PSST and PMT (parent management training) leads to better results than either used alone. The involvement of parents and/or teachers has been found to enhance the generalization of the skills learned and the duration of treatment effects.

COGNITIVE BEHAVIORAL THERAPY FOR CHILD SEXUAL ABUSE (CBT-CSA)

Cognitive Behavioral Therapy for Child Sexual Abuse (CBT-CSA), a SAMHSA model program, is designed for children and adolescents aged three through eighteen who have experienced sexual abuse and exhibit posttraumatic stress, depression, and other abuse-related difficulties (e.g., age-inappropriate sexual behaviors, problematic fears, social isolation). It has been used successfully with African American, Hispanic/Latino, and Caucasian children from all socioeconomic backgrounds. The program is used by therapists in community settings, including child protection and mental health programs in urban, suburban, and rural settings. Children are generally referred for treatment following an investigation conducted by child protection or law enforcement personnel in which allegations of sexual abuse are found to be credible. Whenever possible, a caregiver or parent who was not involved in the abuse is encouraged to participate along with the child.

CBT-CSA is designed to assist children in talking about their experiences and in coping with their feelings and concerns. It also focuses on helping parents cope with abuse-specific distress, respond effectively to their children's emotional and behavioral problems, and improve parent-child communication and interactions. Cognitive behavioral techniques are used to help parents learn to cope with their own distress as well as respond effectively to their children's behavioral difficulties.

CBT-CSA consists of parallel sessions with children and their parent(s) who were not involved with the abuse, as well as joint parent-child sessions during the later stages of therapy. It can be implemented in twelve individual or group therapy sessions. Treatment components for both the children and parents include:

- Education regarding child sexual abuse and healthy sexuality
- Coping skills training, including relaxation, emotional expression, and cognitive coping
- Gradual exposure and processing of traumatic memories and cues
- Personal body safety skills training

Parents receive behavioral management training to foster children's positive behaviors and minimize behavioral difficulties. Joint parent-child sessions focus on assisting parents and children with practice and utilization of the skills learned, while promoting more effective parent-child communication about the abuse and related issues.

Outcomes studies indicate that children who participate in CBT-CSA with their parents who were not involved with the abuse display reductions in symptoms of posttraumatic stress disorder and depression, and externalizing behaviors. Parents demonstrate reductions in emotional distress and intrusive thoughts related to their children's sexual abuse.

TRAUMA FOCUSED COGNITIVE BEHAVIOR THERAPY (TF-CBT)

Trauma-Focused Cognitive Behavioral (TF-CBT) is an empirically supported intervention designed to help children and adolescents, aged three to eighteen, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. The program can be provided in individual, family, and group sessions. It targets symptoms of posttraumatic stress disorder, which often co-occur with depression and behavior problems. The intervention also addresses issues commonly experienced by children who have been traumatized (e.g., poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior).

TCF-CBT is a SAMHSA model program that consists of twelve to sixteen sixty to ninety-minute sessions (held for thirty to forty-five minutes each with parents and children) for children and their parents, three of which are held jointly, typically provided on a weekly basis. It incorporates learning principles, cognitive-behavioral therapy, and stress inoculation training to reduce children’s negative emotional and behavioral responses, and modify their beliefs and attributions related to abusive experiences. It also aims to provide support and skills to help parents who were not involved in the abuse cope effectively with their own emotional distress and provide appropriate support to their children who have suffered abuse.

Components of the TF-CBT protocol:

- **Psychoeducation** regarding child abuse, typical reactions of victims, normalization of reactions, safety skills, and healthy sexuality

- **Stress management techniques** such as focused breathing, progressive muscle relaxation, emotional expression skills, thought stopping, thought replacement, and other cognitive therapy interventions
- **Constructing the Trauma Narrative** which entails gradual exposure techniques including verbal, written and/or symbolic recounting (using dolls, puppets, etc.) of abusive event(s)
- **Cognitive processing** (or cognitive reframing) which consists of exploration and correction of inaccurate attributions about the cause of, responsibility for, and results of the abusive experience(s)
- **Parental participation** in parallel or conjoint treatment including psychoeducation, gradual exposure, anxiety management and correction of cognitive distortions
- **Parental instruction** in child behavior management strategies
- **Family work** to enhance communication and create opportunities for therapeutic discussion about the abuse

The parent treatment component is an integral part of this treatment model. It parallels the interventions used with the child so that parents are aware of the content covered with the child and are prepared to reinforce or discuss this material with the child between treatment sessions and after treatment has ended. Parents are assisted to explore their own thoughts and feelings regarding their child's experience, resolve their own personal trauma related distress, learn effective parenting skills, and provide support to their children. Children acquire skills in stress management, cognitive processing, communication, problem-solving, and safety. Sessions address feeling identification, introduction of cognitive triangle, stress inoculation therapy, gradual exposure (creating a narrative of the traumatic events the child experienced), and cognitive processing. Adaptive skills for dealing with stress are developed along with reduced anxiety, thinking or talking about the event.

Beneficial outcomes including significantly fewer behavior problems, reductions in posttraumatic stress disorder and depressive symptoms, negative attributions (such as self-blame) about the traumatic event, defiant and oppositional behaviors, anxiety, and improved social competences that have been demonstrated to be maintained well over a year after the termination of treatment. The program has also been found to enhance accurate and helpful cognitions and children's personal safety skills, as well as resolve parental distress regarding their child's experience. Finally it has been shown to prepare children to anticipate and cope with reminders of traumatic loss. The cost is estimated to be $1,001 to $5,000.

BEHAVIORAL TREATMENT FOR NOCTURNAL ENURESIS

Nocturnal enuresis[36] occurs in about ten percent of children aged five to sixteen. Urine alarm with behavioral intervention that includes family participation in treatment has been shown to be the most effective intervention for this problem.

Behaviorally based conditioning programs, using a portable, battery-operated alarm, a written contract, thorough instruction, frequent monitoring, overlearning, and intermittent reinforcement before discontinuation, are the most effective first-line interventions for children with enuresis and are especially effective when families are engaged and committed to the process. Training

[36] It is recommended that a physical exam be conducted to rule out diseases of the urinary tract and other medical problems prior to the initiation of treatment.

Daytime enuresis is not addressed as it appears to be more associated with urinary tract abnormalities (e.g., structural or functional disorders, incomplete bladder emptying, fractionated voiding curve) which require medical intervention (e.g., medication, surgery).

procedures vary across published reports and guides, but generally include full arousal, going to the bathroom to complete (or attempt) voiding, changing bedding and pajamas, resetting the alarm, and going back to bed. In most procedures, a urine alarm is used by the child. If the child does not respond to the alarm, the family awakens the child to turn off the alarm. Procedures that include parents depend on the saliency of the alarm stimulus to awaken the parents or periodic checking to attend to accidents. One intervention, Dry Bed Treatment (DBT), entails waking the child, practice, cleanliness training, and verbal praise. The procedure has been found to much more effective when combined with a urine alarm.

Full Spectrum Home Training (FSHT) is a multi-component manualized approach that includes a urine alarm, retention control training with monetary rewards, cleanliness training, self-monitoring of wet and dry nights, graduated overlearning for relapse prevention and a family component. It can be conducted in either group or individual session formats in one ninety-minute or two sixty-minute sessions. Retention control is done once per day and children are given money for delaying urination for increasing amounts of time up to forty-five minutes in fifteen three-minute incremental steps (with a total of $6.25 to be earned). The first goal is fourteen consecutive dry nights, which takes an average of sixteen to twenty weeks, (or longer for children who wet the bed more than once a night). Overlearning is designed as a relapse prevention component of the treatment and is comprised of drinking specified amounts (which increases with each night of dryness) of water fifteen minutes prior to bedtime. A wall chart (titled Daily Steps to a Dry Bed) is used to display progress.

Studies show alarm-based behavioral intervention is more effective than medications or other interventions and that the rate of success is higher and relapse rate lower than that for any other technique. Family involvement and participation have been found to optimize outcomes. The majority of unsuccessful results have been found to be due to lack of adherence to treatment procedures.

INTERPERSONAL PSYCHOTHERAPY FOR ADOLESCENTS (IPT-A)

Interpersonal Psychotherapy for Adolescents with depression is an adaptation of Interpersonal Psychotherapy (IPT).[37] IPT-A is a manualized, time-limited (once weekly for twelve weeks), problem-focused intervention that entails engagement in activities, problem-solving, and improvement of interpersonal relationships. IPT-A, in contrast to cognitive-behavior therapy, centers on addressing interpersonal conflicts, deficits and issues, rather than on altering patterns of cognition and erroneous ideation. Hence, IPT-A may be more beneficial for adolescents with depression involving interpersonal issues or problems in social functioning.

Adolescents whose families are supportive and participate in treatment have been found to be more likely to experience beneficial outcomes. IPT-A incorporates a variety of techniques to involve family members in treatment. These include face-to-face visits, telephone sessions, and role playing techniques with the clinician and adolescent during sessions. In the latter procedure, the adolescent first practices with the therapist and then practices at home between sessions. The therapist maintains availability by phone and/or offers additional sessions to provide support for the adolescent in his or her efforts to institute change.

The single parent family was added to the IPT paradigm for adolescents since this has been shown to be a challenging issue as well as a precursor to depressive symptoms in adolescents. The objectives of the approach have been adapted to developmental tasks of adolescence such

[37] A discussion of IPT can found in *A Guide to Evidence-Based Practices for Adults with Mental Illness* available on-line at http://sccmha.org/quality.html.

as individuation, establishing autonomy, developing interpersonal relationships with members of the opposite sex and potential romantic partners, coping with initial experiences of death and loss, and managing peer pressure. Strategies for dealing with specific issues that may arise including school refusal, physical or sexual abuse, involvement of child protective agencies, and dealing with suicidality are also included.

The following depicts the areas covered by IPT-A:

Problem Area 1:	Grief
Problem Area 2:	Interpersonal Disputes
Problem Area 3:	Role Transitions
Problem Area 4:	Interpersonal Deficits
Problem Area 5:	Single-Parent Families

IPT-A is recommended for adolescents who experience an identifiable interpersonal event or an exacerbating factor that precipitates an episode of depression. It is not indicated for those whose depression is of a long-standing nature, have severe interpersonal problems, or are currently experiencing a crisis, suicidality, homicidality, psychotic symptoms, bipolar disorder, or a substance use disorder. IPT-A has been shown in studies to reduce depressive symptoms and enhance social functioning.

DIALECTICAL BEHAVIOR THERAPY FOR ADOLESCENTS (DBT-A)

Dialectical Behavior Therapy (DBT)[38] has been adapted for adolescents aged thirteen to nineteen who are suicidal. It focuses on helping teens and their families master the challenges of the transition from adolescence to adulthood as well as ameliorate problematic behaviors that are sometimes used to deal with extreme emotional intensity. The intervention has been modified for use in outpatient as well as inpatient settings. The first phase of treatment has been shortened from one year to sixteen weeks. The number of skills has been reduced in order to teach them in sixteen weeks. Parents are included in the skills training group in order to enhance generalization and maintenance of skills. Family members are taught to use skills and improve the adolescent's home environment. A new skills training module, Walking the Middle Path, has been added to teach behavioral principles and validation as well as address the dialectical dilemmas inherent in parent-adolescent interactions.

Parents are required to attend a multi-family parents' group where they learn the DBT skills of mindfulness, distress tolerance, interpersonal effectiveness, emotion regulation and Walking the Middle Path. In addition, parents learn to understand and respond to specific adolescent behaviors, encourage the use of skills at home, and receive support from each other within a DBT framework. One of the group skills trainers provides parents with skills coaching for occasions of distress. Parents and/or other family members are included in individual sessions when indicated. The language on the skills handouts has been simplified to make them developmentally and culturally appropriate for adolescents.

In the DBT-A outpatient format the consumer attends twice-weekly psychotherapy for sixteen weeks. One of these weekly sessions is for multifamily group skills training, and the other is for individual therapy. The focus is on stabilization and control of the acute behavior that precipitated the intervention. The inpatient format of DBT-A is briefer, more intensive, and even

[38] A discussion of DBT can found in *A Guide to Evidence-Based Practices for Adults with Mental Illness* available on-line at http://sccmha.org/quality.html.

more focused on the behavior that precipitated the hospital admission. Here therapy goals are limited to establishing a commitment to treatment and stabilization of life-threatening behavior.

Both the adolescent and multi-family skills training groups use the following skills modules:

- **Core Mindfulness Skills** entails focusing one's mind, directing attention, and understanding how one feels. This module is designed to diminish identity confusion and self-dysregulation. It includes teachings of Zen meditation to enhance emotional control.
- **Emotion Regulation Skills** are aimed at reducing emotional intensity, identifying emotions, reducing emotional vulnerability, and increasing positive events.
- **Distress Tolerance** is designed to reduce impulsivity by teaching acceptance and tolerance of painful situations with self-soothing, distraction from pain, and by generating ideas about the positive and negative aspects of painful situations.
- **Interpersonal Effectiveness** is designed to maintain stable relationships, get one's needs met, enable interpersonal problem-solving through assertiveness training, and help the adolescent become more aware of their goals in interpersonal situations.
- **Walking the Middle Path** entails helping with adolescent-family issues. It focuses on teaching adolescents and their parents the concepts of dialectics, validation, and behavioral therapy. Emphasis is placed on the relationship between parents and teens.

The components of DBT-A are as follows:

- Adolescents and their parents address capability enhancement during a weekly two-hour multifamily skills training group. The group provides an opportunity for skills acquisition through instruction and modeling and provides opportunities for skills strengthening through behavioral rehearsal and reinforcement of new skills.
- Weekly individual psychotherapy sessions to address enhancing motivation by focusing on emotional dysregulation, cognitive errors, and contingencies that may compromise motivation. Consumers and therapists review weekly diary cards (documenting suicidal, self destructive behaviors, and those that interfere with treatment and quality of life) and engage in behavioral analysis of maladaptive events recorded on the diary cards. These sessions also provide an opportunity for skill strengthening and generalization.
- Phone consultations with the therapist are conducted during the first twelve weeks of treatment to discuss skills that may be useful to decrease suicidal behaviors, report positive behaviors and events, and resolve conflicts. The therapist is available to the consumer for telephone consultation (before the consumer engages in parasuicidal behavior) to facilitate generalization of skills. The consumer can also phone the therapist to report positive news or work on the consumer-therapist relationship if needed.
- Therapists attend weekly DBT therapist consultation groups to address their own skills and motivation.
- Various additional interventions (e.g., collateral family sessions, meetings with other treatment providers, and contacts with school personnel) are used to structure the environment and help ensure the consumer does not have to become more symptomatic or engage in more self-destructive behavior in order to get help.
- Consumer consultation groups for mutual assistance in utilizing skills to cope with life circumstances are held during the second twelve weeks of treatment.

Research has demonstrated that use of this approach leads to reductions in suicidal behavior, premature treatment termination, psychiatric hospitalizations, substance abuse, anger, and interpersonal difficulties. Some research also indicates that teens are very receptive to the techniques used in DBT-A.

INTEGRATED DUAL DISORDERS TREATMENT (IDDT)

Studies indicate that forty-one to sixty-five percent of all adolescents and young adults who receive mental health services have co-occurring substance use disorders. Adolescents who experience emotional and behavioral difficulties are almost four times more likely to be dependent on alcohol or illicit substances than others. Nearly two-thirds of youth with substance use disorders who are incarcerated have at least one other mental health disorder. Conduct disorder and depression most frequently co-occur with substance abuse. Children who have ADHD and learning disorders in combination with depressive or anxiety disorders have an increased risk for developing a co-occurring substance use disorder. The severity of problems experienced is directly correlated to increases in the likelihood of drug use and dependence. Therefore, children who have been diagnosed with one or more of these conditions should be screened periodically for substance use disorders.

Youth who experience co-occurring disorders engage in higher rates of crime and exhibit more alcohol and illicit drug use than those who have mood disorders. They are also at higher risk for out-of-home placement and other adverse outcomes. They are vulnerable to relapses and rehospitalizations, manifest greater levels of depression and suicidality, violence, and nonadherence to medication regimens. Additionally, these individuals experience more significant social problems such as housing instability and homelessness, increased family burden, and vulnerability to HIV and other infections. Parents frequently do not seek intervention for the initial disorder when the behavior exhibited is not deemed disruptive or dangerous. Therefore, opportunities for prevention and early intervention are often overlooked.

Too often youth experience legal problems due to lack of intervention. Additionally, when untreated or under treated, dual disorders engender significant levels of family stress, and can escalate conflicts between parents, children and siblings. The developmental task of leaving home is even more challenging for youth who suffer co-occurring disorders. They can encounter major barriers to recovery due to fragmentation of services and supports. Those who lack housing, transportation, and other supports are especially at risk of not achieving this developmental task. Youth who have co-occurring disorders and are also involved in the child welfare system are even more challenged by the additional task of negotiating emancipation and achieving independence with limited supports.

Integrated mental health and substance use treatment[39] has a strong evidence base and has been shown to result in fewer rehospitalizations, decreased psychiatric symptomatology, increased sobriety, and improvement in social relationships. However, youth who experience co-occurring disorders and their families frequently lack access to integrated programs and services for the treatment of both disorders.

Current integrated treatment programs for dual disorders are based on adult models. However, these models require modification to take into account developmental readiness to assume personal responsibility and family issues. Co-occurring disorders affect the entire family and

[39] More information on Integrated Dual Disorders Treatment, can be found in *A Guide to Evidence-Based Practices for Adults with Mental Illness* located on the web at http://www.sccmha.org and in the SAMHSA IDDT Toolkit located at http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/.

everyone who plays a central role in the child's life needs to be included. Family support is crucial for many treatment components and follow-up care.

The following have been shown to be effective components:

- There should be no wrong door to enter treatment. Providers should eliminate barriers to access through collaboration among housing, primary health, mental health/substance abuse treatment and others to ensure access to all needed agencies.
- All significant social supports should be involved.
- Peer-to-peer outreach, social network development and support for youth, and family-to-family outreach for their families (e.g., speakers' bureaus, crisis and warm lines, brochures, public service announcements).
- Accurate and useful information (on illness, treatment, aftercare and funding sources) for both youth and families.
- Integrated treatment that includes the whole family and promotes child and family interaction. (Efforts should be made to help build supports for those who are disengaged from their families and/or social networks.)
- Respect for youth and their families' decisions regarding services and supports and offering choice and information.
- Actively engaging youth in the design and evaluation of programs.
- Focus on positives and strengths and the youth's vision of his or her future.
- Gender-specific programming. (Females with co-occurring disorders have substantially different treatment needs than males. Females with co-occurring disorders may engage in high-risk sexual behavior, have more complicated health conditions, and have histories of exposure to physical and sexual violence.)

