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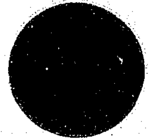

Strengthening America's Families:

Promising Parenting and Family Strategies for Delinquency Prevention

140781 Pt. I

USER'S GUIDE

140781
Pt. 1

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USER'S GUIDE

Office of Juvenile Justice and Delinquency Prevention
Acting Administrator, Gerald (Jerry) P. Regier

Strengthening America's Families:

Promising Parenting and Family Strategies for Delinquency Prevention

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November 1992

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(part I)

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National Institute of Justice

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PROMISING PROGRAMS IN FAMILY AND PARENTING: RISK AND PROTECTIVE FACTORS IN THE PREVENTION OF DELINQUENCY

Years of program development and research have provided effective strategies for strengthening America's families to prevent delinquency. This document has been written to help program planners, policy makers and service providers determine the most effective family-focused and parenting intervention strategies for the high-risk youth and families they serve. This guide will review what is currently known about the impact of family characteristics on risk for delinquency as well as the most promising family change interventions. Providers using the guide will be better able to choose or modify existing programs or create new interventions for high-risk youth.

This guide contains three major sections:

Part I: Family Influence on Youth Delinquency

This section will help providers understand why certain family strengthening approaches reduce delinquency among youth. It is not always easy to see the connection between early childhood parenting practices or family environment and later juvenile delinquency in youth. This section describes research literature on the most important family factors that should be addressed by a family program.

Part II: Review of Family Strengthening Programs

This section describes a national search to find the best family intervention strategies. This guide reviews only those programs shown to be effective in preventing problems that often lead to delinquency. Critical issues such as recruitment, attrition, staff training, and program evaluation are also discussed.

Part III: Examples of Promising Family Strengthening Programs

The final section presents one to three page descriptions of selected promising parenting and family programs.

PART I: FAMILY INFLUENCE ON YOUTH DELINQUENCY

A HISTORICAL PERSPECTIVE OF THE DELINQUENCY PROBLEM

Strengthening high-risk and dysfunctional families to raise children successfully is one of the most critical social issues in America. Failure to deal directly with this problem will result in making the United States less competitive in the 21st Century. Unfortunately, economic circumstances, cultural norms, and federal legislation in the last two decades have helped to create an environment that is less supportive of strong, stable families. Americans must face the reality that alterations in American society have weakened the ability of families to successfully raise children. Many unfortunate circumstances have converged to create this problem: a weak economy that forces many mothers into the workplace, increasing divorce rates, reducing marriage rates, increasing teen pregnancy rates and numbers of children born outside of marriage, reduced paternal responsibility for child support or childrearing, increased child abuse and neglect, and increasing numbers of children being raised by poorly educated parents, mother-only families, and in poverty.

It is difficult to know where to lay blame because of a complex interaction of these circumstances. For instance, federal legislation concerning public assistance helped to reduce the numbers of fathers in low income families. In part as a consequence, the number of American children raised without fathers and in poverty doubled from 1960 to 1979. An unbelievable one in five American children are growing up in poor families headed by women (Levy, 1987). In 1991, 36% of the 11.7 million female-headed families were poor and these families represented half of all poor families compared to only 23% in 1959 (U.S. Bureau of the Census, 1991). According to Garfinkel and McLanahan (1986) "families headed by women with children are the poorest of all major demographic groups regardless of how poverty is measured" (p.11). The vast majority of these families remain poor for long periods because they have very low education levels and low earning capacity. They lack sufficient child support from absent fathers and receive low levels of public aid (Garfinkel & McLanahan, 1986).

Poverty has also become centralized in large urban areas. The number of metropolitan poor increased 62% from 1969 to 1982 and an urban black under-class emerged during this period (Wilson, 1987). In the United States, the rich have been getting richer and the poor poorer since the early 1970s, according to public policy analysts. Before 1970, family income distribution was moving toward equality, but since then, upper and lower family incomes have become increasingly less equal.

At the same time that these economic changes have occurred, the extended family support system has eroded. Between 1979 and 1982 the number of children being cared for by extended family members dropped by half. As other supports and role models have decreased, the burden on parents of socializing their children has increased. Hamburg and Takanishi (1989) of the Carnegie Corporation write:

> Throughout most of human history, small communities provided durable networks, familiar human relationships, and cultural guidance for young people, offering support in time of stress and skills necessary for coping and adaptation. In contemporary societies, these social supports have eroded considerably through extensive geographical mobility, scattering of extended families, and the rise of single-parent families, especially those involving very young, very poor, and socially isolated mothers (p. 825).

Many research studies have found that children raised by socially deprived families are at higher risk of chronic, severe delinquency and drug use (Blumstein, Farrington, and Moitra, 1985; Farrington, 1985). Children from families with higher income and occupational status do engage in non-chronic delinquency and occasional alcohol use and marijuana experimentation (Simcha-Fagan and Gersten, 1986). Hawkins and his associates (Hawkins, Lishner, Jenson, and Catalano, 1987) have pointed out, however, that "persistent serious crime and the regular use of illicit drugs appear more prevalent among those raised in conditions of extreme social and economic deprivation (p.92)".

Public policy to strengthen American families has been slow to evolve. Americans have had to realize families were in trouble before they would consider changing public policy. In addition, they needed to believe that there were effective family strengthening strategies to attack the problem. Lisbeth Schorr's *Within Our Reach: Breaking the Cycle of Disadvantage* (1988) reviews a number of promising family programs and ends with the statement:

> We know how to intervene to reduce the rotten outcomes of adolescence and to help break the cycle that reaches into succeeding generations. Unshackled from the myth that nothing works, we can mobilize the political will to reduce the number of children hurt by cruel beginnings. By improving the prospects for the least of us, we can assure a more productive, just, and civil nation for all of us (p.294).

According to a 1986 Louis Harris poll, three quarters of the American public favors programs to help children, and particularly children living in poverty. Harris warned, "Politicians who ignore these pleadings from the American people do so at their own peril. It is a plaintive and poignant demand that simply will not go away." Senator John D. Rockefeller, IV in his Chairman's Preface for the *Final Report of the National Commission on Children* (1991) accurately summarizes the Commission's "stark and urgent message to all Americans:"

> As a nation, we must set a new course to save our children, strengthening their families, and regain control of our national destiny. There are no quick fixes to the problems than threaten the lives and prospects of so many of America's young people. But the solutions are within reach.

The knowledge gleaned from this national search for the most promising programs to strengthen the family to raise successful and non-delinquent children will help us meet the demand of Americans to strengthen America's families and improve child outcomes.

DEFINITION OF "FAMILY"

The family is the basic institutional unit of society primarily responsible for child-rearing functions. When families fail to fulfill this responsibility to children everyone suffers. Families are responsible for providing physical necessities, emotional support, learning opportunities, moral guidance and building self-esteem and resilience.

This paper considers the "family" to be the constellation of adults or siblings who care for a child. Non-traditional family arrangements include single parent families, divorced families with joint custody of the child, children living with extended family members, adoptive parents, protective custody (such as temporary or permanent foster homes, group homes or institutions), and step-parents, (sometimes in blended families with children from two or more prior marriages).

A structurally non-traditional family does not necessarily indicate a high-risk family. The relationships within the family and the amount of support and guidance provided the child are the most important variables in the prediction of delinquency. In general, if the remaining family is stable, supportive and well managed, children who have lost a parent to divorce or death do not appear to be at greater risk of delinquency (Mednick, Baker, & Carothers, 1990). However, as the recent final report to the National Commission on Children points out: "When parents divorce or fail to marry, children are often the victims. Children who live with only one parent, usually their mothers, are six times as likely to be poor as children who live with both parents (U.S. Department of Commerce, 1990)." Some researchers have found they are also more likely to suffer more emotional, behavioral, and intellectual problems resulting in a higher risk of dropping out of school, alcohol and drug use, adolescent pregnancy and childbearing, juvenile delinquency, mental illness, and suicide (Emery, 1988; McLanahan, 1980; Zill & Schoenborn, 1988)."

The results are quite conflicted as other researchers (Rosen & Neilson, 1982; Farnsworth, 1984; Gray-Ray & Ray, 1990; Parson & Mikawa, 1991; White, 1987) have found no association between single-parent families and delinquency. Some studies suggest that sons appear to develop more problems than daughters when the loss of a father is early in their development; however, adolescent girls are particularly vulnerable to emotional distress when they loose their fathers (Baltes, Featherman, & Learner, 1990; Hetherington, Anderson, & Stanley-Hagan, 1989; Heatherington & Parke, 1986; Zaslow & Hayes, 1986). Other researchers have not supported these differential age and gender effects (Wells & Rankin, 1991). Living in an abusive or conflict-ridden, two-parent home is considered by experts as generally more harmful for children than divorce. Loeber and Stouthamer-Loeber (1986) concluded after a reviewing about 40 studies examining family structure and delinquency that marital discord was a stronger predictor of delinquency than family structure. According to Wright and Wright (1992) four factors may

explain the relationship between single-parent families and delinquency: 1) economic-deprivation, 2) reduced supervision, formal controls, social supports; 3) living in poverty neighborhoods characterized by high crime rates and alienation (McLanahan & Booth, 1989), and 4) an increased criminal justice system response to children from single-parent families. Because of the importance of fathers reducing these factors by socializing and protecting children, providing additional monetary support and community leadership, marriage counselors are emphasizing solving family problems within marriage (Peterson & Zill, 1986; Taylor, 1991).

An increasing number of children live in complex, shifting, highly stressed family arrangements. These include homeless children and children living in foster care. In these cases, it is more difficult to describe the total family environment and the impact on the child. Few studies have been conducted on the impact of such family environments.

IMPACT OF FAMILIES ON YOUTH

From as early as the turn of the century experts in juvenile delinquency (Morrison, 1915) have recognized the family's early and primary role in influencing delinquency. A number of literature reviews or meta-analyses of research studies (Geismar & Wood, 1986; Henggeler, 1989; Loeber & Dishion, 1983; Loeber & Stouthamer-Loeber, 1986; Snyder & Patterson, 1987) all support the conclusion that family functioning variables have an early and sustained impact on family bonding, conduct disorders, school bonding and adaptation, and later delinquency in youth. Family dysfunction and poor parental supervision and socialization are major influences on children's subsequent delinquency. In fact, community environmental factors, such as poor schools and neighborhoods as correlates of poverty, have not been supported as powerful predictors of delinquency as family risk and protective factors discussed below.

Unfortunately, it has only been until recently that the impact of family factors in delinquency has received much attention or research funding. Implications of existing research are that the family environment can either protect children from subsequent delinquency or put them at greater risk. As more studies are conducted, the delinquency field will have a better picture of the indirect and direct influence of families on youth. More detailed information on what is known follows.

Family Correlates of Delinquency

Depending on the level of functioning, families can negatively impact a child's development. Loeber and Stouthamer-Loeber (1986) conducted an impressive meta-analysis of approximately 300 research studies. In longitudinal studies, socialization factors (i.e., lack of supervision, parental rejection of the child and child rejection of the parent, and lack of parent/child involvement) were found to be the strongest predictors of delinquency. Parental dysfunction, such as criminality, and poor marital relations were mid-level predictors and parental health and absence were weak predictors. In concurrent comparative studies, the strongest correlate of problem behaviors in children and youth was the child's rejection of the parents and/or the parent's rejection of the child. The importance of effective parental discipline

was higher in these studies than in the longitudinal studies. The effect of these risk factors appear to be the same for boys and girls.

From this and other reviews (including Kumpfer, 1987; Wright & Wright, 1992) as well as other primary sources, a list of family correlates of delinquency can be assembled:

- **Poor socialization practices**, including parents' modeling of antisocial values and behaviors, failure to promote positive moral development, and neglect in teaching life, social, and academic skills to the child.

- **Poor supervision of the child**, including failure to monitor the child's activities, neglect, latch-key conditions, sibling supervision, and too few adults to care for the number of children.

- **Poor discipline skills**, including lax, inconsistent, or excessive discipline, expectations unrealistic for the developmental level of the child (which creates a failure syndrome), and excessive, unrealistic demands or harsh physical punishment;

- **Poor parent/child relationships**, including rejection of the child by the parents or of the parents by the child, lack of involvement and time together, and maladaptive parent/child interactions;

- **Excessive family conflict and marital discord** with verbal, physical or sexual abuse;

- **Family chaos and stress** often because of poor family management skills or life skills or poverty;

- **Poor parental mental health**, including depression and irritability that cause negative views of the child's behaviors;

- **Family isolation** and lack of community support resources, and;

- **Differential family acculturation** and role reversal or loss of parental control over adolescents by parents who are less acculturated than their children.

Resiliency and Protective Family Factors

Though most reviews of the causes of delinquency and other problem behaviors have primarily focused on risk factors rather than protective factors, it is possible that protective factors are as important, or more important. Garmezy and his associates (Garmezy, 1985; Masten & Garmezy, 1985) contributed significantly to the prevention field with their studies of stress resistant "invulnerable" or resilient children as well as "vulnerable" children. One of the

major findings in these studies of children of mentally disordered parents was that high intelligence is a protective factor.

Michael Rutter (1987b, 1990) has published recently on the concept of psychosocial resilience. From his own longitudinal research he has concluded that protective mechanisms operate at key junctures in youths' lives and that they must be given special attention. Resilient children and youth are better able to deal with stressors in their lives because they have coping skills to minimize negative impacts and focus on maintaining their self-esteem and gaining access to opportunities. In this way they develop self-efficacy. The process of developing resiliency in youth by teaching them skills for dealing with challenges and life traumas has been explored by Richardson and his associates (Richardson, Neiger, Jensen, and Kumpfer, 1990).

Having a dream, engaging in long-range planning and being able to delay gratification have also been shown to be important in resilient youths. In a longitudinal study of institutionally-reared women, Rutter and Quinton (1984) found that women with the most successful life adjustments and marriages were those who exercised "planning" in their life choices (e.g., marriage partner, job, pregnancies). Women who planned had better marriages to less deviant husbands, had much more positive school experiences, and had significantly lower teenage pregnancy rates (19% vs 48%). It appears that the ability to develop long range goals or a "dream" is critical in protecting youth from potentially disastrous life decisions.

Good marital relationships reduce delinquency (Rutter & Quinton, 1984). However, when family or marital discord exists, positive interpersonal relationships with one caring parent is a major protective factor for conduct disorders, psychiatric disorders, and later delinquency and drug use (Minty, 1988; Rutter, 1987b; Werner, 1986). Most often the one caring parent is as the mother, hence maternal characteristics become critical. Researchers (McCord, 1991; Lytton, 1990) have found that competent mothers who are affectionate, self-confident, non-punitive, and have leadership skills produce children less likely to become delinquent.

Most integrated, etiological theories of delinquency stress the importance of family, school, and community bonding. This ability to "bond" is highly correlated with positive outcomes according to many empirical studies of delinquency (Hawkins & Weis, 1985; Kumpfer & Turner, 1991; Thornberry, 1987). The ability to develop a close, trusting relationship with someone else may be the actual resiliency factor. Therefore, in the absence of an opportunity to form a close attachment to a positive, caring parent attachments with another caring adults (grandparent, relative, older sibling, adoptive or foster parent, teachers, or "adopted surrogate parent" or friend's parents can provide the needed bond with "one caring adult". Some youth have been found to exercise self-agency (Bandura, 1989) by escaping rejecting, violent, or chaotic homes and finding more positive family or institutional settings. Desistance from delinquency (Mulvey & LaRosa, 1986) and reduced risk of alcohol and drug abuse (Wolin & Wolin, in press) is related to the youth's ability to create a more positive "family" life for themselves. Children in abusive family situations are less likely to become delinquent if they have additional social supports from a close relationship with a sibling or teen sport coaches and team mates (Kruttschmitt, Ward, & Sheble, 1987).

Other protective factors that can be influenced by the family or caretaker include: 1) providing the right degree of hazard in life experiences so that youth have opportunities to develop coping skills and self-confidence (Rutter, 1987b), 2) maintaining family routines and rituals (Wolin, Bennett, & Noonan, 1979), 3) support with academic, social, and life skills development, 4) promoting positive normative and moral development (Damon, 1988) through family religious involvement and family values education, and 5) help in selecting positive friends and activities.

Families can help a child by teaching positive coping skills. Such skills protect children against life stressors that might push them into delinquent behavior. In addition, families can help youths to make good decisions that will influence their life for some time, such as educational or vocational training, job selection, choice of a mate, and social groups to join.

Longitudinal studies by Rutter and others have found that making positive choices at such critical life junctures can have a major impact on future problems (Rutter and Quinton, 1984). A supportive family with years of accumulated wisdom from elder members can help youths make good decisions. In addition, supportive families are likely to discuss family values and attitudes about the world, including alcohol and drug use. They also can help youths to learn to delay gratification and develop dreams about what they want to be and do someday. Without a vision for themselves or a dream for the future, they are more prone to make unwise choices that would jeopardize their chances for success.

Structural Versus Functional Family Factors

Jones and DeMaree (1975) in their research on high-risk families, concluded that structural or demographic characteristics such as race, socioeconomic status, poverty, frequent family moves, low educational level, and unemployment are intricately interrelated with family functioning. These structural factors, often out of the control of family members, may contribute to family disruption, overcrowding and stress, depression and other interrelated factors.

Reviews concur that the final pathway in which family factors influence delinquency is the way that the family functions, rather than external demographic variables. According to Zill (in press): "It is important to look at the realities of how families are actually functioning, rather than labeling some types of families as inevitably bad and others as invariably good ", for instance "many single parents do manage to provide stable, secure, stimulating and supportive homes for their youngsters (p.22)." However, many structural factors tend to be positively correlated with family dysfunction. Some of these structural factors include:

- **Poverty**, which is the overarching cause of many of the other structural and functional family factors. Parents who are poor do not have the money to provide the same opportunities for their children as more prosperous families. Many of the poor are single working mothers who do not have enough money to provide adequate child care, health care, or educational opportunities.

- **Neighborhood disorganization**, which is related to increased crime. There are two possible reasons for this relationship. First, in disorganized neighborhoods, youth do not have close bonds with neighbors, and second, informal monitoring of youth in such neighborhoods is limited.

- **High density housing**, which is related to juvenile crime and family dysfunction. Families are often socially isolated in public housing projects and live under a great deal of stress.

- **Reduced educational, cultural, and job opportunities.** The economic robustness of a neighborhood often determines the quality of the schools, access to community cultural resources, and number of jobs available for youth.

- **Discrimination**, which is also related to poor growth outcomes, whether caused by religious, ethnic, cultural, gender or family background factors. Youth who are not accepted by the mainstream youth in their school, church, or neighborhood are not likely to bond to these social institutions.

Multiple Pathways and Multiple Risk Factors in High-risk Families

There are many pathways to delinquency (Huizinga, Esbensen, & Weiher, 1991) and a variety of family circumstances contribute to negative behavior in children (Wright & Wright, 1992). Studies of family risk factors for delinquency conclude that the probability of a child becoming a delinquent increases rapidly as the number of family problems or risk factors increases (Rutter, 1987a). Children and youth generally appear to be able to withstand the stress of one or two family problems. When they are continually bombarded by family problems, however, their normal development is impeded.

Unfortunately, family risk factors often tend to cluster. For example, children of poverty typically contend with multiple problems, including parental absence because parents must work or because fathers unable to support their family have left; irritable and depressed parents or caretakers; lack of money for social or educational opportunities; and in severe cases, lack of adequate food and clothing, and even homelessness.

CHILD VERSUS FAMILY-FOCUSED INTERVENTIONS

In both the delinquency and substance abuse prevention or intervention fields, most programs are aimed at working with problem youths themselves, rather than the whole family. Historically, earlier approaches to rehabilitation and therapy assumed that it was the youth who had the problem, not the family. In addition, working with children and youths is easier than working with parents and other family members -- children and adolescents are generally more accessible through schools or community groups for participation in delinquency prevention activities than are entire families.

Although efforts focusing on youths themselves should be continued, mounting evidence demonstrates that strengthening the family has a more enduring impact on the child. In a review of both family- and child-focused approaches to the reduction of conduct disorders, McMahon (1987) concludes that child "skills training approaches have failed to demonstrate a favorable outcome or evidence of generalization in more naturalistic settings (p. 149)". Conversely, family-focused approaches have demonstrated outcomes that are both positive and enduring.

PART II: REVIEW OF FAMILY STRENGTHENING PROGRAMS

The previous review highlighted the need for family-level intervention in the prevention of delinquency. Today there are many different types of parenting and family strengthening programs designed to address the family problems discussed. Psychotherapy has stressed the importance of family interventions. Coleman and Stanton (1978, p. 479) wrote: "It is an understatement to say that family approaches to psychotherapy have increased in popularity and breadth during recent years." Family systems theory and family therapy techniques are widely taught in training programs for therapists.

The increased success of treatment when the family is involved is widely acknowledged by therapists and documented in the research literature (Gurman and Kniskern, 1978; Stanton and Todd, 1982). Most therapists are acutely aware of the damage that a family can do to client's therapeutic progress if the family is not supportive of the treatment goals or are unaware of their impact on the client. Obvious and subtle forms of sabotage occur as family members attempt to redevelop the former family balance and dynamic.

A number of prevention researchers (Loeber and Stouthamer-Loeber, 1986; Fraser, Hawkins and Howard, 1986; McMahon, 1987) strongly support family-focused prevention interventions as the most effective intervention strategy for delinquency and substance abuse (Kaufman and Kaufman, 1979; Kaufman, 1986; Stanton and Todd, 1982).

DEFINITION OF "FAMILY STRENGTHENING PROGRAMS"

For the purposes of this review, a **family strengthening** program will be defined as any intervention that works with either a parent or caretaker of a child or some members of a family (including at least one target child) with the goal of reducing risk or increasing protective factors for problem behaviors. Parent or family programs can vary from a single session to a much longer and more intensive series of sessions.

Programs that use volunteers or professionals working directly with a child are considered **"surrogate" parenting** programs. Examples of these programs include Big Brothers or Big Sisters, Partners, Foster Grandparent programs (if they work with the child and not the parent), intensive foster parent programs or professional group home programs. They technically do not meet the criteria for a parent or family strengthening program, but they are covered in this review, within a loose definition of "family" as child rearers.

A national search for the best methods for strengthening families yielded 25 different intervention strategies (as well as many variations or combinations). These do not exhaust all the possibilities. One of the reasons for such a wide diversity of family strengthening programs is that the needs of the families vary and programs must be tailored to meet those needs. As shown in Figure 1, major factors to consider in the selection of the most appropriate family program are the age of the child at risk and the level of identified dysfunction of the family.

FIGURE 1: MATRIX OF PROGRAM TYPES BY AGE OF CHILD AND SEVERITY OF FAMILY OR CHILD PROBLEMS

AGE	GENERAL POPULATION FAMILY PROGRAMS	HIGH-RISK FAMILY PROGRAMS	IN-CRISIS FAMILY PROGRAMS
Pre-parent	• High school parent education • Parent/teen sex education • Teen pregnancy prevention peer education	• Pre-parenting • High school pre-parenting • Pregnancy prevention/ sex education	• Pre-parenting education for foster care youth • Pre-parenting for delinquents in custody
Prenatal	• Infant parenting and health care • Parent education	• Prenatal substance abuse prevention program • Infant mortality case management	• Teen pregnancy case manager • Substance abuse treatment • Pregnant teen school • Pregnant teen residency
Infancy/toddler	• Parent education (TV, video) • Parent support	• In-home parent education (PHS nurse, social worker) • Parent aide • Parent training • Case work • Family services • Parent support	• Protective services • Nurturing program for child abuse/neglect • Foster parents • Teen parent support services • Young parents' school
Childhood	• Parent education • School-based home/school achievement programs • Media-based prevention	• Preschool parent training • School and treatment agency • Parent training • Parent aid • Family skills training • Surrogate parent training • Parent involvement	• Family services • Family skills training • Foster parent training • Protective services • Family preservation • Family reunification • Family treatment • Residential shelter • Day treatment • Parent aid • Parent training
Preteen/adolescent	• Parent education • Family education • Family meetings and activities • Sex education	• Family communication and relationship enhancement • Parent support groups • Family volunteers • Parent involvement in youth group • Surrogate parent training • Parent/school/treatment - truancy • Juvenile diversion/gang prevention • Parent education • Parent skills training • Drop-out education prevention	• Family therapy • Family services • Parent or family support • Protective services • Family preservation • Intensive probation • Teaching family model • Day treatment/alternative school • Foster parents program • Residential treatment

At the top left are the earliest interventions possible, such as family or parent education i schools before young people even become parents. Family education can begin as early as elementary school in order to prepare youth for future family responsibilities. At the other extreme are programs for families in crisis who have a youth on probation for criminal involvement.

MODELS OF FAMILY STRENGTHENING PROGRAMS

Only the most popular and promising intervention strategies included in Figure 1 will be reviewed here. One major dichotomy of the intervention strategies are those that involve the parents or caretakers only, called *parenting approaches*, and those that involve the parents with at least the target child, often called *family approaches*. Some basic variants of each of these two major approaches will be discussed below, including several model programs.

Parenting Approaches

The major parenting approaches defined and described below include parent education, behavioral parent training, Adlerian parent training, parent support groups, in-home parent education or parent aid, and parent involvement in youth groups.

Parent Education Programs

Parent education programs are distinguished in this paper from parent training programs in that education programs generally involve fewer sessions and do not have the parents practice skills in the groups or do assigned homework. Parent education programs can range from a single motivational lecture to a series of lectures that may involve experiential exercises and self-ratings.

These programs generally involve teaching parents ways to improve their parenting or family relationships. Sometimes these programs involve increasing awareness of community resources to help their family or child. Parent education may include appropriate behavioral expectations, ways to better supervise and discipline children, tips for how to improve moral and ethical thinking in children, ways to discuss family values and ways to monitor stealing and lying. Such programs also often include information about the risks of alcohol and drug use, early warning signs of use, other behavioral or family risk factors, the family disease concept, and ways to talk with children about alcohol and drug abuse.

Parent education can be conducted in many different ways. For example, high-risk families may not have time to attend parenting classes, but most watch television. Popkin's Active Parenting Program has been shown on PBS in the state of Washington. Some parenting programs are available on audio tape or video tape to be reviewed at home. Magazines often carry feature or serial articles on improving parenting and family relations. Some businesses offer parenting classes during lunch hours (an excellent way to attract fathers). Some school

alcohol and drug prevention programs include homework assignments to be done with the parents.

Popular anti-drug programs such as the Parents' Resource Institute for Drug Education (PRIDE) and the National Federation for Drug Free Youth include parent education components about such topics as teaching parents how to talk to their children about alcohol or drugs (as does the National Council on Alcoholism's "Talking With Your Kids About Alcohol" developed by the Prevention Research Institute).

Hawkins and his associates (Hawkins, Lishner, Jenson, and Catalano, 1987) have developed a risk factor based parent education program, called Preparing for the Drug-free Years, that can be implemented in five sessions with the support of video tapes. The program works well for statewide dissemination through schools and community agencies. The program is being tailored for high-risk and ethnic families.

Behavioral Parent Training Programs

This group of programs teaches parents of a difficult child how to discipline the child more effectively and control overt conduct disorders. The programs are highly structured and trainers use programmed instructional aids and manuals with special topics and exercises with homework assignments each week. Typically a course includes 8 to 14 weekly sessions lasting about 1 to 2 hours. Skills typically taught include behavioral shaping principles of positive reinforcement, attending to wanted behaviors and ignoring unwanted behaviors. Parents are taught first how to "catch your child being good" and reward the child for good behavior. These techniques improve the child's problem behavior and develop a more positive relationship between parents and children. Once parents have mastered paying attention to the good things their children do, they are taught to decrease inappropriate or unwanted behaviors by not attending to these behaviors or using mild punishments, such as time outs, natural consequences, and loss of privileges.

The basic parent education and training programs have been well documented to be effective in reducing problem behaviors in children. There is less evidence concerning the applicability of these programs to reduce delinquency, since the programs work primarily with younger children. The programs have, however, demonstrated effectiveness for reducing overt conduct disorder problems in children. Approximately 50% of all children diagnosed with conduct disorders develop delinquency in adolescence and the others often show other social and developmental problems (Kazdin, 1987).

There are many types of behavioral parent training programs, but most are variants of the parenting model developed by Patterson and his associates at the Oregon Social Learning Center. Patterson's book: *Families: Applications of Social Learning to Family Life* (1975) explains this type of parent training. Family members read his other book, *Living with Children* (1976) prior to starting the group. Another widely used parenting resource book is Becker's book called *Parents are Teachers: A Child Management Program* (1971).