SOMATIC THERAPY

PSYCHOPHARMACOLOGY

Psychopharmacology is a continuously changing area and recommendations regarding medications and treatment regimens can become outdated in a short period of time. Therefore, prescribers and other practitioners need to continuously review the research related to evaluations and approvals of psychotropic medications for children.

Very young children, who are in a state of rapid developmental growth and change, are often prescribed potent psychotropic medications despite the lack of data on their use. The safety and efficacy of these medications have not been ascertained for children under the age of six and many drugs that are used have not been tested in children under the age of sixteen. There is a lack of information related to the short and long-term effects of psychoactive agents on the developing brain. Most of the drugs studied have been in open trials as opposed to randomized controlled trials, and longitudinal studies are almost nonexistent. This scarcity of research on children and adolescents has engendered widespread off-label[40] prescription of psychotropic medications. And, there are concerns that studies of efficacy in adults may not be appropriately generalized to children who have different metabolisms, presentation and etiology for similar disorders. Because of these issues, many experts recommend using psychosocial interventions as a first-line treatment to deal with psychiatric symptoms occurring in young children. Moreover, even when medication is prescribed for children and adolescents, a multimodal approach that combines medication and psychosocial intervention is recommended.

The short term efficacy of psychostimulants for ADHD[41] has been clearly demonstrated. Stimulants have also been shown to ameliorate the symptoms of ADHD and co-occurring disorders, (e.g., conduct disorder and anxiety disorder). Stimulant medications, however, have not been shown to lead to improvements in academic achievement or social skill development and do not ameliorate the various behavioral problems exhibited by children who have ADHD. Few studies have been conducted on their longer term (more than twenty-four months) efficacy. Moreover, these medications are only effective for the duration they are taken. Most are rapidly absorbed and metabolized and so are of short duration. The onset of their effect occurs within thirty minutes of ingestion and peaks within one to three hours and rarely last beyond five hours

[40] A medication that has been approved by the U.S. Food and Drug Administration (FDA) for use in adults or older children may be prescribed to younger children based on experience or medical information. This type of use of medication is termed "off-label." Most medications prescribed for childhood mental disorders are prescribed off-label because only a few of them have been systematically studied for safety and efficacy in children. Medications that have not undergone such testing are dispensed with the statement that "safety and efficacy have not been established in pediatric patients." All new drug applications to the FDA have to include reports on the efficacy and safety the drugs with neonates, infants, and children under age seventeen as of December 2000.

[41] Attention deficit/hyperactivity disorder (ADHD) is the most widely researched mental disorder of childhood.

It has been reported that up to two-thirds of children seen in mental health settings with ADHD have co-occurring conditions, including oppositional disorder, conduct disorder, mood disorders, and anxiety disorders. Tourette's and chronic tic disorder also co-occur with ADHD. Substance abuse may co-occur with ADHD in adolescents. Speech and language delays learning disorders are fairly common in children with ADHD. It is estimated that thirty to eighty percent of children with ADHD continue to have features of ADHD persisting into adolescence and up to sixty-five percent into adulthood. In addition, ADHD is associated with difficulties in memory, cognitive processing, sequencing, motor skills, social skills, and modulation of affect, response to discipline, and sleep disorders.

(with the exception of pemoline). The need for a multi-dosing schedule can lead to nonadherence and some level of so-called roller coaster effects, the potential for a rebound effect, and short-term wear off effects. The NIMH Collaborative Multisite Multimodal Treatment Study of children who have ADHD found that adherence improves with less frequent dosing. Once per day dosing[42] has been shown to result in the best rates of adherence (as is true for all medications).

Research demonstrates that there are minimal differences in the effects of the various stimulants, but methylphenidate (MPH) has been studied the most and is the one most often prescribed. Recent studies have raised concerns regarding sudden death, increased aggressiveness, and hallucinations that have been shown to occur in some children and adolescents taking stimulant medications. It has been recommended that any history (child or family) of cardiac abnormalities be evaluated prior to starting a course of stimulants. Atomoxetine has been shown to lead to increased suicidal ideation, with an especially high risk for those who have bipolar disorder, a family history of bipolar disorder, and a history or family history of suicidal attempts.

Studies indicate that medication used in combination with psychosocial intervention[43] is effective, but stimulants are superior to psychosocial interventions. Multimodal interventions (i.e., combined behavioral therapy and medication) have been found to be no more effective than medication alone, but superior to routine community care. Some evidence indicates that behavior therapy in combination with medication can improve peer interactions and educational achievement.

Tourette's syndrome often co-occurs with ADHD, obsessive-compulsive disorder (OCD) and other disruptive behavior disorders. There is no standard treatment strategy for Tourette's. Intervention typically focuses on ameliorating manifestations that interfere with functioning at home and/or school[44]. Alpha Agonists (e.g., clonidine, guanfacine) have been found to reduce the frequency of tics, mood fluctuations, and explosive behaviors that are associated with Tourette's syndrome. Tics can also be treated with antipsychotic medications, but these are not recommended as a first-line intervention due to side effects. (One large study indicated that baclofen and botulinum toxin type A (BTX-A) injections in affected muscles of the neck, face, vocal cords, and extremities were effective in treatment of tics in Tourette's syndrome.) Most children with the disorder have been found to need medication for one to two years, but fifteen percent require long-term intervention to control tics.

[42] A number of the newer medications only need to be taken once a day and can last for up to twelve hours. The sustained release forms of these medications obviate the need for a lunch time dose and often last after school hours when the child is doing homework assignments.

[43] Psychosocial interventions involve behavioral treatment that includes parent management training, behavior therapy (e.g., contingency management procedures at home and in school), and cognitive-behavioral therapy (including self-monitoring, verbal self-instruction, problem-solving techniques, and self-reinforcement).

[44] Behavior therapy, often recommended as a first-line intervention, targets skill building in the areas of social and academic skills and reducing the frequency and intensity of behavior excesses. The latter should be a focus since some children who receive behavior therapy targeted to symptoms experience an exacerbation. Habit covariance is used to reduce problem behaviors that occur in contemporaneously with unproblematic ones. Habit reversal focuses on awareness, motivation, correction and prevention of behavioral symptoms.

NIMH Children's Medication Chart		
Trade Name	Generic Name	Approved Age
Stimulant Medications		
Adderall	amphetamine	3 and older
Adderall XR	amphetamine (extended release)	6 and older
Concerta	methylphenidate (long acting)	6 and older
Cylert*	pemoline	6 and older
Dexedrine	dextroamphetamine	3 and older
Dextrostat	dextroamphetamine	3 and older
Focalin	dexmethylphenidate	6 and older
Metadate ER	methylphenidate (extended release)	6 and older
Ritalin	methylphenidate	6 and older
Non-stimulant for ADHD		
Strattera	atomoxetine	6 and older
*Because of its potential for serious side effects affecting the liver, Cylert should not ordinarily be considered as first-line drug therapy for ADHD.[45]		
Antidepressant and Antianxiety Medications		
Anafranil	clomipramine	10 and older (for OCD)
BuSpar	buspirone	18 and older
Effexor	venlafaxine	18 and older
Luvox (SSRI)	fluvoxamine	8 and older (for OCD)
Paxil (SSRI)	paroxetine	18 and older
Prozac (SSRI)	fluoxetine	18 and older
Serzone (SSRI)	nefazodone	18 and older
Sinequan	doxepin	12 and older
Tofranil	imipramine	6 and older (for bedwetting)
Wellbutrin	bupropion	18 and older
Zoloft (SSRI)	sertraline	6 and older (for OCD)
Antipsychotic Medications		
Clozaril (atypical)	clozapine	18 and older
Haldol	haloperidol	3 and older
Risperdal (atypical)	risperidone	18 and older
Seroquel (atypical)	quetiapine	18 and older
Mellaril	thioridazine	2 and older
Zyprexa (atypical)	olanzapine	18 and older
Orap	pimozide	12 and older (for Tourette's syndrome—Data for age 2 and older indicate similar safety profile)
Mood Stabilizing Medications		
Cibalith-S	lithium citrate	12 and older
Depakote	valproic acid	2 and older (for seizures)
Eskalith	lithium carbonate	12 and older
Lithobid	lithium carbonate	12 and older
Tegretol	carbamazepine	any age (for seizures)

[45] In May 2005, Abbott chose to stop the sales and marketing of Cylert in the U.S. All companies that make generics also agreed to stop their sales and marketing.

Pharmacotherapy for depression in children is typically provided only in combination with psychosocial intervention, and is not recommended as a singular treatment. Selective Serotonin Reuptake Inhibitors (SSRIs) have been demonstrated to be effective as a short-term treatment for severe and persistent major depressive disorder in children and adolescents. Fluoxetine is approved by the FDA for the treatment of depression in children and adolescents aged eight and older. (It has also been shown to be effective for selective mutism in children aged five to fourteen.) Sertraline, citalopram and escitalopram are also commonly used as an initial medication. The last two have fewer interactions with other medications.

An FDA public health advisory published October 15, 2004 indicated that antidepressants increase the risk of suicidal thinking and behavior in children and adolescents who have major depressive disorder and other mental illnesses. The FDA recommended increased monitoring of children and adolescents on antidepressants with the following visit frequencies: once a week for the first four weeks, then every two weeks for the next month, and at the end of the twelfth week. In addition, the FDA recommended increased frequency if problems or questions arise. The American Academy of Child and Adolescent Psychiatry also recommends close monitoring during the first month for the following symptoms: anxiety, agitation, insomnia, panic attacks, irritability, aggressiveness/hostility, impulsivity, akathisia, hypomania and mania.

While the tricyclic antidepressants (TCAs) have been used for more than twenty years and have demonstrable efficacy for a number of disorders in children and adolescents, there are concerns regarding their safety in children and overdoses of TCAs are potentially lethal. Moreover, many studies indicate that tricyclic antidepressants (imipramine, desipramine, nortriptyline) are no more effective than a placebo in children and adolescents. They require careful monitoring for adverse reactions (e.g., cardiovascular abnormalities, sweating, dry mouth, serotonergic syndrome, mania). TCAs are recommended only after other medications or interventions have failed or are contraindicated, with the exception of co-occurring anxiety, ADHD, or enuresis.

The Food and Drug Administration has approved the following agents for treatment of obsessive compulsive disorder (OCD) in the specified age groups: Clomipramine (CMI) for children aged ten and older; fluvoxamine for children aged eight and older; and sertraline for children aged six and older. Of these, CMI has been studied the most extensively in children.

Lithium has been demonstrated to have efficacy for bipolar disorder in adolescents. The FDA approved the use of lithium for adolescents who are aged twelve and older and have bipolar disorder. However, overdose is potentially lethal and blood level monitoring is required.

Antipsychotic medications are used for psychotic disorders (e.g., schizophrenia) and Tourette's, (as mentioned above) particularly haloperidol, pimozide and risperidone. They require monitoring for adverse effects. First generation antipsychotics (FGAs) and second generation antipsychotics (SGAs) have also been found to alleviate aggression in children and adolescents. SGAs, with the exception of clozapine (due to its side effect profile), are recommended as a first-line intervention for schizophrenia. Research indicates that the SGAs are also effective for co-occurring anxiety and depression. Adequate therapeutic trials of four to six weeks duration at sufficient dosages are needed to determine the effectiveness of the medication for children and adolescents. Studies on the use adjunctive medications (e.g., antiparkinsonian medications, mood stabilizers, antidepressants and benzodiazepines) in children and adolescents are lacking.

There is inadequate empirical support for the use of any particular medication to treat posttraumatic stress disorder (PTSD) in children. SSRIs are often used as first-line interventions despite the lack evidence to support their use. Imipramine is frequently used for children who have co-occurring symptoms of panic. Studies of anxiolytics and other medications have shown mixed results or are lack trials in children and adolescent populations.

Imipramine and desmopressin acetate (DDAVP), have been shown in studies to be effective in forty to sixty percent of children with enuresis. DDAVP is a synthetic analogue of the antidiuretic hormone (ADH) vasopressin, which decreases urine production at night when taken at bedtime. It is administered orally or, less commonly, intranasally as a spray, each night. Studies indicate it is ten to sixty-five percent effective, but the relapse rate can be as high as eighty percent. The possibility of cardiac arrhythmia associated with tricyclic antidepressants such as imipramine has led to the recommendation of pretreatment electrocardiograms to detect underlying rhythm disorders (even though the highest dose used to treat enuresis is lower than the dose commonly used to treat depression).

Sleep difficulties can be rather problematic for children and adolescents.[46] And, while soporific medications are commonly prescribed for children and adolescents, studies on dosing and the effects these medications have on the still-developing brain are lacking. Moreover, no sleep medications have been approved by the FDA for use in individuals under the age of eighteen. In 2004 more than one hundred thousand individuals under the age of twenty took medication to aid sleep, an increase of eighty-five percent from 2000. Clonidine and other alpha agonists, prescription antihistamines, antidepressants, benzodiazepines, antianxiety drugs and older generation sleeping medications are prescribed for children.

Research indicates that newer generation medications (e.g., zaleplon, eszopiclone, zoldipem tartrate) are not as habit-forming as the older generation of sleeping medications. They have a shorter half-life and are thus less likely to induce feelings of dizziness, grogginess or hang-over the next morning. Also, zoldipem tartrate is a Category B drug for pregnancy so it does not pose risk for a developing fetus. Since teenagers are more likely to experience difficulty falling asleep, rather than staying asleep all night, short-acting medications (e.g., zoldipem tartrate) are considered more suitable. Ramelteon, approved in 2005 for use in adults, may have a more selective effect since it is directed at receptors in the suprachiarsmatic nucleus which sets the internal clock.[47]

ALGORITHMS

The Children's Medication Algorithm Project (CMAP) involves developing and testing specific medication treatment guidelines, or algorithms, for attention deficit/hyperactivity disorder (ADHD) and major depressive disorder (MDD) in children and adolescents. It is a collaborative venture involving the Texas Department of State Health Services, The University of Texas, parent and family representatives, and representatives from various mental health advocacy

[46] Attention deficit disorder, as well as longer-acting stimulant medications that are used to treat the disorder, can cause sleep disturbances.

[47] Teenagers are more alert in the evening due to the natural shift ahead of their internal clocks. Also, they tend to stay up late due to the stimulation of television, homework, instant messaging, and caffeinated soft drinks. Later bed times cause a shift in the circadian system; there is a tendency to stay up later and sleep later in the morning. This shift in the circadian system allows for ready adaptation to late bedtime and wake-time schedules and causes difficulties moving to early bedtime and wake-time schedules since the circadian system adapts more quickly to phase delays than phase advances.

It is fairly typical for high school students to get six hours of sleep per night at a time (during pubertal maturation) when they require eight to nine and a half hours from a developmental standpoint. Such sleep deprivation can lead to negative effects on learning and academic performance, mood, self-regulatory abilities (e.g., concentration, irritability, emotional lability). Attempts to catch up on sleep on the weekends by sleeping in late in the morning results in jet lag type symptoms when attempts to shift back to early wake-up times on school nights are made. Some schools are testing later start times and are finding improvements in grades and mood ratings during the first year subsequent to the change.

groups. CMAP, like the adult TMAP (Texas Medication Algorithm Project), is really a disease management program that consists of four major components:

- Treatment algorithms
- Clinical and technical support for treating physicians
- Consumer/family psychoeducation
- Uniform documentation of consumer outcomes

The CMAP algorithms can be found on the web at http://www.dshs.state.tx.us/mhprograms/CMAP.shtm.

The Treatment Recommendations for the Use of Antipsychotics for Aggressive Youth (TRAAY) is another medication algorithm for the use of antipsychotic medications with children and adolescents who display aggressive/assaultive behaviors. It is a collaborative effort involving The New York State Office of Mental Health and Columbia University. TRAAY guidelines provide a seven-step process for developing multidimensional treatment plans that incorporate diagnostic evaluations, assessment, psychosocial intervention(s), education, and pharmacological treatment. The initiative is based on available research and prevailing expert consensus. It aims to prevent unnecessary use of psychotropic medications for youth who display aggression by providing a specific methodology for determining the need for psychopharmacological intervention. The TRAAY Treatment Recommendations support the following principles:

- Completing a diagnostic assessment before using medication
- Treating co-occurring or primary psychiatric disorders before treating aggression
- Using psychosocial interventions with the child and family as a first-line treatment (i.e., prior to prescribing medication)
- Using a conservative dosing strategy
- Carefully monitoring side effects and effectiveness of medication
- Minimizing use of STAT or PRN medications for managing acute aggression

Information on TRAAY can be found on the web at www.columbia.edu.

ELECTROCONVULSIVE THERAPY (ECT)

ECT has been found to be most effective for bipolar illness. It is not used in younger children. Second opinions, discontinuation of medications and administration on an inpatient basis are recommended by American Academy of Child and Adolescent Psychiatry (AACAP) prior to starting a course of ECT. The procedure has been modified from that used with adults. Unilateral electrode placement to the non-dominant hemisphere (to minimize post treatment memory problems), use of a brief pulse (instead of a sine wave), and a lower dose of electricity are recommended. A course of ECT is usually six to fifteen treatments administered thrice weekly.

Electroconvulsive therapy is generally considered for bipolar disorder during pregnancy, the presence of catatonia, medical conditions that preclude the safe use of medication, and for the treatment of neuroleptic malignant syndrome. It is used for adolescents with bipolar disorder who do not respond to at least two eight to ten week trials of pharmacotherapy.

CRISIS INTERVENTION AND OUT-OF-HOME SETTINGS

Studies on crisis services are comprised of uncontrolled trials. However, all suggest positive behavioral and adjustment outcomes, and most studies show that crisis services can prevent the need for hospitalization and other out-of-home placements. Current models include mobile crisis teams, short-term residential services, and intensive in-home services. Booster sessions and ongoing supports are often used to maintain gains.

Research indicates most families with children who experience serious emotional disturbances seek help from informal supports first (e.g., spouses, friends and extended family). Thus, respite care (e.g., crisis respite and crisis nurseries) and parent support groups can be used to provide needed support during crises. It should also be noted that families have been shown to benefit from services that focus on the prevention of crises and the availability of sustained supports rather than short-term crisis intervention.

MOBILE URGENT TREATMENT TEAM (MUTT)

Wraparound Milwaukee's Mobile Urgent Treatment Team is a crisis intervention approach that uses a team of psychologists, social workers, nurses, a case manager and consulting psychiatrist who are available on a twenty-four hour basis to families with a child who is experiencing a mental health crisis and whose behavior places them at risk for removal from home, school, community, etc.

The team travels to the place where the crisis is occurring, assesses the situation and makes a determination regarding whether the child's behavior or mental health condition can benefit from interventions in the home or whether a crisis group home, other emergency setting, or inpatient hospitalization is required. The Team also provides short-term case management and links the child and family to other community services. MUTT also oversees the operation of an eight bed crisis/respite group home, which can be used as an alternative to inpatient hospitalization or as a step-down for transition from inpatient treatment to the community.

HOME-BASED CRISIS INTERVENTION (HBCI)

HBCI is modeled on the HOMEBUILDERS program (see description above in the section on family strengthening programs) and provides short-term, intensive, in-home crisis services to families whose children are at imminent risk of psychiatric hospitalization or out-of-home placement. HBCI programs are linked to emergency rooms and provide intensive in-home intervention for four to six weeks. They are designed to divert children from inpatient services, teach problem-solving skills to the family, and link the child and family with community-based resources and supports. Caseloads are small with one counselor working with one or to two families at a time, and access to a counselor is available twenty-four hours per day. Benefits include reductions in hospital admissions and out-of-home placements. Outcomes are improved when flexible funds and access to respite services are added to HBCI.

PARTIAL HOSPITALIZATION PROGRAMS (PHP)

Partial hospitalization, also called day treatment or partial care, is being used more frequently for children and adolescents, but not as frequently as it could due to lack of third-party payer support.

Partial hospitalization typically consists of a structured milieu that includes education, counseling, and family interventions that can be provided in a variety of settings including hospitals, schools, and mental health treatment settings. PHP is used as a transitional, or step-down, service subsequent to psychiatric hospitalization or residential treatment when a child or adolescent no longer requires twenty-four hour care but is not ready to return to the community. It is also used as a diversion to prevent hospitalization or other out-of-home placement.

Studies on partial hospitalization as an alternative to inpatient treatment generally indicates benefits are derived from a structured daily environment that allows youth to return home at night to be with family and peers. Overall, the research literature points to positive gains in behavior and family functioning, but most of the studies conducted are uncontrolled. Partial hospitalization has also been shown to lead to reductions in, or delays of, hospitalization and residential care which may reduce overall costs of treatment. Outcomes related to improvements in academic achievement show mixed results and point to the potential for consideration of implementing school-based models. The data show that seventy-five percent of participants return to regular school, often with support from special education or other school and/or community-based services. It should be noted that studies also demonstrate that family participation during and following day treatment is essential to obtaining and maintaining benefits.

RESIDENTIAL CARE

Residential and group settings are recommended only when there are no other alternatives available. Evidence indicates that the most effective settings incorporate the following:

- Cognitive-behavioral therapeutic interventions, especially for children who display disruptive behaviors
- A strong emphasis on working with families to promote generalization of improvements in the community
- Provision of educational, recreational and employment (for older adolescents) supports
- Parent training in behavior management skills
- Weekend home visits
- Point and level systems wherein privileges are conditioned on positive behavior[48]

TEACHING-FAMILY MODEL (TFM)

The Teaching-Family Model is an evidence-based residential treatment program for children and adolescents within the juvenile justice and child welfare systems. In this model, a married couple, the teaching parents, live with children/adolescents in a group home and teach them essential interpersonal and living skills. Services and supports are provided by trained staff in homes located in the community where participants can attend local schools. Each home typically serves five to ten consumers. An array of therapeutic interventions are used which include individual psychotherapy, group therapy, and behavior modification. The teaching family model emphasizes structured behavioral interventions to teach new skills and reinforce improved behavior.

[48] It should be noted that while parent-child contact is often deemed one of those privileges, evidence consistently indicates that ongoing contact with a caregiver is associated with improved behavior and more rapid family reunification.

The Teaching Family Model is comprised of the following components:

- A positive, proactive interaction style that fosters learning appropriate problem-solving skills. This style entails starting all interactions with a positive empathic statement, using specific behavioral descriptions, explanations of how the behavior helps or hinders the individual, examination of alternatives, engagement of the individual in the interaction, administration of praise and consequences for all appropriate behaviors
- Teaching problem-solving and self-control skills and the appropriate experience of emotion in various situations
- Engaging parents and children in supportive relationships with agency staff to create trust
- Providing advocacy for children and their families
- Using behavior management or motivation systems to encourage and support children's acquisition of appropriate skills

Research indicates that this model is less effective for adolescents with emotional disturbances. Although therapeutic group home programs produce positive gains in adolescents while they are in the home, these changes are rarely maintained after discharge. Therapeutic foster care (see discussion below) is a more effective alternative that is well supported by research.

The Teaching-Family Association provides consultation and has developed standards for the certification of member agencies that are reviewed on annual basis to ensure fidelity to the model. The Teaching-Family Certification Manual can be found on the web at http://www.teaching-family.org/. Michigan's Teaching Family Organization is located on the web at http://www.teachingfamilyhomes.org/.

FOSTER CARE

Foster care can be classified as either respite (i.e., short-term for emergencies, assessment or preparation for long-term placement; medium term respite; and long-term respite) or specialized foster care. Foster care can be either temporary or permanent. Various alternatives of this out-of-home model are discussed below.

KINSHIP CARE

Title IV-E of the Social Security Act requires states to give preference to relatives (who meet child protection standards) over non-related caregivers when placing a child. Kinship care is provided by relatives, members of their tribes or clans, godparents, stepparents, or any adult who has a kinship bond with a child. Kinship caregivers are unlicensed caregivers approved by courts because they are relatives by blood, marriage, or adoption, or have a significant, long-standing relationship with the child's family. Kinship care programs provide community-based support services to relative caregivers so that children can remain with their extended families and avoid placement in the foster care system.

Kinship care should be the first option considered when a child needs to be removed from his/her home for emergency placement. Experts believe there are substantial benefits to placing children separated from their parents with relatives rather than with unrelated foster parents. Relatives can provide family support and frequent contact with birth parents and siblings. Kinship connections help reduce children's and families' trauma and stress, child abuse and neglect, as well as maintain connections with family and community, increase the possibility of reunification, and achieve permanency and stability.

FAMILY-TO-FAMILY PROGRAM

The Family-to-Family program has been implemented in several counties across Michigan, including Saginaw. It is a partnership between local Departments of Human Services and communities designed to decrease disruption in the lives of at-risk children and ensure that birth parents, foster parents, and community representatives are involved in the decision-making process concerning children's placement and service needs. The program is intended to ensure that children who must be removed from their families are placed with one permanent and stable family in their own community until reunification with birth families or a release for adoption occurs. Foster families, also known as resource families, work with biological families in this approach.

Family-to-Family aims to reduce the number of children served in institutional and congregate care, lengths of stay in out-of-home placements, children served away from their own families, children who re-enter care, and placement moves experienced by children in care, as well as increase the number of siblings placed together and planned family reunifications.

Family-to-Family is comprised of four strategies:

- Recruitment, training, and support for resource families (i.e., foster parents and relative care givers)
- The creation of community partnerships among organizations in neighborhoods with high rates of referral to create supports for families involved in the child welfare system
- Team decision-making involving foster parents, caseworkers, birth families, and community members in all placement decisions to create a support network
- Evaluation data on child and family outcomes to assess progress and delineate areas for change

A 1998 national evaluation of Family-to-Family indicated that foster children in this program moved less frequently and were more likely to live with relatives. In some communities they were also found to be reunited with their parents more often. Information on the program can be found on the web at http://www.aecf.org/initiatives/familytofamily/.

THERAPEUTIC FOSTER CARE (TFC)

Therapeutic foster care is an alternative to incarceration, hospitalization, group, and residential treatment for children and adolescents who have a history of delinquency, emotional disturbance, and who display ongoing antisocial behavior. It provides a highly structured environment that rewards (reinforces) positive social behaviors and penalizes aggressive and disruptive behaviors. It also separates participants from peers who engage in delinquent acts. Close supervision at home and in school is provided. Therapeutic foster care is considered the least restrictive form of out-of-home therapeutic placement for children who have severe emotional disorders.

In this model trained foster parents function as the primary interventionists and provide care in their homes. While therapeutic foster care programs vary, they have the following features in common:

- Foster parents receive extensive pre-service training, in-service training, supervision, and support.
- Biological parents or legal guardians are taught how to provide effective supervision, discipline, support, encouragement, use daily behavioral

management point systems, conflict management, communication and problem-solving skills. (Regular home visits allow for the practice of these skills.)

- Therapeutic foster parents are given a higher stipend than that given to traditional foster parents.
- Frequent contacts between participants and their biological parents/legal guardians, including home visits, are maintained.
- Progress in school is monitored.
- Coordination with probation/parole officers is provided.
- Frequent contact between case managers/care coordinators and foster families is maintained.
- Psychiatric consultation and medication management are available.
- Peer associations are closely monitored and access to negative peer associations is restricted.
- An individualized daily program comprised of scheduled activities and behavioral expectations is designed by a case manager in conjunction with the foster parents.
- Appropriate and positive behaviors are reinforced. A point system is assigned that specifies the number of points that can be earned for acceptable performance. Points are removed for misbehaviors and rule violations.
- Close supervision is provided at all times.

  There may be three levels of supervision:

  1. Level one, which usually lasts for three weeks, entails continuous supervision; the youth is within visual contact at all times (except when asleep), and is driven to and from school.
  2. Level two, which usually lasts four months, entails limited free time in the community that can be earned through substantial program rule compliance.
  3. Level three, which usually lasts from one and a half to three months, entails more frequent home visits and less structured peer activities.
- Clear, specific and consistent rules and limits are set.
- There is consistent follow through with consequences.
- The development of academic skills and positive work habits are encouraged.
- Family conflict and communication skills are taught.

Research indicates that adolescents aged twelve to eighteen years who display chronic delinquency benefit significantly from therapeutic foster care. Studies show about a seventy percent reduction in the commission of violent crimes when compared to standard group residential treatment. It has been estimated that $14.00 are saved by the juvenile justice system for every dollar invested in the program model. Costs range from $20,351 to $81,664 per participant.

MULTIDIMENSIONAL TREATMENT FOSTER CARE (MTFC)

MTFC an evidence-based, therapeutic foster care, SAMHSA model program developed by the Oregon Social Learning Center (OSLC) as an alternative to institutional, residential or group home placement for teens who have histories of chronic and serious criminal behaviors and are at risk for incarceration. It is a six to nine month program that is far less costly and disruptive than institutional care. Youth are referred to MTFC by the juvenile justice, foster care, and mental health systems.

MTFC provides:

- Close supervision
- Equitable and consistent limits
- Predictable consequences for violations of rules
- A supportive relationship with at least one mentoring adult
- Reduced exposure to peers with similar problems

The intervention is multifaceted and occurs in multiple settings. The intervention components 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
- Psychiatric consultation and medication management as needed

Core components:

Children/Adolescents:

- Daily structure and support
- An individualized point system
- Weekly individual treatment
- Consistent didactic nonphysical discipline
- Psychiatric consultation and medication management as needed

Families:

- Weekly family therapy with a focus on skill development
- Behavioral management techniques instruction
- Frequent home visits from staff
- Access to crisis services and supports on a twenty-four hour, seven day per week basis

Foster parents:

- Daily telephone contacts
- Support and training
- Access to crisis services and supports twenty-four hour, seven day per week basis

Foster parents are recruited, trained and supervised by clinical staff of the Oregon Social Learning Center (OSLC). They must complete twenty hours of pre-service training during which they are taught principles of social learning theory and how to implement a daily behavior management program at home. Adolescents earn daily points for adaptive and prosocial behaviors across home, school, and community settings; points are lost for negative or undesirable behaviors. The points can used to purchase privileges. The levels of responsibility and privilege increase as they progress through the program. The adolescents participate in weekly individual therapy sessions that focus on developing effective problem-solving, social, and emotion regulation skills. Their parents or guardians attend weekly family therapy sessions designed to teach effective parenting and family management techniques. The adolescents attend public schools; their attendance and performance are monitored daily. OSLC staff members provide support to foster and biological parents/guardians on a twenty-four hour, seven-day-a-week basis.

Studies have demonstrated that compared to alternate residential models, participants spend sixty percent fewer days incarcerated, experience significantly fewer subsequent arrests, elope

from the program three times less often, use significantly less hard drugs, and are placed far more rapidly into community settings from more restrictive settings. An inverse correlation between the number of days in treatment and the number of days of subsequent incarceration has been noted.

The program has been modified to include MTFC-P for preschool-aged children (aged three to five), MTFC-L for latency-aged children (aged six to eleven), and MTFC-A for adolescents (aged twelve to eighteen). OSLC provides training, consultation and clinical supervision which cost $40,000 for the first year. The program costs $120/day. Information on all three models can be obtained from OSLC at www.oslc.org.

INPATIENT CARE

Inpatient care can consume significant amounts of resources, yet has the weakest research base to support its use. Although most of the research consists of uncontrolled studies, they indicate that children who display conduct problems and psychotic features do as well with community-based interventions. MST, for example, has been shown to be more effective than psychiatric hospitalization in decreasing antisocial behaviors, enhancing family cohesion and social relationships, and maintaining children in the community and in school. Other alternatives with a strong evidence base include intensive case management, home-based therapies, therapeutic foster care, and nurse home visitation models, all of which allow children to remain in their communities.

Inpatient milieus that use behavioral interventions such as token economies to reward positive behaviors, differential reinforcement (e.g., selectively ignoring unwanted behaviors, rewarding alternative behaviors) and the provision of explicit instructions are more effective in producing long-term changes. A number of the interventions discussed in this report (e.g., Aggression Replacement Training, Coping With Depression, DBT-A, etc.) can be used in inpatient settings to enhance beneficial outcomes. Involvement of the family in treatment is critical. Follow up aftercare for the consumer and family post discharge are also essential.

MEASUREMENT TOOLS

The consistent use of standardized, validated assessment tools provide an understanding of unique strengths, risk factors, and needs in multiple domains. Follow-up assessments, completed at regular intervals, provide opportunities to distinguish areas of progress, revise support and service plans as needed, ascertain whether families are achieving their goals, and whether they are satisfied with services and supports.

The development of children unfolds in a variety of contexts. Therefore, assessment, treatment planning, service delivery, and outcome measurement need to take into account the contextual factors and significant individuals in a child's life (e.g., parents, siblings, peers, and teachers) as well as developmental factors. And, since early childhood is a period of rapid growth and development, observation over time is necessary in order to ascertain whether a behavior is transient. Infant and child behaviors also need to be viewed within the context of familial and cultural expectations.

Examples of standardized instruments include:

Functional Status

Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 1990)
Children's Global Assessment Scale (CGAS) (Shaffer et al., 1983)
Residential Living Environment (Roles) and Placement Stability Scale (Pressley Ridge School, 1992)

Family Functioning

Family Adaptability and Cohesion Evaluation Scales (FACES III) (Olson et al., 1982)

Clinical Symptoms

Achenbach Questionnaires (Achenbach, 1991)
- Child Behavior Checklist (CBCL)
- Teacher Report Form (TRF)
- Youth Self-Report (YSR)

Diagnosis (Structured Interviews)

Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS) (Puig-Antich & Chambers, 1978)
Diagnostic Interview Schedule for Children (DISC) (Costello et al., 1982; 1984)
Diagnostic Interview for Children and Adolescents (DICA) (Herjanic & Reich, 1982)

Symptom-Specific Scales

Center for Epidemiologic Studies-Depression Scale (CES-D) (Radloff, 1977)
Beck Depression Inventory (BDI) (Beck, 1961)
Conner's Parent & Teacher Rating Scales (Conners, 1969; 1973)
Yale-Brown Obsessive-Compulsive Scale - Children (Y-BOCS) (Goodman et al., 1989b, 1989c)
Revised Children's Manifest Anxiety Scale (RCMAS) (Reynolds & Paget, 1981; 1983)

Consumer Satisfaction

Client Satisfaction Questionnaire: CSQ-8 (Attkisson et al., 1989)
Family Empowerment Scale (FES)
Family Satisfaction and Needs Questionnaire

OUTCOMES

In the past, the numbers of consumers served and/or cost of services were used to evaluate effectiveness in the public sector. And, program design is still often based upon meeting the needs of a system or organization rather than the needs of the children/adolescents and families served.

A significant paradigm shift over the past couple of decades has engendered changes in public sector evaluation. Performance-based contracting, managed care, consumer advocacy efforts, federal regulations (e.g., performance measures required by the Office of Management and Budget, the Government Performance and Result Act of 1993), and health care reform efforts have spurred increased focus on evaluation to improve the effectiveness of services, enhance accountability, and increase consumer satisfaction.

Data on outcomes can offer empirical evidence regarding effectiveness and costs. Moreover, program evaluation is a vital instrument for planning, developing, fine tuning, and maintaining evidence-based practices at both the program level and consumer level. Outcome data needs to be disseminated to families (so they can celebrate achievements and advocate for changes where needed), program managers (so they can make informed decisions regarding resource allocation and program administration, and identify staff training needs), and the public (so that the community gains awareness of the return on its investment in mental health services for children, adolescents, and families).

The primary concerns for service delivery should be: (1) whether families can get what they need, (2) when they have the need, (3) in ways that are acceptable to them, and (4) in a manner that is consistent with their strengths and challenges.