Adlerian Parenting Programs

These programs are based on clinical psychology principles of improving the whole person. Dinkmeyer and McKay's (1976) Systematic Training for Effective Parenting (STEP) is based on the theoretical teachings of Alfred Adler. This program involves local groups of parents in 8 to 12 weekly two-hour sessions covering parenting topics such as understanding the child's behavior and emotions, using encouragement, listening and communicating more effectively, disciplining by using natural and logical consequences rather than punishment, establishing family meetings, and developing confidence as a parent. The goal of this program is to improve the child's self-concept and dignity.

The popular Parent Effectiveness Training (PET) program developed by Gordon (1970) is based on the self theory of Rogers. The primary focus of this program is enhancing the family's communication, problem-solving, and mediation skills. Parents are taught active and reflective listening skills and the use of open-ended questions. They are taught to consult with children regarding problems, but to leave the child to make his or her own choices. Parents also learn about parental power and the problems of being overly permissive or authoritarian.

Another popular program that stresses communication is Glenn's (1984) "Developing Capable Young People" program. This 10-session program focuses on the parent's role in socializing children in pro-social ways.

Parent Support Groups

These groups are generally grassroots organizations of parents who provide support and education for members. Examples of these groups include The National Federation of Parents for Drug Free Youth, Toughlove, PRIDE, The Cottage's Families in Focus, Mothers at Home, Mothers of Pre-Schoolers (MOPS) and Families in Action. These national organizations provide parenting and alcohol and drug education materials. Their local chapters often offer parent support groups. In these support groups parents can share their concerns and problem-solve with the group. Some of these groups, like Toughlove, provide temporary respite care for parents having problems with their adolescents. Some organizations, like STRAIT, provide residential treatment for drug-using youths, followed by several months of living with other parents in the support group.

Parent Aid or In-home Parent Education

This type of program offers parent education to parents who find it difficult to come to group meetings. Teen Moms is an example of this type of program. Professional public health nurses and social workers often deliver in-home parent education and occasionally parent training to new mothers. If paid professionals are not available, parent aids are sometimes used to deliver these services. Parent aids are highly trained volunteers who are willing to work in homes to teach parents to improve care of an infant.

Parent Involvement in Youth Groups

This approach includes a wide variety of ways to get busy or distrustful parents to become more involved with their child through the child's participation in a preschool, school, church, or children's agency group or activity. High-risk parents, who would not volunteer for a parent training group, are gradually involved in the children's groups and are exposed to improved parenting skills through observing teachers or trainers work with the children. For example, City Lights in Washington, D.C. gradually gains the trust and interest of inner city, low SES parents by calling them to notify them about their child's achievements in their youth activities program. After a period of increasing contact, parents occasionally are willing to volunteer to help with the youth activities or join a parenting group.

Headstart and pre-school programs have for some time informally taught parenting skills by involving parents in preschool activities. The positive results of the Perry Pre-school Project may be mainly due to this direct modeling of appropriate ways to discipline, support, and help children. The parents learn by watching the teachers and by working with their own child and other children. In San Antonio, the Los Ninos Project includes three levels of parent involvement in the children's groups, ranging from no involvement to helping with food and materials for the groups, and, finally, to helping with the children's activities.

Family Prevention Approaches

Several major family interventions have been used to help prevent delinquency, substance abuse, and other teen problems. These include family education programs, family skills training programs, family therapy, family services, and in-home family crisis services or family preservation programs. Each intervention type is discussed below.

Family Education Programs

These programs provide the family with lectures or educational sessions on family values, responsibility to society and others, law-related education, family communications, alcohol and drug use, relationship enhancement techniques, and other family strengthening strategies. This approach has been used as either a single session or a series of lectures or experiential sessions conducted in schools, churches, community centers, juvenile courts, youth rehabilitation centers, adolescent group homes, alcohol and drug treatment centers and public agencies. Workbooks are also available for families to conduct independent family discussions at home.

Family Skills Training Programs

These programs are often called behavioral family therapy or behavioral parent training (if the child is included in the sessions). They specifically involve structured family training sessions. A number of behavioral family therapy programs have been reviewed by McMahon (1987). Intensive family skills programs combine adapted behavioral parent training programs with children's social skills training programs and family relationship enhancement programs.

Examples include the Strengthening Families Program (Kumpfer, DeMarsh, and Child, 1989a, b, c) and The Nurturing Program (Bavolek, Comstock and McLaughlin, 1983), and Families and Schools Together (McDonald, Plant, & Billingham, 1988).

Family skills training programs have been evaluated rigorously by researchers and found to be effective in reducing a number of family, parent, and child risk factors for delinquency. Kumpfer and DeMarsh (1986) state that they were able to reduce problem behaviors in youths and improve family functioning with their Strengthening Families Program.

Family Therapy Programs

This group of programs includes a number of different clinical approaches to the family such as structural family therapy (Minuchin, 1974; Szapocznik et al., 1983), functional family therapy (Alexander and Parsons, 1973, 1982), strategic family therapy (Haley, 1963), and structural-strategic family therapy (Stanton and Todd, 1982). These family intervention approaches depend on the discretion of the individual therapist to determine the appropriate application and timing of specific techniques and exercises.

The Functional Family Therapy approach was evaluated primarily for the prevention of delinquency in young status offenders by Alexander and Parsons (1973). They found reductions in recidivism and improvements in problem behaviors as well as a preventive impact on delinquency in younger siblings (Klein et al., 1977).

Family Services Models

This is the traditional family services model in which a large number of needed services are brokered by a caseworker or a case manager. High risk families often need more than family therapy or skills training. Rather, they often have immediate basic needs, such as food, clothing, medical care, and housing. Only after these emergency needs are met can the family begin to consider parenting and family enhancement program involvement.

In-home Family Preservation Programs

This approach includes a number of in-home crisis services that are often used for the preservation of the family when out-placement of a child is imminent. Homebuilders, the prototype program, was developed in Washington by Haapala and Kinney (1979). This model has been so successful in reducing placement of youths in state custody and institutions or group homes that it is currently being replicated in many states. In this model, a team of highly trained family services workers arrive at the family's home and provide whatever in-home services are needed. The intervention is very much like that delivered by the traditional social worker, but the services are more intensive and short term.

Surrogate Family Approaches

If the biological parents are not involved with the child or able to participate in parent or family programs, working with extended family members or other parent surrogates is possible. Parenting and family programs have been developed for adoptive parents, blended families, group home parents, foster grandparents, Big Brothers or Big Sisters, volunteer sponsors, and for foster parents (Guerney, 1974).

An application of behavioral parent training has been developed by Patterson and his associates for delinquent youths committed to state institutions. At the Oregon Social Learning Center's (OSLC) Specialized Foster Care Model, institutionalized or to-be-institutionalized delinquents are assigned to specially selected and trained foster care parents. The foster parents have daily contact with the OSLC staff and the youth's teacher. Chamberlain and Reid (1987) reported success in preventing recidivism among youth who completed the program.

The Teaching Family Model (TFM) was developed for married couples who run community-based residential programs for treating conduct disordered adolescents. The prototype of this type of surrogate family model is Achievement Place, which first opened in Kansas in 1967. There are now over 215 residential group homes employing this treatment model (Wolf, Braukmann, and Ramp, 1987). The teaching parents are rigorously trained in a one-year training program that culminates in certification by the National Teaching-Family Association.

The Teaching Family Model has been evaluated by the originators (Kirigin, Braukmann, Atwater and Wolf, 1982) and by an independent evaluation (Weinrott, Jones and Howard, 1982). Both evaluations found significant reductions in official records of delinquent behaviors in youths in the TFM program compared to youths in other group homes. These reductions lasted for the time they were in the residential homes, but did not continue in the following year. A longer term follow-up may reflect later "sleeper effects". Chamberlain and Reid (1987) report that a similar approach to the foster parent TFM program developed by Patterson and colleagues has demonstrated reductions in conduct disorders over time.

OUTCOMES OF FAMILY STRENGTHENING PROGRAMS

Summary of Program Effectiveness

Overall, family-focused interventions have been shown to be superior to child-only interventions. McMahon (1987) discusses the relative failure of school-based children's programs for the reduction of conduct disorders and concludes that these skills training

programs, though widely used, "have failed to demonstrate a favorable outcome or evidence of generalization in more naturalistic settings (p.149)".[1]

McMahon (1987) summarizes the deficits in most children's skills training programs:

> It seems quite unrealistic to assume that altering a single skill deficit is likely to have a wide-ranging impact on youth with problems as pervasive as those typically seen in conduct disordered populations. A more clinically-defensible strategy would be the systematic evaluation of some of these interventions as adjuncts to family-based treatments, with particular attention being paid to the extent of the developmental progression of the conduct disordered behaviors and the identification of particular deficits for individual children (p.149).

The evaluations of family programs differ in quality and some have not been replicated by other researchers with other populations. Taken as a whole, however, these evaluations indicate the strength of family-focused approaches. Family skills training appears to be most the most promising family-focused approach. The target child, along with the rest of the family participates in structured activities designed to modify interaction patterns. This strategy is desirable for high-risk families in which the therapist should monitor the changes in the parents and child interaction patterns throughout the training process. Many variations of family skills training have been developed and can be tailored to the specific needs of the family.

Recommendations to Improve Effectiveness of Family Interventions

A number of program design and implementation issues can make the difference between success and failure of family intervention programs. Some of the most important issues are discussed below.

Provide Programs of Sufficient Intensity

High-risk families need considerable time and support before they are capable of making changes. Many family service programs find that standardized parenting or family training programs cannot even begin until staff spend a number of sessions getting to know the family's needs, locating support services, and developing trust. The more needy the family and parents, the more sessions this requires.

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[1] Three possible exceptions noted are Kazdin, Esveldt-Dawson, French and Unis' (1987) Problem Solving Skills Training Intervention, Kumpfer and DeMarsh's (1983) Children Skills Training Program, and Lochman, Lampron, Gemmer and Harris' (1987) Anger Coping Program. Both the Kazdin and Kumpfer children skills training programs are based on the Spivak and Schure Interpersonal Problem Solving Program (1979) and have demonstrated positive results when used in conjunction with parent training.

Kazdin (1987) suggests that parent training programs of less than ten hours duration are unlikely to be successful. In their study, Kumpfer and DeMarsh (1985) observed that some high risk and lower education level parents could have used more than the 14 sessions in their Strengthening Families Program, particularly if these parents missed a number of sessions and were having difficulty implementing the concepts at home. A number of family training specialists estimate that, with high-risk families, at least 30 to 40 contact hours are needed to have a positive and lasting impact.

Match the Program to the Family's Needs

Accurate assessment of the family's problems is needed to tailor the family interventions to the family's needs. One good example of how such tailoring can be accomplished is provided by L'Abate's (1977) Family Enrichment Program. L'Abate developed a clinical assessment tool that specifies the type of training and the number of sessions needed, depending on the family's scores on different family factor scales on a test. This tailoring approach is recommended for high-risk families who have multiple problems.

Assessments are required to determine whether a child's acting out behaviors are likely to evolve into serious problems later on. It would not be cost-effective to intervene with all non-compliant young children, as many of these children grow out of these behaviors. The literature suggests that children with a large number of risk factors are those most in need of prevention interventions because of their increased risk for delinquency.

Time Programs for Developmental Appropriateness

In order to be most effective, family interventions must be appropriately timed to the developmental stages of youth. For example, programs to teach parents to monitor their teenager's stealing and lying are probably too little, too late. Such parental training programs are needed from the 2nd to the 5th grades at the latest.

Make Programs Culturally Relevant and Easily Understood

Most parenting and family programs have not been adapted for use by different ethnic groups. Generally, prevention programs are developed and evaluated for effectiveness with a broad general population before adapting them for special populations. In the last few years parent training programs have begun to be revised to be more culturally sensitive and appropriate. Alvy, Fuentes, Harrison and Rosen (1980) at the Center for the Improvement of Child Caring (CICC) in Ventura, California have developed a "Confident Parenting" program for African-American parents and another for Hispanic parents. Kumpfer, DeMarsh, and Child (1989) have developed a parent training programs for African-American, low SES substance abusing parents as part of their Strengthening Families Program. Hawkins and his associates have modified their training manual for "Preparing for the Drug-Free Years" to include the results of focus groups with different ethnic groups. A number of issues that should be considered in developing family programs for Hispanic families have been researched by

Szapocznik and his associates (in press) at the University of Miami. Some of these cultural issues are discussed by Paul Cardenas in his manuscript for the project "Culture and Cultural Competency: Youth Focused Prevention and Intervention".

Program materials should also be appropriate to the reading and conceptual level of the population being served. This is one area that requires close scrutiny, because many high-risk families have very low reading and educational levels. If materials are too difficult to read or understand, program effectiveness is diminished.

Pay Attention to Parental Dysfunction

Parental dysfunction should be considered when screening for admission to a family program. Dumas (1986) found a composite index of maternal and paternal psychopathology, family violence, and SES disadvantage to be most predictive of outcomes in parent training. It is recommended that the Beck Depression Inventory and the Global Assessment Scale (GAS) be used as screening instruments. Potential clients with very high depression or mental health problem scores should be referred for treatment before admission to the family program. Kumpfer (1990) found in her modification of the Strengthening Families Program for African-American families that parents with low functioning scores on the GAS still had positive results in terms of changes in children's risk status. Hence, low functioning parents should be admitted as long as they can follow the program and gain from the experience. Excessively disruptive parents should be screened from the group, however, because of the detrimental impact on the group as a whole.

Pay Sufficient Attention to Recruitment and Retention

Family intervention programs for high-risk families generally have problems with recruitment and attrition. Successful programs modify their format to make it attractive for family members to attend. Therapists must recognize that a key step in helping families is promotion and recruitment. Many therapist are not trained to do recruitment and narrowly define their role as sitting in an office and "doing family therapy". Changes in attitudes through improved clinical training programs will be needed when training students to be successful therapist for high-risk families.

Many of the parent training and family therapy programs were developed and tested for relatively high-functioning parents. Patterson's basic behavioral parent training program requires parents to be motivated, organized, and capable of reading programmed tests and completing homework assignments. Little time is programmed in the course to deal with crises and problems, which are frequent in high-risk families. Despite this lack of course material or specific topics on parental problems, Patterson and Chamberlain (1988) estimate that approximately 30% of the course time is spent dealing with such parental problems.

Kazdin (1987b) found that only about 25% of parents of conduct disordered children are willing to participate in the basic behavioral parent training program. What can be done for the

other 75% parents of conduct disordered children to get them involved? Though the original parent training programs generally require fairly motivated and educated parents, adaptations have been made recently to reach more dysfunctional parents and those with low socio-economic status (Fleishman and Szykula, 1980; Sachs, 1986; Stanton and Todd, 1982).[2]

The following principles are important in recruitment and retention of high-risk families:

- Provide transportation, a safe convenient and non-stigmatizing place for the program, and child care;
- Provide incentives for involvement until bonding to the leaders and group occurs. Examples include refreshments, toys for children, and prizes for completed homework or attendance;
- Hold discussions during the first session on possible barriers to attendance, extend personal invitations to join the group and ask leaders and other group members to contact members who miss sessions;
- Use indigenous trainers to increase program accessibility;
- Involve parents in program modifications to foster a sense of program ownership.

Develop Strategies to Overcome Barriers

Despite almost universal theoretical agreement that involving family members in treatment or prevention interventions for high-risk youths is most effective, there are practical barriers to doing so. The first and most difficult problem, as discussed above, is to get family members to agree to participate in programs and to attend sessions once they have enrolled. Reasons for difficulties in recruitment and retention include transportation problems, lack of child care for the other children, lack of time, and lack of a perceived need to improve their parenting skills or family relationships, and fear of having children taken away.

Agency staff must develop strategies for dealing with each barrier to recruitment and attrition. A helpful tool for developing awareness of barriers is a self assessment test developed by Kumpfer and DeMarsh (1988) that includes questions about barriers to involvement in prevention activities and possible strategies to overcome these barriers.

[2] Kumpfer and DeMarsh (1985) summarized many of the suggestions for ways to recruit and maintain high-risk and low socioeconomic families in family programs. A more complete review of possible reasons for recruitment and attrition problems and tips on how to decrease this problem were presented by Kumpfer and DeMarsh (1988) to the Second National Office of Substance Abuse Prevention (OSAP) Learning Community Conference in Washington, D.C. An article by Kumpfer (1991) is included in the new monograph published by OSAP, *Parent Training Is Prevention: Preventing Alcohol and Other Drug Problems Among Youth in the Family.*

Transportation problems can be overcome by providing bus tokens or arranging car pools or van pick-ups. Child care problems can be overcome by providing child care or by running a structured children's skills training group during the time of the parenting class, as does the Strengthening Families Program. If lack of time is an issue, for example, there are often ways to decrease the time cost by running the parenting group prior to a group that the parents regularly attend anyway, such as an Alcoholics Anonymous or therapy. Free child care can be offered during the time parents are in their support group, if they also attend a parent training group. Other strategies are to offer parent training at work sites on lunch hours or to show parenting videos while parents wait at general assistance offices or patient waiting rooms.

Meeting the overtly stated needs is often possible, but it is more difficult to overcome underlying, unstated barriers. Some of these unstated barriers include lack of ownership of the program, fear of the agency (for example, concern that the agency will report the parent to protective services), and perceived cultural or ethnic differences. In general, it is important to involve leaders from the target group of parents in the design of the program. These leaders can help recruit high-risk parents, help select program staff and provide feedback on the relevancy of the topics covered. The program should include time for personal sharing in order to build group support for members. If word gets around that trainers don't know anything about parents' real needs or about raising children, it will be very hard to recruit parents.

Provide Other Needed Services

Family interventions for the prevention of delinquency should be embedded within comprehensive family service agencies. It is nearly impossible to have much impact on high-risk families without providing a range of other supportive services to the family. Such family interventions should recognize the social environment of the family and strive to find ways to reduce stress and increase informal support networks. Volunteer family sponsorship programs may be a way to reach high risk families. Such programs may be particularly effective if they involve successful parents from the same neighborhoods or social groups. At one time other social institutions, such as neighborhood churches, provided informal community support for families. These supports, however, may no longer be as available to high risk families or may be underutilized by them.

Pay Attention to Cost-Effectiveness

A major issue in the selection or development of family programs for high-risk families is the availability, quality and cost of the manuals and of the support materials, such as videos, parent handbooks or workbooks, films, and evaluation materials.

Some of the reviewed programs have developed video, audio, and film materials to be used within the structured training course. Webster-Stratton's Videotape Modeling Group Discussion Program (VMGD) (1987) has put the entire program on video tape. Such an approach makes the program easy and inexpensive to disseminate.

Measure Program Effectiveness

Clinicians should be encouraged to measure the effectiveness of the program in changing behavior during and after the family intervention. Clinicians are often reluctant to carry out evaluations of program effectiveness. One way to encourage such evaluations would be for public and insurance funders to tie continued funding to demonstrated effectiveness.

Follow-up studies are also needed to track the longer term effectiveness of promising programs. Funding from the beginning of the program should be earmarked for the follow-up evaluation.

SUMMARY

This report presents highlights of a comprehensive literature review and discusses protective and risk factors within families that are related to delinquency. It also describes different family strategies, based on these factors, that can strengthen families' ability to raise youths who will not engage in delinquent activities.

Figure 1 presents a matrix to help organize the wide variety of possible parent and family programs and services according to the age of the child and the level of functioning of the family. This conceptualization will be useful in helping agencies determine the most appropriate family services for their target populations.

The main purpose of this review is to demonstrate that there is no one best family strategy for the prevention of delinquency. Instead, several types of parenting programs are needed. There are programs best suited for parents of infants, of children, or of adolescents. Some programs are best suited for well functioning families while others can be used by dysfunctional families. There is no single best program, but there are elements which make some family programs more effective. One key factor is the fit between the family's needs and the content and duration of the course. Other major factors in the success of the program include implementation issues, such as successful recruitment and retention strategies, and follow up.

Kazdin (1987b) suggests that we should not think in terms of "single shot" family inoculation programs. Multi-problem families with long-term problems are not likely to benefit from weak dose, single shot family programs. They need coordinated and long term help, including ongoing support and booster sessions with coordinated family services. Such intensive, comprehensive programs are likely to be most successful in helping high-risk families raise non-delinquent children.

PART III: EXAMPLES OF PROMISING FAMILY STRENGTHENING PROGRAMS

Following are brief descriptions of 25 family strengthening programs reviewed for this manual. The programs are arranged in alphabetical order within five categories: Parent Training, Family Skills, Family Therapy, Family Prevention, and Probation and Rehabilitation. Also included is an addendum of several programs that were not part of the original survey but were invited by the Office of Juvenile Justice and Delinquency Prevention to participate in the conference, Strengthening America's Families: Promising Parenting and Family Strategies for Delinquency Prevention.

A. Parent Training Programs

1. Birth to Three
2. Child Behavior Institute Parent Training Program
3. Effective Black Parenting Program
4. Minnesota Early Learning Design (MELD)
5. Parenting Skills Program
6. Parents and Children Videotape Series
7. Preparing for the Drug-Free Years
8. Treatment Foster Care Program (TFCP)

B. Family Skills Training Programs

9. CEDEN
10. Families and Schools Together (FAST)
11. Families in Focus
12. New Futures School
13. Nurturing Program for Parents and Adolescents
14. Parenting and Family Skills Program:
    Helping the Noncompliant Child
15. Strengthening Families Program

C. **Family Therapy Programs**

16. COSSMHO Project Esperanza
17. Family Relationship Enhancement (RE)
18. Functional Family Therapy
19. Prime Time In-Home Family Therapy
20. Structural Family Therapy for Hispanic Families

D. **Family Preservation Programs**

21. HOMEBUILDERS Program
22. Maryland Intensive Family Services (IFS): A Family Preservation Service Delivery Model
23. Tennessee Home TIES

E. **Probation and Rehabilitation Service Programs**

24. Adolescent Intensive Rehabilitation Services
25. Juvenile Intensive Probation Supervision (JIPS)

See Addendum for Additional Programs

A. PARENT TRAINING PROGRAMS

1. BIRTH TO THREE PROGRAM

Mailing Address: Minalee Saks, Executive Director
Birth To Three
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Eugene, Oregon 97405
(503) 484-5316

Target Population: Birth to Three is designed for a broad range of parents with infants and young children. All programs are free or on a sliding fee scale and open to all families. Many families are self-referred. Others are referred by public health nurses, physicians, counselors, school personnel, children's protective services workers, family, and friends. Programs include: *Infant/Toddler and Drop in* (for families with infants and toddlers); *Teenaged Parents* (pregnant and parenting adolescents age 12-21); *Make Parenting a Pleasure* (parents with children age 0-10, for families experiencing high levels of stress); and *We're A Family* (for pregnant and parenting women in recovery from alcohol and other drug abuse).

Program Origin: The original funding for Birth to Three came from the National Center on Child Abuse and Neglect (NCCAN). Since its start, Birth to Three has provided parent education and support services to over 10,000 families.

Program Objectives: Birth To Three is a nationally recognized community-based prevention program. Its primary mission is to ensure the well-being of children, strengthen families and help prevent child abuse and neglect. It accomplishes these goals through parent education, peer support groups and support services. All programs are built on the following assumptions:

- parents want the best for their children;
- there is no perfect way to parent; and,
- parents want information, tools, and support as their child's first and perhaps most important teachers and role models.
  Therefore,
- providing a parent education/peer support program for parents as early as possible in family life will positively affect parenting and support the healthy development of children.

Program Strategies: The original format was to bring together new parents from the same neighborhoods into a support group to share their parenting experiences, learn about normal early childhood development, develop a support network, and learn about other community resources available to them. Birth To Three has grown considerably in response to the changing needs and dynamics of the family. However, its philosophy and mission have remained unchanged.

Services: All participants in Birth To Three programs receive the following:

- **Membership** in a Birth To Three group.

- **A subscription to the bimonthly Birth To Three newsletter** filled with articles relevant to the concerns of parents with young children, as well as listings of community activities available to children and their parents, book reviews, and updates on program activities.

- **Access to the Parent Resource Telephone "Warmline,"** a community service provided to any parent who calls. A staff peer counselor is available to answer questions, make appropriate referrals, do crisis intervention, and listen.

- **Admission to Birth To Three educational events** that are open to the community. Usually designed as a panel presentation on a relevant topic (discipline, couple issues, etc.), community professionals volunteer as guest speakers at these events.

- **The Birth To Three Resource Poster** which is also given to all parents in the community through the hospitals when they give birth. Additional posters are displayed in the offices of doctors, social service agencies, schools, libraries, and other appropriate locations.

In addition, Birth To Three sponsors a weekly column in the Oregon Life section of the *Register-Guard* newspaper. This column is written by staff and other community professionals. Subjects cover a wide range of issues that concern parents. A series of twelve articles have been translated into Spanish and are printed monthly in the statewide *El Hispanic* newspaper.

In many of the programs, free childcare is provided while group members meet.

Recruitment and Retention: Parents learn about Birth To Three from a variety of sources: obstetricians, hospitals/birthing centers, pediatricians, teachers and school counselors, social service agency workers, and friends. All programs are voluntary and most families stay with a group for at least a year. Birth To Three has been in the community for 14 years, during which time it has built a solid reputation as a model prevention program. Physicians, midwives, social service providers, school personnel, and others know about the programs Birth To Three offers and refer clients.

Staffing: Birth To Three employs 18 people with backgrounds in early childhood education, counseling, social work, human services, education, pediatric nursing, and community organization. Over 150 volunteers serve Birth To Three facilitating groups, raising funds at special events, participating in community outreach, doing public education, and in other roles.

Resources Needed and Materials Available: Publications available include: 1) *Birth To Three: Support for New Parents* (photocopy only). 2) *Make Parenting a Pleasure: A Program Guide and Curriculum for Parents Under Stress.* A recent grant from US WEST enables Birth To Three to expand, enhance, and revise the curriculum, the program is also developing video vignettes and audio tapes for classroom use. Printed materials on the teenaged parents program and infant program are available and program guides will be written.

Special Characteristics: Birth To Three provides parent education/peer support programs for a broad base of parents with young children through the following programs:

Infant/Toddler: Within this program there are groups for parents with different needs (e.g., single parents, parents of multiples, working parents, parents with children who have special needs). A parent educator facilitates a 10-session, five-month curriculum that covers birth experiences, stress/anger management, early childhood development, adult relationships, health and safety, parenting strategies, group agreements, play and learning, baby massage, and childcare issues. Groups are encouraged to continue to meet after this initial five month period. Volunteers from within the group become facilitators, attending a Training Workshop, quarterly in-services, and bimonthly trainings. Staff are available to ongoing groups for supervision, training, mediation, and support. Volunteer facilitators receive a listing of community resource speakers who donate their time to provide valuable information to group members. Facilitators can use any of the materials (handouts, books, audio and video tapes) in the Birth To Three Library. The *Toddler Series* is a 10 week curriculum focusing on families with toddlers. The goal is to develop parenting skills that can be used throughout the parenting years.

Make Parenting a Pleasure was developed in 1983 in collaboration with the YMCA. It is a 10-week parenting class followed by a 10-week peer support group to parents with low incomes who are experiencing high levels of stress. A Birth To Three parent educator teaches the class component and a trained mentor facilitates the peer support group. This group then becomes a parent-led Birth To Three group. Topics include handling anger and stress, communication, and normal child development issues. The YMCA provides free membership to their facility for participants in Make Parenting A Pleasure and the children's program that runs concurrently. Make Parenting A Pleasure is part of an Oregon Department of Education grant to provide its parent education and peer support model to parents at two elementary school sites in the area.

We're A Family is a program for pregnant and parenting women in recovery from substance abuse. This program has been designated as a state demonstration model program.

Birth To Three For Teenaged Parents provides parent education and peer support groups to pregnant and parenting adolescents. Groups meet weekly and discussion

focuses on personal growth and development, parenting, community resources, and special topics (legal aid, the welfare system, etc.). Supplemental services include home visits, crisis intervention, referral to other community resources, and assistance in meeting basic needs (housing, food, clothing). Birth To Three has also developed a Teen Parent Panel service. Teenaged parents and their children serve as speakers at middle and high school family life/health classes and discuss the realities of teenage pregnancy and parenting.