The three leading goals identified by parents who seek services and supports for their children are:

- Behavioral improvement
- Improvement in school and academic achievement
- Living a productive life based on societal norms

Families tend to define treatment success in terms of:

- Meeting basic needs and other identified goals
- Individual achievements by their children
- School success
- Improvement in their children's self-esteem and interpersonal relationships with adults, especially authority figures
- Their ability to solve problems independently

The following indicators may be used to ascertain the effectiveness of intervention strategies:

- The family perceives that intervention made a difference in the child's life
- The family perceives that intervention made a difference in the family's life
- The family has a positive regard for the professional and service system
- The intervention enabled the family to help their child grow, learn, and develop
- The intervention enhanced the family's ability work with professionals and advocate for services
- The intervention helped the family develop a strong support system

- The intervention fostered an optimistic outlook for the future
- The intervention enhanced the family's quality of life

It is essential to move beyond assessment of symptoms to more general measures of functioning and quality of life and, ultimately, the ability to make a successful transition to adulthood and contribute to society in a self-directed manner.

SUMMARY AND CONCLUSIONS

Managed care and other trends have engendered the impetus for decreased service duplication, and increased efficiency and accountability for outcomes. Federal initiatives have pushed for new treatment paradigms that include interagency collaboration. States have also pushed for collaboration to reduce spending and enhance outcomes. Families have demanded high quality, accessible and appropriate services and supports as well as participation in service planning and delivery.

Evidence-based interventions have not been broadly disseminated to the children/adolescents and their families who can most benefit from them, or to providers. Moreover, different reviews and expert panels have used different criteria and guidelines to determine levels of evidence so that there is no consensus on what the evidence base is comprised of.

The fragmentation of the service delivery system creates significant barrier to access. Many of the traditional service and support models in use are not of benefit to children/adolescents and families. Current trends in service delivery include moving away from clinic-based settings toward more consumer-centered family-based out-of-office settings including the Internet, home, primary care, and schools.

Services and supports need to be tied to early identification and assessment to take advantage of opportunities to intervene and prevent escalation of problems. Ongoing and continuous assessment needs to take into account children's changing developmental needs. Services should follow needs. Funds should follow children and their families. Children and their families should be able to enter the service system through any door.

Psychotherapeutic approaches invariably involve cognitive-behavioral interventions, are based on principles of social learning, provided within an ecological perspective, and involve families. Most of the medications used for children are prescribed off label and there is consensus in the literature that medications should not be used as a sole intervention; multimodal approaches are recommended.

A number of core values and principles guide mental health services and supports for children and adolescents:

- **Child-Centered:** Services are planned to meet the individual needs of children and families, rather than fitting them into an existing service. Services need to consider the child's family and community contexts, be developmentally appropriate and child/adolescent-specific. Children and adolescents should be invited and encouraged to participate and be part of the decision-making regarding their own care to the fullest extent feasible.
- **Family-Focused**: Families are the primary support systems for their children. Families should be empowered to advocate for themselves. Families need to participate as full partners in all stages of the decision-making and treatment planning process including implementation, monitoring and evaluation. Families may include biological, adoptive and foster parents, siblings, grandparents, other relatives, and other adults. Families and professionals function as partners working together in all aspects of planning, program development, service delivery, and evaluation based on relationships of mutual respect and support. Families are the guiding voice and have choice in decisions regarding treatment plans for their children.

- **Community-Based:** Whenever possible, services are delivered in children's and adolescents' home communities. They include formal as well as informal resources, and promote participation in the community so that there is minimal disruption of daily living and opportunity for participation by central figures in children's and families' lives. Community resources include mental health professionals and agencies, as well as social, religious, cultural organizations and other natural community support networks.
- **Collaborative and Integrated:** A comprehensive and effective system of care recognizes that children and adolescents with severe emotional disturbances often require services from more than one system. Staff work collaboratively together across discipline and agency boundaries to provide integrated, effective, and efficient services and supports.
- **Culturally Competent:** Culture determines an individual's worldview and provides general principles for living and patterns for interpreting reality are reflected in behavior. There are racial and ethnic differences in family preferences and patterns of help-seeking as well as manifestation and perception of symptoms. Specialized programs and supports linked with the culture of the community being served have been found to be successful in promoting favorable patterns of service utilization. Services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people. This entails the recognition of cultural differences, understanding how families and systems are shaped by their cultures, attending to the dynamics of differences, and making adaptations to better serve culturally diverse families.
- **Holistic:** An effective system is based on a broad, ecological framework wherein a child is viewed in the context of family, community, and culture. Services and supports need to incorporate emotional, physical, cognitive, social, spiritual, and environmental dimensions.
- **Individualized:** Treatment and support plans are tailored to meet the specific needs and goals of the individuals being served. Services and supports need to be responsive to gender, culture, and other unique circumstances of children and families.
- **Strengths-Based**: An emphasis is placed on strengths, capabilities, resources, and needs of children, families, cultures, and communities, rather than on deficits. Challenges and difficulties are addressed by harnessing strengths and resources; interventions are designed to facilitate families' awareness of their own capacities to help themselves.

RECOMMENDATIONS

1. Review existing practices/programs and ferret out those currently in use that are either contraindicated or ineffective and redirect resources to the implementation of those that have an empirical evidence base to support their use.
2. Offer comprehensive transition services and supports during the entire transition stage, from age fourteen or sixteen through twenty-six. Transition coordinator positions can be added to existing teams to provide appropriate services and supports.
3. Continue to build on the legacy of cross-system cooperation and collaboration with other child-serving agencies, including the substance abuse coordinating agency, local Human Services Department, juvenile justice system, and schools and support a no wrong door entrance policy.
4. Continue to integrate mental health services into existing child-serving agencies to identify families who are at-risk, and coordinate services and support delivery with those agencies (e.g., schools).
5. Coordinate child and adult services with blended funding to prove integrated, family-centered services and supports, particularly for children who have a parent with a mental illness and for consumers who are of transition age.
6. Continue to include parents as members of policy-making and service delivery teams.
7. Offer services that strengthen the capacity of parents and other caregivers in the areas of behavior management, anger management, and positive and effective discipline.
8. Design services and supports for the *whole* family and ensure that pejorative labels are not used. Families are not dysfunctional; they often experience complex problems in multiple domains which may require a variety of services and supports to ameliorate difficulties.
9. Ensure that the organization's mission, vision and values explicitly promote consumer empowerment, resiliency, and recovery.
10. Evaluate the potential of medication algorithms to promote effective use of psychopharmacological interventions.
11. Consider prioritizing the installation of PMTO since it is one of the evidence-based practices selected by the Michigan Department of Community Health for the public mental health system.

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APPENDIX B: SELECTED RESOURCES

Early Childhood:

Center for Evidence-Based Practice: Young Children with Challenging Behavior
http://www.challengingbehavior.fmhi.usf.edu/

Center on the Social and Emotional Foundations for Early Learning (CSEFEL)
http://www.csefel.uiuc.edu/

National Center for Children in Poverty (NCCP)
At Columbia University's Mailman School of Public Health
/www.nccp.org/
The mission of NCCP is to identify and promote strategies that reduce the number of young children living in poverty in the United States, and that improve the life chances of the millions of children under age six who are growing in poverty.

Technical Assistance Partnership for Child and Family Mental Health
1000 Thomas Jefferson Street, NW
Washington, DC 20007-3835
Phone: (202) 342-5600
http://www.tapartnership.org/

Michigan Association for Infant Mental Health
13101 Allen Road
Southgate, MI 48195
Phone : 734-785-7700, ext. 7194
http://mi-aimh.msu.edu/

Association for Children's Mental Health
100 W. Washtenaw St., Suite 4
Lansing MI 48933-2129
Phone: (517) 372-4016
Parent Line: (888) ACMH-KID (226-4543)
http://www.acmh-mi.org/

Committee for Children
http://www.children.org/

Federation of Families for Children's Mental Health
http://www.ffcmh.org/

The National Center on Children in Poverty (NCCP)
http://www.nccp.org/

National Early Childhood Technical Assistance Center (NECTAC)
http://www.nectac.org/

The National Technical Assistance Center for Children's Mental Health
http://www.gucchd.georgetown.edu/

Research & Training Center on Family Support and Children's Mental Health
http://www.rtc.pdx.edu/

Zero to Three: The National Center for Infants, Toddlers, and Families
734 15th Street, NW, Suite 1000
Washington, DC 20005
Phone: (202) 638-1144
Web site: www.zerotothree.org
Children who need support at a very young age may not readily fit into a specific diagnostic category. Moreover, many assessment and diagnostic tools have been constructed based on social and developmental contexts of European American and middle-class children. The DSM IV has been found to have limited value in the accurate diagnosis of young children's mental health disorders. It has also been criticized for it cultural biases. A diagnostic tool designed specifically for very young children is the Diagnostic Classification: Zero to Three. It uses a classification system for infants and young children to assess a child's physiological and emotional development within the psychosocial context of the child's relationships and environment. Axis I consists of the primary disorder(s) – e.g., adjustment disorders, posttraumatic stress disorder, sleep disorder, eating disorders, regulatory disorders, and disorders of communication (developmental). Axis II depicts the child's relationship capacities or deficits with primary caregivers. Axis III lists medical conditions. Axis IV indicates psychosocial stressors (e.g., adoption, death of a parent) and the effects of psychosocial stressors on the child's behavior. Axis V is used to indicate the child's level of emotional development. The DC: 0-3 costs $27.00 and has an accompanying casebook manual that costs $37.00. It is available on the web at http://www.edrs.com/default.cfm.

Concerns regarding the use of the DC: 0-3 center on the limited empirical evidence available to support a number of the primary diagnostic categories. Moreover, there is a lack of quantifiable guidance regarding the number of characteristics required to make a diagnosis of a specific disorder.

Center on Infant Mental Health and Development
http://www.depts.washington.edu/chdd

Institute for Training in Infant and Preschool Mental Health
http://www.ycs.org/

National Institute of Mental Health (NIMH)
http://www.nimh.nih.gov/

The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Mental Health Information Center
http://www.mentalhealth.org/

Child Adolescent, and Family Branch of the Center for Mental Health Services
http://www.mentalhealth.samhsa.gov/cmhs/ChildrensCampaign/

American Academy of Child and Adolescent Psychiatry (AACAP)
http://www.aacap.org/

Homebuilders
A family preservation program developed by Kinney and colleagues in 1977
http://www.institutefamily.org/

Child Welfare:

U.S. Department of Health and Human Services, Administration for Children and Families
Information on federal programs for child welfare are summarized
www.acf.dhhhs.gov/programs/cb/programs

American Association for Protecting Children
American Humane Association, Children's Division
63 Inverness Drive East
Englewood, CO 80112-5117
Phone (303) 792-9900
www.americanhumane.org

Annie E. Casey Foundation
701 St. Paul Street
Baltimore, MD 21202
Phone (410) 547-6600
Fax (410) 547-6624
www.aecf.org

Chapin Hall Center for Children
The University of Chicago
1313 East 60th Street
Chicago, IL 60637
Phone (773) 753-5900
Fax (773) 753-5940
www.chapin.uchicago.edu/index.html

Child and Family Policy Center
218 Sixth Avenue
Suite 1021
Fleming Building
Des Moines, IA 50309
Phone (515) 280-9027
Fax (515) 244-8997
www.cfpciowa.org

The Child Welfare League of America
440 First Street, NW
Suite 310
Washington, DC 20001-2085
Phone (202) 638-2952
Fax (202) 638-4004
www.cwla.org

Families for Kids
W.K. Kellogg Foundation
One Michigan Avenue East
Battle Creek, MI 49017-4058
Phone (619) 968-1611
www.wkkf.org/ProgrammingInterests/YthEdHighEd/ffk_init.htm

National Abandoned Infants Assistance Resource Center
School of Social Welfare
University of California
1950 Addison, Suite 104
Berkeley, CA 94704
Phone (510) 643-7020
Fax (510) 643-7019
E-mail: aia@uclink4.berkeley.edu

http://socrates.berkeley.edu/~aiarc

National Adoption Information Clearinghouse
330 C Street, SW
Washington, DC 20447
Phone (703) 352-3488
(888) 251-0075
Fax (703) 385-3206
www.calib.com/naic

National Association of Foster Care Reviewers
1349 W. Peachtree Street, NE
Suite 900
Atlanta, GA 30309-2956
Phone (404) 876-3393
Fax (404) 897-5325
www.nafcr.org

National Child Welfare Resource Center for Family-Centered Practice
Learning Systems Group
1150 Connecticut Avenue, NW, Suite 1100
Washington, DC 20036
Phone (800) 628-8442
Fax (202) 628-3812
www.cwresource.org

National Child Welfare Resource Center on Legal and Judicial Issues
740 15th Street, NW
9th Floor
Washington, DC 20005-1009
Phone (202) 662-1746
Fax (202) 662-1755
www.abanet.org/child/rclji/home.html

National Clearinghouse on Child Abuse and Neglect Information
330 C Street, SW
Washington, DC 20447
(800) FYI-3366
Phone (703) 385-7565
Fax (703) 385-7565
www.calib.com/nccanch

National Indian Child Welfare Association
3611 SW Hood Street, Suite 201
Portland, OR 97201
Phone (503) 222-4044
Fax (503) 222-4007
www.nicwa.org

National Resource Center on Child Maltreatment
The Child Welfare Institute
1349 West Peachtree Street
Suite 900
Atlanta, GA 30309

Phone (404) 876-1934
Fax (404) 876-7949
www.gocwi.org/nrccm

National Resource Center for Community-Based Family Resource and Support Programs
(FRIENDS)
Chapel-Hill Training Outreach Project
800 Eastowne Drive, Suite 105
Chapel Hill, NC 27514
Phone (800) 888-7970
Fax (919) 968-8879
E-mail: jldenniston@intrex.net
www.friendsnrc.org/friends.htm

National Resource Center for Foster Care and Permanency Planning
Hunter College School of Social Work
129 East 79th Street
New York, NY 10021
Phone (212) 452-7053
Fax (212) 452-7051
http://guthrie.hunter.cuny.edu/socwork/nrcfcpp

National Resource Center for Information Technology in Child Welfare
440 First Street, NW, Suite 310
Washington, DC 20001-2085
Phone (202) 662-4285
Fax (202) 638-4004
www.nrcitcw.org

National Child Welfare Resource Center for Organizational Improvement
Edmund S. Muskie School of Public Service
University of Southern Maine
One Post Office Square, 400 Congress Street
P.O. Box 15010
Portland, ME 04112
Phone 1-800-Help Kid
Fax (207) 780-5817
www.muskie.usm.maine.edu/research/natlchildwel

National Resource Center for Special Needs Adoption
Spaulding for Children
16250 Northland Drive, Suite 120
Southfield, MI 48075
Phone (248) 443-7080
Fax (248) 443-7099
www.spaulding.org

National Resource Center for Youth Services
College of Continuing Education
University of Oklahoma
202 West 8th Street
Tulsa, OK 74119-1419
Phone (918) 585-2986
Fax (918) 592-1841

www.nrcys.ou.edu

National Technical Assistance Center for Children's Mental Health
Georgetown University Child Development
Center
3307 M Street, NW Suite 401
Washington, DC 20007
Phone (202) 687-5062
Fax (202) 687-1954
http://gucdc.georgetown.edu/cassp.html

Childhelp USA®
1-800-4-A-CHILD. (1-800-422-4453)
This is a national organization that provides crisis assistance, counseling, and referral services. The Childhelp USA® National Child Abuse Hotline is staffed 24 hours a day, 7 days a week, with professional crisis counselors who have access to a database of 55,000 emergency, social service, and support resources. All calls are anonymous.

Juvenile Justice:

The Office of Juvenile Justice and Delinquency Prevention (OJJDP)
810 Seventh Street, NW
Washington, DC 20531
Phone: (202) 307–5911
ojjdp.ncjrs.org

Information on federal programs for funding services that prevent brushes with the law by juveniles are summarized on the **Department of Justice**'s web site: http://www.ojp.usdoj.gov

Mental Health Needs of Youth and Young Offenders:

The Coalition for Juvenile Justice provides a quick overview of the key facts and key recommendations.http://www.juvjustice.org/resources/fs002.html

Incarceration of Youth who are Waiting for Community Mental Health Services in the United States: Based on 2003 data, the U.S. House of Representatives Committee on Government Reform wrote a July 2004 report that documented the widespread use of juvenile detention facilities to house youth waiting for community mental health services.
http://democrats.reform.house.gov/Documents/20040817121901-25170.pdf

Criminal Neglect: Substance Abuse, Juvenile Justice and the Children Left Behind. The National Center on Substance Abuse at Columbia University found that of the 2.4 million juvenile arrests in 2000, 1.9 million involved substance abuse and addiction but that only 68,600 of those arrested received any substance abuse treatment. The reported suggests modifications that would improve the way the nation treats juvenile offenders and ultimately result in fewer juvenile substance abusers and addicts
Press release:
http://66.135.34.236/absolutenm/templates/PressReleases.asp?articleid=385&zoneid=61

Juvenile Justice and the Transition to Adulthood
In a policy brief, the MacArthur Foundation Research Network on Transitions to Adulthood claims, "the juvenile justice system not only arrests youth but can also arrest their development." Lack of communication, coordination and collaboration among corrections and other local agencies interferes with getting the appropriate services to detained youth during and after incarceration.http://www.pop.upenn.edu/transad/news/briefs.htm

The Provider System for Children's Mental Health: Workforce Capacity and Effective Treatment
This National Health Policy Forum brief reviews two major issues in meeting children's unmet needs for mental health care – ensuring an adequate supply of providers and ensuring that the delivered care is effective.http://www.nhpf.org/index.cfm?fuseaction=details&key=534
Mental Health Treatment for Youth in the Juvenile Justice System
In this 2004 compendium the National Mental Health Association reviews promising practices and programs as well as some that don't work for youth in the juvenile justice system. http://www.nmha.org/children/JJCompendiumofBestPractices.pdf

IAP Plans for Re-Entry Services From the Beginning
Planning for a young person's return to the community should begin when a youth first enters residential placement, based on the cooperative assistance of institutional staff, community aftercare staff, and community service providers. Drs. David Altschuler and Troy Armstrong have developed "Intensive Aftercare Programs".
http://www.csus.edu/ssis/cdcps/iap.htm

NIH Panel Concludes "Scare Tactics" Counterproductive in Juvenile Justice
An NIH panel found that long-term programs, like Multi-Systemic therapy, are effective because they emphasize social competency skills and family involvement. "Get tough" programs like boot camps and group detention centers are not effective, and can be counterproductive.
http://consensus.nih.gov/ta/023/023youthviolencepostconfintro.htm
Press Release: http://www.nih.gov/news/pr/oct2004/od-15.htm