Effectiveness: As a part of the evaluation process, Birth To Three submits 100 names quarterly to the state Children's Services Division. Of the 1,200 names submitted for a random check (through August, 1992), less than five names have been verified as suspected (not confirmed) child abuse cases. Birth To Three also uses pre- and post-questionnaires to assess parenting knowledge, social support system, and program satisfaction. Self report data suggest that 87% of parents found new ways to be more positive in dealing with their child through Birth to Three participation and 71% reported gaining new skills as a parent; 88% received new parenting information and 67% indicated they were more educated on child development and children.

Comments on Implementation/Replication: *Birth To Three: Support for New Parents* (available in photocopied manual form) is a book that was designed to help parents and professionals set up a parent support program on the Birth To Three model. Training and additional assistance have also been made available.

2. THE CHILD BEHAVIOR INSTITUTE PARENT TRAINING PROGRAM

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Target Population: All children referred to the Child Behavior Institute Parent Training Program must be between five and twelve years of age, be experiencing conduct problems, and have a disadvantaged family (as indicated by socioeconomic indicators, such as low income, low parent education, or having a single parent).

Program Origin: The program was formally initiated in 1971 based on earlier research by the director (Robert G. Wahler) and other behaviorally oriented clinical researchers, such as Gerald Patterson (Oregon Social Learning Center).

Program Objectives: An immediate objective is to dissolve the reinforcement strategies that maintain coercive parent-child relationships. Intermediate objectives include "freeing" the parent from contextual influences behind coercion traps set up by the child. Long-range objectives focus on maintenance of the improved parent-child relationship.

Program Strategies: The analytic teaching of parenting skills is designed to help terminate the child's antisocial behaviors (e.g., fighting, temper outbursts, stealing), since their occurrence depend on engaging a parent in an exchange of aversive responses. Parents will ultimately become capable of discriminating between child-produced stimuli and surrounding contextual events surrounding these stimuli. On average, program duration is 10 months. Parents and the target child attend weekly sessions in which they are taught specific skills such as discipline, listening, and solitary activities (self-entertainment). Parents also attend synthesis teaching sessions that are separate from the analytic teaching procedures involved in child care. One staff person is responsible for the analytic teaching and synthesis teaching of any particular family. In addition to the clinic sessions, a professional observer visits the family home once weekly. These home sessions entail naturalistic observation of parent-child interactions and parent interviews geared to reports of child antisocial behavior and parent social contacts in the community.

Recruitment and Retention: Most referrals are mandated by social agencies such as public schools and the county Department of Human Services. There is no charge for the services of the Child Behavior Institute (CBI). Parents are expected to arrange their own transportation to clinic sessions; however, CBI offers a $10.00 weekly stipend for those parents involved in an experimental "friendship liaison" version of synthesis teaching. In this version, the parent brings a friend to the sessions with the understanding that these partners will continue the synthesis teaching process in their day to day contacts with one another.

Staffing: All instructors in the analytic and synthesis teaching process are graduate students in clinical psychology. Graduate training is a prerequisite to such work with troubled parent-child dyads.

Resources Needed and Materials Available: CBI does not offer written materials or audio-visual devices.

Special Characteristics: The home visits engineered for this program are unusual in that most behavior parent training formats do not allow for this type of extensive observation in the family's own home.

Effectiveness: The bulk of CBI findings reflect process issues and immediate outcome in contrast to long term results. Analytic teaching of child care skills can significantly reduce parent-child conflict and child antisocial behavior. These reductions are not stable with families marked by the contextual problems of poverty, sparse parent social support and parent-adult coercive relationships. More recent findings suggest that synthesis teaching might foster the more stable changes produced by analytic teaching of child care skills. (See Wahler & Graves, 1983; Wahler & Dumas, 1986, 1989; Wahler & Barnes, 1989).

Comments on Implementation/Replication: Implementation of this program is limited by access to appropriately trained staff members.

3. EFFECTIVE BLACK PARENTING PROGRAM

Mailing Address: Kerby T. Alvy, Ph.D.
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Target Population: The program was initially designed and field tested with inner city African-American parents of preschool and elementary school age children. In 1988 the program was first used with middle and upper income African-American families and with parents of older children. The majority of the program's information is likely to be relevant to all African-American parents because it is grounded in basic information and parenting strategies that are useful for all parents. It addresses issues that are of general concern to African-American parents in the U.S. The specific child management skills and much of the child development information is particularly useful for parents of children two through 12 years of age.

Program Origin: This program was developed by the Center for the Improvement of Child Caring (CICC) in response to the criticism in the late 1970's that none of the widely used parent training programs in the U.S. were created specifically for African-American Parents. In 1985, the Effective Black Parenting Program was developed that integrated all of the research findings and field test results.

Program Objectives: This cognitive-behavioral program is designed to foster effective family communication, healthy African-American identity, extended family values, child growth and development, and healthy self-esteem. It is also designed to facilitate community efforts to combat child abuse, substance abuse, juvenile delinquency, gang violence, learning disorders, behavior problems, and emotional disturbances.

Program Strategies: Effective African-American Parenting is based on a prosocial achievement orientation to African-American parenting and recognizes the special "street pressures" in inner city African-American communities that make it difficult for African-American parents to maintain such an orientation. Two major parenting strategies are presented: The Family Approach for Developing Respectful Behaviors (utilizing family rules and family rule guidelines) and the Thinking Parent's Approach to Disrespectful Child Behaviors (utilizing systematic decision making processes). The program teaches rule development, family meeting and problem assessment skills, and shares basic child development information to help parents make age-appropriate rules. The program also teaches several basic child management skills: effective praise, mild social disapproval, systematic ignoring, time out, and special incentives. The regular program consists of 14 three-hour training sessions and a fifteenth session for a graduation ceremony. Each training session includes an extensive review and role playing of ideas and skills which were taught in previous

sessions. Optimal group size appears to be about 15 to 20 parents, but more could be accommodated if necessary. A one-day seminar version of the program is also available, which can be conducted for 50 to 500 parents.

Recruitment and Retention: An extensive Plan for Generating and Maintaining classes is shared with instructors who receive workshop training from CICC. When child care and other support services are provided, attendance averages 75% - 85%. Without such support, attendance is closer to 50%.

Staffing: Instructors should have a background in African-American studies, African-American parenting, parent education, child development, group processes and behavior modification. Training workshops last five days and can be conducted at any location in the U.S. or abroad (providing the sponsoring group pays travel, per diem and lodging expenses for workshop leader). Instructors receive provisional authorization to run one class in Effective African-American Parenting Program. After conducting their first class, they receive official certification to conduct the Effective African-American Parenting Program.

Resources Needed and Materials Available: Materials include an instructor's manual, instructional charts, a parent's notebook, a promotional video, promotional flyers, and graduation certificates. Three supplementary books are also available.

Special Characteristics: This program includes discussion of traditional African-American discipline and contrasts this with modern African-American discipline strategies in teaching parents new skills. Also presented are issues relevant to African-American pride and ways of coping with racism. Child abuse information is included in a discussion of the disadvantages of using corporal punishment as a disciplinary technique.

Effectiveness: Field test results indicate that the program in its fully integrated form has direct and positive effects on many of the family and child risk factors that have been found through research to put children at risk for drug abuse, delinquency and other social and health problems. It reduces negative family communication, enhances parental involvement with children, reduces child behavior problems, enhances limit-setting, and improves the general psychological well-being of parents.

Comments on Implementation/Replication: Positive results have been replicated in classes in 35 states, including improvements in the quality of relationships, reductions in harsh and rejecting attitudes and behaviors, reductions in children's different behavior problems, and improvements in parental psychological well-being.

4. MELD

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Target Population: MELD programs include MELD for New Parents (for parents to two years of age) designed for first-time parents; MELD Plus (for parents with children over 2 years); MELD for Young Moms (MYM) for teen mothers of children age 0-2; MYM Plus for young mothers with children over 2 years; La Familia MELD for Hispanics parents with children age 0-3; Hearing Impaired Parents Program (also for parents of very young children); MELD Special (for parents with handicapped or chronically ill children age 0-3); and Nueva Familia, for Mexican and Mexican-American parents who are very low-income, have a low reading vocabulary, and whose family is at risk of dysfunction, especially during a period of cultural transition.

Program Origin: The idea for MELD grew from a 1973 Lilly Endowment research and development grant. MELD began delivering services in a self-help group format to pilot groups in 1975. These groups began in the last trimester of pregnancy before any family dysfunction could occur. By 1987, MELD curricula included programs for teens as well as adults and was replicated in over 90 agencies in the U.S., Germany, Australia and Canada.

Program Objectives: MELD's goal is to create healthy, happy families, and to prevent instances of emotional or physical abuse and family dysfunction by creating a healthy family atmosphere before these instances might occur. This means providing parenting services as early as the last trimester of pregnancy.

Program Strategies: MELD meetings are held in churches, neighborhood centers and homes. MELD groups are led by a team of volunteer parent group facilitators who represent two families. Parents combine informal discussion with curriculum models and materials called "Parent Parts," each concerned with a preselected topic. Besides psychological support, MELD curriculum focuses on child development, child guidance, health, parent development, and family management.

Recruitment and Retention: Parents are either self-referred or recruited by professionals or home visitors.

Staffing: MELD volunteer facilitator are carefully selected, trained, and supported by professionals. They have experiences similar to those of the families in therapy (the

MYM meetings are led by women who were once teen mothers and have achieved a degree of self-sufficiency while raising healthy, happy children). Those implementing the MELD program within a community must have a good deal of experience in community development, child development, parent training and volunteer management. Facilitators receive 16 hours of basic orientation training, 12 hours of in-service training, frequent phone interaction with MELD professionals to receive support and ongoing training, and curriculum manuals that can help them to organize and prepare for a parent group meeting in as little as 20 minutes.

Resources Needed and Materials Available: Materials are provided for the group participants, the group facilitator, the professional MELD site coordinator, the agency incorporating the program into their services, and any co-sponsor that might be hosting a group at their location. Public relations materials are also available. The MELD curriculum is not sold to agencies or individuals who are not planning to receive the entire training contract necessary to replicate the program. When a contract is signed, the agency receives enough materials to start four, eight-parent groups. Some of the parenting books are available to the general public through MELD.

Special Characteristics: MELD is one of the few parenting programs available that bring parents into the program before the birth of the child.

Effectiveness: Evaluation materials include a series of process forms to evaluate groups in-process: a Community Outreach Log, completed by site coordinators (evaluates community support for the program); group information is taken from a Parent Group Facilitator Application, a parent contact log, group and attendance logs, parent group rosters, dropout forms, PGF Performance Reviews and supervision forms. Adolescent group members complete the form "My MYM Group...How It's Working." A series of outcome forms are also available which provide demographic information, information on future plans, examine self-esteem and use of community resources, satisfaction with support from family and friends, inventory life events, and look at coping patterns group members use for daily problems. MELD succeeds in providing relevant information and support to parents. The Bush Foundation has funded an extensive evaluation of the MELD's New Parents (adult) groups. Preliminary findings from the Child Welfare League of America indicate that 80% of MELD's participants are continuing in high school. Their repeat pregnancy rate is lower than the general population, and they have improved health and knowledge and family planning.

Comments on Implementation/Replication: It is helpful to include men as leaders to facilitate fathers joining the groups. When male leaders are involved, as many as 40% of adult group members are men.

5. PARENTING: A SKILLS TRAINING PROGRAM

Mailing Address: Louise F. Guerney, Ph.D.
Parenting: A Skills Training Program
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(814) 865-1751

Target Population: This program is designed to be used by a variety of parents, including those of low social economic status and of varying ethnic and religious backgrounds. The program is also designed for children from infancy through adolescence who are at high risk for delinquency, alcohol and other drug abuse, child abuse, and for handicapped children. Program materials are currently being translated into Spanish.

Program Origin: The Parenting Skills Programs for problem prevention and enrichment was developed in the mid and late 1970's. It is an offshoot of the Filial Therapy Program, which has been in use since the early 1960's. The therapy program is the work of Bernard G. Guerney, Jr.; the adaptation for training natural and foster parents was developed by Louise F. Guerney.

Program Objectives: Primary objectives include teaching parents skills that will help them relate to their children in a manner designed to foster good psycho-social adjustment and freedom from drug and alcohol abuse, delinquency, teen-aged pregnancy, and school drop-out. Improved academic performance and better pro-social skills are also expected.

Program Strategies: There is much flexibility in the program format. It can be conducted over a series of day-long or weekend meetings or at weekly meetings. The size of the group can vary from a single family to groups as large as 20. Typically, 12 to 16 parents meet weekly for two hours with a single trainer or a pair of trainers. Training techniques include readings and homework assignments, lectures, and role playing. The greatest emphasis is on skill training, with practice and supervisory feedback through role playing. In the therapeutic version of the method, children are brought in for play sessions and the parents practice their skills, receive reinforcement, and obtain feedback from the trainers.

Recruitment and Retention: Recruitment practices, transportation and daycare provisions depend on the setting. It is recommended that transportation and daycare be provided for families in rural and inner-city settings.

Staffing: No special educational background is required. Training is provided through a non-profit institute, IDEALS (Institute for the Development of Emotional and Life Skills). Certification as a trainer and as a trainer supervisor is available. IDEALS trainers travel throughout the United States and Canada. Training fees include a daily

charge plus per diem travel and expenses. Usually 12 enrollees are necessary to make the per-trainee cost reasonable. Additional supervision is available via audio or video tape and telephone after the initial training. Such supervision is required for certification.

Resources Needed and Materials Available: Leader's and parents manuals are available.

Special Characteristics: None noted.

Effectiveness: The program has been very thoroughly investigated in its foster parent form. In relation to foster parents, parental acceptance and parenting skills improve significantly on pre-post tests. FPSTP outcomes were significantly higher for both parents and their foster children than the outcomes of a control group. These significant changes in parent attitudes, skills acquisition, and caseworker evaluation of family and children continued over a period of five years for six waves of parent trainees. Also, trainers trained to offer the program showed positive changes in relation to their own skill use and job performance. (Three reports from IDEALS are available on these results.)

In relation to the infant version, parents in the local Childbirth Education Association, trained to conduct the program, were able to bring about significant pre-post changes in parents of babies six months and younger in age. These results were significantly more positive than a comparable new mother-support/discussion group offered during the same pre-post period.

VIDEO PRESENTATION PROGRAM

6. PARENTS AND CHILDREN VIDEOTAPE SERIES

Mailing Address: Carolyn Webster-Stratton, Ph.D.
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Target Population: This program is designed to help parents of normal children aged 2 to 8 years, parents of "oppositional" children between the ages of 3 and 8 years, parents at risk of abuse or neglect, teenagers taking babysitting classes or family life courses, family therapists, social workers, child psychologists, teachers, nurses, physicians, child protective service workers, and day care providers.

Program Origin: This course is based on well-established behavioral/social learning principles that describe how behaviors are learned and how they can be changed.

Program Objectives: Short term objectives for parents are to improve communication skills with their children, improve limit-setting skills by means of nonviolent discipline techniques, improve their own problem-solving skills, and learn effective methods of anger management. For children, short term objectives include reduction of the frequency and number of conduct problems and improvement of prosocial skills.

Program Strategies: The basic and advanced series consists of 16 videotape programs, each building on the last. Five two-hour sessions are usually required to complete the first two programs, though some groups may take longer. Most parent groups take 12-14 weeks (2 to 2½ hours per week) to complete the basic series (10 videotapes). The advanced series takes an additional 6-19 sessions (16 videotapes). Groups usually range from 10 to 14 participants; one trainer is needed per group. On-site day care is recommended for those parents who cannot arrange or afford babysitting.

Recruitment and Retention: Families at risk for abuse or with a history of abuse and/or child misconduct problems may be referred by therapists or clinicians.

Staffing: While the program has been researched with extensively trained and experienced therapists, it could be used by many groups in the community who work with families (e.g., teachers, parent educators, nurses, physicians, child protective service workers, etc.) Professional backgrounds of instructors who have used the program include advanced degrees in psychology, social work and nursing. Instructor training is through self-study with the leader's manual and videotapes provided with the program. Training workshops are offered; duration has varied from 1 day to 2 weeks, depending on the background and experience of the leaders-in-training, and on

the nature of the families they work with. Workshop costs vary depending on length.

Resources Needed and Materials Available: The complete program includes videotapes, an instructor's manual, and a set of manuals for the participants. The leader's guide for the parents and children series contains a brief recap of the parent/child interactions and the author's narration for each vignette, a summary of the important points, topics for discussion, and all of the necessary checklists and forms for administering the program. The leaders guide also describes how to use the parents and children series as a self-administered program, or with groups. The participants' workbooks for each of the video cassettes contain all of the information needed by participants using the basic program in a self-administered format. This workbook contains all of the checklists, forms, and handouts for using the parents and children series. The complete program costs $1,300. Individual programs cost $175 - $245 each.

Special Characteristics: None noted.

Effectiveness: The series has been researched and field tested with over 600 families, including normal children and those with conduct problems (Webster-Stratton, 1981, 1982, 1989, 1990, 1991). Results indicate that parents were able to significantly reduce children's behavior problems and to increase their prosocial behavior. Parents reported that they felt more confident and comfortable about their parenting skills after completing the course. One to three year follow-up assessments indicate that more than two-thirds of the clinic-referred (i.e., abusive, conduct-disordered) families continued to maintain positive parent-child interactions and normal child behavior.

Comments on Implementation/Replication: This program should be fairly easy to implement, due to the extensive materials available.

In 1992, three new programs (5 videotapes) were produced for school aged children, including parent models representing over 50% of families from differing cultural backgrounds. The purposes of these programs are to promote parents' self-confidence and competence in using positive parent management strategies in order to promote children's social skills, support their academic success, increase their self-esteem, and reduce inappropriate behavior at home and at school.

A new five-part videotape program focuses on helping parents understand ways to support their children's education. It includes promoting self-confidence, fostering good learning habits, dealing with academic discouragement, parents participating in homework, and using parent-teacher conferences to advocate for your child.

New Videotapes for Children The Dinosaur Social Skills and Problem-Solving Curriculum for Young Children is designed to promote non-aggressive ways for children to solve common conflicts, appropriate classroom behaviors, and positive social skills with other children and adults. It contains 9 videotapes, teacher manuals, letters to parents, and 40 laminated teaching materials.

7. PREPARING FOR THE DRUG (FREE) YEARS

Mailing Address: J. David Hawkins, Ph.D.
Richard F. Catalano, Ph.D.
Developmental Research and Programs
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(800) 736-2630

Target Population: "Preparing for the Drug (Free) Years" is a five session program that trains parents of children aged 9 to 12 years old to reduce the risk that their children will develop alcohol or other drug problems.

Program Origin: The program was developed by Drs. J. David Hawkins and Richard F. Catalano of the University of Washington in conjunction with Developmental Research and Programs.

Program Objectives: Hawkins and associates (1987) identified 11 risk factors that research has shown to be related to later alcohol and other drug abuse. Family risk factors include a family history of alcoholism, family management problems, parental drug use or positive parental attitudes toward use, and low social bonding. School risk factors include a low degree of commitment to school and academic failure. The single peer factor is having friends who use drugs. Personal risk factors include antisocial behavior, a favorable attitude towards drug use, and early first use of drugs. The program is based on the assumption that if these factors are reduced, children will be less likely to develop alcohol or other drug problems.

Program Strategies: The program covers the following topics in each session: the risk factors for drug abuse; establishing a family position on drug use; how to stay out of trouble; how to handle family conflict and anger; and how to increase opportunities for children to be more involved in family responsibilities, duties and activities.

Recruitment and Retention: It appears to be difficult to attract and recruit high-risk parents to attend the program. Most (71.6%) of the families in the existing program implementations were recruited through schools. Hawkins and his associates (Hawkins, Catalano, Jones, & Fine, 1987) mention that "for some high-risk parents, schools themselves represent places of failure and alienation. Perhaps churches, religious groups, and other community organizations will provide a more fruitful base for recruitment of high-risk parents." Businesses that employ many high-risk parents would also be good sites for recruitment and replication of the program.

Staffing: The program is designed to be led by two persons, both with good verbal skills. One leader should be a parent, preferably with prior experience in teaching or group facilitation. The training period for group leaders is three days.

Resources Needed and Materials Available: A curriculum kit is available for the program, including a leader's guide, a family activity book, video training tapes, and a guide for adapting the program for diverse communities.

Special Characteristics: The primary tool for improving family relations is the family meeting. This concept has been around for a long time and is imbedded in several general population programs such as Popkin's Active Parenting Program. It may not be effective with high-risk families without supervision and modeling. It may be too difficult for high-risk families to conduct family meetings. Democratic principles with youth input is a middle-class idea and may not be acceptable to more authoritarian parents. Hawkins is planning focus groups of different minority parents to learn how to modify the program for their values and needs.

Unfortunately, the intensity of the implementation depends on the ability of the parents to develop a family meeting system and conduct the program in their homes. Many high risk parents are not capable of such organization and control. The school factors are only weakly addressed as are child or adolescent discipline issues. The program is strongest with encouraging improved family relations, democratic family management through family meetings, conflict resolution ideas, and encouraging the parents to give meaningful roles to children.

Effectiveness: This program has only been weakly evaluated. The program evaluation was reported in "Preparing For the Drug (Free) Years Television Community Service Project Evaluation Report" prepared by Kent, Wald and associates (March 1988). This evaluation measured whether the participants learned the concepts taught. Most of the knowledge and attitude items showed significant differences at the end of each session. Behavioral changes were not measured, except whether the families completed their homework assignment of conducting family meetings. No follow-up results are reported to ascertain how many of the families continued with their family meetings and implemented the suggested family activities in their home.

Comments on Implementation/Replication: This program may be good for general population families, but it has not yet been adapted and tested for high-risk minority families or for low socio-economic status families. Only 16% of the families in the Washington state media project were judged to be high-risk families. The program is very short--only five sessions. Weak, short-term programs have not been found effective with high-risk parents. Currently, the program's primary usefulness with high-risk families is as an adjunct to a more comprehensive program.

8. TREATMENT FOSTER CARE PROGRAM (TFCP)

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Treatment Foster Care
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(503) 485-2711

Target Population: The program provides 6-month foster care placements for 12 to 18 year-old adolescents who have been committed to the Oregon State Training schools or are at risk of commitment because of delinquency. The Treatment Foster Care Program is essentially a parent training program that focuses on foster parents as well as the natural parents of these adolescents.

Program Origin: This therapeutic or treatment oriented foster care program was developed by Patricia Chamberlain and John Reid at the Oregon Social Learning Center in 1983. It was designed as one of 13 statewide diversion programs funded by the Oregon State Children's Services Division (CSD).

Program Objectives: The program philosophy is that the "conduct of youngsters can be altered by the circumstances that influence them; and second, that their natural or aftercare placement families can be helped to support positive social behaviors so that community adjustments can be made, reducing the likelihood of institutionalization." The most global long-range goal is for the participants to avoid institutionalization. Reduction of delinquency, improvements in school attendance and completion, reduction in substance abuse, and improved adjustment in the community are all treatment goals. Intermediate objectives include improving the parenting skills of the teenager's natural, step, or adoptive family; the teenager's prosocial skills are also targeted.

Program Strategies: Program staff use a "high impact model" for working with chronic delinquents who had been removed from their house by the courts. The foster parents learn problem solving, communication skills, and behavior management practices, such as supervision/monitoring, encouragement, and limit setting. They implement an individualized daily point program for each youth and use allowance and privileges to reward good behaviors.

Recruitment and Retention: Referrals come from state juvenile courts, attorneys, parole officers, and CSD workers.

Staffing: Foster parents are screened, selected and trained in a twenty-hour pre-service training and orientation. They are then supervised and supported by daily telephone

calls and weekly foster parent groups. The foster parent training is conducted by an experienced foster parent and other program staff.

Resources Needed and Materials Available: This foster care program is part of the larger comprehensive service tracking and monitoring system created for these delinquents. This system includes a case manager who coordinates all services with the probation officers, school, foster parents, and individual and family treatment staff, and child advocate. The cost for this and the services referenced below is a flat $10,000 capitation per child for the 6 months of services. The cost (ca. 1990) for the foster parent program is $500 to $700 compared to $1000 for hospitalization. Program materials include a foster parent manual and video vignettes for training. There are also published journal articles describing the program.

Special Characteristics: Other services provided for the foster parents include respite families, daily telephone contacts, crisis backup, and regular and on-call consultation with the case manager. The youths have regular home visits beginning after the third week of the program. The natural parents participate in family therapy once per week.

Effectiveness: This program is very effective in reducing delinquency and recidivism in delinquent youths. Compared to residential care and institutionalization, the program has been shown to be effective and cost effective.

Comments on Implementation/Replication: In-home crisis family preservation programs should be considered before out-placement. It is recommended that Alexander's Functional Family Therapy or Szapocznik's Structural Family Therapy be combined and conducted in the home as an adjunct to this program. The program director recommended a Family Resource Enhancement Program with aftercare supports for the natural families after the six months of foster care treatment. Big Brothers/Big Sisters would be helpful, since most of the youth are from single-parent families. Transportation and money for continued community opportunities would also be helpful.

B. FAMILY SKILLS TRAINING PROGRAMS

9. CEDEN

Mailing Address: Emily Vargas Adams, Ph.D., Exec. Director
CEDEN Family Resource Center
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Target Population: CEDEN programs are appropriate for parents of developmentally delayed infants or young children, primarily low income families; or parents whose infants or young children are at high risk for developmental delay, either through biological/medical or environmental circumstances.

Program Origin: CEDEN was founded in 1979 by Dr. Emily Vargas Adams, now Executive Director. Dr. Adams conducted a needs assessment with low-income families in East Austin, and determined that the highest priority of need was for services to improve child and family development.

Program Objectives: CEDEN strives to promote and strengthen families in need through family-focused, community-based services. A variety of programs interact to provide this support. The Parent-Child Program is the focus of this program description.

Program Strategies: The Parent-Child Program provides full-scale child and family screening and assessments, individualized family service plans, weekly home visits and monthly group meetings on infant stimulation, health, nutrition, safety, and home improvement.

Recruitment and Retention: Clients are self-referred by hospitals, clinics, physicians, schools, human services agencies, child care centers, child therapy centers, family violence programs, police departments, churches, past participants, and concerned citizens. Early intervention specialists (home parent educators) also canvas neighborhoods in order to identify those lowest-income families who do not have an adequate support network. All families are screened before admittance to the program.

Staffing: Instructors are required to have a minimum of a college degree and three years of experience in child development, have demonstrated ability to read and write well in English and/or in Spanish, and have a current driver's license, car insurance, and car to conduct home visits. Parent educators should be empathetic, motivated, and non-judgmental.

Resources Needed and Materials Available: CEDEN has a variety of resource materials for use by home educators and parents alike. The CEDEN Infant Development Curriculum is available for home educators. There are also 20 Health and Nutrition packets available for caregivers. CEDEN has an extensively field-tested infant development book called *My Baby Book*, also available in Spanish as *Libro de Mi Bebe'*. The Parent-Child Program Evaluation Manual is used by CEDEN for internal program evaluation. The curriculum for classes on parenting and communication skills provides content and methods to teach parents the essentials of parenting. Many other materials on prenatal and parenting education are also available from CEDEN.

Special Characteristics: CEDEN is a comprehensive program that has been presented here only in part. Some portions of the full CEDEN program are dependent on available community services. Since such services may vary from site to site, only such information as may be implemented across sites (i.e., the home visitor program) has been presented.

Effectiveness: This program is exceptional in its commitment to program evaluation and research, and has extensive internal evaluation procedures available. CEDEN has maintained a three-person research department since 1979.

Comments on Implementation/Replication: This program is an excellent infant parenting program for very high-risk families, especially for parents who need services in their home. The home visitor provides other needed referrals and support services such as transportation or emergency support. The program would be difficult to implement in very dangerous neighborhoods; however, CEDEN maintains that its home educators are most often welcomed because of CEDEN's reputation as a helping organization. The program has a drop-in center and also provides child care centers with a range of services including home visits, parent education classes, parent support groups, and parent involvement groups. They also hold parent/child language development and literacy groups in their offices for parents.

10. FAMILIES AND SCHOOLS TOGETHER (FAST)

Mailing Address: Lynn McDonald, Ph.D.
FAST/Family Services
128 East Olin Avenue, Suite 100
Madison, WI 53713
(608) 251-7611

Target Population: The program is designed to assist preschool, elementary, and middle-school aged children whom teachers have identified as at risk for later problems——such as school failure, substance abuse, and delinquency——and their families.

Program Origin: FAST was developed by Dr. Lynn McDonald and Family Service of Madison, Wisconsin, in collaboration with the Prevention and Intervention Center for Alcohol and other Drug Abuse and the Madison Public Schools. Original funding came from grants by the United Way and the State of Wisconsin Department of Health and Human Services.

Program Objectives: The FAST program is designed to:

(1) Enhance family functioning by strengthening the parent-child relationship in specific ways and empowering the parents to become primary prevention agents for their own children.

(2) Prevent the target child from experiencing school failure by improving the child's behavior and performance, empowering parents as partners in the education process, and increasing family feelings of affiliation with their schools.

(3) Prevent substance abuse by the child and the family members by increasing knowledge and awareness of substance abuse and its impact on child development and linking the family to assessment and treatment services if necessary.

(4) Reduce the everyday stress that parents and children experience by developing an ongoing support group for parents of at-risk students, linking participants to needed resources, and building the self-esteem of each family member.

Program Strategies: FAST uses a collaborative, whole family approach to achieve its goals. An 8-week curriculum of multiple-family group activities, followed by ongoing monthly meetings, incorporates the following activities: a meal hosted by a family, a family sing-along, structured family communication exercises, family feelings identification exercises, parent support meetings while children play, one-to-one quality time, winning-as-a-family-unit exercises, a closing ritual, a substance abuse education component, graduation, and development of a school-based parent advisory council of FAST program graduates.

Recruitment and Retention: FAST identifies participants through a strong and active recruitment process in which school personnel identify at-risk children. Other recruitment activities include home visits and training in recruitment, plus a positive nonstigmatizing programmatic approach that focuses on strengths and empowerment, incentives, and removal of obstacles to participation through provision of transportation and child care. Of families initially telephoned by schools, 63 percent agreed to attend at least one meeting. Eighty-two percent of families that attend at least one meeting graduate from the FAST program. Recruitment and retention rates reflect first-time implementation at new sites; rates at ongoing sites are typically substantially higher.

Staffing: FAST is a collaborative effort between a school, a mental health agency, an alcohol and other drug abuse prevention specialist, and parents. Multifamily group meetings are staffed by a school staff member such as a social worker, counselor, psychologist, or principle; a parent, liaison worker, or FAST facilitator; an alcohol and other drug abuse prevention specialist; and a mental health professional. Volunteers are recruited and trained to help at meetings.

Resources Needed and Materials Available: Necessary resources include a large room and materials to execute family activities. The *FAST Program Workbook* describes all the resources needed.

Special Characteristics: FAST targets whole families, reaches "unreachable" families, and uses a truly collaborative approach. FAST breaks down barriers to trust and stereotypes and promotes development of active parent groups and advocacy councils. FAST utilizes a stress/social-support model that builds on family strengths. FAST is explicit about program values. The FAST program model and activities are strongly grounded in an empirical research base.

Effectiveness: Scores on objective, standardized assessment instruments demonstrate significant pre- to post-program improvements in child behavior problems, as rated by both parents and teachers; improvements in family cohesion; decreases in social isolation of parents; and increases in involvement of parents with their children's schools. Collaborative teams rate the program as very successful. Data have been collected on over 700 elementary school children, and continuing evaluations of program effectiveness are in progress.

Comments on Implementation/Replication: FAST has been successfully replicated at more than 70 schools in Wisconsin and 6 other States in rural, medium-sized, and urban communities. FAST groups have been made up of culturally diverse families, as well as solely Spanish-speaking people, Native Americans, African Americans, Asian Americans, or European Americans. FAST has developed a thorough and highly effective training model that includes links between communities and onsite training of collaborative teams.

11. FAMILIES IN FOCUS - "Seven Secrets to a Successful Family"

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Target Population: Families whose children are at high risk for alcohol and drug use because of a family history of alcohol and drug abuse, parental communication problems, family management problems, or youth problems.

Program Origin: *Families in Focus* (FIF) began just over 5 years ago as result of The Cottage Program International's 15 years of working with families to prevent alcohol, drug abuse and other behavioral disorders. Its companion program *Foco Interno Familiar* for Spanish speaking families was translated, adapted, and implemented in Hispanic/Latino populations in the United States and Latin America in 1988.

Program Objectives: The program objectives are to reduce alcohol and drug use and their accompanying behavioral disorders, decrease parental denial, educate parents and youth about the consequences of alcohol and drug use, and encourage participation in health promotion and risk-reduction programs.

Program Strategies: The program involves 36 hours of in-home or small group workshops in family skills training. Service providers and volunteers are trained to conduct and maintain these prevention services. Meetings are usually held every two weeks to complete the initial phase of the nine session program. The family members complete a Family Profile questionnaire which is adapted from the Family Adaptability and Cohesiveness Evaluation Scale (FACES III). Once the Family Profile is completed and charted, it directs the family to a specific activity based on their family needs. The Home Learning Guide contains 53 different family activities as well as stress tests for adults and adolescents. Families maintain contact with FIF over several months and, in many instances, years through a toll-free number. Newsletters and follow-up contacts and other activities are part of the ongoing support services.

Recruitment and Retention: The families are referred by educational institutions, businesses, religious organizations, agencies, and the general communities where the program operates throughout the United States. The program receives substantial attention from the print and electronic media, attracting large numbers of families to participate in the program. Families who become involved in FIF tend to complete the training cycle and maintain contact with the program over an extended period.

Staffing: Both volunteers and professionals are used for the program. Two trainers are required for groups of up to 20. The volunteer trainers are trained in 12 hours of

classroom training and 12 hours of field work, followed by continuous in-service training each month. Volunteers have access to a toll-free telephone number for ongoing consultation.

Resources Needed and Materials Used: The FIF program includes the Home Learning Guide; the Volunteer Training Manual; the Replication Training Manual; the Community Development Manual; Family Profile; and assorted charts, lists, and brochures.

Special Characteristics: This program was developed primarily to strengthen families and prevent the onset of alcohol, drug abuse, and other behavioral disorders. It seeks to promote social and personal values which are consistent with the behavioral health and emotional well-being of individuals and their environment. Its empowerment philosophy and community orientation embrace the Self-efficacy Theory and the Health Belief Model.

Effectiveness: Families in Focus undergoes a complete process and outcome evaluation. The evaluation quantifies the effects of participation. The impact that Families in Focus has on drug abuse, age of first use, abstinence, and use expectancies are measured. Pre- and post-measurement of family functioning and family satisfaction are considered. Results show gains in family functioning and family satisfaction. Further, it is indicated that the program significantly reduces the incidence of alcohol and drug abuse. Expectancy scores are also predictive of fewer problems with alcohol and drugs. Foco Interno Familiar is producing similar results in Spanish speaking populations.

Comments on Implementation/Replication: Currently, there are over 10,000 families throughout the United States who have participated in the FIF program. The U.S. Department of Education is providing funding for its implementation. FIF has operated successfully for over three years in Thibodaux, Louisiana and is being replicated statewide in Louisiana during this school year. For over 4 years, Willmar Regional Treatment Center in Willmar, Minnesota has successfully operated FIF in a rural 17 county area. Southwest Texas State University in San Marcos, Texas has carried out the program for Spanish-speaking individuals for more than three years and shows positive results.

The Utah State Prison has utilized the Families in Focus Program for inmates and their families at the prison site. J.C. Penney, Unisys, Citibank, and other businesses have found the program to be very helpful in improving employee morale.

12. NEW FUTURES SCHOOL

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Target Population: Pregnant adolescents and adolescent parents.

Program Origin: New Futures School is a comprehensive program for pregnant adolescents and adolescent parents located in Albuquerque, New Mexico. The program was begun in 1976 at the YWCA. Since that time, it has served over 5,000 adolescent parents. As a comprehensive program, it offers educational, health, counseling, vocational and child care services to pregnant adolescents and adolescent parents. It is an alternative school of the Albuquerque Public Schools and is supported by a non-profit, community-based organization--New Futures, Inc.

Program Objectives: The mission of New Futures School is to assist and motivate school-age parents to make responsible, informed decisions, to make progress toward completion of their secondary education, to become more mature, to have healthy pregnancies and families, to become responsible parents (which for some may mean a choice to release for adoption) and to become well-adjusted, contributing, self-sufficient members of their communities.

Program Strategies: The program is very comprehensive and is housed in its own architecturally designed facility. The students helped to determine how the space in the facility should be arranged to meet their needs. This program includes almost all basic services except housing. New Futures provides education, vocational training, child care, health services, job development and job finding, counseling and social services, parent training and child care training, low cost goods sold at a volunteer-run "Dime Store", a library with children's toys and books, and opportunities for self-development through participation in the teenage pregnancy prevention outreach program to high schools. Group health instruction is provided by nurse/health educators. The University of New Mexico School of Medicine's Maternity & Infant Care Project operates a weekly prenatal clinic in this facility for students. New Futures School operates four child care facilities on its premises for children of clients. A Jobs Training class is offered to 30-40 students per year. This program emphasizes job-finding and job-keeping skills. Five Foster Grandparents provide volunteer services for New Futures School.

Recruitment and Retention: No teen mothers requesting services are denied access to the program.

Staffing: A variety of staff with varying areas of expertise participate in this program. As independent consultants or through technical assistance contracts, New Futures staff provide workshops, training and technical assistance to adolescent pregnancy programs and concerned agencies and organizations throughout the United States and Canada. Specialized staffing is needed for the various medical, counseling, and training components of the program, as well as for childcare and other program components.

Resources Needed and Materials Available: The New Futures School is extremely comprehensive in design and implementation. Extensive funding would be required to establish comparable programs.

Special Characteristics: There are two departments of the New Futures School in-school program. The largest and oldest, now called the Perinatal Program, serves the teen who enters during her pregnancy and remains until the end of the semester in which her child is born. (If the child is less than 3 months old at semester's end, the mother may remain through the next semester.) A girl may receive services in this program for only one pregnancy. The second department, called the Young Parents' Center is designed to serve school-age mothers and fathers, who for identified reasons cannot successfully participate in a regular school program in the years following the birth of their child. Enrollment is limited, with students accepted after a screening process. The Young Parents' Center, therefore, serves the most high risk of a high risk group. It, too, offers the full range of educational and support services described. Clients may remain in this program as long as their need exists if they are showing steady progress toward their diploma or GED. Individual contracts may be used to specify expectations and measures of progress.

<u>Prevention Services:</u> New Futures School responds to requests from schools, churches, and community agencies for presentations aimed at reducing pregnancy. The focus of these presentations is on helping teens to understand the realities and responsibilities of teen parenthood, and on leading teens to consider how a teen pregnancy would affect their lives. New Futures students sometimes participate in these presentations. Extensive use is made of the video made by New Futures, Inc., "See What The Future Will Bring." Fifteen hundred to 2,000 teens are reached annually with these presentations.

New Futures, Inc. sponsors training series for parents of pre-teens entitled "Family Talks." The program is designed to assist parents in educating their children about sex. It emphasizes helping children to develop a strong sense of self-worth.

Effectiveness: This school has had impressive results with high-risk pregnant teens and teenage mothers. Almost three-quarters of their students continue on to post-secondary education and child abuse is nonexistent. The program has only been evaluated by non-experimental designs consisting mainly of comparisons of their graduates with local or national statistics. They have found that the services of New

Futures School have probable benefits for the participants and for the community, if their students are similar to comparison group norms. The rate of low birth weight babies is less than the national rate for children of teen mothers. Repeat pregnancy rates for clients are less than half of the national rates for teenage pregnancies. A study in 1987 found that 77 percent of New Freedom School students contacted had either completed a secondary education or were still in school. Fifty-four percent of the graduates had gone on to post-secondary education or training. Nationally, less than half of teen parents graduate from high school. Only 16% of the former students were receiving welfare. Perhaps equally important are the observations that clients are better adjusted young women who have learned from their experiences, who face the future with increased confidence and abilities, and who have developed parenting skills which will provide their children with a better chance in life.

Comments on Implementation/Replication: This alternative school in Albuquerque is almost perfect in terms of the comprehensiveness of the services provided and the number of risk factors addressed. The primary barrier to dissemination is the cost of the facility and the fact that the students are put into their own alternative school. Few school districts today have the money to establish a free-standing facility such as New Futures. Most schools today have pregnant students attend the same classes with the rest of the students. Unfortunately, special needs of the pregnant teenager or new mother are difficult to address in a regular school.

13. THE NURTURING PROGRAM

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Target Population: Each of six separate Nurturing Programs are designed for specific groups. There are Nurturing Programs tailored for parents with children from birth to 5 years; for parents with children from age 4 to 12 years; for parents with adolescent children; a program designed specifically for teenage parents and their families; a program for parents who have special learning needs; and a Nurturing Program for foster and adoptive families. The Nurturing Programs were designed for families experiencing serious interaction problems.

Program Origin: The original Nurturing Program was designed as an NIMH grant to reduce child abuse and neglect by improving child nurturing in abusive parents.

Program Objectives: The Nurturing Programs seek to reduce family dysfunction and to build healthy, positive interactions in the family. The Programs' philosophy is that parenting is learned and parenting styles are passed from parent to child.

Program Strategies: The Nurturing Programs address parents' needs for nurturance and reparenting and also provide concurrent nurturing learning experiences for children. Parents and children are taught similar skills and attitudes to maximize learning and maintenance of new knowledge. Each program consists of weekly sessions; these range from 45 minutes (in the program for very young children) to 2 1/2 hours. Overall program lengths also vary. Each session has a particular focus and requires the use of previously learned skills.

Recruitment and Retention: No specific information available.

Staffing: The Programs are designed for skilled professionals and paraprofessionals in social services, mental health, education and other helping professions. Training in group instruction, home visits, and working with children from infancy through adolescence is required. Instructor training workshops are available nationwide; these focus on the nurturing philosophy, results of field testing, and implementing and conducting the weekly sessions. Workshops are generally about 2 days long.

Resources Needed and Materials Used: A variety of instruction manuals, games, audiovisual presentations, dolls, coloring books and other items are available.

Special Characteristics: The Nurturing Programs are based on the following learning principles and goals: a) the family is a system and involvement of all members is essential for change; b) a major focus is to build empathy among all family members; c) parenting exists on a continuum; d) adults, children and adolescents learn on both cognitive and feeling levels; e) a major goal is to increase self-esteem and positive self-concept; and f) all families would prefer to display healthy interaction (rather than abusive, problem interactions) given a chance.

Effectiveness: These programs have been field tested nation-wide; results of such trials are included in program materials. Nurturing Programs use the Adult-Adolescent Parenting Inventory (AAPI) as a pre/post test to measure parenting attitudes.

Comments on Implementation/Replication: This program is fairly easy to replicate because of the standardized materials and manuals. The cost is reasonable for training and materials. It is widely disseminated nationally and internationally. Excellent training manuals and parent handbooks are available as well as videos and films. However, for very high-risk families this program would be more effective if embedded in a more comprehensive social services system.

14. PARENTING AND FAMILY SKILLS PROGRAM: HELPING THE NONCOMPLIANT CHILD

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Target Population: Parents and their three- to eight- year-old children who are exhibiting noncompliance and other conduct problems. There are no specific criteria for parent participation. The involvement of both parents is actively encouraged.

Program Origin: This program is based on a parent training program originally developed by Dr. Constance Hanf at the University of Oregon Medical School in the late 1960's (Hanf & Kling, 1973) to treat noncompliance in young, physically handicapped children. This adaptation by Forehand and McMahon (1981) is the most formally operationalized and validated version of the Hanf approach to working with conduct-problem children.

Program Objectives: Primary goals are secondary prevention of serious conduct disorder problems in preschool and early elementary school-aged children, and the primary prevention of subsequent juvenile delinquency. Short-term and intermediate objectives include: a) disruption of coercive parent-child interactions and the establishment of positive, prosocial interactions; b) improved parenting skills in tracking the child's positive behaviors, increased use of praise and positive statements, ignoring of minor inappropriate behaviors, provision of clear and appropriate instructions, and provision of appropriate consequences for compliance, noncompliance, and other behaviors; and c) increased child prosocial behaviors and decreased conduct problems.

Program Strategies: The parent training program focuses on teaching parents to change maladaptive patterns of interaction with their children. The 60 to 90 minute sessions are conducted in a clinic setting with individual families rather than in groups. In an ideal setting, sessions occur in clinic playrooms equipped with one-way mirrors for observation, sound systems, and sound devices by which the therapist can unobtrusively communicate with the parent; however, these are not necessary for the successful implementation of the program. This is a very active program that places a great deal of emphasis on helping the parent become competent and comfortable with the various parenting skills taught in the program. Progression to each new parenting skill in the program is based on the competent performance of the earlier skills. This allows for individualization of the treatment program by allocating training time more efficiently, since the therapist can focus attention on more serious parenting skill difficulties. The number of sessions needed for completion of each phase of treatment depends on the speed with which the parent demonstrates

competence and the child's response to treatment. The average number of sessions is 10-12. Sessions are typically held once or twice weekly.

Recruitment and Retention: No specific information available.

Staffing: A single family therapist is all that is necessary to conduct the program successfully. However, if resources permit, use of a co-therapist can increase the therapist's flexibility in demonstrating various skills to the parent (e.g., the therapist and co-therapist may demonstrate these by role-playing the parent and child).

Resources Needed and Materials Available: A comprehensive presentation of the program is contained in the therapist's manual (Forehand & McMahon, 1981). Parents are given handouts specific to each skill for reference in the home setting, are assigned homework to practice their newly acquired skills, and are given data sheets to record their results.

Special Characteristics: This is a social-learning based program comprising two phases. Phase I (the differential attention phase) helps the parent to use positive verbal and physical attention contingent upon compliance and other appropriate behaviors, and to ignore minor inappropriate behavior. Phase II teaches the parent to use clear instructions and to provide appropriate consequence for child compliance and noncompliance. The parent learns to issue instructions one at a time that are clear, concise, and direct, and to allow the child sufficient time to comply. The parent is taught to praise or attend to the child within 5 seconds of compliance initiation. A time-out procedure is used when the child is noncompliant. "Standing rules" are designed and implemented for each child.

Effectiveness: This parent training program has been extensively evaluated (see McMahon & Forehand, 1984). Both parent and child behaviors have been shown to improve in the home to within the normal range as a function of treatment, as have parents' perceptions of their child's adjustment. Furthermore, these improvements occur regardless of the families' socioeconomic status (although families from lower socioeconomic backgrounds are less likely to complete the program) or age of the children (within the three to eight year-old range). Improvement in child compliance has been shown to be accompanied by decreases in other conduct problem behaviors such as aggression, tantrums, destructiveness, and inappropriate verbal behavior. Maintenance of effects has been demonstrated in a series of studies with follow-up assessments ranging from six months to more than 14 years after treatment termination. Parents have also indicated high levels of satisfaction with the parent training program. The parent training program has also been successfully employed with other high-risk populations, including children with handicaps (Hanf & Kling, 1973), those with attention-deficit hyperactivity disorder (Pisterman, McGrath, Firestone, Goodman, Webster, & Mallory, 1989), mothers at risk of child abuse and neglect (Wolfe, Edwards, Manion, & Koverola, 1988), and as a component of a

preventative intervention for children of alcohol and drug abusing parents (Kumpfer & DeMarsh, 1987).

Comments on Implementation/Replication: As with other programs that require a trained therapist, the costs of this program may make it difficult for some agencies to implement.

15. THE STRENGTHENING FAMILIES PROGRAM

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Target Population: This conference program is designed for families of six- to 12-year-old children of dysfunctional families and children of alcohol and other drug abusers. The program has been modified to be appropriate for African-American families and families with low education or reading levels.

Program Origin: This program was developed by Kumpfer and associates in 1983 to prevent children of drug abusers from also becoming abusers. The program has been replicated in Alabama with African-American, alcohol and drug-using, single parent, and low income families.

Program Objectives: The primary objectives of this program are to reduce risk factors for drug use in high-risk children, including behavioral problems (depression, aggression, social withdrawal, school failure), emotional problems (depression, anxiety, fear), academic problems, and social problems (shyness, lack of social skills). These risk factors are addressed by improving family relationships, parenting skills, family environment and improving the youth's social and life skills.

Program Strategies: This 14 week program meets weekly for 2-3 hours. It includes three separate courses: Parent Training, Children's Skills Training, and Family Life Skills Training, taught co-jointly. This program was designed for children of substance abusers and their parents in treatment (primarily methadone maintenance patients). Because these are very difficult, high-risk parents and children, the program works with the parents and children separately, and then the whole family together. The families arrive at the community center or clinic and are separated into their own groups for the first hour and reunited in the second hour, either with individual therapists, or in small family groups. Many special incentives are built into the program to assure attendance and completion of homework assignments.

Recruitment and Retention: This program includes more special techniques for involving high-risk and hard-to-reach parents than any other program reviewed. Transportation, child care, meals and snacks, fun activities, prizes for completion of homework and attendance are encouraged by this program to reduce barriers to attendance. The program is held in a non-stigmatizing location, such as a community center.

Staffing: This program requires four trainers to run the groups: two Child Skills Trainers and two Parent Skills Trainers. There are no minimum qualifications, but the trainers generally have at least a bachelor's degree and experience in working with high-risk families in mental health settings. Being a parent and having experience in running groups is helpful. Other selection considerations are based on the requirements of target populations. Instructor training requires at least three days, with a maximum of 12 trainees per training group.

Resources Needed and Materials Available: The program is completely standardized in three trainer manuals, a Parent Workbook, and a Children's Handbook, with films and videos available for use in training. The 14 session Strengthening Families Program is now available in both the original version (Kumpfer and DeMarsh, 1983) and a version modified for parents with a second grade reading level. This version is being evaluated with rural, southern African-American substance abusing parents (Kumpfer, DeMarsh, and Child, 1988). This second version contains adaptations of the Bavolek Nurturing Program for the children's groups and contains separate programs for preschoolers, elementary age children and older children. An evaluation package is available that contains a parent interview, child interview, and a follow-up test.

Special Characteristics: This program was designed as a combination of the most effective family programs: Forehand and McMahon's Helping the Non-compliant Child Program, Patterson's Behavioral Parent Training, Gurney's Family Relationship Enhancement Program, Spivak and Schure's Children's Social Skills Training, Bavolek's Nurturing Program, and Kids Are Special COSA Program.

Effectiveness: The first Strengthening Families Program was found to be effective in improving the child's behavior, improving family functioning and decreasing risk factors of substance abuse, as well as decreasing existing alcohol and tobacco use (Kumpfer, 1986). The second year evaluation of the Strengthening Black Families replication of the program for southern African-Americans shows very positive results, with clinically and statistically significant improvements in the children's behaviors and emotions on the Achenbach Child Behavior Checklist, as well as improvements in family environment on the Moos Family Environment Scale (FES).

Comments on Implementation/Replication: Because the trainer manuals are extremely complete and are low cost, the program is fairly easy to replicate. All handouts and assignments are included in the Parent and Children's Handbooks. There are video tape materials available, and additional videos are being developed.

C. FAMILY THERAPY PROGRAMS

16. COSSMHO PROYECTO ESPERANZA (PROJECT HOPE)

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Target Population: This project is designed exclusively for Hispanic families.

Program Origin: Four years ago the Office of Juvenile Justice and Delinquency Prevention (OJJDP), concerned about child abuse and the incidence of runaways in the Hispanic population, began funding a national program to help community agencies respond to these problems. This idea has been developed by the National Coalition of Hispanic Health and Human Services Organizations (COSSMHO). During Proyecto Esperanza's early stages, it became clear to OJJDP that special resources were needed to help Hispanic youth who had already entered the juvenile justice system. To respond to this need, OJJDP asked COSSMHO to work closely with two organizations that had not until then been part of COSSMHO's network: the National Court Appointed Special Advocates Association (CASA) and the National Council of Juvenile and Family Court Judges (NCJFCJ).

Program Objectives: This program is designed to reduce juvenile delinquency by treating some of the underlying family problems that cause youth to run away and become at risk for delinquent behavior. Program objectives are to reduce delinquency and drug or alcohol use in high risk Hispanic adolescents. Other goals are to develop an operations manual, develop training packages and disseminate the structural family therapy programs for Hispanic youth to providers nationally.

Program Strategies: Most Proyecto Esperanza sites have combined direct services, such as counseling and shelter placement, with public education programs for the Hispanic community. Several sites have trained personnel of other agencies in ways to deal with Hispanic youth more effectively. These agencies include departments of local governments, religious and secular service organizations, and schools. CASA trains volunteers who advise the court about what is best for children whose home placement is being decided by the court, usually as a result of abuse or neglect. NCJFCJ's Permanency Planning for Children Project encourages judges to reduce the number and duration of a child's foster home placement and to return a child to the natural family or find a permanent family through adoption as soon as possible. As part of Proyecto Esperanza, COSSMHO has provided technical assistance to improve these organizations' services to Hispanic youth.

Recruitment and Retention: Recruitment and referral strategies vary with the COSSMHO site and type of service being offered, however, Proyecto Esperanza is very sensitive to the special recruitment needs of high-risk Hispanic families. Their New Haven site, for example, used a graduation dinner and formal graduation ceremony as an opportunity to have graduates invite other possible recruits to attend the group. By allowing these recruits to see how happy and proud the graduates were of their accomplishments and meeting the staff at such a happy occasion, they were able to increase the numbers of families involved in the program.

Staffing: Staff needs and qualifications vary with the type of service being provided and the type of agency involved.

Resources Needed and Materials Available: These vary with the particular program. All are developed primarily for Hispanic families, therefore, the program materials and manuals would have to be modified for other cultural groups.

Special Characteristics: This Project is designed specifically for Hispanic families. The multi-site system of support programs makes local adaption possible and also opens the possibility of wide dissemination.

Effectiveness: The Proyecto Esperanza demonstrations were launched in eight communities in partnership with existing community-based organizations. Although outside funding for Proyecto Esperanza has ended, many of the community agencies taking part in the project have incorporated these programs into their overall services.

Comments on Implementation/Replication: Throughout the project, implementation was limited to Hispanic families. Cultural adaptations would be required in order to make the information contained in the manuals provided by COSSMHO appropriate for different populations.

17. FAMILY RELATIONSHIP ENHANCEMENT PROGRAMS.

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Target Population: Most appropriate for adolescents and their parents. The program can be used with all educational and cultural levels (client literacy is not a requirement for program success). It is very appropriate for working with high risk families and for stopping substance abuse, child abuse/neglect, and other problems, as well as in prevention of such problems.

Program Origin: The original program was designed for children between 4-12 years of age; infancy and adolescent programs were added later. The program was developed in the early 1970's, first with parent/adolescent dyads and then with families and with groups of families.

Program Objectives: The program is designed to prevent substance abuse by increasing family supportiveness, cohesion, and appropriate perceptions and level of control. The goals of this program are to create a therapeutic, growth enhancing family system.

Program Strategies: Participants are taught nine skills: *expressive skill*, in order to become more in touch with one's own goals, values and feelings and to increase self-awareness; *empathic skill* to encourage others to express with honesty and openness, with a sensitivity to their needs and feelings in order to build trust and compassion in a relationship; *discussion/negotiation skill* to preserve a positive emotional climate in working through problems and conflicts and to avoid unnecessary digressions in order to explore root issues; *problem/conflict resolution skill* to help clients to devise (or help others to devise) creative solutions to problems which maximize mutual need-satisfaction; *self-change skill* to implement changes in attitudes/feelings,behaviors in order to implement interpersonal agreements and objectives; *helping-others-change skill* enables others to change similarly; *generalization skill* to help clients use relationship skills in daily life; *teaching skill* to enable clients to train others to use relationship-enhancing skills in daily life; and *maintenance skill* to enable clients to maintain usage of such skills over time.

Recruitment and Retention: Recruitment practices vary, including recruitment through churches, public announcements, or talks at high schools. Special incentives in the form of lottery cards for participation and payment for completion of research measures have been used. It may be desirable to provide funds or other assistance for transportation, babysitting, etc.

Staffing: There are no formal educational requirements for staff. Problem prevention and enrichment group leaders are trained through workshops and supervision. Additional supervision can lead to certification. Training is conducted through IDEALS (Institute for Development of Emotional and Life Skills) nationally and in Canada. Usually a group of 8-12 trainees is needed to provide sufficient funding for the trainer and the traveling costs.

Resources Needed and Materials Available: Texts and materials are available from IDEALS.

Special Characteristics: The program emphasizes improving family communications and is most appropriate for older children. The program format can be easily varied. Full day sessions and weekend formats, repeated if desired, are feasible. Locations and the size of the group may vary widely. Typically, however, the format is weekly sessions of 2-1/2 hours for 13 weeks. Eight to sixteen trainees typically attend.