Screening and Supporting Kids in Juvenile Justice: A Guide for Practitioners
In December of 2004 the Office of Juvenile Justice and Delinquency Prevention published a resource guide for practitioners with information about youth in the juvenile justice system, their problems with substance abuse and the best practices for screening and assessing their mental health.http://www.ojjdp.ncjrs.org/publications/PubAbstract.asp?pubid=11936
The chances that a child with mental illness will wind up in the juvenile or criminal justice system rather than in a treatment program are disturbingly high. However, Laurel Stine, director of federal relations with the Bazelon Center for Mental Health Law, says the legal landscape is changing for the better.http://www.connectforkids.org/articles/kids_mental_health_justice

The Research Network for Adolescent Development and Juvenile Justice
http://www.pop.upenn.edu/transad

Connect for Kids: Juvenile Justice Topic Pages
http://www.connectforkids.org/taxonomy/term/350

The Center for the Promotion of Mental Health in Juvenile Justice
http://www.promotementalhealth.org/steeringcommittee.htm

Matrix of Model Programs
http://www.strengtheningfamilies.org/html/programs_1999/matrix_1999.html
and http://www.dsgonline.com/mpg2.5/mpg_index.htm

Violence Prevention:

American Youth Policy Forum
www.aypf.org

California Institute for Mental Health
www.cimh.org

Center for Substance Abuse Prevention (CSAP), Department of Health and Human Services, National Registry of Effective Programs (NREP)

http://modelprograms.samhsa.gov

Center for the Study and Prevention of Violence, Blueprints Initiative
www.colorado.edu/cspv/blueprints

Communities that Care, Developmental Research and Programs, Inc.
www.preventionscience.com/ctc/CTC.html

CSAP's Decision Support System (DSS)
www.preventiondss.org

Department of Criminology and Criminal Justice, University of Maryland
www.preventingcrime.org

Department of Education, Safe and Drug-free Schools
www.ed.gov
Select Visit US Department of Education; use search option for "OSDFS"; select Office of Safe and Drug Free Schools—Publications; go to Publications—online publications— Exemplary and Promising Safe, Disciplined, and Drug-Free Schools Program 2001, Expert Pane)

Office of Juvenile Justice and Delinquency Prevention, National Program Review Committee, **University of Utah, and CSAP** (has information on interventions for children with disruptive behaviors)
www.strengtheningfamilies.org

Prevention Research Center for the Promotion of Human Development, Pennsylvania State University
www.prevention.psu.edu/CMHS.html

U.S. Department of Health and Human Services
www.surgeongeneral.gov/library/youthviolence

Culture:

The National Center for Cultural Competence
Includes self-assessment checklists for Promoting Cultural Diversity and Cultural Competence
http://gucchd.georgetown.edu/nccc/framework.html

Child Welfare League of America
Cultural Competence Self-Assessment Instrument (2002)
http://www.cwla.org/pubs/pubdetails.asp?PUBID=8404

National Center on Minority Health and Health Disparities, National Institutes of Health
http://ncmhd.nih.gov

The National Indian Child Welfare Association (NICWA)
http://www.nicwa.org/

Respite:

ARCH National Respite Network
800 Eastowne Drive, Suite 105,
Chapel Hill, North Carolina 27514
Tel: (919) 490-5577
Fax: (919) 490-4905
http://www.archrespite.org/index.htm

Wraparound:

National Wraparound Initiative
http://www.rtc.pdx.edu/nwi/

Center for Effective Collaboration and Practice – Wraparound Planning
http://cecp.air.org/wraparound/default.htm

Community Partners, Inc. (Mary Grealish)
105 Robinwood Lane
Mc Murray, PA 15317
(724) 941-9454 McMurray, PA 15317Tel: 724-941-9454
http://www.wraparoundsolutions.com/steps.asp
This web site has a number of resources for wraparound training

Wraparound Evaluation and Research Team (WERT)
This site has a tested fidelity tool for wraparound and is part of the National Wraparound Initiative
http://depts.washington.edu/wrapeval/

National Mental Health Association
Phone: 1-703-684-7722
Information: 1-800-969-6642
www.nmha.org

Center for Mental Health Services, Knowledge Exchange Network (KEN)
Substance Abuse and Mental Health Services Administration
www.mentalhealth.org/child

National Center for Mental Health and Juvenile Justice
Policy Research Associates, Inc.
Phone: 1-866-962-6455
E-Mail: ncmhjj@prainc.com
Website: http://www.ncmhjj.com/

Bazelon Center for Mental Health Law
Phone: 1-202-467-5730
www.bazelon.org
Substance Abuse and Mental Health Administration Center for Mental Health Services
Child and Adolescent Services Branch
Phone: 1-301-443-1333
Website: www.samhsa.gov/centers/cmhs/cmhs.html

Office of Juvenile Justice and Delinquency Prevention (OJJDP)
Phone: 1-202-514-9395
www.ojp.usdoj.gov

Federation of Families for Children's Mental Health
Phone: 1-703-684-7710
Website: www.ffcmh.org

Washington Business Group on Health
National Resource Network for Child and Family Mental Health
Phone: 1-202-62893
www.wgbh.com

National Technical Assistance Center for Children's Mental Health
Phone: 1-202-687-0100
www.georgetown.edu

Research and Training Center for Children's Mental Health
Phone: 1-813-974-4602
www.fmhi.usf.edu

Portland State University
Research and Training Center
www.rtc.pdx.edu

Information and Advocacy:

Federation of Families for Children's Mental Health
1101 King Street, Suite 420
Alexandria, Virginia 22314
(703) 684-7710
http://www.ffcmh.org

Child Welfare League of America (CWLA)
CWLA is an association of more than 900 public and private nonprofit agencies that assist more than 3.5 million children who are abused and neglected and their families each year with a range of services.
440 First Street, NW, Third Floor
Washington, DC 20001-2085
Phone: 202/638-2952
Fax: 202/638-4004
http://www.cwla.org/

Center for the Improvement of Child Caring
http://www.ciccparenting.org/

Fast Track:

The Fast Track Project: http://Fasttrackproject.org
National Institute of Mental Health: http://www.nimh.nih.gov/publicat/violenceresfact.cfm
PATHS Curriculum Homepage: http://www.prevention.psu.edu/PATHS/

Functional Family Therapy:

Functional Family Therapy Homepage: http://www.fftinc.com/

MST:

MST Institute: http://www.mstinstitute.org/
DOJ/OJJDP: http://www.ncjrs.org/txtfiles/165151.txt
WA State Institute for Public Policy: http://www.wa.gov/wsipp

Parental Mental Illness:

www.parental.illness

American Academy of Child and Adolescent Psychiatry
Offers a wide selection of resources for families living with mental illness. Within "Facts for Families," see fact sheet on children of parents with mental illness. www.aacap.org

Beacon of Hope
Directed toward men and women who are partners of someone with a serious mental illness. Provides information about mental illness and specific links to sites for both partners and children.
www.lightship.org

Mental Health Net—Parenting Resources
Provides a comprehensive list of on-line parenting information and self-help resources. Sample topics include fatherhood, non-custodial parenting, effective parenting strategies, single motherhood and pregnancy.
mentalhelp.net/guide/parents.htm

National Mental Health Association (NMHA)
Provides on-line forums for consumers and providers to share information. Presents updates on topical legislation and news relevant to persons in the mental health community.
www.nmha.org

National Women's Health Information Center (NWHIC)
Serves as a gateway for information about women's health issues. Parenting, reproductive health, abuse, access to health care, financial assistance, and services and supports are discussed as they relate to women with disabilities.
www.4women.gov

Parenting Options Project (POP)
University of Massachusetts Medical School: A 3-year, National Institute of Disability and Rehabilitation Research-sponsored project to develop education and skills training materials for parents with mental illness. Offers a parent manual, self-assessment tool and a quarterly newsletter, PARENT LINK.
www.umassmed.edu/POP

Through the Looking Glass (TLG)
A community-based, non-profit organization that provides services, referrals and information to families in which one or more members (parents or children) have a disability or medical condition. TLG supports interventions that are empowering to consumers.
www.lookingglass.org

General Information Regarding Mental Health Issues:

American Academy of Child and Adolescent Psychiatry
http://www.aacap.org/
Includes Facts for Families Resource, which is geared towards assisting parents and families in understanding developmental, emotional, behavioral, and mental disorders affecting children and adolescents.

Center for the Advancement of Children's Mental Health at Columbia University
www.kidsmentalhealth.org
Information about a range of children's psychiatric diagnoses and treatment explanations for parents and physicians.

New York Presbyterian Hospital
http://www.noah-health.org/english/
Basic explanations, diagnoses and symptoms, care and treatment, complications and concerns, and information for children on a wide range of psychiatric disorders, including published articles about these disorders.

Internet Mental Health
http://www.mentalhealth.com/
Information about basic mental health and diagnoses, research, and treatment for mental health professionals, consumers, and families.

National Alliance for the Mentally Ill (NAMI)
Phone: 1-703-524-7600
NAMI Helpline: 1-800-950-6264
www.nami.org
Information for parents and caregivers on a range of child and adolescent mental health illnesses and treatments; consumer, family, and provider education programs; and resources and book reviews for families.

National Institute of Mental Health (NIMH)
http://www.nimh.nih.gov
Information about NIMH–sponsored grants; mental disorder information and statistics for the public; consumer education, research reports, and fact sheets for practitioners; and funding opportunities, training, conferences and workshops, and services for researchers.

National Mental Health Association
http://www.nmha.org
Latest news on mental disorders, advocacy resources, and information for parents and practitioners.

The Center for Mental Health Services
http://www.mentalhealth.org/cmhs/
A federal-agency-run site that provides services and programs to support of users of mental health services, their families, and workers in the mental health field.

Major Depression:

Massachusetts General Hospital
Mood and Anxiety Disorders Institute
http://www.mghmadi.org
Includes a family resource section for mood and anxiety disorders; information on consumer education, treatment programs, and clinical training and tools.

Depression and Bipolar Support Alliance (DBSA)
http://www.ndmda.org/
Resource-kit information, information about mood disorders, support groups, programs, publications, resources, and advocacy for consumers and families.

Bipolar Disorder:

The Bipolar Child
http://bipolarchild.com/
News, books, information, articles, research, and workshops for families of children with bipolar disorder.

Bipolar Kids Home
http://www.geocities.com/EnchantedForest/1068
Education and support for parents, guardians, doctors, teachers, and those who live with childhood bipolar disorder in their lives. Contains articles and resources for children and families, written by people who have experienced childhood bipolar disorder.

Child and Adolescent Bipolar Foundation
http://www.bpkids.org/

Online presentations for parents, assessment scales and treatment guidelines for practitioners, a community resource center, and a directory of support groups.

ADHD/ADD:

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)
http://www.chadd.org/
Evidence-based information about ADHD for parents, educators, professionals, the media, and the general public.

National Attention-Deficit Disorder Association
http://www.add.org/
Information and resources for children and teens with ADD, parents and families, schools, and practitioners, as well as guiding principles for the diagnosis and treatment of ADD and guidelines for ethical ADD coaching practices.

Conduct Disorder:

Conduct Disorders.com
http://www.conductdisorders.com
Information for parents raising children who are oppositional and resistant to parenting. The site offers many different methods and treatment plans with a variety of results.

Struggling Teens.com
http://strugglingteens.com/
Support information for teens experiencing conduct-disorder issues, including program information, a phone hot line, parent support, FAQs, and a resource guide.

Anxiety Disorders:

Freedom from Fear
http://www.freedomfromfear.com
Information about anxiety and depressive illnesses, including a referral network and a directory for treatment centers by zip code. (English and Spanish)

Anxiety Disorders Association of America
http://www.adaa.org/
Resources for researchers and treatment providers in all disciplines, resources for individuals with anxiety disorders and their family members, as well as fast facts, statistics, news releases, and more for media professionals. Includes a referral directory by city or state.

Anxiety-Panic.com
http://anxiety-panic.com/
Search option links for information about anxiety, panic, trauma, fear, phobia, stress, obsession, depression, and additional mental health diagnoses for the general public.

Anxiety-Panic-Stress
http://www.anxiety-panic-stress.com/
Information and support for those suffering from anxiety, panic, stress, and other similar symptoms. The site includes a detailed list of resources and a referral network.

Obsessive-Compulsive Foundation
http://www.ocfoundation.org/indright.htm
Physician-focused site provides recent publications and videos and information on OCD.

PTSD Support Services
http://www.ptsdsupport.net/

Support services for individuals experiencing trauma or PTSD, resources for families, education opportunities, and information about treatments.

National Center for PTSD
http://www.ncptsd.org/
Information about PTSD, a database with literature on PTSD, FAQs, and a description of assessment instruments geared towards families and practitioners.

Social Phobia/Social Anxiety Association
http://www.socialphobia.org/
Information for individuals with social phobia and social-anxiety disorder, including fact sheets, literature, and resources.

Madison Institute of Medicine—Facts for Health
http://www.factsforhealth.org/
Information about social-anxiety disorder and PTSD for individuals with the disorders, information on continuing education on the recognition, diagnosis, and treatment of these conditions for clinicians.

Trauma Resources:

National Center for Post-Traumatic Stress Disorder, Department of Veteran Affairs
Treatment of PTSD http://www.ncptsd.org/facts/treatment/fs_treatment.html

Suicide Prevention and Child Safety Resources:

Children's Safety Network (CSN)
55 Chapel Street
Newton, MA 02458-1060
(617)969-7100, ext. 2207 (617)244-3436 FAX
For general technical assistance on youth suicide prevention: (617)969-7100,
ext. 2207 or (202) 466-0540 in Washington, D.C.
For rural youth suicide issues: (715)389-4999
For youth suicide data information: (619)594-3691
For youth suicide economic and data information: (301)781-9891
www.edc.org/HHD/csn

The Children's Safety Network
http://www.childrenssafetynetwork.org/
The Children's Safety Network is a unique group of resource centers working to assist states, communities, and others to prevent child and adolescent injuries. CSN's four national resource centers provide information, training, and technical assistance to facilitate the development of new injury and violence prevention programs and to enhance and support existing efforts. CSN is funded by the Health Resources and Services Administration's Maternal and Child Health Bureau.

Centers for Disease Control and Prevention (CDC)
National Center for Injury Prevention and Control (NCIPC)
Division of Violence Prevention
Mailstop K60
4770 Buford Highway NE
Atlanta, GA 30341-3724
(770)488-4362 (770)488-4349 FAX
www.cdc.gov/ncipc/dvp or http://www.cdc.gov/

In June 1992, the CDC established the National Center for Injury Prevention and Control. As the lead federal agency for injury prevention, NCIPC works closely with other federal agencies; national, state, and local organizations; state and local health departments; and research institutions. It has four priority areas for violence prevention: youth violence, family and intimate violence, suicide, and firearm injuries. NCIPC provides funds for suicide prevention. It also functions as an information center on suicide, including statistics, research findings, and research programs.

Suicide Prevention Resource Center (SPRC)
http://www.sprc.org/

The American Academy of Child & Adolescent Psychiatry (AACAP)
3615 Wisconsin Avenue, NW
Washington, DC 20016-3007
(202)966-7300
(202)966-2891 FAX
www.aacap.org
This website is designed to serve both AACAP members and parents and families. It provides information to aid in the understanding and treatment of the developmental, behavioral, and mental disorders affecting children and youth.

The American Association of Suicidology (AAS)
4201 Connecticut Avenue, NW Suite 408
Washington, DC 20008
(202)237-2280
(202)237-2282 FAX
www.suicidology.org
AAS is dedicated to the understanding and prevention of suicide. AAS promotes research, public awareness programs, education, and training for professionals and volunteers. In addition, it serves as a national clearinghouse for information on suicide and publishes directories of members, suicide prevention centers, and support groups; these directories mainly cover the United States, though other countries are represented. AAS also publishes and maintains a certifying program for new centers that sets standards for operations.

The American Foundation for Suicide Prevention (AFSP)
120 Wall Street, 22nd Floor
New York, NY 10005
(212)363-3500
(212)363-6237 FAX
(888)333-AFSP (toll free)
www.afsp.org
AFSP is dedicated to advancing knowledge of suicide and the ability to prevent it. The foundation's activities include supporting research projects that help further the understanding and treatment of depression and the prevention of suicide; providing information and education about depression and suicide; promoting professional education for the recognition and treatment of depressed and suicidal individuals; publicizing the magnitude of problems of depression and suicide and the need for research, prevention, and treatment; and supporting programs for suicide survivor treatment, research, and education.

American Psychological Association (APA)
750 First Street, NE
Washington, DC 20002
(202)336-5500

www.apa.org/psychnet
APA provides information on psychology and its applications. PsycINFO is an electronic database of abstracts on more than 1,350 scholarly journals.

Light For Life Foundation International
Yellow Ribbon Suicide Prevention Program
P.O. Box 644
Westminster, CO 80036-0644
(303)429-3530
(303)426-4496 FAX
www.yellowribbon.org
The Yellow Ribbon cards empower youth, giving them permission and a way to ask for help. Seminars and presentations that teach awareness and suicide prevention skills are available. The Yellow Ribbon Program has chapters around the country to provide support services to prevent suicide. The program provides information on suicide, survivors support groups, task forces and coalitions around the country.

National Institute of Mental Health (NIMH)
6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: (301) 443-4513 or (866) 615-NIMH (6464)
www.nimh.nih.gov
NIMH is one of 27 components of the National Institutes of Health (NIH), the Federal government's principal biomedical and behavioral research agency. NIH is part of the U.S. Department of Health and Human Services. NIMH provides information on specific mental disorders, diagnosis and treatment, Consensus Conference proceedings, NIMH long-range plans and research reports, publications order forms, QuickTime videos, anxiety disorders, depression, suicide information, and other resources (también publicaciones en Español para pacientes y el público en general). It also provides funding for research. NIMH's publication, In Harm's Way: Suicide in America, is available from the NIMH website.

The National Organization for People of Color Against Suicide
Dr. Donna Barnes, Founder and President
P.O. Box 125
San Marcos, TX 78667
(830)625-3576
e-mail: db31@swt.edu
This small organization focuses on giving suicide survivors a way to heal and to reach into communities with high suicide rates.

Pierre@virtualcity.com
(403)245-8827
www.virtualcity.com/youthsuicide
e-mail: Pierre@virtualcity.com
Provides an extensive collection of information related to Gay/Bisexual Male suicide, Internet Resource Links, and Bibliography with Links to Abstracts.