Effectiveness: Studies have found improvement in relationship skills; marital, adolescent and family satisfaction; communication; social skills; and self esteem. Superior results in comparison to no treatment and to alternate treatment controls have been repeatedly demonstrated.

Comments on Implementation/Replication: The program has been used with alcoholics, spouse abusers, adolescent and adult psychiatric patients and their families as well as families from the general population.

18. FUNCTIONAL FAMILY THERAPY

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(801) 581-6538 or 581-6123

Target Population: Families with identified status offenders and other youths identified early in the delinquency cycle. This program has also been found to prevent problems among younger siblings. Several versions of Functional Family Therapy (FFT) programs exist, including an in-home version and one designed to be used with multiple-offending juveniles who have been incarcerated. This program has also been used with youth who have initiated use of alcohol, tobacco, or drugs.

Program Origin: This program is a blend of family systems theory and behavioral social learning theory developed by James Alexander and his colleagues at the University of Utah (Alexander & Parsons, 1982; Barton & Alexander, 1981). As with many programs that have been evaluated and used for several years, FFT exists in several versions.

Program Objectives: The main goals of FFT are to increase reciprocity and positive support among family members and to improve clear and positive communications. The program is designed to reduce interpersonal problems by teaching communication skills, helping family members to identify what they desire from each other, and to identify possible solutions to family problems. Alexander (1973) found that families of delinquents have more defensive and less supportive communication patterns. A major goal of treatment is to improve family communication and supportiveness.

Program Strategies: In its most recent form, FFT contains five phases of family therapy: the Introduction/Impression Phase (family members' expectations for therapy are determined); the Assessment Phase (family processes or functions in need of change are identified); the Induction/Therapy Phase (maladaptive patterns are modified through cognitive therapy techniques such as relabeling), the Behavior Change/Education Phase (behavior change techniques, communication skills training, social skills training, coping skills training, behavior contracting, anger and stress management, and contingency management are used to change the family behavior patterns); and the Generalization/Termination Phase (here, focus is on maintaining the therapeutic gains while helping the family to terminate and reduce dependency on the therapist).

Recruitment and Retention: A version of this program, developed by Gordon and associates (Gordon, Arbuthnot, Gaslefson and McGreen,1984; Gordon, Groves and Arbuthnot, 1986), is conducted within the high-risk family's homes. There were

positive effects on the younger siblings as reported by Klein et al., (1977). Providing information at home avoids some of the recruitment and attrition problems usually experienced with high-risk families.

Staffing: This program requires professional therapists, therefore, the cost is relatively high.

Resources Needed and Materials Available: Communication charts and manuals are available for family members during the behavior change phase. If possible, sessions are tape recorded for therapist review and/or for families to take tapes home for practice reminders.

Special Characteristics: This program has demonstrated effectiveness with identified status offenders and other youths identified early in the delinquency cycle. FFT is one of the only family programs that combines components of social learning with family systems therapy.

Effectiveness: The program has demonstrated impact on reducing delinquency in targeted teenagers and 18 month follow-up studies suggest that the impact is lasting. The program has a preventive influence on the younger siblings. It is one of the few family-focused programs which has been tested for effectiveness with adolescent status-offenders.

Comments on Implementation/Replication: FFT is a fairly standardized program that could be disseminated widely as it is not dependent on a special facility nor is it a difficult program to implement. It does require that trained therapists conduct the intervention.

19. PRIME TIME IN-HOME FAMILY THERAPY

Mailing Address: Ann Rogers, Executive Director
The House Next Door
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Deland, Florida 32720
(904) 734-7571

Target Population: Targeted youth are generally between 12 and 15 years old and are selected because they are failing in school, frequently truant, are manifesting behavior problems, or their behaviors suggest experimentation with alcohol, marijuana, or tobacco.

Program Origin: Prime Time, an in-home family strengthening program, was developed by The House Next Door in Deland, Florida, with funding from the Office for Substance Abuse Prevention (now called the Center for Substance Abuse Prevention).

Program Objectives: The primary goals of this program are: 1) to improve the quality and increase the amount of communication within the family; 2) to develop or improve important personal and social life skills; 3) to explore family-centered activities that encourage family interaction and provide positive family experiences.

Program Strategies: The in-home family therapy lasts for approximately 14 sessions. In addition, monthly family support group meetings are held. During the first hour of these these group meetings, the families gather in a multi-family group. After the first hour of instruction and discussion, family members separate into a children's group, an adolescents' group, and a parents' group. Each group continues discussion and exercises on various topics (risk factors for drug abuse, anger management, drug family policy, etc.) introduced in the family meeting. The sessions are followed by a meal and general socializing.

Recruitment and Retention: Eligibility is determined based on the age of the child, severity of substance abuse, family willingness to allow in-home intervention, and the absence of severe dysfunction requiring more intensive/structured care. Families are asked to participate in some type of positive community action that demonstrates a commitment to the philosophy of non-use by youth.

Staffing: The instructors' qualifications are a BA degree with background and course work in psychology, child development, behavior disorders, group skills, behavior management, and family counseling, as well as two years experience in family or youth counseling.

Resources Needed and Materials Available: The following evaluation tools are included as part of the program: an Intake Questionnaire, a Counselor Self-Report Check Sheet,

and an Exit Questionnaire. Because this program is currently being tested and developed, the trainer's manual is only in draft at this time.

Special Characteristics: This program, like others, focuses on family interaction but with an emphasis on providing positive interactive experiences both within and between families, while the groups learn necessary skills.

Effectiveness: This model program is only two years old and has not been evaluated. Evaluation is complicated by the fact that the family therapy model is not structured in detail, but rather is adapted for each family's needs. A process evaluation has been conducted to document what occurs in the family therapy sessions and an outcome evaluation is currently being conducted.

Comments on Implementation/Replication: This program has several advantages over the other family therapy programs. It is a prevention program where high-risk youths are identified by the schools, not the corrections system; the program combines in-home family therapy with some general social service referrals and supports often needed by high-risk families; the program reduces social isolation by running both multi-family groups which involve family discussions and separate parent, children and adolescent groups; finally, the program is relatively low-cost, because the in-home therapists are therapy trainees supervised by a licensed therapist.

20. STRUCTURAL FAMILY THERAPY PROGRAM FOR HISPANIC FAMILIES

Mailing Address: Jose Szapocznik, Ph.D.
Spanish Family Guidance Center
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The Sieron Building
Suite 302
Miami, FL 33136
(305) 548-4592

Target Population: Hispanic families with high-risk youth experiencing behavioral and alcohol or drug problems. Szapocznik postulates a "high-risk syndrome" for behavior problems in Hispanic families. This syndrome includes current family structural dysfunction, future potential for intergenerational conflict, and future potential for intercultural conflict. Youth from such families are often at high-risk because they have become more acculturated than their parents.

Program Origin: The National Coalition of Hispanic Health and Human Service Organizations (COSSMHO) received funding from OJJDP to select and disseminate a model family strengthening program for Hispanic families. Based on their first year of assessment of potential model programs, their advisory group of Hispanic professionals selected Szapocznik's Structural Family Therapy model for dissemination.

Program Objectives: Six types of family risk categories are addressed by the Structural Family Therapy Program: disorganized families; multi-problem families; inner city families; suburban families; extended families; and blended families. Szapocznik has found that highly acculturated youth of non-acculturated parents are more likely to reject parental authority. These youth also tend to be less bonded to the larger society. Hence, the objectives of this program are to reduce the behavior problem by improving family relationships and parental control of the youth.

Program Strategies: The structural family therapy program uses the family systems strategies employed in family therapy as developed from the work of Minuchin (1974), Haley (1976) and Madanes (1981). This approach views individual pathology as arising from, and being maintained by, interactions between family members. As a naturally occurring system, a family develops habitual patterns in interactions among family members and the environment. A healthy system is one that supports and stimulates the well-being and growth of each individual member. Problems occur when a family's habitual patterns of interacting are not effective in the management of new situations brought into the family through change in one family member or by

some external stress. If the family system is too rigid, it will fail to make needed changes when problems arise.

Recruitment and Retention: Dr. Szapocznik and his associates have emphasized factors that should be considered when recruiting Hispanic families. These principles are built into the COSSMHO programs. (See Number 15 under Family Therapy Programs). The program has developed special recruitment techniques and retention materials that are culturally appropriate for Hispanic families. For example, one strategy is to deal first with the father of the family to insure his cooperation with the family therapy sessions.

Staffing: The Structural Family Program generally requires at least two professional family therapy counselors or trainees, who are at least at the Masters degree level.

Resources Needed and Materials Used: COSSMHO has spent the last year developing an operations manual and a dissemination plan to provide this program to Hispanic counseling centers across the country. A training manual for the therapists is also available. In addition, training by the program developer is recommended.

Special Characteristics: This program was selected by COSSHMO and OJJDP initiative as the best program in the country for strengthening Hispanic families. The sensitivity of this program to cultural bonding and differential acculturation issues as well as the sensitivity to cultural needs in recruitment methods are the outstanding characteristics of this program. A unique aspect of this family therapy model is that it is often implemented in the homes of youth who are already manifesting behavior or drug abuse problems. The program has a high rate of family engagement, because the staff have developed and perfected a strategic structural-systems engagement system (SSSE).

Effectiveness: The Structural Family Therapy Program has been rigorously evaluated in a number of studies and found to be effective in reducing recidivism among youthful offenders and in improving family relationships. Structural family therapy has been successfully applied to the prevention of substance abuse in high risk families, such as low income Hispanic families. COSSMHO has endorsed the structural family therapy model and are implementing it in a number of Hispanic mental health centers nationally.

Comments on Implementation/Replication: One possible barrier to dissemination is access to high quality family therapy professionals or trainees for staffing the program. In addition, this program requires the supervision of Dr. Szapocznik or his staff for program implementation. They are currently writing an operations manual to help disseminate the model. As more therapists are trained in the model, the program will be easier to disseminate. The strategy of imbedding the structural family therapy program within a comprehensive Hispanic family service agency should improve this

program's effectiveness. This program has been used primarily with Hispanic families, but has also been used with African American families.

D. FAMILY PRESERVATION PROGRAMS

21. HOMEBUILDERS PROGRAM

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David Haapala, Ph.D.
HOMEBUILDERS Program
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FAX: (206) 838-1670

Target Population: The program is designed for only the most seriously troubled families. Families are referred to HOMEBUILDERS from a number of child service agencies, such as child protective services, juvenile justice, mental health, and developmental disabilities services. Reasons for referral include child abuse and neglect, truancy, status offenses, family violence, substance abuse, delinquency, disrupted special needs adoptions, mental health problems, or developmental disabilities.

Program Origin: This program was developed by Drs. Jill Kinney and David Haapala in 1974 to help families who were failing in community programs, thus putting their children at risk for out-of-home placement. The most rigorous evaluation effort to date indicates that 71 percent of the children targeted for foster care and served by HOMEBUILDERS remain at home with their families 12 months after service intake. The program currently has 45 therapists serving twelve counties in Washington State. From 1987-1991 Behavioral Sciences Institute carried out a demonstration project in the Bronx, New York. Recently that program has been picked up and expanded city-wide through the city's Child Welfare Administration.

Program Objectives: HOMEBUILDERS is an in-home, psycho-educational, skills-oriented model of intervention grounded in social learning theory and research. The intervention involves defusing the immediate crisis, engaging the family, assessing the problem and developing goals, and teaching the family members specific skills to help them solve problems, function more effectively, and avoid future crisis.

Program Strategies: HOMEBUILDERS intervenes directly and immediately at the clients' convenience in a variety of areas which are beyond the scope of many intervention programs. It should be remembered that this program is designed for high-crisis situations and families that are often at immediate risk of dissolution.

Recruitment and Retention: Services are provided when and where the clients wish so that basic needs are met. Participating families are referred by public agency workers who have the authorization to place children and youth in foster, residential, or institutional care.

Staffing: HOMEBUILDERS therapists are Masters degree level or other social workers or psychologists trained in social learning and cognitive intervention strategies within an ecological framework. They are trained to help families achieve behavioral changes (e.g., improve communication and parenting skills), cognitive changes (e.g., anger and depression management) and environmental changes (e.g., clean house, obtain food and clothing).

Resources Needed and Materials Available: Training and consultation to enhance the replication of HOMEBUILDERS-like programs have been provided by Behavioral Sciences Institute (BSI) nationally and abroad, ranging from telephone discussions about program start-up to state-wide, on-site program development training and consultation efforts. The following video and books describe and explore the philosophy, practice and evaluation of HOMEBUILDERS: *Skills for Family and Community Living* (a video tape program and leader's guide book), *Families in Crisis, The Impact of Intensive Family Preservation Services, Keeping Families Together: The Homebuilders Model,* and *Reaching High-Risk Families.* Additional training and consultation information can be obtained by calling the BSI Training Division.

Special Characteristics: HOMEBUILDERS is a fairly costly program ($2,600 per family) for 4 to 6 weeks of services but is preferable when the alternative is out-placement at tremendous costs. The intervention is immediate (within 24 hours of referral), intensive and time-limited to 4 to 6 weeks. Case loads are small, with each therapist handling only 18 to 20 families per year. Therapists are on call for clients 24 hours a day, seven days a week.

Effectiveness: A recent evaluation by Fraser, Pecora, and Haapala (1991) found that 67 percent of the children at risk of placement in the combined study sites of Washington and Utah (N=342) were still at home 12 months after service intake. In contrast, only 14.8 percent (N=27) of the children in a Utah comparison group remained at home during the same time frame. When primary caretakers in families who had been provided services rated problem severity in 28 areas of child, household, parent, and family functioning, there were, on average, improvements on 26 of the 28 items. Pre- and post-service ratings of parent and child functioning on the 25-item Family Risk Scales indicated significant improvements on 22 items. There were significant pre- and post-service reductions in "aversive relations" for both mothers and fathers in these families. Research interest in the area of service is rapidly expanding with HOMEBUILDERS model replication programs growing across the U.S.

Comments on Implementation/Replication: HOMEBUILDERS is a service mark owned by Behavioral Sciences Institute. They have a well-established training program and a standards program. They are experimenting with a project that takes the HOMEBUILDERS program philosophy, theory, and improved technology to address the needs of drug-affected families within a more conventional treatment format. This program meets most of the criteria for a comprehensive family program. Its draw-back is that it is applied to families only after they are in crisis because the child

or adolescent is in danger of being removed from the family. It is not a prevention program.

22. MARYLAND INTENSIVE FAMILY SERVICES (IFS): A FAMILY PRESERVATION SERVICE DELIVERY MODEL

Mailing Address: Sondra M. Jackson
Social Services Administration, 5th Floor
311 West Saratoga Street
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(301) 333-0254

Target Population: Families and their children who would otherwise be at extreme risk for placement outside the home.

Program Origin: The Maryland Department of Human Resources, Social Service Administration, chose the Intensive Family Service (IFS) model of service delivery to provide services to eight local departments in 1985. By 1986, the service area had been expanded to include 17 (of 24) Maryland jurisdictions.

Program Objectives: A primary objective of the program is to prevent foster care placement and maintain the child in his/her own home, in the belief that most children thrive best in their own families. It is explicitly conceived as a service to prevent foster care placement for children who have already been identified as needing such placement if IFS is not provided. In this way, the State seeks to ensure that this very intensive service is targeted to those families who most need it. The emphasis is on time-limited, intensive services with families in crisis and/or at risk of dissolution. The goal is to protect children from potential assaults and/or neglect, while keeping them in contact and engaged with the entire family, to see if preservation is desired and/or indicated.

Program Strategies: Services are intensive; at any given time the caseload of the IFS team is limited to six families. This enables the team to be in the home actively working with the family as frequently as necessary. An additional component of the IFS model is the availability of "flexible funds," a cash fund the team can use for any emergency assistance needed by the family. A wide range of services is available to the client/family, including: initial assessment and determination of family problems and family strengths; basic family counseling and work with family systems techniques; and provision of support services (homemaker services, day care, respite care, housing assistance, employment assistance, etc.).

Recruitment and Retention: Families and children are referred by a variety of agencies (e.g., Child Protective Services, and Social Services).

Staffing: The IFS unit consists of one or more teams. Each team consists of a worker and a parent aide assigned to a family. Each team is expected to carry a caseload of six families during a 90-day period. The team must have flexible working hours, as well as a central 24-hour hotline with emergency response capability. The IFS unit

Supervisor is responsible for administration and serves as a consultant, resource person, departmental liaison, advocate, program coordinator, and, when warranted, field worker in conjunction with team members. A consultant, experienced in family therapy, should be available to provide clinical consultation in individual cases, and ongoing technical assistance to the IFS teams. All staff should be trained in a basic family-centered curriculum with emphasis on the family systems approach and family-based services techniques. Staff to be trained should include social workers, aides, and supervisors working directly with families, as well as the social services staff who serve as the screening committee for referred families. Training should be given in two parts and at different times; one section on philosophy, organization, and implementation; the second on family-centered counseling. Training should be ongoing with advanced training in areas of concern identified by the staff. This training can be part of the family consultant's role, which can also include providing technical assistance, staff development, case consultation, and group facilitation.

Resources Needed and Materials Available: A manual is available offering information on basic principles, preparation for service, beginning, intermediate, and closure interventions, and program evaluation strategies. The IFS model relies on the availability of other social services for the family.

Special Characteristics: The IFS model provides a means by which the worker and aide may develop a common knowledge base, build a common set of values and an agency orientation to serving families, and practice the development of a variety of team intervention strategies. In addition to concrete services (e.g., food, clothing, shelter, and specialized services such as psychiatric treatment, etc.), IFS also provides crisis intervention services, training in parenting skills, child development, etc., ongoing case assessment with the family to set and achieve goals, and identification of resources within the community that are available to the client. Services are assessed by the entire team on a weekly basis in order to redefine roles of team members and identify the changing service needs of the family. A written service agreement must be developed for every IFS case, specifying treatment goals, types and duration of services to be provided, and the responsibilities of all involved parties.

Effectiveness: A preliminary investigation of the IFS foster care prevention program shows that the program has been substantially effective in preventing foster care placement in Maryland. A major factor apparently contributing to the program's success is the intensive in-home provision of specific services designed to ameliorate each family's problems.

Comments on Implementation/Replication: This model requires intensive staff training and the expenditure of substantial funds. However, cost analysis shows significant savings with IFS when compared with traditional foster care placement.

23. TENNESSEE HOME TIES THERAPEUTIC INTERVENTIONS AND EDUCATIONAL SERVICES

Mailing Address: C. Paul Chisena, Ed.S.
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Tennessee Home TIES
511 Eighth Street
Clarksville, Tennessee 37040
(615) 552-5969

Target Population: Families on the verge of having a child removed from their home and for whom no other community or preventive service is available to avert out-placement.

Program Origin: This program was developed in response to the Governor's Social Services Council in 1985. In 1987, the Harriett Cohn Center initiated the Intensive Family Services (IFS) program where children at risk of committal by the Department of Corrections were court-ordered to participate. Since 1989, family preservation services have been made available to children from all departments as an alternative to state custody and out of home placements.

Program Objectives: The goal of the program is to reduce the number of commitments and unnecessary placements of juveniles into state funded facilities. The intent is to remove the risk of harm to the child instead of removing the child from the home.

Program Strategies: Home TIES strategies are taken from other home-based models, as well as from learning and behavior modification theories, family systems approaches, alcohol and drug treatment programs, and recovery programs. Emphasis is placed on assessing the family's strengths and the source of the family dysfunction. The program facilitates the reduction of stressors on the family and, through therapeutic intervention, corrects the dysfunction. The families may require access to community resources and/or treatment services. They may be helped to establish proper parental hierarchy and rules through contracting. The program is a 30-day home based intervention.

Recruitment and Retention: Referrals are made through the state's Community Health Agency only as the last available resource to avert the out-of-home placement of the child at risk.

Staffing: Home TIES personnel are trained by "Homebuilders" (see program #20) in behavior modification, use of community resources and case management. Training of staff is continuous with a variety of opportunities for personnel to take part in workshops in such areas as sexual abuse, substance abuse, and parenting skills. The therapist conducts sessions with the entire family, with individual family members,

and with extended family when appropriate. These sessions are held in the family's home at times that are convenient for them.
Therapists must have a M.S. or M.A. in psychology and two years experience, at least one of which is with multi-problem families.

Resources Needed and Materials Available: Therapists have access to numerous articles on family systems, intervention strategies, and other materials to provide them with as much information as possible to correct the family dysfunction.

Special Characteristics: Home TIES philosophy is based on the belief that a child's family of origin is the most desirable environment for that child to grow up in, and that most parents want to be good parents and can be helped to change when problems occur. The job of the therapist is to instill hope and empower families by teaching them skills to solve their own problems. The process of "Joining" with the family is essential in relieving the distrust and ambivalence families sometimes feel when faced with dealing with service providers.

Home TIES is a short term, home-based, crisis intervention program, with a per-therapist case load of two families. Therapists are available to their families 24 hours a day to provide services in case of an emergency or crisis, thereby proving the greatest opportunity for change in the family system.

The Home TIES program is allocated funds to be used for family needs when no other community resources are available for rent, utilities, food, clothing, etc. The maximum amount to be used per family is $250.00.

Effectiveness: Family Preservation programs like Home TIES have a good safety record. The therapist is on the scene to monitor danger signals and work with parents and children to minimize the threat of violence.

Studies on family functioning have found that in even the most difficult family situations, intensive family preservation programs significantly increased parenting skills in dealing with a variety of economic, drug abuse, and social problems.

On a per-case basis, family preservation services are clearly more cost effective than placing a child in foster care.

Comments on Implementation/Replication: A large amount of time is allocated in this program for the provision of concrete services. Attention to practical needs, coupled with therapy and outside referrals help parents regain control and maintain a consistency in dealing with behavior problems at home.

E. PROBATION AND REHABILITATION SERVICE PROGRAMS

24. ADOLESCENT INTENSIVE REHABILITATION SERVICES

Mailing Address: Linda Rodenbach
Department of Health and Welfare, Juvenile Justice Unit
4411 Emerald
Boise, Idaho 83706
(208) 334-3093

Target Population: Youth, aged 12 to 17 years, who have serious problems in major life areas (such as school, or in peer or family interactions) and whose behaviors bring them into conflict with family, schools, law enforcement agencies, and the courts; youth in custody under the Juvenile Justice or Child Protection Act who are at extreme risk for placement in residential or group care; clients of the Health and Welfare Department's Mental Health Unit who need not be in state custody. Probable exclusions are those youth who are exhibiting psychotic behavior, are extremely assaultive, and some youth with a history of sexual assault.

Program Origin: Adolescent Rehabilitation Services was started in 1986 by the Idaho Department of Health and Welfare, Family and Children's Services Division. The Youth Rehabilitation Unit (re-named Juvenile Justice Unit) is a primary resource, backed by internal support staff as well as community resources (e.g., therapists, schools, job search programs, etc.). Collaboration and support has also been contributed by the Boise Independent School District and the Ada County Juvenile Detention Center.

Program Objectives: It was noted that a number of youth who had been placed out of the community had difficulty with re-entry into their normal life situation. Families became more difficult to engage in treatment and planning for their children. This created problematic transition periods when the youth were returned home, and in some cases made reunification with families virtually impossible for older adolescents. Therefore, though treating youth in the community presents a greater challenge (i.e., due to continued contact with negative peers, less external control, increased risk for further acting out), in many cases program founders believe the risk is worth the effort. An underlying belief is that youth who are searching for self-worth and identity would rather accept positive models if channeled in that direction. They can be successfully dealt with in short term intensive treatment that includes school, group, family and individual work as key components. These treatment components are coupled with aftercare planning and intensive follow-up. Ultimate outcome goals include reductions in delinquency, substance abuse, teen pregnancy, and school failure. Positive objectives include improved self image, effective problem solving skills, improved parent/child relations, improved parenting skills, reduction of acting

out behavior, better management of authority issues, motivation for success, and improved coping skills.

Program Strategies: This is a day treatment program for adolescents and their families. Social services and educational programming are provided to adolescents who are in jeopardy of being placed in long-term structured residential care. This program provides intensive multi-disciplinary services to youth and families with the goal of fully integrating youth into normal community systems within 30 - 90 days. This program also provides a transitional support program for youth returning from residential care that consists of the following six components: 1) Eight participants are taught at the Learning Center for 3 1/2 hours, 5 days a week by a special education teacher with a family technician as a classroom aide. 2) Four days a week, 1 1/2 hours daily, the youth participate in a guided group following a "positive peer" model. 3) Once weekly for 1 1/2 hours a drug/alcohol group is held (maximum 8). 4) The recreation component of the program involves the participants in some sort of outing at least once a week, with outings of about one week's duration taking place twice yearly. 5) A partial-day treatment group is also available for 1 1/2 hours once weekly (this is a guided group interaction format, most participants attend two "rounds" of this group for a total of 16 weeks). 6) Parent support groups are held for 6-8 families, running for 8 weeks in evening sessions of 1 1/2 hours each.

Recruitment and Retention: Most youth are adjudicated, court-referred. No special retention or recruitment strategies are used.

Staffing: Staff include a special education teacher, two family services technicians, six senior social workers, a staff psychologist, and support staff. A psychiatric consultant and drug and alcohol counselor are used on a part-time basis.

Resources Needed and Materials Available: Costs for materials are nominal. Overhead projectors, VCRs, television monitors and films are used.

Special Characteristics: This program provides a substitute for institutionalization for problem youth who would otherwise suffer transition trauma in attempting to reintegrate into the family/community structure.

Effectiveness: No evaluations are available to date.

Comments on Implementation/Replication: Program leaders are willing to make one to two day workshops available for between eight and thirty participants.

25. JUVENILE INTENSIVE PROBATION SUPERVISION (JIPS)

Mailing Address: Bill Stanton
Arizona Supreme Court
Juvenile Intensive Probation Supervision
1501 West Washington #337
Phoenix, Arizona 85007
(602) 542-9443

Target Population: This program diverts serious, nonviolent juvenile offenders from overcrowded institutions. Juveniles are eligible who have been adjudicated as a result of a delinquent act or a technical violation of probation originating from a delinquent act, and would otherwise be recommended for commitment to the State Department of Corrections or for placement in an out-of-home institutional or residential setting.

Program Origin: This program was developed in 1987 in response to the increasing cost and overcrowding of Arizona State's Department of Corrections. The program restricts the activities of the juvenile offenders involved to provide protection for the community while emphasizing appropriate restitution to victims.

Program Objectives: The program strives to demonstrate to citizens and offenders that probation means accountability and consequences as well as productive rehabilitative activities. Juvenile Intensive Probation Supervision (JIPS) provides intensive supervision and structure for the adolescent without institutionalization.

Program Strategies: When a minor is placed in the JIPS program he or she is expected to complete 32 hours a week of service, including a combination of school, work, court-ordered treatment or supervised community service. If the minor is not participating in one of these activities, he or she must remain in their place of residence unless given permission by the probation officer to attend an approved activity. The supervising probation team maintains a minimum of four face-to-face contacts per week with each minor in the program. These contacts are varied and unanticipated. The team also maintains bi-weekly contact with employers, schools, and parents.

Recruitment and Retention: All cases are court-referred. There are no specific retention strategies.

Staffing: Each probation team consists of an experienced probation officer and two or more probation officers who have experience in detention, intake and field probation services. Each veteran probation officer will be matched with a new probation officer. Each team has primary and secondary job responsibilities. Primary responsibilities for the new probation officers include surveillance and school and community contacts; secondarily, these officers perform social case investigations, attend court hearings and case staffing. The veteran probation officer's primary duties are staffing, casework, pre-dispositional social investigations and court hearings.

Resources Needed and Materials Available: A JIPS manual is available detailing requirements for each position and implementation instructions. Support staff are also described.

Special Characteristics: This program is essentially an intense form of house arrest coupled with highly curtailed and supervised activities.

Effectiveness: The JIPS program is presently operating in all fifteen counties in the state of Arizona. Approximately 70% of the involved youth successfully complete the program.

Comments on Implementation/Replication: Implementation of this program might necessitate a change in referral procedures for juvenile delinquents.

ADDENDUM: Additional Program Descriptions

1. INSIGHTS TEEN PARENT PROGRAM/LEARNING WITH INFANTS AND TODDLERS (LIT)

Mailing Address: Learning with Infants and Toddlers
Insights Teen Parenting Program
1811 Northeast 39th Avenue
Portland, OR 97212
(503) 281-5366

Target Population: The program is designed to reach adolescent parents and older parents at risk of abusive behavior, as well as their prenatal to 36-month-old children.