Suicide Information & Education Center (SIEC)
201-1615 10th Ave. SW
Calgary, Alberta, CANADA T3C 0J7
(403)245-3900
(403)245-0299 FAX
www.siec.ca

SIEC is the largest English-language suicide information resource center and library in the world. Established in 1982, SIEC holds more than 26,000 print and audiovisual materials on all aspects of suicidal behaviors. SIEC has extensive information on suicide prevention, postvention, and intervention efforts and trends. It provides information useful for developing successful suicide prevention, intervention, and postvention programs. Statistical information, key resource people, computer literature searches, and document delivery are some of the resources SIEC offers. Some of the resource materials are available on the website.

Suicide Prevention Advocacy Network (SPAN)
5034 Odin's Way
Marietta, GA 30068
(888)649-1366
(770)642-1419 FAX
www.spanusa.org
SPAN, a nonprofit organization is dedicated to the creation of an effective national suicide prevention strategy. SPAN links the energy of those bereaved by suicide with the expertise of leaders in science, business, government, and public service to achieve the goal of significantly reducing the national rate of suicide by the year 2010.

Office of the Surgeon General
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201
(202)205-0463 FAX
www.surgeongeneral.gov
The Surgeon General's Office has issued The Surgeon General's Call to Action to Prevent Suicide and accompanying fact sheets. Additional information on the Healthy People 2000 and 2010 Objectives are available from the Office and through the website. The website also has links to the Surgeon General's publications, and a special section for children, parents and teachers.

CSN Injury Data Technical Assistance Center
(619)594-369
www.injurypreventionweb.org/nidtac/nidtac.htm
Local, state and national suicide data.

Institute of Medicine
500 Fifth Street, NW
Washington, DC 20001
Phone: (202) 334-2352
www.iom.edu
The Institute of Medicine released a report titled *Reducing Suicide: A National Imperative*. The report contains four recommendations from The Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide, which examined the state of the science base, gaps in knowledge, strategies for prevention, and research designs for studying suicide. The report reflects different perspectives and levels of analysis and states precisely what decision makers need to do to advance the science and improve health and social perspectives. This project was funded by the CDC, the National Institute of Mental Health, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the Substance Abuse and Mental Health Services Administration, and the Veterans Administration. The views expressed in this report are those of the Institute of Medicine Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide and are not necessarily those of the funding agencies.

National Center for Suicide Prevention Training
55 Chapel Street
Newton, MA 02458-1060
Phone: (617) 618-2418
www.ncspt.org/courses/orientation
The National Center for Suicide Prevention Training currently has two Internet-based workshops. The first one, “Locating, Understanding, and Presenting Youth Suicide Data,” is available on an ongoing basis. The second workshop, "Planning and Evaluation for Youth Suicide Prevention," is being prepared for pilot testing. The Center’s website provides more information on training.

The National Strategy for Suicide Prevention (NSSP)
www.mentalhealth.samhsa.gov/suicideprevention
The NSSP represents the combined work of advocates, clinicians, researchers, and survivors nationwide. NSSP lays out a framework for developing an array of suicide-prevention services and programs. NSSP is a catalyst for social change and has the power to transform attitudes, policies, and services. The NSSP Goals and Objectives for Action was published by the U.S. Department of Health and Human Services (May 2001) and includes guidance from the surgeon general.

National Youth Violence Prevention Resource Center
PO Box 6003
Rockville, MD 20849-6003
Phone: (866) 723-3968
www.safeyouth.org
Developed by CDC in partnership with 10 other federal partners, the Resource Center provides current information pertaining to youth violence that has been developed by federal agencies and the private sector. The NYVPRC is a gateway for professionals, parents, teens, and other interested individuals to obtain comprehensive information about youth violence—including suicide prevention and intervention.

The Office of Juvenile Justice and Delinquency Prevention (OJJDP)
810 Seventh Street, NW
Washington, DC 20531
Phone: (202) 307–5911
ojjdp.ncjrs.org
The OJJDP provides national leadership, coordination, and resources to prevent and respond to juvenile delinquency and victimization. OJJDP supports states and communities in their efforts to develop and implement effective and coordinated prevention and intervention programs. OJJDP also works to improve the juvenile justice system so that it protects public safety, holds offenders accountable, and provides treatment and rehabilitative services tailored to the needs of juveniles and their families. Their publication, "Juvenile Suicides, 1991–1998" (NCJ 196978), draws on CDC-compiled data to examine trends and characteristics of more than 20,000 suicides committed by juveniles during that period. "Juvenile Suicides" is available from the OJJDP website

Reporting on Suicide: Recommendations for the Media
www.afsp.org/education/newrecommendations.htm
The media play a powerful role in educating multiple audiences about suicide prevention by informing readers and viewers about the likely causes of suicide, warning signs, trends in suicide rates, and recent advances in prevention. These recommendations will help guide the media in educating readers and viewers about the steps that can be taken to prevent suicide.

Substance Abuse and Mental Health Services Administration (SAMHSA)
Room 12-105 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-8956
www.samhsa.gov
SAMHSA is the Federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

Suicide Awareness Voices of Education (SAVE)
7317 Cahill Road, Suite 207
Minneapolis, MN 55439-2080
Phone: (952) 946-7998
www.save.org
SAVE's mission is to educate about suicide prevention, eliminate stigma, and support those touched by suicide.

Suicide Prevention Resource Center
Education Development Center, Inc.
55 Chapel Street
Newton, MA 02458-1060
Phone: (877) 438-7772
www.sprc.org
The Suicide Prevention Resource Center supports suicide prevention by offering the best of science, skills, and practice. The Center provides technical assistance, training, and informational materials to strengthen suicide prevention networks and advance the National Strategy for Suicide Prevention.

The Suicide Prevention Action Network
1025 Vermont Avenue, NW
Suite 1200
Washington, DC 20005
Phone: (202) 449-3600
www.spanusa.org
The Suicide Prevention Action Network USA is a non-profit national organization that links the energy of those bereaved or touched by suicide with the expertise of leaders in science, health, business, government and public service to achieve the goal of significantly reducing the national rate of suicide by the year 2010.

The Surgeon General's Call to Action to Prevent Suicide
www.surgeongeneral.gov/library/calltoaction/default.htm
This document introduces a blueprint for addressing suicide: Awareness, Intervention, and Methodology (AIM). This approach is derived from the collaborative deliberations of the 1st National Suicide Prevention Conference participants. As a framework for suicide prevention, AIM includes 15 key recommendations that were refined from consensus and evidence-based findings presented at the Reno conference.

Training Institute for Suicide Assessment and Clinical Interviewing
www.suicideassessment.com
This website is designed specifically for mental health professionals, substance-abuse counselors, school counselors, primary-care physicians, and psychiatric nurses who are looking

for information on the development of suicide prevention skills, crisis intervention skills, and advanced clinical interviewing skills.

World Health Organization (WHO)
World Report on Violence and Health
www.who.int/violence_injury_prevention/violence/world_report/wrvheng/en/
This report, produced by the WHO, is written mainly for researchers and practitioners. Its goals are to raise global awareness about the problems of violence and to make the case that violence is preventable and that public health systems have a crucial role to play in addressing its causes and consequences. The report includes a chapter specifically on self-directed violence (chapter 7).

American Academy of Child and Adolescent Psychiatry
http://www.aacap.org/
Facts for Families: Teen Suicide http://www.aacap.org/publications/factsfam/suicide.htm; The Depressed Child http://www.aacap.org/publications/factsfam/depressd.htm; Manic-Depressive Disorder in Teens http://www.aacap.org/publications/factsfam/bipolar.htm; Gay and Lesbian Teens http://www.aacap.org/publications/factsfam/63.htm

American Association of Suicidology
http://www.suicidology.org/

American Foundation for Suicide Prevention
http://www.afsp.org/
Excellent site with links to research articles and youth-suicide facts and information for researchers.

American Psychiatric Association
Teen Suicide http://www.psych.org/
Good summary for parents and peers listing where to get help.

Australian National Youth Suicide Prevention Strategy Communications Project
http://www.aifs.org.au/external/ysp/ysplinks.html
A guide to many excellent Australian Web sites listing prevention strategies and resources.

Canadian Association For Suicide Prevention
Community Lifelines http://www3.sympatico.ca/masecard/
Non-profit national Canadian association with text in French and English.

Centers for Disease Control
CDC Prevention Guidelines: Programs for the Prevention of Suicide Among Adolescents and Young Adults (1994)
http://aepo-xdv-www.epo.cdc.gov/wonder/prevguid/m0031525/ m0031525.htm
Suicide Contagion and the Reporting of Suicide: Recommendations from a National Workshop (1994) http://aepo-xdv-www.epo.cdc.gov/wonder/prevguid/ m0031539/m0031539.htm
Youth Suicide Prevention Programs: A Resource Guide (1992)
http://aepo-xdv-www.epo.cdc.gov/wonder/prevguid/p0000024/p0000024.htm
CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters (1988)
http://aepo-xdv-www.epo.cdc.gov/wonder/prevguid/p0000214/ p0000214.htm
National Center for Injury Prevention and Control: Suicide and Violence (fact sheet)
http://www.cdc.gov/ncipc/dvp/suifacts.htm

National Depressive and Manic-Depressive Association
http://www.ndmda.org/

Suicide http://www.ndmda.org/suicide.htm
Suicide and Depressive Illness Booklet http://www.ndmda.org/suicide.htm#Suicide and Depressive Illness
Many excellent links on suicide and depression and bipolar disorder for families and children.

National Institute Of Mental Health (NIMH)
Suicide Research Consortium http://www.nimh.nih.gov/research/suicide.htm
Includes a suicide fact sheet, epidemiological information, bibliographies, and information for researchers.

Prevention Yellow Pages
Suicide http://www.tyc.state.tx.us/prevention/40001ref.html#SUI
Reference list for many recent research articles on programs designed to prevent youth suicide.

Suicide Information and Education Centre (SIEC)
http://www.siec.ca/
Extensive resources provided, as well as answers to frequently asked questions and library resources.

Site for Survivors
1000 Deaths (by Christine Smith) http://www.1000deaths.com/

Email Support for Survivors
suicide-survivors-request@research.canon.com.au

Bullying:

Office of Juvenile Justice and Delinquency Prevention, Department of Justice
www.ncjrs.org/pdffiles1/ojjdp/fs200127.pdf
Addressing the Problem of Juvenile Bullying
This fact sheet reviews recent research on bullying and presents information on effective bullying prevention approaches.

CDC's Division of Violence Prevention
www.cdc.gov/ncipc/dvp/dvp.htm
National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
This Web site contains a number of fact sheets and publications on youth violence, with links to other valuable resources. It also includes the truth and myths about youth violence, kids' stories, things you can do to avoid violence, and a reading list for teens.

Bullying In Schools. ERIC Digest
www.ericfacility.net/ericdigests/ed407154.html
U.S. Department of Education
This document provides a concise summary of research on bullying and what we know about effective programs to prevent bullying in schools.

Survey on Bullying in U.S. Schools
www.nichd.nih.gov/new/releases/bullying.cfm
National Institute of Child Health and Human Development, National Institutes of Health
This news release summarizes the results of a recent national survey of 6th to 10th graders on bullying in U.S. schools.

A Teenager's Guide to... Fitting in, Getting involved, Finding yourself
www.ncfy.com/expreng.pdf

Virtual Library on Bullying in Schools
http://ericcass.uncg.edu/virtuallib/bullying/bullyingbook.html

ERIC Clearinghouse on Counseling and Student Services, U.S. Department of Education
This site offers a rich collection of documents on bullying, ranging from techniques to avoid bullying to descriptions of effective bullying prevention programs.

National Youth Violence Prevention Resources Center
P.O. Box 6003
Rockville, MD 20849-6003
www.safetyouth.org

Transition Resources:

Academy for Educational Development, Disabilities Studies and Services Center, National Transition Alliance for Youth with Disabilities (NTA)
Gives examples of how the NTA promotes the transition of youth with disabilities toward employment through postsecondary education training and independent living. Provides information on publications, search engines for disability-related information and links to federal and transition-related resources.
http://www.dssc.org/nta

Beach Center on Families and Disability
Offers information on disability and family studies, updates on current research and resources for behavioral support. Provides consumer news for families, social service providers and policymakers. Specific details of products, including newsletters and links to similar resources, are provided. http://www.lsi.ukans.edu/beach/beachhp.htm

Program for Youth with Severe Emotional Disturbance
A calendar of disability-related events for educators and parents is also provided.
http://www.keene.edu/RESOURCES/IOED/default.html

National Center on Institutions and Alternatives
Demonstrates how the National Center's Youth-In-Transition (YIT) Program offers services to prevent out-of-home placements and facilitate family reunification. Offers information on treatment programs for adolescents, life skills services, transitional living programs and referral and assessment services. http://www.igc.apc.org/ncia/yit.html

National Technical Assistance Center for State Mental Health Planning (NTAC)
Maintains a comprehensive web site providing information on innovative programs and technical assistance on issues of importance to mental health planning, service delivery and evaluation. The web site contains information that can be used in planning for services and programs in a wide range of areas. NTAC's audience includes state mental health agencies, consumers, family members and state mental health planning councils.
http://www.nasmhpd.org/ntac

ResourceNet at Florida Mental Health Institute, Department of Child and Family Studies, University of South Florida
Describes a wide variety of department activities, including Research and Evaluation in Children's Mental Health, the System Accountability Project for Children's Mental Health and the Research and Training Center for Children's Mental Health. Links to resources for Building Communities for Children & Families and other service and demonstration programs are provided.
http://lumpy.fmhi.usf.edu

Parent Training and Information Centers (IDEA resources):

CAUSE
Parents Training Parents

6412 Centurion Dr. Suite 130
Lansing, MI 48917
517-886-9167 Voice & TDD & TDY
517-886-9366 FAX
1-800-221-9105 in MI
E-mail: info@causeonline.org
Website: www.causeonline.org

National Technical Assistance Center for Children's Mental Health
Georgetown University Center for Child and Human Development
3307 M. Street, NW
Suite 401
Washington, DC 20007
(202) 687-5000
(202) 687-1954 (fax)
childrensmh@georgetown.edu

Bazelon Center for Mental Health Law
1101 15th Street, NW, Suite 1212
Washington, DC 20005-5002
Phone: (202) 467-5730
www.bazelon.org
Of special relevance: Information on mental health issues

Center for Law and Social Policy
1616 P Street, Suite 150
Washington, DC 20036
Phone: (202) 328-5140
www.clasp.org
Of special relevance: Analysis of welfare-related issues

Center on Budget and Policy Priorities
820 First Street, NE, Suite 510
Washington, DC 20002
Phone: (202) 408-1080
www.cbpp.org
Of special relevance: Information on welfare-related issues

Children's Defense Fund
25 E Street, NW
Washington, DC 20001
Phone: (202) 628-8787
www.childrensdefense.org
Of special relevance: Information on child care, welfare, and child welfare issues

Child Trends, Inc.
4301 Connecticut Avenue, NW
Washington, DC 20008
Phone: (202) 362-5580
www.childtrends.org
Of special relevance: Analysis of research related to children and poverty

Child Welfare League of America
440 First Street, NW, Third Floor

Washington, DC 20001-2085
Phone: (202) 638-2952
www.cwla.org
Of special relevance: Publications dealing with substance abuse problems in the context of child welfare

Federation of Families for Children's Mental Health
1021 Prince Street
Alexandria, VA 22314-2971
Phone: (703) 684-7710
www.ffcmh.org
Of special relevance: Parent advocacy for children with emotional and behavioral challenges

Legal Action Center
153 Waverly Place
New York, NY 10014
Phone: (212) 243-1313
and
236 Massachusetts Avenue, NE, Suite 505
Washington, DC 20002
Phone: (202) 544-5478
www.lac.org
Of special relevance: Information on issues related to substance abuse

National Center for Children in Poverty
Columbia University
154 Haven Avenue
New York, NY 10032
Phone: (212) 304-7100
www.nccp.org
Of special relevance: Information on policies and practices regarding young children and welfare reform and state policies for young children and families, and syntheses of empirical data on welfare-related studies at www.researchforum.org

National Head Start Association
1651 Prince Street
Alexandria, VA 22314
Phone: (703) 739-0875
www.nhsa.org
Of special relevance: Annual institute on mental health in Head Start programs

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314
Phone: (703) 684-7722
www.nmha.org
Of special relevance: Child health outreach initiative and advocacy for children with behavioral challenges.

National Technical Assistance Center for Children's Mental Health
Georgetown University Child Development Center
3307 M Street, NW
Washington, DC 20007-3935
Phone: (202) 687-5000

www.georgetown.edu
Of special relevance: Technical assistance related to early childhood mental health

Taylor Institute
926 N. Wolcott
Chicago, IL 60622
Phone: (773) 342-0630
www.taylorinstitute.org

The Project for Research on Welfare, Work, and Domestic Violence
www.ssw.umich.edu/trapped
Of special relevance: Information on domestic violence issues

The Better Homes Fund
181 Wells Avenue
Newton, MA 02459-3344
Phone: (617) 964-3834 or (800) 962-4676
Of special relevance: Information related to homeless young children and families

The Urban Institute
2100 M Street, NW
Washington, DC 20037
Phone: (202) 833-7200
www.urban.org
Of special relevance: Analysis of welfare-related issues

Welfare Information Network (WIN)
1000 Vermont Avenue, Suite 600
Washington, DC 20005
Phone: (202) 628-5790
Web site: www.welfareinfo.org
Of special relevance: Web site bibliographies and resources on hard-to-serve families and general welfare information

Zero to Three: The National Center for Infants, Toddlers, and Families
734 15th Street, NW, Suite 1000
Washington, DC 20005
Phone: (202) 638-1144
www.zerotothree.org
Of special relevance: Publications that focus on the emotional well-being of infants and toddlers; also hosts a technical assistance center for Early Head Start

Federal Agencies:

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Center for Substance Abuse Prevention
Center for Substance Abuse Treatment
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-0001
www.samhsa.gov

Administration for Children and Families
U.S. Department of Health and Human Services
330 C Street, SW, Suite 2018
Washington, DC 20201
Phone: (202) 205-8572
www.acf.dhhs.gov/news/welfare

National Institute on Early Childhood Development and Education
Office of Education Research and Improvement
U.S. Department of Education
555 New Jersey Avenue, NW
Washington, DC 20208
Phone: (202) 219-1935
www.ed.gov/office/OERI/ECI

Consultation to Schools:

Center for Mental Health in Schools
University of California at Los Angeles
http://smhp.psych.ucla.edu

Appendix C: QUICK REFERENCE GUIDES

INTERVENTIONS FOR SPECIFIC DISORDERS

Behavior/Disorder	Consistent Evidence	Inconsistent Evidence	Unproven or Harmful Interventions	Comments
ADHD	Parent Management Training (PMT) Behavior Therapy Stimulant medications Home and Classroom Contingency Management	Social Skills Training Systemic Family Therapy Supportive Therapy	Dietary replacement, exclusion; mineral, vitamin and herbal regimens; biofeedback; perceptual stimulation Megavitamin Therapy Anti-Motion Sickness Medication Anti-Candida Albicans Medication Biofeedback Sensory Integrative Training Optometric Vision Training Irlen Lenses Chiropractic Manipulation Cognitive-Behavior Therapy	
Adjustment Disorders	Cognitive-Behavior Therapy Stress Management Family Therapy Group Therapy			
Anorexia Nervosa	Nutritional Rehabilitation & Monitoring Family Psychotherapy Cognitive-Behavior Therapy Inpatient Behavioral Program		Individual Psychotherapy Group Therapy 12-Step Programs Somatic Treatments Electroconvulsive Therapy Vitamins Hormones Tricyclic Antidepressants	Many individuals with AN require long-term monitoring and intervention due to limited response to intervention
Generalized Anxiety, Specific Phobia, Separation Anxiety, Social Phobia	Systematic Desensitization Contingency Management Cognitive-Behavior Therapies: Exposure & Response Prevention Extinction Counter-Conditioning Coping Cat Modeling Exposure Cognitive Behavioral Therapy (CBT) + Parent Component Cognitive Behavioral Therapy (CBT) + Group Cognitive-Behavioral Group Therapy for	Systemic Family Therapy Supportive Therapy Tricyclic Antidepressants	Herbal supplements may impede diagnosis and cause symptoms of anxiety Psychoanalytic Therapy Home-Based Tutoring for Separation Anxiety Disorder Beta-Blockers Neuroleptic Medications in the absence of Tourette's Syndrome Antihistamines Neuroleptics unless the anxiety co-occurs with Tourette's Eye Movement Desensitization and Reprocessing Play Therapy Educational Support	Phobias respond to systematic desensitization. Parenting strategies and behavior management strategies are also effective. Medication should not be used as the sole intervention. Benzodiazepines are used for anticipatory anxiety and panic disorder but must be used with caution due to their addictive potential

Behavior/Disorder	Consistent Evidence	Inconsistent Evidence	Unproven or Harmful Interventions	Comments
	Adolescents (CBGT-A) Selective Serotonin Reuptake Inhibitors (Luvox)		Supportive Therapy Physical Restraint Involuntary medication administration	
Panic Disorder Agoraphobia	Systematic Desensitization Modeling Contingency Management Cognitive Behavior Therapy – Relaxation Training	Supportive Therapy Systemic Family Therapy Benzodiazepines (Klonopin, Xanax) Selective Serotonin Reuptake Inhibitors (SSRIs) Tricyclic Antidepressants (Norpramin, Tofranil)		No positive trials of medications for panic disorder for children and adolescents have been conducted. SSRIs, benzodiazepines, TCAs have shown positive effects in adults.
Bipolar Illness	Lithium Electroconvulsive Therapy (adolescents)	Interpersonal and Social Rhythm Therapy Functional Family Therapy Supportive Therapy Systemic Family Therapy Mood Stabilizers (Depakote, Lithium) Antipsychotics (Haldol, Risperdal, Zyprexa)		There are no psychosocial interventions with consistently positive effects for children and adolescents. Very few studies of antipsychotics and mood stabilizers have been conducted for children and adolescents.
Bulimia Nervosa	Cognitive-Behavior Therapy (CBT) Combined treatments Group Therapy Selective Serotonin Reuptake Inhibitors		Bupropion Monoamine Oxidase Inhibitors (MAOIs) Family Therapy	Treatment includes intervention for co-occurring disorders, establishing regular non-binge meals and improving attitudes related to the disorder
Fire Setting	Cognitive-Behavior Therapy (CBT) Fire Safety Education Parent Management Training			Children do not typically outgrow this behavior; intervention is required
Major Depressive Disorder and Dysthymia	Interpersonal Psychotherapy for Adolescents (IPT-A) Cognitive-Behavioral Therapy (CBT) Cognitive Therapy Self-Control Therapy Coping with Depression Combined Treatments Group Therapy Fluoxetine	Family Systemic Therapy Supportive Therapy	Dietary supplements such as Omega-3, St. John's Wort, SAM-e which may have harmful side effects Tricyclic Antidepressants	
Oppositional Defiant (ODD) & Conduct Disorder (CD)	Problem-solving Skills Training Parent Management Training Problem-Solving Skills Training (PSST) + Parent Management Training (PMT) Functional Family Therapy Multisystemic Therapy	Parent-Child Interaction Therapy Social Skills Training Conflict Resolution and Anger Management Programs Supportive Therapy Systemic Family Therapy	Boot Camps Wilderness/Adventure Program Shock Incarceration Psychiatric Hospitalization Medication trials Brief courses of Cognitive Behavioral Therapy Holding therapy Rebirthing Therapy Prone Wrap-Up physical	Interventions are typically provided in school and home. Comorbid conditions often occur with ODD and CD. Medications must only be prescribed in conjunction with psychological intervention such as parent training. Neuroleptics reduce aggressive behavior, but potential side effects may outweigh benefits

Behavior/Disorder	Consistent Evidence	Inconsistent Evidence	Unproven or Harmful Interventions	Comments
	Anger Coping Therapy Stimulants Mood Stabilizers		restraint technique Isolated Medication Trials Stimulant Medication Individual Psychodynamic Psychotherapy Group Therapy with other children with delinquent behaviors Residential Care	
Schizophrenia	Psychoeducational Therapy for the Child and Family Cognitive-Behavioral Strategies and Social Skills Training Family Psychoeducation Supported Employment Supported Education Illness Management & Recovery Assertive Community Treatment	Antipsychotic medications (Clozaril, Haldol, Risperdal, Zyprexa)		Lack of well conducted psychopharmacological trials. In children and adolescents Second Generation Antipsychotics are superior to First Generation Antipsychotics.
Self Injury	Cognitive-Behavior Therapy Selective Serotonin Reuptake Inhibitors Dialectal Behavior Therapy for Adolescents			Hospitalization is used as a last resort.
Sex Offending	Multisystemic Therapy Cognitive-Behavior Therapy (CBT)	Individual Therapy Selective Serotonin Reuptake Inhibitors Antiandrogens (reserved for the most severe and not used in those under 17)	Phallometric Assessment Aversive Conditioning	Promising practices often combine an intensive, multimodal approach with early intervention. Comprehensive CBT programs often focus on taking responsibility for one's sexual behavior, developing victim empathy, and developing skills to prevent future offending.
Suicide	Interpersonal Therapy for Adolescents Dialectal Behavior Therapy for Adolescents Lithium Clozapine Selective Serotonin Reuptake Inhibitors (for comorbid disorders)		TCAs (tricyclic antidepressants) Broad-based suicide awareness and screening programs	Close, consistent monitoring of medications that may increase disinhibition or impulsivity.
Tourette's Disorder	Habit Covariance Habit Reversal Alpha agonists Neuroleptics	Baclofen BTX-A (botulinum toxin) injection	Plasma exchange Intravenous Immunoglobulin (IVIG)	Medication may be helpful when tics interfere with functioning and/or there are no other disorders present.
Obsessive-Compulsive Disorder	CBT (Exposure / Response Prevention) CMI (Clomipramine) Fluvoxamine Sertraline	Supportive Therapy Systemic Family Therapy	Psychosurgery (gamma knife, circumscribed anterior capsulotomy, cingulotomy, subcaudate tractotomy)	
Posttraumatic	CBT	Supportive Therapy	Eye Movement	

Behavior/Disorder	Consistent Evidence	Inconsistent Evidence	Unproven or Harmful Interventions	Comments
Stress		Systemic Family Therapy Selective Serotonin Reuptake Inhibitors Imipramine	Desensitization and Reprocessing (EMDR)	
Reactive Attachment Disorder	Infant-Parent Psychotherapy Interaction Guidance		Therapeutic Holding Compression Holding Rebirthing Therapy Regression Promotion	
Enuresis	Imipramine Desmopressin Acetate Behavioral Conditioning with Urine Alarm		Bladder Stretching Exercises Hypnotherapy Dietary Manipulation Desensitization to Allergens	
Child Maltreatment	Respite Therapeutic Day Care Abuse Specific CBT			

COLORADO BLUEPRINTS PREVENTION & INTERVENTION PROGRAM MATRIX

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	Matrix of Programs (Updated 11/02/2005)	American Youth Policy Forum (1)	Blueprints for Violence Prevention (2)	Center for Mental Health Services-Greenberg et al. (3)	Center for Substance Abuse Prevention (CSAP) (4)	Department of Education-Safe Schools (5)	Communities That Care-Developmental Research and Programs (6)	Mihalic & Aultman-Bettridge (2004) (7)	National Institute of Drug Abuse (NIDA) (8)	Sherman et al. (1997) (9)	Strengthening America's Families (10)	Surgeon General's Report (2001) (11)	Title V (OJJDP) (12)
2	Academic Tutoring and Social SkillsTraining												Effective
3	Accelerating Language Development Through Picture Book Reading						Effective						
4	Across Ages				Model		Effective	Favorable					Exemplary
5	Adolescent Alcohol Prevention Trial (AAPT)				Promising		Effective		Effective				
6	Adolescent Portable Therapy												Promising
7	Adolescent Transitions Program			Effective			Effective		Effective		Exemplary 2		Exemplary
8	Aggression Replacement Training					Promising				Effective			Promising
9	Aggressors, Victims & Bystanders: Thinking & Acting to Prevent Violence					Promising							
10	Al's Pals: Kids Making Healthy Choices				Model	Promising		Favorable					Exemplary
11	Albuquerque Victim-Offender Mediation Program												Promising
12	Alcohol Misuse Prevention						Effective						Effective
13	All Stars				Model	Promising	Effective						Effective
14	American Indian (Zuni) Life Skills				Effective								Effective
15	Anchorage Youth Court												Effective
16	Anger Coping Program			Effective				Favorable		Effective			Effective
17	Asian Youth Alliance				Promising								
18	Assertiveness Training Program									Effective			
19	Athletes Training and Learning to Avoid Steroids (ATLAS)		Promising		Model	Exemplary	Effective	Favorable	Effective				Exemplary

	A	B	C	D	E	F	G	H	I	J	K	L	M
20	Baby Safe (Substance Abuse Free Environment) Hawaii				Promising								
21	Baltimore Choice Program												Promising
22	BASIS									Effective			
23	Baton Rouge Partnership for the Prevention of Juvenile Gun Violence												Effective
24	Be A Star				Promising								Promising
25	Behavioral Monitoring and Reinforcement Program (Formerly Preventive Intervention - Bry)		Promising		Promising			Promising		Effective		Promising 2	Effective
26	Behaviorally-Based Prevention Program						Effective						
27	Bereiter-Engleman/DISTAR Model						Effective						
28	Bethesda Day Treatment										Promising		Promising
29	Bethlehem Police Family Group Conferencing Project												Exemplary
30	Bicultural Competence Skills Approach						Effective						Exemplary
31	Big Brothers Big Sisters of America	Effective	Model	Effective			Effective			Effective			Exemplary
32	Bilingual/Bicultural Counseling and Support Services				Promising								
33	Book Lending Library						Effective						
34	Border Binge Drinking Reduction Program				Model								
35	Boston Gun Project	Effective											
36	Boys and Girls Club	Effective								Effective			Effective
37	Boys and Girls Club Educational Enhancement												Effective
38	Boys and Girls Club Gang Prevention Through Targeted Outreach												Promising
39	Brainpower Program			Effective	Promising								
40	Brief Alchohol Screening and Intervention for College Students				Model								Exemplary

	A	B	C	D	E	F	G	H	I	J	K	L	M
41	Brief Strategic Family Therapy (BSFT)	Effective	Promising		Model		Effective				Exemplary 2		Exemplary
42	Brookline Early Education Project (BEEP)						Effective						
43	Buddy System						Effective						
44	Bullying Prevention Program (BPP)	Effective	Model	Effective	Model		Effective	Exemplary		Effective		Promising 2	Effective
45	California Smoker's Helpline				Effective								
46	Canberra Reintigrative Shaming Experiments												Exemplary
47	Capital and Violent Offender Program (Formerly Capital Offenders Program)	Effective											Promising
48	CAPSLE							Favorable					
49	Career Academy												Exemplary
50	Career Beginnings												Effective
51	Carolina Abecedarian Project						Effective	Favorable					
52	CASASTART		Promising		Model	Exemplary						Promising 1	Exemplary
53	CEDEN Family Resource Center										Model		
54	Challenging College Alcohol Abuse (CCAA)				Model								
55	Chicago Alternative Policing Strategy												Effective
56	Chicago Child-Parent Center and Expansion Program (CPC)							Favorable					Effective
57	Child Development and Community Policing Model												
58	Child Development Project			Effective	Model	Promising	Effective	Favorable		Effective			Effective
59	Children in the Middle				Model								Exemplary
60	Children of Divorce Intervention Program			Effective	Effective		Effective						Effective
61	Children of Divorce Parenting Program			Effective									
62	Chronic Truancy Initiative												Promising
63	Class Action (Part of Project Northland)				Model								

	A	B	C	D	E	F	G	H	I	J	K	L	M
64	Classroom Organizational Strategies						Effective						
65	Clayton County Restitution Program												Exemplary
66	Club Hero				Promising								Promising
67	Coca-Cola Valued Youth Program							Favorable					
68	Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)				Promising								Promising
69	Cognitive Behavioral Therapy for Child and Adolescent Stress (CBT-CATS)												Exemplary
70	Cognitive Behavioral Therapy for Child Sexual Abuse (CBT-CSA)				Model								Exemplary
71	Colorado Youth Leadership Project				Promising								
72	Comer School Development Program							Favorable					
73	Commit to Quit				Effective								
74	Communities In Schools (Formerly Cities In Schools)												Promising
75	Communities Mobilizing for Change on Alcohol				Model								Exemplary
76	Communities That Care						Effective						
77	Community Laws and Policies Related to Weapons						Effective						
78	Community of Caring					Promising							
79	Community Policing Strategies						Effective						
80	Community/School Policies						Effective						
81	Community Trials Intervention to Reduce High-Risk Drinking (RHRD)				Model								Effective
82	Comprehensive Gang Strategy (Little Village Gang Reduction Program)									Effective			Effective

	A	B	C	D	E	F	G	H	I	J	K	L	M
83	Computer-Assisted Instruction						Effective						
84	Consistency Management & Cooperative Discipline (CMDC)							Favorable					Effective
85	Continuous Progress Instruction						Effective						
86	Cooperative Learning Programs						Effective						
87	Coping Power			Promising	Effective								Exemplary
88	Coping With Stress Course			Effective									
89	Coping with Work and Family Stress				Model								
90	Counselors CARE and Coping and Support Training			Effective									
91	Creating Lasting Family Connections				Model	Promising	Effective				Model		Exemplary
92	Dando Fuerza a la Familia				Promising								
93	DARE To Be You Program				Model						Model		Effective
94	Delaware Juvenile Drug Court Diversion Program												Promising
95	Depression Prevention Program			Effective									
96	Detention Diversion Advocacy Program	Effective											Promising
97	Dialectical Behavior Therapy Program for Incarcerated Female Juvenile Offenders												Promising
98	Dona Ana County (NM) Teen Court												Promising
99	Earlscourt Social Skills Group Program			Effective				Favorable					
100	Early Detection and Treatment of Postnatal Depression						Effective						
101	Early Intervention for Preterm Infants Project						Effective						
102	Early Risers *Skills for Success* Program				Model				Effective				Effective
103	East Texas Experiential Learning Center				Effective								Promising

	A	B	C	D	E	F	G	H	I	J	K	L	M
104	Effective Black Parenting			Effective							Model		Effective
105	Eight Percent Program	Effective											
106	Enough Snuff				Effective								
107	Enterprise Zones									Effective			
108	Extended-Service Schools Initiative												Promising
109	Facing History and Ourselves					Promising							Promising
110	Faith Based Prevention				Promising								
111	Families and Schools Together (FAST)			Promising	Model						Model		Exemplary
112	Families in Action												Exemplary
113	Family Bereavement Program			Effective									
114	Family Effectiveness Training (FET)				Model								Effective
115	Family Health Promotion				Promising								Promising
116	Family Literacy Programme						Effective						
117	Family Matters				Model								Exemplary
118	FAN (Family Advocacy Network) Club				Effective								
119	FAST Track		Promising	Effective			Effective	Promising				Promising 2	Effective
120	Field Interrogations						Effective						
121	First Step to Success			Effective			Effective	Favorable					Effective
122	Focus on Families				Promising		Effective		Effective		Model		Effective
123	Friendly PEERsuasion				Effective								
124	Functional Family Therapy (FFT)	Effective	Model				Effective				Exemplary 1	Model 1	Exemplary
125	Gang Prevention Curricula						Effective						
126	Gang Resistance Education and Training (G.R.E.A.T.)												Effective
127	Gang Resistance is Paramount (GRIP)												Promising
128	Gatekeeper Case Finding and Response System				Promising								
129	Gentreaux Program									Effective			
130	Get Real About Violence				Promising								Promising
131	Girl's Circle												Promising
132	Good Behavior Game	Effective	Promising	Effective	Effective		Effective	Promising				Promising 2	Effective