Program Origin: LIT was developed as the turnkey project of Parents Are Teachers in St. Cloud, Minnesota, and moved in 1981 to Warner Pacific College in Portland, Oregon. Originally established as a practicum for education students to gain experience with younger-than-preschool children, the project began administering to adolescent parents in 1984. LIT left Warner Pacific College to join Insights Teen Parent Program as a program division in 1988.

Program Objectives: LIT is designed to benefit adolescent parents and their infant children by preventing child abuse and teaching parents to have realistic expectations of their children. The program also aims to prevent future serious social and emotional problems in the children themselves. LIT stresses that parents can change their behaviors if they so choose and teaches parents that respect for others, including children, is the foundation for all positive behavior.

Program Strategies: LIT implements its objectives by providing a safe and constructive environment for teenage parents to interact with their children and each other. Parents learn about child care, normal development, gentle behavior, and how children learn, as well as how to teach their children. The program promotes the parents' personal growth by providing role models, guided discussion, and structured observation.

Recruitment and Retention: Insights Teen Parent Program staff, who make daily visits to young mothers at three major hospitals, refer families to LIT as do other social services providers and agencies including community health nurses and the children's services division. LIT also operates under contract in five high schools where young parents take part in LIT for class credit. Three LIT community groups meet weekly for 10 weeks; about 40 percent of the participants go on to take part in another 10-week segment. Some participants have entered the program even before their child's birth and have continued until their child was 36 months old. Several participants have returned as subsequent children were born.

Staffing: LIT has one full-time program director and four part-time parent/child educators who are supported by Insights' 16-person staff, several practicum students, and many volunteers.

Resources Needed and Materials Available: Equipment necessary to the program includes playroom equipment, minivan, parent discussion area, television, VCR, and handouts. Materials available from the program include a resource list of valuable sources of parenting information.

Special Characteristics: LIT provides to parents and children an appropriate and safe place for hands-on play and observation. The parents separate from the children to discuss developmentally appropriate topics that are determined by the parents themselves.

Effectiveness: Evaluation is provided primarily through the use of tools such as KIDI (Knowledge of Infant Development Inventory) and personal satisfaction instruments, as well as through voluntary repeat participation, referrals by social service personnel and program participants, and staff observations of parent/child interactions.

Comments on Implementation/Replication: Replications are facilitated through training, either at LIT facilities or the site of the new program. Materials and resources may be obtained through Parents Are Teachers in St. Cloud, Minnesota, or from LIT's suggested resource list.

2. BETHESDA DAY TREATMENT CENTER

Mailing Address: Dominic P. Herbst, Managing Director
Bethesda Day Treatment Center
P.O. Box 270
West Milton, PA 17886
(717) 568-1131

Target Population: The Bethesda Day Treatment Center serves preadjudicated and adjudicated male and female juveniles between the ages of 10 and 18 who have committed both status and delinquent offenses. The client's whole family is engaged in his or her treatment plan. As a community-based prevention strategy, Bethesda also provides out-patient counseling for conduct-disorder youth and families in crisis.

Program Origin: The Bethesda program was founded and implemented by the current managing director in December 1983. Seed money was provided by the Pennsylvania Commission of Crime & Delinquency under the Juvenile Justice & Delinquency Prevention Act formula grant program. Bethesda currently serves seven counties in Pennsylvania and has targeted four additional counties for service by early 1993; interstate options also are being considered.

Program Objectives: The Bethesda program's goals are to provide adolescents and young adults who have conduct disorders and are unable to function in existing social/academic environments with a comprehensive individual- and family-centered, values-oriented treatment program that will facilitate their reentry into mainstream society.

Primary goals of the program are to:

(1) Stabilize the client's behavior at home, at school, and in the community by structuring his or her time in order to block and eventually eradicate his or her destructive actions.

(2) Assess the root causes for the client's behavior and hold him or her accountable for antisocial behavior by requiring him or her to take responsibility for his or her actions.

(3) Provide such positive substitutes for the client's antisocial behavior as employment, life skills, and career or vocational opportunities.

(4) Assess the causes of the client's family dysfunction and devise a plan of action to resolve conflict and restore order and stability to the home.

(5) Provide individualized educational alternatives for those clients who have failed academically or socially in mainstream education.

Program Strategies: Bethesda provides intensive intervention through the home, the school, the peer group, and the community to facilitate the containment of antisocial behavior and treatment of the whole family. Nontraditional hours of intervention (evenings and weekends) and a comprehensive menu of services (group, individual, and family counseling; drug/alcohol counseling; foster care) combine for a daily treatment strategy to resolve the underlying conflict which has accelerated and contributed to the pattern of dysfunction.

Recruitment and Retention: Clients are recruited through outreach and referrals from juvenile courts, parents, teachers and other school personnel, other clients, and other agencies.

Staffing: Bethesda's unique staffing pattern allows for specialization in an area of treatment or therapy while engendering a cohesion and bonding between clients and staff. Caseworkers and counselors make up the core of the direct-service staff; leadership for group functions is provided by therapists and consultants. The staff-to-client ratio is 1 to 3. Some staff members oversee the client's performance in all areas, while other staff members are highly specialized such as family-systems counselors or therapists.

Resources Needed and Materials Available: Bethesda draws from existing resources in the community by harnessing and orchestrating every available service to provide a catalyst for positive change. The program center is strategically located in the target area and staffed with personnel who understand the culture and geography of the area. Implementation materials including manuals, handbooks, and strategy reports are available.

Special Characteristics: Bethesda offers a unique blend of treatment and intervention for the whole family during nontraditional hours (evenings and weekends). The treatment modalities are all inclusive and provide the intensity of a residential center without removing the client from his or her home or community. Included in its full menu of services are group, individual, family, and parental counseling; career/work sites; vocational opportunities; family activities; drug/alcohol treatment; family systems counseling; individualized education; foster care when necessary; and much more.

Effectiveness: One preliminary study reveals recidivism rates (10.4 percent) significantly lower than the State and national norms. Other studies are pending. Based on number-specific measures, significant positive changes in client attitudes and behaviors have been documented; group-specific measures reveal increased self-awareness and improved personal relationships. These results are most relevant in light of the fact that Bethesda provides one of the most cost-effective services available.

Comments on Implementation/Replication: The Bethesda program is extremely adaptable and flexible to any city or community. For instance, urban areas require street counselors who have an understanding of the inner city and who are able to intensively intervene in the home and community. Rural areas need to use a conventional form of intervention that brings clients and families to the program center on a regular basis. While any

community in the country would certainly benefit from the program's unique treatment approach, a contract with Bethesda's administration office is necessary to ensure successful replication. Bethesda's multifaceted treatment approach offers every possible level of intervention under the direction of one community-based agency. Therefore, intensive training must be provided to adequately understand the varied treatment strategies and the complex integration of services which help define an individual service plan for each client and family.

3. THE NATIONAL INSTITUTE FOR RESPONSIBLE FATHERHOOD AND FAMILY DEVELOPMENT

Mailing Address: The National Institute for Responsible Fatherhood
and Family Development
8555 Hough Avenue
Cleveland, OH 44106
(216) 791-1468

Target Population: The program addresses the needs of teen fathers, teen mothers, their parents, and significant others.

Program Origin: The National Institute for Responsible Fatherhood and Family Development (formerly the Teen Father Program) was established by Charles A. Ballard. Mr. Ballard developed the concept for the program after conducting extensive interviews with teenage fathers in a local hospital's maternity waiting room.

Program Objectives: The mission of the National Institute for Responsible Fatherhood and Family Development is to create and maintain an environment in which adolescent fathers can develop psycho-social health and educational and economic skills in order to provide increased life opportunities for their children and the mothers of their children. Goals of the program include helping the teen father to:

(1) Legitimize his child or children.

(2) Complete high school and/or a vocational training program.

(3) Find meaningful employment.

(4) Use the program's extended support network to achieve personal goals.

(5) Develop a sense of empowerment that will help him achieve his life goals.

Program Strategies: Program services are delivered through outreach and counseling. Staff carry pagers and are on call 24 hours a day. Staff work with courts, schools, churches, and other community organizations to reach and impact the teen parents who are called proteges.

Recruitment and Retention: Proteges are recruited through outreach and referrals from juvenile courts, parents, teachers and other school personnel, other proteges, and other agencies.

Staffing: The Institute's 14-person staff consists of professionals and volunteers.

Resources Needed and Materials Available: The resources needed to operate the program include trained and experienced staff with outreach skills, as well as ongoing financial and human resources.

Special Characteristics: The program utilizes the skills and experience of staff members who were teen fathers themselves, in addition to staff members with special expertise. Staff serve as wounded healers, and everyone is considered a protege at some level.

Effectiveness: The 16-year history of the program, as well as ongoing referrals, positive evaluations, financial support, and the transformation of proteges' lives testify to the program's effectiveness. Fathers learn to take responsibility for their lives, the lives of their children, and the mothers of their children. They acquire their GED's or high school diplomas, gain meaningful employment, and establish paternity.

Comments on Implementation/Replication: An expansion committee is leading the program through the initial stages of local, State, and national replication.

4. HARTFORD AREA RALLYING TOGETHER (HART) ANTI-DRUG PROJECT

Mailing Address: HART
660 Park Street
Hartford, CT 06106
(203) 525-3449

Target Population: The HART Anti-Drug Project is designed to assist 25,000 to 30,000 people in the inner city of Hartford, Connecticut. The target population is largely Hispanic (75 percent) with a high concentration of young, single female-parent households.

Program Origin: Begun in 1989 as a collaborative effort of community and public agencies to fight drugs in several targeted neighborhoods, HART grew to focus its efforts on young Hispanic families and targeted drug prevention and treatment strategies.

Program Objectives: The HART Anti-Drug Project's primary goals are to:

(1) Develop after-school programs for 1,000 at-risk youth in 10 elementary schools in Hartford.

(2) Develop parent training programs for 50 parents at 2 troubled elementary schools.

(3) Redevelop the infrastructure of the youth services and resources in one targeted neighborhood (that is, recreational and education facilities, housing improvements, crime-free neighborhoods).

(4) Develop a successful case management program for at-risk and adjudicated young people between the ages of 11 and 14, aiming for an 85-percent success rate to be judged by the lack of recidivism.

(5) Decrease crime by 5 percent a year in three targeted neighborhoods over a 3-year period.

Program Strategies: To achieve these goals, HART empowers the parents, youth, and community through specific skills development and community improvements. The aim is to bring about needed changes relevant to improved person-in-environment transactions and interaction. The program is based on a comprehensive strategy that addresses the needs of families and the larger community environment.

Recruitment and Retention: Trained staff recruit participants, largely Hispanics ages 11 to 35, from neighborhoods and from other service agencies. Recruitment and retention statistics show very strong outcomes.

Staffing: Two full-time staff members run the family service program. Three full-time staff are involved in the anti-drug project. One full-time and one half-time staff run after-school programs.

Resources Needed and Materials Available: Crucial to the success of the project is the organizational capacity to provide materials duplication, meeting rooms, offices, phone services, a receptionist, and other support. Many materials are available to provide assistance to staff, participants, and other programs.

Special Characteristics: All programs are run through a community-based organization whose chief purpose is one of empowerment and community change. Programs are likely to involve larger numbers than more qualitative or selective programs.

Effectiveness: The HART Anti-Drug Project is recognized nationally for effectiveness. Decreases in the crime rate in project neighborhoods further indicate success, as does community participation in the project. Program outcomes related to objectives show a high level of significant success.

Comments on Implementation/Replication: The program is replicable when the replicating organization sincerely incorporates empowerment strategies into the fabric of the program.

5. THE DYNAMICS OF RELATIONSHIPS: A GUIDE TO DEVELOPING SELF-ESTEEM AND SOCIAL SKILLS IN YOUTH

Mailing Address: Patricia Kramer
Equal Partners
3371 Beaverwood Lane
Silver Spring, MD 20906
(301) 871-9665

Target Population: The program targets all school children in grades K-12, or ages 5 to 18.

Program Origin: Originally designed as a school program, the Dynamics of Relationships program has been used in many different settings, including hospitals, residential treatment centers, and teen parenting programs.

Program Objectives: The program's objectives are to allow young people to develop the following attributes:

(1) A strong and secure sense of self-worth that will help them to say no to drugs, alcohol, gang involvement, negative peer influence, and other self-destructive behaviors.

(2) More effective communication skills that will allow them to better interact with others and to handle anger and conflict on a safe level while learning that violence is never acceptable.

(3) The ability to constructively cope with stress, disappointment, loss, and rejection.

(4) Clearer and more realistic expectations about their future roles in life.

(5) A deeper understanding of the commitment necessary to achieve and maintain lasting and loving relationships.

(6) A feeling of empowerment—so that they feel valued and effective as human beings and no longer view themselves as victims.

Program Strategies: The Dynamics of Relationships project establishes as many programs as possible in all types of settings with trained facilitators and parental involvement so that parents and children can implement at home the skills learned in the program.

Recruitment and Retention: The program director visits schools, parent organizations, health worker organizations, and mental health organizations to promote the program the Organizations that wish to implement the program then hire the director to come back to the organization and train individuals as facilitators to present the curriculum to children.

Staffing: The program director trains teachers, parents, social workers, mental health workers, and others to provide the program. One facilitator can work with a group of 20 to 25 young people.

Resources Needed and Materials Available: There are two teacher/facilitator manuals: one for the teen program and one for the preteen program. Also available are student manuals which afford students the opportunity to work with their own books during the program's hours, as well as at home with their families.

Special Characteristics: The Dynamics of Relationships program teaches children coping skills, how to build self-esteem, and how to deal with stress and anger. The program is unique because the director takes the curriculum into established organizations and trains existing authority figures to be the facilitators of.

Effectiveness: The program has demonstrated measurable success in many settings. Although there is an evaluation instrument to measure effectiveness, those who continue to use the program after many years have not used the instrument to evaluate it.

Comments on Implementation/Replication: The program can and has been implemented in myriad settings and has proved equally effective in all settings. Behavioral and attitudinal changes have been demonstrated in cases where the program has been implemented for a long duration. The most dramatic impact has been demonstrated when the program is implemented as a year-long, school elective course where students share their experiences and skills with their parents. Under optimum conditions, teachers/facilitators include parents in the program through periodic parent/student workshops.

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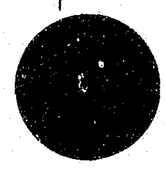

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Program Fair Guide

26 Exemplary Programs

140781 (Part II)

U.S. Department of Justice
National Institute of Justice

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ACQUISITIONS

1. ADOLESCENT INTENSIVE REHABILITATION SERVICES (AIRS)

Representative: **Jack Kaper**
Social Worker Senior

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Juvenile Justice Unit
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Target Population: Youth, aged 12 to 17 years, who have serious problems in major life areas (such as school, or in peer or family interactions) and whose behaviors bring them into conflict with family, schools, law enforcement agencies, and the courts; youth in custody under the Juvenile Justice or Child Protection Act who are at extreme risk for placement in residential or group care; clients of the Health and Welfare Department's Mental Health Unit who need not be in state custody. Probable exclusions are those youth who are exhibiting psychotic behavior, are extremely assaultive, and some youth with a history of sexual assault.

Program Origin: Adolescent Rehabilitation Services was started in 1986 by the Idaho Department of Health and Welfare, Family and Children's Services Division. The Youth Rehabilitation Unit (re-named Juvenile Justice Unit) is a primary resource, backed by internal support staff as well as community resources (e.g., therapists, schools, job search programs, etc.). Collaboration and support has also been contributed by the Boise Independent School District and the Ada County Juvenile Detention Center.

Program Objectives: It was noted that a number of youth who had been placed out of the community had difficulty with re-entry into their normal life situation. Families became more difficult to engage in treatment and planning for their children. This created problematic transition periods when the youth were returned home, and, in some cases, made reunification with families virtually impossible for older adolescents. Therefore, though treating youth in the community presents a greater challenge (i.e., due to continued contact with negative peers, less external control, increased risk for further acting out), in many cases program founders believe the risk is worth the effort. An underlying belief is that youth who are searching for self-worth and identity would rather accept positive models if channeled in that direction. They can be successfully dealt with in short a term intensive treatment that includes school, group, family and individual work as key components. These treatment components are coupled with aftercare planning and intensive follow-up. Ultimate outcome goals include reductions in delinquency, substance abuse, teen pregnancy, and school failure. Positive objectives include improved self image, effective problem solving skills, improved parent/child

relations, improved parenting skills, reduction of acting out behavior, better management of authority issues, motivation for success, and improved coping skills.

Program Strategies: This is a day treatment program for adolescents and their families. Social services and educational programming are provided to adolescents who are in jeopardy of being placed in long-term structured residential care. This program provides intensive multi-disciplinary services to youth and families with the goal of fully integrating youth into normal community systems within 30 - 90 days. This program also provides a transitional support program for youth returning from residential care, consisting of six components: 1) Eight participants are taught at the Learning Center for 3 1/2 hours, 5 days a week by a special education teacher with a family technician as a classroom aide. 2) Four days a week, 1 1/2 hours daily, the youth participate in a guided group following a "positive peer" model. 3) Once weekly for 1 1/2 hours a drug/alcohol group is held (maximum 8). 4) The recreation component of the program involves the participants in some sort of outing at least once a week, with outings of about one week's duration taking place twice yearly. 5) A partial-day treatment group is also available for 1 1/2 hours once weekly (this is a guided group interaction format, most participants attend two "rounds" of this group for a total of 16 weeks). 6) Parent support groups are held for 6-8 families, running for 8 weeks in evening sessions of 1 1/2 hours each.

Recruitment and Retention: Most youth are adjudicated, court-referred. No special retention or recruitment strategies are used.

Staffing: Staff include a special education teacher, two family services technicians, six senior social workers, a staff psychologist, and support staff. A psychiatric consultant and drug and alcohol counselor are used on a part-time basis.

Resources Needed and Materials Available: Costs for materials are nominal. Overhead projectors, VCRs, television monitors and films are used.

Special Characteristics: This program provides a substitute for institutionalization for problem youth who would otherwise suffer transition trauma in attempting to reintegrate into the family/community structure.

Effectiveness: No evaluations are available to date.

Comments on Implementation/Replication: Program leaders are willing to make one to two day workshops available for between eight and thirty participants.

2. BETHESDA DAY TREATMENT CENTER

Representative: **Dominic P. Herbst**
Managing Director

Mailing Address: Bethesda Day Treatment Center
P.O. Box 270
West Milton, Pennsylvania 17886
(717) 568-1131

Target Population: The Bethesda Day Treatment Center serves preadjudicated and adjudicated male and female juveniles between the ages of 10 and 18 who have committed both status and delinquent offenses. The client's whole family is engaged in his or her treatment plan. As a community-based prevention strategy, Bethesda also provides out-patient counseling for conduct-disorder youth and families in crisis.

Program Origin: The Bethesda program was founded and implemented by the current managing director in December 1983. Seed money was provided by the Pennsylvania Commission of Crime & Delinquency under the Juvenile Justice & Delinquency Prevention Act formula grant program. Bethesda currently serves seven counties in Pennsylvania and has targeted four additional counties for service by early 1993; interstate options also are being considered.

Program Objectives: The Bethesda program's goals are to provide adolescents and young adults who have conduct disorders and are unable to function in existing social/academic environments with a comprehensive individual- and family-centered, values-oriented treatment program that will facilitate their reentry into mainstream society.

Primary goals of the program are to:

(1) Stabilize the client's behavior at home, at school, and in the community by structuring his or her time in order to block and eventually eradicate his or her destructive actions.

(2) Assess the root causes for the client's behavior and hold him or her accountable for antisocial behavior by requiring him or her to take responsibility for his or her actions.

(3) Provide such positive substitutes for the client's antisocial behavior as employment, life skills, and career or vocational opportunities.

(4) Assess the causes of the client's family dysfunction and devise a plan of action to resolve conflict and restore order and stability to the home.

(5) Provide individualized educational alternatives for those clients who have failed academically or socially in mainstream education.

Program Strategies: Bethesda provides intensive intervention through the home, the school, the peer group, and the community to facilitate the containment of antisocial behavior and treatment of the whole family. Nontraditional hours of intervention (evenings and weekends) and a comprehensive menu of services (group, individual, and family counseling; drug/alcohol counseling; foster care) combine for a daily treatment strategy to resolve the underlying conflict which has accelerated and contributed to the pattern of dysfunction.

Recruitment and Retention: Clients are recruited through outreach and referrals from juvenile courts, parents, teachers and other school personnel, other clients, and other agencies.

Staffing: Bethesda's unique staffing pattern allows for specialization in an area of treatment or therapy while engendering a cohesion and bonding between clients and staff. Caseworkers and counselors make up the core of the direct-service staff; leadership for group functions is provided by therapists and consultants. The staff-to-client ratio is 1 to 3. Some staff members oversee the client's performance in all areas, while other staff members are highly specialized such as family-systems counselors or therapists.

Resources Needed and Materials Available: Bethesda draws from existing resources in the community by harnessing and orchestrating every available service to provide a catalyst for positive change. The program center is strategically located in the target area and staffed with personnel who understand the culture and geography of the area. Implementation materials including manuals, handbooks, and strategy reports are available.

Special Characteristics: Bethesda offers a unique blend of treatment and intervention for the whole family during nontraditional hours (evenings and weekends). The treatment modalities are all inclusive and provide the intensity of a residential center without removing the client from his or her home or community. Included in its full menu of services are group, individual, family, and parental counseling; career/work sites; vocational opportunities; family activities; drug/alcohol treatment; family systems counseling; individualized education; foster care when necessary; and much more.

Effectiveness: One preliminary study reveals recidivism rates (10.4 percent) significantly lower than the State and national norms. Other studies are pending. Based on number-specific measures, significant positive changes in client attitudes and behaviors have been documented; group-specific measures reveal increased self-awareness and improved personal relationships. These results are most relevant in light of the fact that Bethesda provides one of the most cost-effective services available.

Comments on Implementation/Replication: The Bethesda program is extremely adaptable and flexible to any city or community. For instance, urban areas require street counselors who have an understanding of the inner city and who are able to intensively intervene in the home and community. Rural areas need to use a conventional form of intervention that brings clients and families to the program center on a regular basis. While any community in the country would certainly benefit from the program's unique treatment approach, a contract with Bethesda's administration office is necessary to ensure successful replication. Bethesda's multifaceted treatment approach offers every possible level of intervention under the direction of one community-based agency. Therefore, intensive training must be provided to adequately understand the varied treatment strategies and the complex integration of services which help define an individual service plan for each client and family.

3. BIRTH TO THREE PROGRAM

Representative: **Ellen Hyman**
Assistant Director

Mailing Address: 3411-1 Wilamette St.
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(503) 484-5316

Target Population: Birth to Three is designed for a broad range of parents with infants and young children. All programs are free or on sliding fee scale and open to all families. Many families are self-referred. Others are referred by public health nurses, physicians, counselors, school personnel, children's protective services workers, family, and friends. Programs include: *Infant/Toddler and Drop in* (for families with infants and toddlers); *Teenaged Parents* (pregnant and parenting adolescents age 12-21); *Make Parenting a Pleasure* (parents with children age 0-10, for families experiencing high levels of stress); and *We're A Family* (for pregnant and parenting women in recovery from substance abuse).

Program Origin: The original funding for Birth to Three came from the National Center on Child Abuse and Neglect (NCCAN). Since its start, Birth to Three has provided parent education and support services to over 10,000 families.

Program Objectives: Birth To Three is a nationally recognized community-based prevention program. Its primary mission is to ensure the well-being of children, strengthen families and help prevent child abuse and neglect. It accomplishes these goals through parent education, peer support groups and support services. All programs are built on the following assumptions:

- parents want the best for their children;
- there is no perfect way to parent; and,
- parents want information, tools, and support as their child's first and perhaps most important teachers and role models.

Therefore,

- providing a parent education/peer support program for parents as early as possible in family life will positively affect parenting and support the healthy development of children.

Program Strategies: The original format was to bring together new parents from the same neighborhoods into a support group to share their parenting experiences, learn about normal early childhood development, develop a support network, and learn about other community resources available to them. Birth To Three has grown considerably in response to the changing needs and dynamics of the family. However, its philosophy and mission have remained unchanged.

Services: All participants in Birth To Three programs receive the following:

- **Membership** in a Birth To Three group.

- **A subscription to the bimonthly Birth To Three newsletter** filled with articles relevant to the concerns of parents with young children, as well as listings of community activities available to children and their parents, book reviews, and updates on program activities.

- **Access to the Parent Resource Telephone "Warmline,"** a community service provided to any parent who calls. A staff peer counselor is available to answer questions, make appropriate referrals, do crisis intervention, and listen.

- **Admission to Birth To Three educational events** that are open to the community. Usually designed as a panel presentation on a relevant topic (discipline, couple issues, etc.), community professionals volunteer as guest speakers at these events.

- **The Birth To Three Resource Poster** which is also given to all parents in the community through the hospitals when they give birth. Additional posters are displayed in the offices of doctors, social service agencies, schools, libraries, and other appropriate locations.

In addition, Birth To Three sponsors a weekly column in the Oregon Life section of the *Register-Guard* newspaper. This column is written by staff and other community professionals. Subjects cover a wide range of issues that concern parents. A series of twelve articles have been translated into Spanish and are printed monthly in the statewide *El Hispanic* newspaper.

In many of the programs, free childcare is provided while group members meet.

Recruitment and Retention: Parents learn about Birth To Three from a variety of sources: obstetricians, hospitals/birthing centers, pediatricians, teachers and school counselors, social service agency workers, and friends. All programs are voluntary and most families stay with a group for at least a year. Birth To Three has been in the community for 14 years, during which time it has built a solid reputation as a model prevention program. Physicians, midwives, social service providers, school personnel, and others know about the programs Birth To Three offers and refer clients.

Staffing: Birth To Three employs 18 people with backgrounds in early childhood education, counseling, social work, human services, education, pediatric nursing, and community organization. Over 150 volunteers serve Birth To Three facilitating groups, raising funds at special events, participating in community outreach, doing public education, and in other roles.

Resources Needed and Materials Available: Publications available include: 1) *Birth To Three: Support for New Parents* (photocopy only). 2) *Make Parenting a Pleasure: A Program Guide and Curriculum for Parents Under Stress.* A recent grant from US WEST enables Birth To Three to expand, enhance, and revise the curriculum, the program is also developing video vignettes and audio tapes for classroom use. Printed materials on the teenaged parents program and infant program are available and program guides will be written.

Special Characteristics: Birth To Three provides parent education/peer support programs for a broad base of parents with young children through the following programs:

Infant/Toddler: Within this program there are groups for parents with different needs (e.g., single parents, parents of multiples, working parents, parents with children who have special needs). A parent educator facilitates a 10-session, five-month curriculum that covers birth experiences, stress/anger management, early childhood development, adult relationships, health and safety, parenting strategies, group agreements, play and learning, baby massage, and childcare issues. Groups are encouraged to continue to meet after this initial five month period. Volunteers from within the group become facilitators, attending a Training Workshop, quarterly in-services, and bimonthly trainings. Staff are available to ongoing groups for supervision, training, mediation, and support. Volunteer facilitators receive a listing of community resource speakers who donate their time to provide valuable information to group members. Facilitators can use any of the materials (handouts, books, audio and video tapes) in the Birth To Three Library. The *Toddler Series* is a 10 week curriculum focusing on families with toddlers. The goal is to develop parenting skills that can be used throughout the parenting years.

Make Parenting a Pleasure was developed in 1983 in collaboration with the YMCA. It is a 10-week parenting class followed by a 10-week peer support group to parents with low incomes who are experiencing high levels of stress. A Birth To Three parent educator teaches the class component and a trained mentor facilitates the peer support group. This group then becomes a parent-led Birth To Three group. Topics include handling anger and stress, communication, and normal child development issues. The YMCA provides free membership to their facility for participants in Make Parenting A Pleasure and the children's program that runs concurrently. Make Parenting A Pleasure is part of an Oregon Department of Education grant to provide its parent education and peer support model to parents at two elementary school sites in the area.

We're A Family is a program for pregnant and parenting women in recovery from substance abuse. This program has been designated as a state demonstration model program.

Birth To Three For Teenaged Parents provides parent education and peer support groups to pregnant and parenting adolescents. Groups meet weekly and discussion focusses on personal growth and development, parenting, community resources, and special topics

(legal aid, the welfare system, etc.). Supplemental services include home visits, crisis intervention, referral to other community resources, and assistance in meeting basic needs (housing, food, clothing). Birth To Three has also developed a Teen Parent Panel service. Teenaged parents and their children serve as speakers at middle and high school family life/health classes and discuss the realities of teenage pregnancy and parenting.

Effectiveness: As a part of the evaluation process, Birth To Three submits 100 names quarterly to the state Children's Services Division. Of the 1,200 names submitted for a random check (through August, 1992), less than five names have been verified as suspected (not confirmed) child abuse cases. Birth To Three also uses pre- and post- questionnaires to assess parenting knowledge, social support system, and program satisfaction.

Comments on Implementation/Replication: *Birth To Three: Support for New Parents* (available in photocopied manual form) is a book that was designed to help parents and professionals set up a parent support program on the Birth To Three model. Training and additional assistance have also been made available.

4. CEDEN Family Resource Center

Representative: **Terry Villalobos Arguello**
Program Coordinator

Mailing Address: CEDEN Family Resource Center
1208 East 7th Street
Austin, Texas 78702
(512) 477-1130

Target Population: Parents of developmentally delayed infants or young children, primarily low income families; or parents whose infants or young children are at high risk for developmental delay, either through biological/medical or environmental circumstances.

Program Origin: CEDEN was founded in 1979 by Dr. Emily Vargas Adams, now Executive Director. Dr. Adams conducted a needs assessment with low-income families in East Austin, and determined that the highest priority of need was for services to improve child and family development.

Program Objectives: CEDEN strives to promote and strengthen families in need through family-focused, community-based services. A variety of programs interact to provide this support, here we focus on the Parent-Child Program.

Program Strategies: The Parent-Child Program provides full-scale child and family screening and assessments, individualized family service plans, weekly home visits and monthly group meetings on infant stimulation, health, nutrition, safety, and home improvement.

Recruitment and Retention: Clients are self-referred by hospitals, clinics, physicians, schools, human services agencies, child care centers, child therapy centers, family violence programs, police departments, churches, past participants, and concerned citizens. Early intervention specialists (home parent educators) also canvas neighborhoods in order to identify those lowest-income families who do not have an adequate support network. All families are screened before admittance to the program.

Staffing: Instructors are required to have a minimum of a college degree and three years of experience in child development, have demonstrated ability to read and write well in English and/or in Spanish, and have a current driver's license, car insurance, and car to conduct home visits. Parent educators should be empathetic, motivated, and non-judgmental.

Resources Needed and Materials Available: CEDEN has a variety of resource materials for use by home educators and parents alike. The CEDEN Infant Development Curriculum is available for home educators. There are also 20 Health and Nutrition packets available

for caregivers. CEDEN has an extensively field-tested infant development book called *My Baby Book*, also available in Spanish as *Libro de Mi Bebe'*. The Parent-Child Program Evaluation Manual is used by CEDEN for internal program evaluation. The curriculum for classes on parenting and communication skills provides content and methods to teach parents the essentials of parenting. Many other materials on prenatal and parenting education are also available from CEDEN.

Special Characteristics: CEDEN is a comprehensive program that has been presented here only in part. Some portions of the full CEDEN program are dependent on available community services. Since such services may vary from site to site, only such information as may be implemented across sites (i.e., the home visitor program) has been presented.

Effectiveness: This program is exceptional in its commitment to program evaluation and research, and has extensive internal evaluation procedures available. CEDEN has maintained a three-person research department since 1979.

Comments on Implementation/Replication: This program is probably the best infant parenting program for very high risk families, especially for parents who need services in their home. The home visitor provides other needed referrals and support services such as transportation or emergency support. The program would be difficult to implement in very dangerous neighborhoods; however, CEDEN maintains that its home educators are most often welcomed because of CEDEN's reputation as a helping organization. The program has a drop-in center and also provides child care centers with a range of services including home visits, parent education classes, parent support groups, and parent involvement groups. They also hold parent/child language development and literacy groups in their offices for parents.

5. THE DYNAMICS OF RELATIONSHIPS: A GUIDE TO DEVELOPING SELF-ESTEEM AND SOCIAL SKILLS IN YOUTH

Representative: **Patricia Kramer**
President

Mailing Address: Equal Partners
3371 Beaverwood Lane
Silver Spring, Maryland 20906
(301) 871-9665

Target Population: The program targets all school children in grades K-12, or ages 5 to 18.

Program Origin: Originally designed as a school program, the Dynamics of Relationships program has been used in many different settings, including hospitals, residential treatment centers, and teen parenting programs.

Program Objectives: The program's objectives are to allow young people to develop the following attributes:

(1) A strong and secure sense of self-worth that will help them to say no to drugs, alcohol, gang involvement, negative peer influence, and other self-destructive behaviors.

(2) More effective communication skills that will allow them to better interact with others and to handle anger and conflict on a safe level while learning that violence is never acceptable.

(3) The ability to constructively cope with stress, disappointment, loss, and rejection.

(4) Clearer and more realistic expectations about their future roles in life.

(5) A deeper understanding of the commitment necessary to achieve and maintain lasting and loving relationships.

(6) A feeling of empowerment—so that they feel valued and effective as human beings and no longer view themselves as victims.

Program Strategies: The Dynamics of Relationships project establishes as many programs as possible in all types of settings with trained facilitators and parental involvement so that parents and children can implement at home the skills learned in the program.

Recruitment and Retention: The program director visits schools, parent organizations, health worker organizations, and mental health organizations to promote the program the Organizations that wish to implement the program then hire the director to come back to the organization and train individuals as facilitators to present the curriculum to children.

Staffing: The program director trains teachers, parents, social workers, mental health workers, and others to provide the program. One facilitator can work with a group of 20 to 25 young people.

Resources Needed and Materials Available: There are two teacher/facilitator manuals: one for the teen program and one for the preteen program. Also available are student manuals which afford students the opportunity to work with their own books during the program's hours, as well as at home with their families.

Special Characteristics: The Dynamics of Relationships program teaches children coping skills, how to build self-esteem, and how to deal with stress and anger. The program is unique because the director takes the curriculum into established organizations and trains existing authority figures to be the facilitators of.

Effectiveness: The program has demonstrated measurable success in many settings. Although there is an evaluation instrument to measure effectiveness, those who continue to use the program after many years have not used the instrument to evaluate it.

Comments on Implementation/Replication: The program can and has been implemented in myriad settings and has proved equally effective in all settings. Behavioral and attitudinal changes have been demonstrated in cases where the program has been implemented for a long duration. The most dramatic impact has been demonstrated when the program is implemented as a year-long, school elective course where students share their experiences and skills with their parents. Under optimum conditions, teachers/facilitators include

6. EFFECTIVE BLACK PARENTING PROGRAM

Representative: **Jeffrey Morrow, Ph.D.**
Associate Director

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11331 Ventura Blvd., Suite 103
Studio City, California 91604
(818) 980-0903

Target Population: The program was initially designed and field tested with inner city African-American parents of preschool and elementary school age children. In 1988 the program was first used with middle and upper income African-American families and with parents of older children. The majority of the program's information is likely to be relevant to all African-American parents because it is grounded in basic information and parenting strategies that are useful for all parents. It addresses issues that are of general concern to African-American parents in the U.S. The specific child management skills and much of the child development information is particularly useful for parents of children two through 12 years of age.

Program Origin: This program was developed by the Center for the Improvement of Child Caring (CICC) in response to the criticism in the late 1970s that none of the widely used parent training programs in the U.S. were created specifically for African-American Parents. In 1985, the Effective Black Parenting Program was developed that integrated all of the research findings and field test results.

Program Objectives: This cognitive-behavioral program is designed to foster effective family communication, healthy African-American identity, extended family values, child growth and development, and healthy self-esteem. It is also designed to facilitate community efforts to combat child abuse, substance abuse, juvenile delinquency, gang violence, learning disorders, behavior problems, and emotional disturbances.

Program Strategies: Effective African-American Parenting is based on a prosocial achievement orientation to African-American parenting and recognizes the special "street pressures" in inner city African-American communities that make it difficult for African-American parents to maintain such an orientation. Two major parenting strategies are presented: The Family Approach for Developing Respectful Behaviors (utilizing family rules and family rule guidelines) and the Thinking Parent's Approach to Disrespectful Child Behaviors (utilizing systematic decision making processes). The program teaches rule development, family meeting and problem assessment skills, and shares basic child development information to help parents make age-appropriate rules. The program also teaches several basic child management skills: effective praise, mild social disapproval, systematic ignoring, time out, and special incentives. The regular program consists of 14 three-hour training sessions and a fifteenth session for a graduation ceremony. Each

training session includes an extensive review and role playing of ideas and skills which were taught in previous sessions. Optimal group size appears to be about 15 to 20 parents, but more could be accommodated if necessary. A one-day seminar version of the program is also available, which can be conducted for 50 to 500 parents.

Recruitment and Retention: An extensive Plan for Generating and Maintaining classes is shared with instructors who receive workshop training from CICC. When child care and other support services are provided, attendance averages 75% - 85%. Without such support, attendance is closer to 50%.

Staffing: Instructors should have a background in African-American studies, African-American parenting, parent education, child development, group processes and behavior modification. Training workshops last five days and can be conducted at any location in the U.S. or abroad (providing the sponsoring group pays travel, per diem and lodging expenses for workshop leader). Instructors receive provisional authorization to run one class in Effective African-American Parenting Program. After conducting their first class, they receive official certification to conduct the Effective African-American Parenting Program.

Resources Needed and Materials Available: Materials include an instructor's manual, instructional charts, a parent's notebook, a promotional video, promotional flyers, and graduation certificates. Three supplementary books are also available.

Special Characteristics: This program includes discussion of traditional African-American discipline and contrasts this with modern African-American discipline strategies in teaching parents new skills. Also presented are issues relevant to African-American pride and ways of coping with racism. Child abuse information is included in a discussion of the disadvantages of using corporal punishment as a disciplinary technique.

Effectiveness: Field test results indicate that the program in its fully integrated form has direct and positive effects on many of the family and child risk factors that have been found through research to put children at risk for drug abuse, delinquency and other social and health problems. It reduces negative family communication, enhances parental involvement with children, reduces child behavior problems, enhances limit-setting, and improves the general psychological well-being of parents.

Comments on Implementation/Replication: Positive results have been replicated in classes in 35 states, including improvements in the quality of relationships, reductions in harsh and rejecting attitudes and behaviors, reductions in children's different behavior problems, and improvements in parental psychological well-being.
parents in the program through periodic parent/student workshops.

7. FAMILIES AND SCHOOLS TOGETHER (FAST)

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Target Population: The program is designed to assist preschool, elementary, and middle-school aged children whom teachers have identified as at risk for later problems——such as school failure, substance abuse, and delinquency——and their families.

Program Origin: FAST was developed by Dr. Lynn McDonald and Family Service of Madison, Wisconsin, in collaboration with the Prevention and Intervention Center for Alcohol and other Drug Abuse and the Madison Public Schools. Original funding came from grants by the United Way and the State of Wisconsin Department of Health and Human Services.

Program Objectives: The FAST program is designed to:

(1) Enhance family functioning by strengthening the parent-child relationship in specific ways and empowering the parents to become primary prevention agents for their own children.

(2) Prevent the target child from experiencing school failure by improving the child's behavior and performance, empowering parents as partners in the education process, and increasing family feelings of affiliation with their schools.

(3) Prevent substance abuse by the child and the family members by increasing knowledge and awareness of substance abuse and its impact on child development and linking the family to assessment and treatment services if necessary.

(4) Reduce the everyday stress that parents and children experience by developing an ongoing support group for parents of at-risk students, linking participants to needed resources, and building the self-esteem of each family member.

Program Strategies: FAST uses a collaborative, whole family approach to achieve its goals. An 8-week curriculum of multiple-family group activities, followed by ongoing monthly meetings, incorporates the following activities: a meal hosted by a family, a family sing-along, structured family communication exercises, family feelings identification exercises, parent support meetings while children play, one-to-one quality time, winning-as-a-family-unit exercises, a closing ritual, a substance abuse education component, graduation, and development of a school-based parent advisory council of FAST program graduates.

Recruitment and Retention: FAST identifies participants through a strong and active recruitment process in which school personnel identify at-risk children. Other recruitment activities include home visits and training in recruitment, plus a positive nonstigmatizing programmatic approach that focuses on strengths and empowerment, incentives, and removal of obstacles to participation through provision of transportation and child care. Of families initially telephoned by schools, 63 percent agreed to attend at least one meeting. Eighty-two percent of families that attend at least one meeting graduate from the FAST program. Recruitment and retention rates reflect first-time implementation at new sites; rates at ongoing sites are typically substantially higher.

Staffing: FAST is a collaborative effort between a school, a mental health agency, an alcohol and other drug abuse prevention specialist, and parents. Multifamily group meetings are staffed by a school staff member such as a social worker, counselor, psychologist, or principle; a parent, liaison worker, or FAST facilitator; an alcohol and other drug abuse prevention specialist; and a mental health professional. Volunteers are recruited and trained to help at meetings.

Resources Needed and Materials Available: Necessary resources include a large room and materials to execute family activities. The *FAST Program Workbook* describes all the resources needed.

Special Characteristics: FAST targets whole families, reaches "unreachable" families, and uses a truly collaborative approach. FAST breaks down barriers to trust and stereotypes and promotes development of active parent groups and advocacy councils. FAST utilizes a stress/social-support model that builds on family strengths. FAST is explicit about program values. The FAST program model and activities are strongly grounded in an empirical research base.

Effectiveness: Scores on objective, standardized assessment instruments demonstrate significant pre- to post-program improvements in child behavior problems, as rated by both parents and teachers; improvements in family cohesion; decreases in social isolation of parents; and increases in involvement of parents with their children's schools. Collaborative teams rate the program as very successful. Data have been collected on over 700 elementary school children, and continuing evaluations of program effectiveness are in progress.

Comments on Implementation/Replication: FAST has been successfully replicated at more than 70 schools in Wisconsin and 6 other States in rural, medium-sized, and urban communities. FAST groups have been made up of culturally diverse families, as well as solely Spanish-speaking people, Native Americans, African Americans, Asian Americans, or European Americans. FAST has developed a thorough and highly effective training model that includes links between communities and onsite training of collaborative teams.

8. FAMILIES IN FOCUS - "Seven Secrets to a Successful Family"

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Target Population: Families whose children are at high risk for alcohol and drug use because of family history of alcohol and drug abuse, parental communication problems, family management problems, or youth problems.

Program Origin: *Families in Focus* (FIF) began just over 5 years ago as result of The Cottage Program International's 15 years of working with families to prevent alcohol, drug abuse and other behavioral disorders. Its companion program *Foco Interno Familiar* for Spanish speaking families was translated, adapted, and implemented in Hispanic/Latino populations in the United States and Latin America in 1988.

Program Objectives: The program objectives are to reduce alcohol and drug use and their accompanying behavioral disorders, decrease parental denial, educate parents and youth about the consequences of alcohol and drug use, and encourage participation in health promotion and risk-reduction programs.

Program Strategies: The program involves 36 hours of in-home or small group workshops in family skills training. Service providers and volunteers are trained to conduct and maintain these prevention services. Meetings are usually held every two weeks to complete the initial phase of the nine session program. The family members complete a Family Profile questionnaire which is adapted from the Family Adaptability and Cohesiveness Evaluation Scale (FACES III). Once the Family Profile is completed and charted, it directs the family to a specific activity based on their family needs. The Home Learning Guide contains 53 different family activities as well as stress tests for adults and adolescents. Families maintain contact with FIF over several months and, in many instances, years through a toll-free number. Newsletters and follow-up contacts and other activities are part of the ongoing support services.

Recruitment and Retention: The families are referred by educational institutions, businesses, religious organizations, agencies, and the general communities where the program operates throughout the United States. The program receives substantial attention from the print and electronic media, attracting large numbers of families to participate in the program. Families who become involved in FIF tend to complete the training cycle and maintain contact with the program over an extended period.

Staffing: Both volunteers and professionals are used for the program. Two trainers are required for groups of up to 20. The volunteer trainers are trained in 12 hours of classroom training and 12 hours of field work, followed by continuous in-service training each month. Volunteers have access to a toll-free telephone number for ongoing consultation.

Resources Needed and Materials Used: The FIF program includes the Home Learning Guide; the Volunteer Training Manual; the Replication Training Manual; the Community Development Manual; Family Profile; and assorted charts, lists, and brochures.

Special Characteristics: This program was developed primarily to strengthen families and prevent the onset of alcohol, drug abuse, and other behavioral disorders. It seeks to promote social and personal values which are consistent with the behavioral health and emotional well-being of individuals and their environment. Its empowerment philosophy and community orientation embrace the Self-efficacy Theory and the Health Belief Model.

Effectiveness: Families in Focus undergoes a complete process and outcome evaluation. The evaluation quantifies the effects of participation. The impact that Families in Focus has on drug abuse, age of first use, abstinence, and use expectancies are measured. Pre- and post-measurement of family functioning and family satisfaction are considered. Results show gains in family functioning and family satisfaction. Further, it is indicated that the program significantly reduces the incidence of alcohol and drug abuse. Expectancy scores are also predictive of fewer problems with alcohol and drugs. Foco Interno Familiar is producing similar results in Spanish speaking populations.

Comments on Implementation/Replication: Currently, there are over 10,000 families throughout the United States who have participated in the FIF program. The U.S. Department of Education is providing funding for its implementation. FIF has operated successfully for over three years in Thibodaux, Louisiana and is being replicated statewide in Louisiana during this school year. For over 4 years, Willmar Regional Treatment Center in Willmar, Minnesota has successfully operated FIF in a rural 17 county area. Southwest Texas State University in San Marcos, Texas has carried out the program for Spanish-speaking individuals for more than three years and shows positive results.

The Utah State Prison has utilized the Families in Focus Program for inmates and their families at the prison site. J.C. Penney, Unisys, Citibank, and other businesses have found the program to be very helpful in improving employee morale.

9. FAMILY RELATIONSHIP ENHANCEMENT PROGRAMS

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Target Population: Most appropriate for adolescents and their parents. The program can be used with all educational and cultural levels (client literacy is not a requirement for program success). It is very appropriate for working with high risk families and for stopping substance abuse, child abuse/neglect, and other problems, as well as in prevention of such problems.

Program Origin: The original program was designed for children between 4-12 years of age; infancy and adolescent programs were added later. The program was developed in the early 1970s, first with parent/adolescent dyads and then with families and with groups of families.

Program Objectives: The program is designed to prevent substance abuse by increasing family supportiveness, cohesion, and appropriate perceptions and level of control. The goals of this program are to create a therapeutic, growth enhancing family system.

Program Strategies: Participants are taught nine skills: *expressive skill*, in order to become more in touch with one's own goals, values and feelings and to increase self-awareness; *empathic skill* to encourage others to express with honesty and openness, with a sensitivity to their needs and feelings in order to build trust and compassion in a relationship; *discussion/negotiation skill* to preserve a positive emotional climate in working through problems and conflicts and to avoid unnecessary digressions in order to explore root issues; *problem/conflict resolution skill* to help clients to devise (or help others to devise) creative solutions to problems which maximize mutual need-satisfaction; *self-change skill* to implement changes in attitudes/feelings,behaviors in order to implement interpersonal agreements and objectives; *helping-others-change skill* enables others to change similarly; *generalization skill* to help clients use relationship skills in daily life; *teaching skill* to enable clients to train others to use relationship-enhancing skills in daily life; and *maintenance skill* to enable clients to maintain usage of such skills over time.

Recruitment and Retention: Recruitment practices vary, including recruitment through churches, public announcements, or talks at high schools. Special incentives in the form of lottery cards for participation and payment for completion of research measures have been used. It may be desirable to provide funds or other assistance for transportation, babysitting, etc.

Staffing: There are no formal educational requirements for staff. Problem prevention and enrichment group leaders are trained through workshops and supervision. Additional supervision can lead to certification. Training is conducted through IDEALS (Institute for Development of Emotional and Life Skills) nationally and in Canada. Usually a group of 8-12 trainees is needed to provide sufficient funding for the trainer and the traveling costs.

Resources Needed and Materials Available: Texts and materials are available from IDEALS.

Special Characteristics: The program emphasizes improving family communications and is most appropriate for older children. The program format can be easily varied. Full day sessions and weekend formats, repeated if desired, are feasible. Locations and the size of the group may vary widely. Typically, however, the format is weekly sessions of 2-1/2 hours for 13 weeks. Eight to sixteen trainees typically attend.

Effectiveness: Studies have found improvement in relationship skills; marital, adolescent and family satisfaction; communication; social skills; and self esteem. Superior results in comparison to no treatment and to alternate treatment controls have been repeatedly demonstrated.

Comments on Implementation/Replication: The program has been used with alcoholics, spouse abusers, adolescent and adult psychiatric patients and their families as well as families from the general population.

10. FUNCTIONAL FAMILY THERAPY

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Target Population: Families with identified status offenders and other youths identified early in the delinquency cycle. This program has also been found to prevent problems among younger siblings. Several versions of Functional Family Therapy (FFT) programs exist, including an in-home version and one designed to be used with multiple-offending juveniles who have been incarcerated. This program has also been used with youth who have initiated use of alcohol, tobacco, or drugs.

Program Origin: This program is a blend of family systems theory and behavioral social learning theory developed by James Alexander and his colleagues at the University of Utah (Alexander & Parsons, 1982; Barton & Alexander, 1981). As with many programs that have been evaluated and used for several years, FFT exists in several versions.

Program Objectives: The main goals of FFT are to increase reciprocity and positive support among family members and to improve clear and positive communications. The program is designed to reduce interpersonal problems by teaching communication skills, helping family members to identify what they desire from each other, and to identify possible solutions to family problems. Alexander (1973) found that families of delinquents have more defensive and less supportive communication patterns. A major goal of treatment is to improve family communication and supportiveness.

Program Strategies: In its most recent form, FFT contains five phases of family therapy: the Introduction/Impression Phase (family members' expectations for therapy are determined); the Assessment Phase (family processes or functions in need of change are identified); the Induction/Therapy Phase (maladaptive patterns are modified through cognitive therapy techniques such as relabeling), the Behavior Change/Education Phase (behavior change techniques, communication skills training, social skills training, coping skills training, behavior contracting, anger and stress management, and contingency management are used to change the family behavior patterns); and the Generalization/Termination Phase (here, focus is on maintaining the therapeutic gains while helping the family to terminate and reduce dependency on the therapist).

Recruitment and Retention: A version of this program was developed by Gordon and associates (Gordon, Arbuthnot, Gaslefson and McGreen,1984; Gordon, Groves and Arbuthnot, 1986) that is conducted within the high-risk family's homes. There were positive effects on the younger siblings as reported by Klein et al., (1977). Providing information at home avoids some of the recruitment and attrition problems usually experienced with high-risk families.

Staffing: This program requires professional therapists, therefore, the cost is relatively high.

Resources Needed and Materials Available: Communication charts and manuals are available for family members during the behavior change phase. If possible, sessions are tape recorded for therapist review and/or for families to take tapes home for practice reminders.

Special Characteristics: This program has demonstrated effectiveness with identified status offenders and other youths identified early in the delinquency cycle. FFT is one of the only family programs that combines components of social learning with family systems therapy.

Effectiveness: The program has demonstrated impact on reducing delinquency in the targeted teenager and 18 month follow-up studies suggest that the impact is lasting. The program has a preventive influence on the younger siblings. It is one of the few family-focused programs which has been tested for effectiveness with adolescent status-offenders.

Comments on Implementation/Replication: FFT is a fairly standardized program that could be disseminated widely as it is not dependent on a special facility nor is it a difficult program to implement. It does require that trained therapists conduct the intervention.

11. HARTFORD AREA RALLYING TOGETHER (HART) ANTI-DRUG PROJECT

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Target Population: The HART Anti-Drug Project is designed to assist 25,000 to 30,000 people in the inner city of Hartford, Connecticut. The target population is largely Hispanic (75 percent) with a high concentration of young, single female-parent households.

Program Origin: Begun in 1989 as a collaborative effort of community and public agencies to fight drugs in several targeted neighborhoods, HART grew to focus its efforts on young Hispanic families and targeted drug prevention and treatment strategies.

Program Objectives: The HART Anti-Drug Project's primary goals are to:

(1) Develop after-school programs for 1,000 at-risk youth in 10 elementary schools in Hartford.

(2) Develop parent training programs for 50 parents at 2 troubled elementary schools.

(3) Redevelop the infrastructure of the youth services and resources in one targeted neighborhood (that is, recreational and education facilities, housing improvements, crime-free neighborhoods).

(4) Develop a successful case management program for at-risk and adjudicated young people between the ages of 11 and 14, aiming for an 85-percent success rate to be judged by the lack of recidivism.
(5) Decrease crime by 5 percent a year in three targeted neighborhoods over a 3-year period.

Program Strategies: To achieve these goals, HART empowers the parents, youth, and community through specific skills development and community improvements. The aim is to bring about needed changes relevant to improved person-in-environment transactions and interaction. The program is based on a comprehensive strategy that addresses the needs of families and the larger community environment.

Recruitment and Retention: Trained staff recruit participants, largely Hispanics ages 11 to 35, from neighborhoods and from other service agencies. Recruitment and retention statistics show very strong outcomes.

Staffing: Two full-time staff members run the family service program. Three full-time staff are involved in the anti-drug project. One full-time and one half-time staff run after-school programs.

Resources Needed and Materials Available: Crucial to the success of the project is the organizational capacity to provide materials duplication, meeting rooms, offices, phone services, a receptionist, and other support. Many materials are available to provide assistance to staff, participants, and other programs.

Special Characteristics: All programs are run through a community-based organization whose chief purpose is one of empowerment and community change. Programs are likely to involve larger numbers than more qualitative or selective programs.

Effectiveness: The HART Anti-Drug Project is recognized nationally for effectiveness. Decreases in the crime rate in project neighborhoods further indicate success, as does community participation in the project. Program outcomes related to objectives show a high level of significant success.

Comments on Implementation/Replication: The program is replicable when the replicating organization sincerely incorporates empowerment strategies into the fabric of the program.

12. HELPING THE NON-COMPLIANT CHILD

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Target Population: Parents and their three- to eight- year-old children who are exhibiting noncompliance and other conduct problems. There are no specific criteria for parent participation. The involvement of both parents is actively encouraged.

Program Origin: This program is based on a parent training program originally developed by Dr. Constance Hanf at the University of Oregon Medical School in the late 1960/s (Hanf & Kling, 1973) to treat noncompliance in young, physically handicapped children. This adaptation by Forehand and McMahon (1981) is the most formally operationalized and validated version of the Hanf approach to working with conduct-problem children.

Program Objectives: Primary goals are secondary prevention of serious conduct disorder problems in preschool and early elementary school-aged children, and the primary prevention of subsequent juvenile delinquency. Short-term and intermediate objectives include: a) disruption of coercive parent-child interactions and the establishment of positive, prosocial interactions; b) improved parenting skills in tracking the child's positive behaviors, increased use of praise and positive statements, ignoring of minor inappropriate behaviors, provision of clear and appropriate instructions, and provision of appropriate consequences for compliance, noncompliance, and other behaviors; and c) increased child prosocial behaviors and decreased conduct problems.

Program Strategies: The parent training program focuses on teaching parents to change maladaptive patterns of interaction with their children. The 60 to 90 minute sessions are conducted in a clinic setting with individual families rather than in groups. In an ideal setting, sessions occur in clinic playrooms equipped with one-way mirrors for observation, sound systems, and sound devices by which the therapist can unobtrusively communicate with the parent; however, these are not necessary for the successful implementation of the program. This is a very active program that places a great deal of emphasis on helping the parent become competent and comfortable with the various parenting skills taught in the program. Progression to each new parenting skill in the program is based on the competent performance of the earlier skills. This allows for

individualization of the treatment program by allocating training time more efficiently, since the therapist can focus attention on more serious parenting skill difficulties. The number of sessions needed for completion of each phase of treatment depends on the speed with which the parent demonstrates competence and the child's response to treatment. The average number of sessions is 10-12. Sessions are typically held once or twice weekly.

Recruitment and Retention: No specific information available.

Staffing: A single family therapist is all that is necessary to conduct the program successfully. However, if resources permit, use of a co-therapist can increase the therapist's flexibility in demonstrating various skills to the parent (e.g., the therapist and co-therapist may demonstrate these by role-playing the parent and child).