	A	B	C	D	E	F	G	H	I	J	K	L	M
133	Great Body Shop				Promising								Promising
134	Growing Healthy					Promising	Effective						Effective
135	Guiding Good Choices (Formerly Preparing for the Drug Free Years)		Promising		Model	Promising	Effective	Promising			Exemplary 1	Promising 2	Exemplary
136	Hardcore Gang Investigators Unit – LA County DA's Office												Effective
137	HeadOn: Substance Abuse Prevention for Grades 6-8				Promising								
138	Head Start												Promising
139	Healthy Families America										Model		Promising
140	Healthy for Life						Effective						
141	Healthy Workplace				Model								
142	Helping the Noncompliant Child				Effective						Exemplary 1		Promising
143	Home-Based Behavioral Systems Family Therapy				Effective								
144	Home Instruction Program for Preschool Youngsters (HIPPY)										Model		
145	HOMEBUILDERS										Model		
146	Houston Parent-Child Development Center		Promising		Effective		Effective	Promising		Effective		Promising 2	
147	I Can Problem Solve (Formerly Interpersonal Cognitive Problem Solving)		Promising	Effective	Promising	Promising	Effective	Promising				Promising 2	Effective
148	Impact of Drinking Age Law				Effective								
149	Improving Social Awareness-Social Problem Solving			Effective			Effective	Favorable					
150	The Incredible Years	Effective	Model		Model		Effective	Exemplary		Effective	Exemplary 1	Promising 2	Exemplary
151	Independence Youth Court (IYC)												Promising
152	Indianapolis Restorative Justice Project												Effective
153	Individual Placement and Support				Effective								
154	Infant Health and Development												Promising

	A	B	C	D	E	F	G	H	I	J	K	L	M
155	Intensified Motorized Patrol						Effective						
156	Intensive Probation Supervision (Cleveland)												Promising
157	Intensive Protective Supervision Project (IPSP)											Promising 1	
158	Intensive Supervision Juvenile Probation Program (Peoria, IL)												Promising
159	Jefferson County Juvenile Gun Court												Promising
160	Job Corps									Effective			Effective
161	Job-Loss Recovery Program				Promising								
162	JOBS Program				Model								
163	Jobstart						Effective						
164	Kansas City Gun Experiment												Effective
165	Keep A Clear Mind (KACM)				Model								Effective
166	keepin' it REAL (Refuse, Explain, Avoid, Leave)				Model								Exemplary
167	Kentucky Adolescent Tobacco Prevention Project				Effective								Promising
168	Keys to Caregiving Videotape Series						Effective						
169	Kids Intervention with Kids in School (KIKS)				Promising								
170	Know Your Body						Effective	Favorable					Promising
171	Last Chance Ranch	Effective											
172	Leadership and Resiliency Program (LRP)				Model								Promising
173	Legal Blood Alcohol Level (Effect of Maine's .05% Limit)				Effective								
174	Let Each One Touch One Mentor Program				Promising	Promising							Promising
175	Life Skills '95												Effective
176	Life Skills Training (LST)		Model		Model	Exemplary	Effective	Exemplary	Effective	Effective		Model 2	Exemplary
177	Linking the Interests of Families and Teachers (LIFT)		Promising	Effective	Promising	Promising		Promising				Promising 2	Exemplary

	A	B	C	D	E	F	G	H	I	J	K	L	M
178	Lions-Quest Skills for Adolescence				Model	Promising							Effective
179	Lions-Quest Working Toward Peace					Promising							Promising
180	Maine Juvenile Drug Treatment Court												Promising
181	Make Parenting a Pleasure										Promising		
182	Mass Media Smoking Prevention Program							Favorable					
183	Massachusetts Tobacco Control Program				Promising								
184	MELD										Model		
185	Mendota Juvenile Treatment Center												Effective
186	Metropolitan Area Child Study						Effective						
187	Michigan Model for Comprehensive School Health Education					Promising		Favorable					Promising
188	Michigan State Diversion Project												Promising
189	Midwestern Prevention Project (Project STAR)		Model		Effective	Promising	Effective	Exemplary	Effective			Model 2	Effective
190	Minimal Intervention Approach to Problem Gambling				Promising								
191	Minneapolis Center for Victim-Offender Mediation												Promising
192	Minnesota Smoking Prevention Program					Promising							Promising
193	Mother-Child Program of Verbal Interaction Project						Effective						
194	Movimiento Ascendencia												Promising
195	Multidimensional Family Therapy (MDFT)	Effective			Effective						Exemplary 2		Effective
196	Multidimensional Treatment Foster Care -OSLC	Effective	Model		Effective	Exemplary					Exemplary 1	Model 1	Exemplary
197	Multimodal Substance Abuse Prevention				Promising								Promising
198	Multisystemic Therapy (MST)	Effective	Model		Model						Exemplary 1	Model 1	Exemplary

	A	B	C	D	E	F	G	H	I	J	K	L	M
199	National Council of Teachers of Mathematics (NCTM) Standards-Based Intervention						Effective						
200	Native American Prevention Project Against AIDS/Substance Abuse (NAPPASA)												Promising
201	NICASA Parent Project										Model		
202	North Karelia							Favorable					
203	N-O-T on Tobacco				Effective								Effective
204	Nurse-Family Partnership (Formerly Prenatal and Infancy Home Visitation by Nurses)		Model		Model		Effective			Effective	Exemplary 2	Model 1	Exemplary
205	Nurturing Parenting Program				Promising						Model		Promising
206	Nurturing Program for Families in Substance Abuse Treatment and Recovery										Promising		
207	Oakland Beat Health Program												Promising
208	Oakland Victim-Offender Reconciliation Program												Promising
209	Open Circle Curriculum					Promising		Favorable					Promising
210	Operation Ceasefire												Promising
211	Orange County Juvenile Substance Abuse Treatment Court												Promising
212	Parent-Child Assistance Program (P-CAP)				Promising								Effective
213	Parent-Child Development Center												Exemplary
214	Parent-Child Interaction Training						Effective					Promising 2	
215	Parenting Partnership				Promising								Promising
216	Parenting Wisely				Model						Exemplary 2		Promising
217	Parenting with Love and Limits												Exemplary
218	Parents Anonymous										Promising		
219	Parents as Teachers										Model		Promising

	A	B	C	D	E	F	G	H	I	J	K	L	M
220	Parents Who Care						Effective				Model		
221	Participate and Learn Skills (PALS)	Effective					Effective			Effective			
222	Partnership for Health				Effective								
223	Pathways to Change				Effective								
224	Peace Works												Promising
225	PeaceBuilders	Effective			Promising	Promising	Effective	Favorable					Exemplary
226	Peaceful Conflict Resolution and Violence Prevention Curriculum							Favorable					
227	Peacemakers Program (Grades 4-8)				Promising	Promising							Effective
228	Peer Assistance and Leadership Program (PAL)				Promising								
229	Peer Coping Skills Training			Effective				Favorable					
230	Peer-Assisted Learning Strategies (PALS)						Effective						
231	Peers Making Peace				Promising	Promising							
232	Perinatal Care Program				Promising								
233	Perry Preschool Program/High Scope	Effective	Promising		Model		Effective	Promising		Effective		Promising 1	Exemplary
234	Philadelphia Youth Violence Reduction												Promising
235	Phoenix House												Effective
236	Physicians Counseling Smokers				Effective								
237	Plan a Safe Strategy (PASS) Program				Promising								
238	Positive Action				Model	Promising		Favorable					
239	Positive Youth Development Program			Effective				Favorable		Effective			
240	Preparing for School Success (PFSS)						Effective						
241	Preventing School Vandalism and Disruptive Behavior							Favorable		Effective			
242	Prevention and Relationship Enhancement Program (PREP)						Effective						
243	Prevention Dimensions Program				Promising								

	A	B	C	D	E	F	G	H	I	J	K	L	M
244	Preventive Alcohol Education Program				Promising								Promising
245	Preventive Treatment Program (Montreal Longitudinal Experimental Study)	Effective	Promising	Effective			Effective	Promising		Effective		Promising 1	Exemplary
246	Primary Mental Health Project			Effective		Promising							Promising
247	Proactive Classroom Management						Effective						
248	Program Development Evaluation (PDE) Method						Effective			Effective			
249	Project ACHIEVE				Model								Promising
250	Project ALERT		Promising		Model	Exemplary	Effective	Favorable		Effective			Exemplary
251	Project Back-on-Track												Promising
252	Project BASIS				Promising								
253	Project Break Away				Promising								
254	Project Care							Favorable		Effective			
255	Project CRAFT												
256	Project EX				Model								Effective
257	Project Family								Effective				
258	Project Link				Promising								Effective
259	Project Northland		Promising		Model	Exemplary	Effective	Promising					Exemplary
260	Project PACE				Promising								Promising
261	Project PATHE (Positive Action Through Holistic Education)												Promising
262	Project Prince									Effective			
263	Project RAISE									Effective			
264	Project SEEK										Model		
265	Project SUCCESS				Model								
266	Project Toward No Drug Abuse (Project TND)		Model		Model								Exemplary
267	Project Towards No Tobacco Use (TNT)				Model	Exemplary	Effective						Exemplary
268	Project Venture				Model								
269	Prolonged Exposure Therapy for Posttraumatic Stress Disorders				Model								Exemplary
270	Promoting Action Through Holistic Education (Project PATHE)		Promising					Promising		Effective			

	A	B	C	D	E	F	G	H	I	J	K	L	M
271	Promoting Alternative THinking Strategies (PATHS)		Model	Effective	Model	Promising	Effective	Exemplary		Effective		Promising 2	Exemplary
272	Promotion of the Use of Front Pack Infant Carriers						Effective						
273	Protecting You/Protecting Me				Model								Effective
274	Quantum Opportunities Program (QOP)	Effective					Effective	Exemplary				Promising 2	
275	Queensland Early Intervention and Prevention of Anxiety Project			Effective			Effective						
276	Raising a Thinking Child						Effective				Exemplary 2		Effective
277	Reading Recovery						Effective						
278	Reconnecting Youth				Model			Favorable	Effective				
279	Reducing the Risk						Effective						
280	Repeat Offender Prevention Program												Promising
281	Residential Student Assistance Program (RSAP)				Model								Effective
282	Resolving Conflict Creatively Program (RCCP)	Effective			Effective								Effective
283	Responding in Peaceful and Positive Ways (RIPP)				Model	Promising							Exemplary
284	Responsive Classroom												Promising
285	Richmond Comprehensive Homicide Initiative												Effective
286	Richmond Youth Against Violence Project: Responding in Peaceful and Positive Ways (RIPP)			Effective			Effective						
287	Rockford Enhanced EAP				Effective								
288	Rural Education Achievement Project				Effective								Promising
289	Safe Dates				Model			Favorable					Exemplary
290	SAFE-T												Effective
291	San Diego County Breaking Cycles												Effective
292	Saving Lives				Promising								Promising

	A	B	C	D	E	F	G	H	I	J	K	L	M
293	Say It Straight (SIS)				Promising	Promising							Promising
294	SCARE Program					Promising							Promising
295	School Development Program						Effective						
296	School Safety Program							Favorable		Effective			
297	School Transitional Environment Program (STEP)		Promising	Effective			Effective	Promising		Effective		Promising 1	Effective
298	School Violence Prevention Demonstration Program				Effective								Effective
299	School-Based and Home-Based Tutoring for Transfer Students						Effective						
300	School-based Smoking Prevention Program							Favorable					
301	Schools and Families Education Children (SAFE Children)				Model								Effective
302	Second Step: A Violence Prevention Curriculum			Effective	Model	Exemplary	Effective						Promising
303	Sembrando Salud				Effective								Effective
304	SISTERS				Promising								Promising
305	SMART Leaders (Booster program for Boys and Girls Clubs of America's Stay SMART & SMART Moves)				Effective								Effective
306	SMART Team (Students Managing Anger and Resolution Together) (Formerly SMART Leaders)				Model	Promising							Effective
307	Smoking Cessation Mass Media Intervention				Effective								
308	SOAR (Skills, Opportunities, and Recognition) (Formerly Seattle Social Development Project)	Effective	Promising	Effective	Effective	Promising	Effective	Promising	Effective	Effective		Model 1	Effective
309	Social Competence Promotion Program for Young Adolescents (SCPP-YA)				Effective								Effective

	A	B	C	D	E	F	G	H	I	J	K	L	M
310	Social Decision-Making & Problem Solving					Promising							Promising
311	Social Relations Program			Effective			Effective						
312	Socio-moral Reasoning Development Program							Favorable					
313	SOS: Signs of Suicide				Promising								Promising
314	Spit Tobacco Intervention				Promising								Effective
315	Star Model						Effective						
316	Start Taking Alcohol Risks Seriously (STARS) for Families				Model								Effective
317	Stopping Teenage Addiction to Tobacco (STAT)				Effective								Effective
318	Storytelling for Empowerment				Promising								
319	Strengthening Families Program				Model		Effective		Effective		Exemplary 1		Exemplary
320	Strengthening Families Program for Parents and Youth 10-14 (Formerly Iowa Strengthening Families Program)		Promising		Model	Exemplary		Promising			Exemplary 2	Promising 2	
321	Strengthening Hawaii Families				Promising						Model		
322	Strengthening Multi-Ethnic Families and Communities Program										Promising		
323	Strengthening the Bonds of Chicano Youth and Families				Promising								Promising
324	Stress Innoculation Training			Effective									
325	Structured Playground Activities						Effective						
326	Student Training Through Urban Strategies (STATUS)							Promising		Effective			
327	Students Helping Others Understand Tobacco (SHOUT)						Effective						
328	Success for All						Effective	Favorable					
329	Success in Stages												Effective

	A	B	C	D	E	F	G	H	I	J	K	L	M
330	Support for At-Risk Children				Effective								
331	Supporting Adolescents with Guidance and Education (SAGE)												Promising
332	Syracuse Family Development Research Program (FDRP)	Effective			Effective		Effective	Promising		Effective		Promising 1	Effective
333	Teaching Students to be Peacemakers				Model								Promising
334	Team Awareness				Model								
335	Teams-Game-Tournament Alcohol Prevention				Promising								Effective
336	Teen Outreach Program						Effective						
337	Teenage Health Teaching Modules				Promising	Promising							Promising
338	Therapeutic Workplace				Promising								
339	Think Time Strategy					Promising							
340	Tinkham Alternative High School				Promising								
341	Tobacco Policy and Prevention (TPP)				Effective								
342	Too Good For Drugs (TGFD)				Model								Promising
343	Too Good For Violence (TGFV)				Effective								Exemplary
344	Trauma Focused Cognitive Behavioral Therapy (TF-CBT) (Formerly Cognitive Behavioral Therapy for Child and Adolescent Traumatic Stress)				Model								Exemplary
345	Tri-Agency Resource Gang Enforcement Team												Effective
346	TRIBES												Promising
347	Truant Recovery Program												Promising
348	Tutoring Programs						Effective						
349	Urban Woman Against Substance Abuse (UWASA)				Promising								Promising
350	Valued Youth Partnership Program						Effective						

	A	B	C	D	E	F	G	H	I	J	K	L	M
351	Violence Prevention Curriculum for Adolescents												Promising
352	Violent Juvenile Offender Program	Effective											
353	VisionQuest												Effective
354	Washington (DC) Community Violence Prevention Program									Effective			
355	Washington, DC, Restitution Program												Promising
356	Wayne County Intensive Probation Program												Promising
357	Weed and Seed												Promising
358	Wellness Outreach Program: A Step-by-Step Guide				Effective								
359	Woodrock Youth Development Project				Promising		Effective						Promising
360	Wraparound Milwaukee	Effective											Promising
361	Yale Child Welfare Project							Promising		Effective		Promising 2	
362	(1) American Youth Policy Forum: *Less Hype, More Help: Reducing Juvenile Crime, What Works-and What Doesn't* by Richard A. Mendel. American Youth Policy Forum, Washington, DC, 2000.												
363	Programs are categorized as ***Effective*** (refer to www.aypf.org)												
364	(2) Blueprints for Violence Prevention:												
365	Programs are divided into ***Model and Promising*** (refer to www.colorado.edu/cspv/blueprints).												
366	(3) Center for Mental Health Services, US Department of Health and Human Services, Prevention Research Center for the Promotion of Human Development:												
367	Programs are divided into ***Effective and Promising*** (refer to www.prevention.psu.edu)												
368	(4) Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, National Registry of Effective Programs:												
369	Programs are divided into ***Model, Promising, and Effective*** (refer to www.modelprograms.samhsa.gov).												
370	(5) Department of Education: Safe and Drug Free Schools:												
371	Programs are divided into ***Exemplary and Promising*** (refer to www.ed.gov/admins/lead/safety/exemplary01/panel.html)												
372	(6) Communities that Care: Posey, Robin, Wong, Sherry, Catalano, Richard, Hawkins, David, Dusenbury, Linda, & Chappell, Patricia (2000). Communities That Care Prevention Strategies: A Research Guide to What Works.												
373	Programs are categorized as ***Effective*** (refer to www.preventionscience.com/ctc/CTC.html; Developmental Research and Programs, Inc., Seattle, WA).												
374	(7) Mihalic, Aultman-Bettridge (2004): A Guide to Effective School-Based Prevention Programs.												
375	Programs are divided into ***Exemplary, Promising and Favorable*** (refer to William L.Turk, Editor. *Policing and School Crime. Englewood Cliffs.NJ:Prentice Hall Publishers, 2003).*												
376	(8) National Institute of Drug Abuse:												
377	Programs are categorized as ***Effective*** (refer to National Clearinghouse for Alcohol and Drug information, #734 at 1-800-729-6686).												
378	(9) Sherman et al (1998): *Preventing Crime: What Works, What Doesn't, What's Promising. University of Maryland Department of Criminology and Criminal Justice. NCJ 165366.*												
379	Programs are categorized as ***Effective*** (refer to www.ncjrs.org/works/wholedoc.htm or www.preventingcrime.org)												
380	(10) Strengthening America's Families:												
381	Programs are divided into ***Exemplary 1***, ***Exemplary 2***, ***Model*** and ***Promising*** (refer to www.strengtheningfamilies.org)												
382	(11) Youth Violence: A Report of the Surgeon General:												

	A	B	C	D	E	F	G	H	I	J	K	L	M
383	Programs are divided into *Model* and *Promising: Level 1-Violence Prevention; Level 2-Risk Prevention* (refer to www.surgeongeneral.gov/library/youthviolence)												
384	(12) Title V (OJJDP): Effective & Promising Programs Guide. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Dept. of Justice.												
385	Programs are divided into *Exemplary, Effective, and Promising (refer to www.dsgonline.com)*												
386													
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390	Updated 11/02/05												