Resources Needed and Materials Available: A comprehensive presentation of the program is contained in the therapist's manual (Forehand & McMahon, 1981). Parents are given handouts specific to each skill for reference in the home setting, are assigned homework to practice their newly acquired skills, and are given data sheets to record their results.

Special Characteristics: This is a social-learning based program comprising two phases. Phase I (the differential attention phase) helps the parent to use positive verbal and physical attention contingent upon compliance and other appropriate behaviors, and to ignore minor inappropriate behavior. Phase II teaches the parent to use clear instructions and to provide appropriate consequence for child compliance and noncompliance. The parent learns to issue instructions one at a time that are clear, concise, and direct, and to allow the child sufficient time to comply. The parent is taught to praise or attend to the child within 5 seconds of compliance initiation. A time-out procedure is used when the child is noncompliant. "Standing rules" are designed and implemented for each child.

Effectiveness: This parent training program has been extensively evaluated (see McMahon & Forehand, 1984). Both parent and child behaviors have been shown to improve in the home to within the normal range as a function of treatment, as have parents' perceptions of their child's adjustment. Furthermore, these improvements occur regardless of the families' socioeconomic status (although families from lower socioeconomic backgrounds are less likely to complete the program) or age of the children (within the three to eight year-old range). Improvement in child compliance has been shown to be accompanied by decreases in other conduct problem behaviors such as aggression, tantrums, destructiveness, and inappropriate verbal behavior. Maintenance of effects has been demonstrated in a series of studies with follow-up assessments ranging from six months to more than 14 years after treatment termination. Parents have also indicated high levels of satisfaction with the parent training program. The parent training program has also been successfully employed with other high-risk populations, including children with handicaps (Hanf & Kling, 1973), those with attention-deficit hyperactivity disorder (Pisterman, McGrath, Firestone, Goodman, Webster, & Mallory, 1989), mothers at risk

of child abuse and neglect (Wolfe, Edwards, Manion, & Koverola, 1988), and as a component of a preventative intervention for children of substance abusing parents (Kumpfer & DeMarsh, 1987).

Comments on Implementation/Replication: As with other programs that require a trained therapist, the costs of this program may make it difficult for some agencies to implement.

13. HOMEBUILDERS PROGRAM

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Target Population: The program is designed for only the most seriously troubled families. Families are referred to HOMEBUILDERS from a number of child service agencies, such as child protective services, juvenile justice, mental health, and developmental disabilities services. Reasons for referral include child abuse and neglect, truancy, status offenses, family violence, substance abuse, delinquency, disrupted special needs adoptions, mental health problems, or developmental disabilities.

Program Origin: This program was developed by Drs. Jill Kinney and David Haapala in 1974 to help families who were failing in community programs, thus putting their children at risk for out-of-home placement. The most rigorous evaluation effort to date indicates that 71 percent of the children targeted for foster care and served by HOMEBUILDERS remain at home with their families 12 months after service intake. The program currently has 45 therapists serving twelve counties in Washington State. From 1987-1991 Behavioral Sciences Institute carried out a demonstration project in the Bronx, New York. Recently that program has been picked up and expanded city-wide through the city's Child Welfare Administration.

Program Objectives: HOMEBUILDERS is an in-home, psycho-educational, skills-oriented model of intervention grounded in social learning theory and research. The intervention involves defusing the immediate crisis, engaging the family, assessing the problem and developing goals, and teaching the family members specific skills to help them solve problems, function more effectively, and to avoid future crisis.

Program Strategies: HOMEBUILDERS intervenes directly and immediately at the clients' convenience in a variety of areas which are beyond the scope of many intervention programs. It should be remembered that this program is designed for high-crisis situations and families that are often at immediate risk of dissolution.

Recruitment and Retention: Services are provided when and where the clients wish so that basic needs are met. Participating families are referred by public agency workers who have the authorization to place children and youth in foster, residential, or institutional care.

Staffing: HOMEBUILDERS therapists are master's level or other social workers or psychologists trained in social learning and cognitive intervention strategies within an ecological framework. They are trained to help families achieve behavioral changes (e.g., improve communication and parenting skills), cognitive changes (e.g., anger and depression management) and environmental changes (e.g., clean house, obtain food and clothing).

Resources Needed and Materials Available: Training and consultation to enhance the replication of HOMEBUILDERS-like programs have been provided by Behavioral Sciences Institute (BSI) nationally and abroad, ranging from telephone discussions about program start-up to state-wide, on-site program development training and consultation efforts. The following video and books describe and explore the philosophy, practice and evaluation of HOMEBUILDERS: *Skills for Family and Community Living* (a video tape program and leader's guide book), *Families in Crisis, The Impact of Intensive Family Preservation Services, Keeping Families Together: The Homebuilders Model,* and *Reaching High-Risk Families.* Additional training and consultation information can be obtained by calling the BSI Training Division.

Special Characteristics: HOMEBUILDERS is a fairly costly program ($2,600 per family) for 4 to 6 weeks of services but is preferable when the alternative is out-placement at tremendous costs. The intervention is immediate (within 24 hours of referral), intensive and time-limited to 4 to 6 weeks. Case loads are small, with each therapist handling only 18 to 20 families per year. Therapists are on call for clients 24 hours a day, seven days a week.

Effectiveness: A recent evaluation by Fraser, Pecora, and Haapala (1991) found that 67 percent of the children at risk of placement in the combined study sites of Washington and Utah (N=342) were still at home 12 months after service intake. In contrast, only 14.8 percent (N=27) of the children in a Utah comparison group remained at home during the same time frame. In addition, when primary caretakers in these families rated problem severity in 28 areas of child, household, parent, and family functioning after the provision of services, there were, on average, improvements on 26 of the 28 items. Pre- and post-service ratings of parent and child functioning on the 25-item Family Risk Scales indicated significant improvements on 22 items. There were significant pre- and post-service reductions in "aversive relations" for both mothers and fathers in these families. Research interest in the area of service is rapidly expanding with HOMEBUILDERS model replication programs growing across the U.S.

Comments on Implementation/Replication: HOMEBUILDERS is a service mark owned by Behavioral Sciences Institute. They have a well-established training program and a standards program. They are experimenting with a project that takes the HOMEBUILDERS program philosophy, theory, and improved technology to address the needs of drug-affected families within a more conventional treatment format. This program meets most of the criteria for a comprehensive family program. Its draw-back is that it is applied to families only after they are in crisis because the child or adolescent is in danger of being removed from the family. It is not a prevention program.

14. JUVENILE INTENSIVE PROBATION SUPERVISION (JIPS)

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Target Population: This program diverts serious, nonviolent juvenile offenders from overcrowded institutions. Juveniles are eligible who have been adjudicated as a result of a delinquent act or a technical violation of probation originating from a delinquent act, and would otherwise be recommended for commitment to the State Department of Corrections or for placement in an out-of-home institutional or residential setting.

Program Origin: This program was developed in 1987 in response to the increasing cost and overcrowding of Arizona State's Department of Corrections. The program restricts the activities of the juvenile offenders involved to provide protection for the community while emphasizing appropriate restitution to victims.

Program Objectives: The program strives to demonstrate to citizens and offenders that probation means accountability and consequences as well as productive rehabilitative activities. Juvenile Intensive Probation Supervision (JIPS) provides intensive supervision and structure for the adolescent without institutionalization.

Program Strategies: When a minor is placed in the JIPS program he or she is expected to complete 32 hours a week of service, including a combination of school, work, court-ordered treatment or supervised community service. If the minor is not participating in one of these activities, he or she must remain in their place of residence unless given permission by the probation officer to attend an approved activity. The supervising probation team maintains a minimum of four face to face contacts per week with each minor in the program. These contacts are varied and unanticipated. The team also maintains bi-weekly contact with employers, schools, and parents.

Recruitment and Retention: All cases are court-referred. There are no specific retention strategies.

Staffing: Each probation team consists of an experienced probation officer and two or more probation officers who have experience in detention, intake and field probation services. Each veteran probation officer will be matched with a new probation officer. Each team has primary and secondary job responsibilities. Primary responsibilities for the new probation officers include surveillance and school and community contacts; secondarily, these officers perform social case investigations, attend court hearings and case staffings.

The veteran probation officer's primary duties are staffing, casework, pre-dispositional social investigations and court hearings.

Resources Needed and Materials Available: A JIPS manual is available detailing requirements for each position and implementation instructions. Support staff are also described.

Special Characteristics: This program is essentially an intense form of house arrest coupled with highly curtailed and supervised activities.

Effectiveness: The JIPS program is presently operating in all fifteen counties in the state of Arizona. Approximately 70% of the involved youth successfully complete the program.

Comments on Implementation/Replication: Implementation of this program might necessitate a change in referral procedures for juvenile delinquents

15. LEARNING WITH INFANTS AND TODDLERS (LIT) INSIGHTS TEEN PARENT PROGRAM

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Target Population: The program is designed to reach adolescent parents and older parents at risk of abusive behavior, as well as their prenatal to 36-month-old children.

Program Origin: LIT was developed as the turnkey project of Parents Are Teachers in St. Cloud, Minnesota, and moved in 1981 to Warner Pacific College in Portland, Oregon. Originally established as a practicum for education students to gain experience with younger-than-preschool children, the project began administering to adolescent parents in 1984. LIT left Warner Pacific College to join Insights Teen Parent Program as a program division in 1988.

Program Objectives: LIT is designed to benefit adolescent parents and their infant children by preventing child abuse and teaching parents to have realistic expectations of their children. The program also aims to prevent future serious social and emotional problems in the children themselves. LIT stresses that parents can change their behaviors if they so choose and teaches parents that respect for others, including children, is the foundation for all positive behavior.

Program Strategies: LIT implements its objectives by providing a safe and constructive environment for teenage parents to interact with their children and each other. Parents learn about child care, normal development, gentle behavior, and how children learn, as well as how to teach their children. The program promotes the parents' personal growth by providing role models, guided discussion, and structured observation.

Recruitment and Retention: Insights Teen Parent Program staff, who make daily visits to young mothers at three major hospitals, refer families to LIT as do other social services providers and agencies including community health nurses and the children's services division. LIT also operates under contract in five high schools where young parents take part in LIT for class credit. Three LIT community groups meet weekly for 10 weeks; about 40 percent of the participants go on to take part in another 10-week segment. Some participants have entered the program even before their child's birth and have continued

until their child was 36 months old. Several participants have returned as subsequent children were born.

Staffing: LIT has one full-time program director and four part-time parent/child educators who are supported by Insights' 16-person staff, several practicum students, and many volunteers.

Resources Needed and Materials Available: Equipment necessary to the program includes playroom equipment, minivan, parent discussion area, television, VCR, and handouts. Materials available from the program include a resource list of valuable sources of parenting information.

Special Characteristics: LIT provides to parents and children an appropriate and safe place for hands-on play and observation. The parents separate from the children to discuss developmentally appropriate topics that are determined by the parents themselves.

Effectiveness: Evaluation is provided primarily through the use of tools such as KIDI (Knowledge of Infant Development Inventory) and personal satisfaction instruments, as well as through voluntary repeat participation, referrals by social service personnel and program participants, and staff observations of parent/child interactions.

Comments on Implementation/Replication: Replications are facilitated through training, either at LIT facilities or the site of the new program. Materials and resources may be obtained through Parents Are Teachers in St. Cloud, Minnesota, or from LIT's suggested resource list.

16. MELD

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Target Population: MELD programs include MELD for New Parents designed for first-time parents; MELD Plus (for parents with children just over 2 years); MELD for Young Moms (MYM) for teen mothers of children age 0-2; MYM Plus for young mothers with children over 2 years; La Familia MELD for Hispanics parents with children age 0-3; Hearing Impaired Parents Program (also for very young children); MELD Special (for parents with handicapped or chronically ill children age 0-3); and Nueva Familia, for Mexican and Mexican-American parents who are very low-income, have a low reading vocabulary, and whose family is at risk of dysfunction, especially during a period of cultural transition.

Program [illegible]gin: The idea for MELD grew from a 1973 Lilly Endowment research and development grant. MELD began delivering services in a self-help group format to pilot groups in 1975. These groups began in the last trimester of pregnancy before any family dysfunction could occur. By 1987, MELD curricula included programs for teens as well as adults and was replicated in over 90 agencies in the U.S., Germany, Australia and Canada.

Program Objectives: MELD's goal is to create healthy, happy families, and to prevent instances of emotional or physical abuse and family dysfunction by creating a healthy family atmosphere before these instances might occur. This means bringing parents to service as early as the last trimester of pregnancy.

Program Strategies: MELD meetings are held in churches, neighborhood centers and homes. MELD groups are led by a team of volunteer parent group facilitators who represent two families. Parents combine informal discussion with curriculum models and materials called "Parent Parts," each concerned with a preselected topic. Besides psychological support, MELD curriculum focuses on child development, child guidance, health, parent development, and family management.

Recruitment and Retention: Parents are either self-referred or recruited by professionals or home visitors.

Staffing: MELD volunteer facilitator are carefully selected, trained, and supported by professionals. They have experiences similar to those of the families in therapy (the

MYM meetings are led by women who were once teen mothers and have achieved a degree of self-sufficiency while raising healthy, happy children). Those implementing the MELD program within a community must have a good deal of experience in community development, child development, parent training and volunteer management. Facilitators receive 16 hours of basic orientation training, 12 hours of in-service training, frequent phone interaction with MELD professionals to receive support and ongoing training, and curriculum manuals that can help them to organize and prepare for a parent group meeting in as little as 20 minutes.

Resources Needed and Materials Available: Materials are provided for the group participants, the group facilitator, the professional MELD site coordinator, the agency incorporating the program into their services, and any co-sponsor that might be hosting a group at their location. Public relations materials are also available. The MELD curriculum is not sold to agencies or individuals who are not planning to receive the entire training contract necessary to replicate the program. When a contract is signed, the agency receives enough materials to start four eight-parent groups. Some of the parenting books are available to the general public through MELD.

Special Characteristics: MELD is one of the few programs available that bring parents into service before the birth of the child.

Effectiveness: Evaluation materials include a series of process forms to evaluate groups in-process. Preliminary findings from the Child Welfare League of America indicate that 80% of MELD's teen participants are continuing in high school. Their repeat pregnancy rate is lower than the general population, and they have improved health and knowledge of family planning.

Comments on Implementation/Replication: It is helpful to include men as leaders to facilitate fathers joining the groups.

17. PARENTING: A SKILLS TRAINING PROGRAM

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Target Population: Children from infancy through adolescence. This program was designed to be used by a variety of parents, including those of low social economic status and of varying ethnic and religious backgrounds. The program is also designed to handle children who are at high risk for delinquency, substance abuse, child abuse, and handicapped children. Program materials are currently being translated into Spanish.

Program Origin: The Parenting Skills Programs for problem prevention and enrichment was developed in the mid and late 1970s. It is an offshoot of the Filial Therapy Program, which has been in use since the early 1960s. The therapy program is the work of Bernard G. Guerney, Jr.; the adaptation for training natural and foster parents was developed by Louise F. Guerney.

Program Objectives: Primary objectives include teaching parents skills that will help them relate to their children in a manner designed to foster good psycho-social adjustment and freedom from drug and alcohol abuse, delinquency, teen-aged pregnancy, school drop-out, etc. Improved academic performance and better pro-social skills are also expected.

Program Strategies: There is much flexibility in the program format. It can be conducted over a series of day-long or weekend meetings or at weekly meetings. The size of the group can vary from a single family to groups as large as 20. Typically, 12 to 16 parents meet weekly for two hours with a single trainer. Training techniques include readings and homework assignments, lectures, and role playing. The greatest emphasis is on skill training, with practice and supervisory feedback through role playing. In the therapeutic version of the method, children are brought in for play sessions and the parents practice their skills, receive reinforcement, and obtain feedback from the trainers.

Recruitment and Retention: Recruitment practices, transportation and daycare provisions depend on the setting. It is recommended that transportation and daycare be provided for families in rural and inner-city settings.

Staffing: No special educational background is required. Training is provided through a non-profit institute, IDEALS (Institute for the Development of Emotional and Life Skills). Certification as a trainer and as a trainer supervisor is available. IDEALS trainers travel

throughout the United States and Canada. Training fees include a daily charge plus per diem travel and expenses. Usually 12 enrollees are necessary to make the per-trainee cost reasonable. Additional supervision is available via audio tape and telephone after the initial training. Such supervision is required for certification.

Resources Needed and Materials Available: Leader's and parents manuals are available.

Special Characteristics: None noted.

Effectiveness: The program has been very thoroughly investigated in its foster parent form. In relation to foster parents, parental acceptance and parenting skills improve significantly on pre-post tests. FPSTP was demonstrated to be more effective for both parents and their foster children than the outcomes of a control group. These significant changes in parent attitudes, skills acquisition, and caseworker evaluation of family and children continued over a period of five years.

In relation to the infant version, parents in the local Childbirth Education Association, trained to conduct the program, were able to bring about significant pre-post changes in parents of babies, six months and younger in age. These results were significantly more positive than a comparable new mother-support/discussion group offered during the same pre-post period.

18. THE PARENTS AND CHILDREN VIDEOTAPE SERIES

Representatives: **Carolyn Webster-Stratton, Ph.D.**
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Lois Handcock
Program Administrator

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Target Population: This program is designed to help parents of normal children aged 2 to 8 years, parents of "oppositional" children between the ages of 3 and 8 years, parents at risk of abuse or neglect, teenagers taking babysitting classes or family life courses, family therapists, social workers, child psychologists, teachers, nurses, physicians, child protective service workers, and day care providers.

Program Origin: This course is based on well-established behavioral/social learning principles that describe how behaviors are learned and how they can be changed.

Program Objectives: Short term objectives for parents are to improve their communication skills with their children, improve limit-setting skills by means of nonviolent discipline techniques, improve their own problem-solving skills, and learn effective methods of anger management. For children, short term objectives include reduction of the frequency and number of conduct problems and improvement of prosocial skills.

Program Strategies: The basic and advanced series consists of 16 videotape programs, each building on the last. Five two-hour sessions are usually required to complete the first two programs, though some groups may take longer. Most parent groups take 12-14 weeks, between 2 and 2 1/2 hours per week, to complete the basic series (10 videotapes). The advanced series takes an additional 6-19 sessions (16 videotapes). Groups usually range from 10 to 14 participants; one trainer is needed per group. On-site day care is recommended for those parents who cannot arrange or afford babysitting.

Recruitment and Retention: Families at risk for abuse or with a history of abuse and/or child misconduct problems may be referred by therapists or clinicians.

Staffing: While the program has been researched with extensively trained and experienced therapists, it could be used by many groups in the community who work with families (e.g., teachers, parent educators, nurses, physicians, child protective service workers, etc.) Professional backgrounds of instructors who have used the program include advanced degrees in psychology, social work and nursing. Instructor training is through

self-study with the leader's manual and videotapes provided with the program. Training workshops are offered; duration has varied from 1 day to 2 weeks, depending on the background and experience of the leaders-in-training, and on the nature of the families they work with. Workshop costs vary depending on length.

Resources Needed and Materials Available: The complete program includes the videotapes, an instructor's manual, and a set of manuals for the participants. The leader's guide for the parents and children series contains a brief recap of the parent/child interactions and the author's narration for each vignette, a summary of the important points, topics for discussion, and all of the necessary checklists and forms for administering the program. The leaders guide also describes how to use the parents and children series as a self-administered program, or with groups. The participants' workbooks for each of the video cassettes contain all of the information needed by participants using the basic program in a self-administered format. This workbook contains all of the checklists, forms, and handouts for using the parents and children series. The complete program costs $1,300. Individual programs cost $175 - $245 each.

Special Characteristics: None noted.

Effectiveness: This series has been extensively researched and field tested with over 600 families, including normal children and those with conduct problems (Webster-Stratton, 1981, 1982, 1989, 1990, 1991). Results indicate that parents were able to significantly reduce children's behavior problems and to increase their prosocial behavior. Parents reported that they felt more confident and comfortable about their parenting skills after completing the course. One to three year follow-up assessments indicate that more than two-thirds of the clinic-referred (i.e., abusive, conduct-disordered) families continued to maintain positive parent-child interactions and normal child behavior.

Comments on Implementation/Replication: This program should be fairly easy to implement, due to the extensive materials available.

In 1992, three new programs (5 videotapes) were produced for school aged children including parent models representing over 50% families from differing cultural backgrounds. The purpose of these programs are to promote parents' self-confidience and competence in using positive parent management strategies in order to: promote children's social skills, support their academic success, increase their self-esteem, and reduce inappropriate behavior at home and at school.

A new five part videotape program focuses on helping parents understand ways to support their children's education. It includes promoting self-confidence, fostering good learning habits, dealing with academic discouragement, parents participating in homework, and using parent-teacher conferences to advocate for your child.

New Videotapes for Children! The Dinosaur Social Skills and Problem-Solving, Curriculum for Young Children is designed to promote non-aggressive ways for children to solve common conflicts, appropriate classroom behaviors, and positive social skills with other children and adults. It contains 9 videotapes, teacher manuals, letters to parents, and 40 laminated teaching materials.

19. PREPARING FOR THE DRUG FREE YEARS

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Target Population: "Preparing for the Drug (Free) Years" is a five session program that trains parents of children aged 9 to 12 years old to reduce the risk that their children will develop alcohol or drug problems.

Program Origin: The program was developed by Drs. J. David Hawkins and Richard F. Catalano of the University of Washington in conjunction with Developmental Research and Programs.

Program Objectives: Hawkins et. al. (1987) identified 11 risk factors that research has shown to be related to later drug and alcohol abuse. Family risk factors include a family history of alcoholism, family management problems, parental drug use or positive parental attitudes toward use, and low social bonding. School risk factors include a low degree of commitment to school and academic failure. The single peer factor is having friends who use drugs. Personal risk factors include antisocial behavior, a favorable attitude towards drug use, and early first use. The program is based on the assumption that if these factors are reduced, youth will be less likely to develop substance use problems.

Program Strategies: The program covers the following topics in each session: the risk factors for drug abuse; establishing a family position on drug use; how to stay out of trouble; how to handle family conflict and anger; and how to increase opportunities for children to be more involved in family responsibilities, duties and activities.

Recruitment and Retention: It appears to be difficult to attract and recruit high-risk parents to attend the program. Most (71.6%) of the families in the existing program implementations were recruited through schools. Hawkins and his associates (Hawkins, Catalano, Jones, & Fine, 1987) mention that "for some high-risk parents, schools themselves represent places of failure and alienation. Perhaps churches, religious groups, and other community organizations will provide a more fruitful base for recruitment of high-risk parents." Businesses that employ many high-risk parents would also be good sites for recruitment and replication of the program.

Staffing: The program is designed to be led by two persons, both with good verbal skills. One leader should be a parent, preferably with prior experience in teaching or group facilitation. The training period for group leaders is three days.

Resources Needed and Materials Available: A curriculum kit is available for the program, including a leader's guide, a family activity book, video training tapes, and a guide for adapting the program for diverse communities.

Special Characteristics: The primary tool for improving family relations is the family meeting. This concept has been around for a long time and is imbedded in several general population programs such as Popkin's Active Parenting Program. It may not be effective with high-risk families without supervision and modeling. It may be too difficult for high-risk families to conduct family meetings. Democratic principles with youth input is a middle-class idea and may not be acceptable to more authoritarian parents. Hawkins is planning focus groups of different minority parents to learn how to modify the program for their values and needs.

Unfortunately, the intensity of the implementation depends on the ability of the parents to develop a family meeting system and conduct the program in their homes. Many high risk parents are not capable of such organization and control. The school factors are only weakly addressed as are child or adolescent discipline issues. The program is strongest with encouraging improved family relations, democratic family management through family meetings, conflict resolution ideas, and encouraging the parents to give meaningful roles to children.

Effectiveness: This program has only been weakly evaluated. The program evaluation was reported in "Preparing For the Drug (Free) Years Television Community Service Project Evaluation Report" prepared by Kent, Wald and associates (March 1988). This evaluation measured whether the participants learned the concepts taught. Most of the knowledge and attitude items showed significant differences at the end of each session. Behavioral changes were not measured, except whether the families completed their homework assignment of conducting family meetings. No follow-up results are reported to ascertain how many of the families continued with their family meetings and implemented the suggested family activities in their home.

Comments on Implementation/Replication: This program may be good for general population families, but it has not yet been adapted and tested for high-risk minority families or for low socio-economic status families. Only 16% of the families in the Washington state media project were judged to be high-risk families. The program is very short--only five sessions. Weak, short-term programs have not been found effective with high risk parents. Currently, the program's primary usefulness with high-risk families is as an adjunct to a more comprehensive program.

20. PROYECTO ESPERANZA (PROJECT HOPE)

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Target Population: This project is designed exclusively for Hispanic families.

Program Origin: Four years ago the Office of Juvenile Justice and Delinquency Prevention (OJJDP), concerned about child abuse and the incidence of runaways in the Hispanic population, began funding a national program to help community agencies respond to these problems. This idea has been developed by the National Coalition of Hispanic Health and Human Services Organizations (COSSMHO). During Proyecto Esperanza's early stages, it became clear to OJJDP that special resources were needed to help Hispanic youth who had already entered the juvenile justice system. To respond to this need, OJJDP asked COSSMHO to work closely with two organizations that had not until then been part of COSSMHO's network: the National Court Appointed Special Advocates Association (CASA) and the National Council of Juvenile and Family Court Judges (NCJFCJ).

Program Objectives: This program is designed to reduce juvenile delinquency by treating some of the underlying family problems that cause youth to run away and become at risk for delinquent behavior. Program objectives are to reduce delinquency and drug or alcohol use in high risk Hispanic adolescents. Other goals are to develop an operations manual, develop training packages and disseminate the structural family therapy programs for Hispanic youth to providers nationally.

Program Strategies: Most Proyecto Esperanza sites have combined direct services, such as counseling and shelter placement, with public education programs for the Hispanic community. Several sites have trained personnel of other agencies in ways to deal with Hispanic youth more effectively. These agencies include departments of local governments, religious and secular service organizations, and schools. CASA trains volunteers who advise the court about what is best for children whose home placement is being decided by the court, usually as a result of abuse or neglect. NCJFCJ's

Permanency Planning for Children Project encourages judges to reduce the number and duration of a child's foster home placement and to return a child to the natural family or find a permanent family through adoption as soon as possible. As part of Proyecto Esperanza, COSSMHO has provided technical assistance to improve these organizations' services to Hispanic youth.

Recruitment and Retention: Recruitment and referral strategies vary with the COSSMHO site and type of service being offered, however, Proyecto Esperanza is very sensitive to the special recruitment needs of high-risk Hispanic families. Their New Haven site, for example, used a graduation dinner and formal graduation ceremony as an opportunity to have graduates invite other possible recruits to attend the group. By allowing these recruits to see how happy and proud the graduates were of their accomplishments and meeting the staff at such a happy occasion, they were able to increase the numbers of families involved in the program.

Staffing: Staff needs and qualifications vary with the type of service being provided and the type of agency involved.

Resources Needed and Materials Available: These vary with the particular program. All are developed primarily for Hispanic families, therefore, the program materials and manuals would have to be modified for other cultural groups.

Special Characteristics: This Project is designed specifically for Hispanic families. The multi-site system of support programs makes local adaption possible and also opens the possibility of wide dissemination.

Effectiveness: The Proyecto Esperanza demonstrations were launched in eight communities in partnership with existing community-based organizations. Although outside funding for Proyecto Esperanza has ended, many of the community agencies taking part in the project have incorporated these programs into their overall services.

Comments on Implementation/Replication: Throughout the project, implementation was limited to Hispanic families. Cultural adaptations would be required in order to make the information contained in the manuals provided by COSSMHO appropriate for different populations.

21. THE NATIONAL INSTITUTE FOR RESPONSIBLE FATHERHOOD AND FAMILY DEVELOPMENT

Representative: **Charles Ballard**
President

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Target Population: The program addresses the needs of teen fathers, teen mothers, their parents, and significant others.

Program Origin: The National Institute for Responsible Fatherhood and Family Development (formerly the Teen Father Program) was established by Charles A. Ballard. Mr. Ballard developed the concept for the program after conducting extensive interviews with teenage fathers in a local hospital's maternity waiting room.

Program Objectives: The mission of the National Institute for Responsible Fatherhood and Family Development is to create and maintain an environment in which adolescent fathers can develop psycho-social health and educational and economic skills in order to provide increased life opportunities for their children and the mothers of their children. Goals of the program include helping the teen father to:

(1) Legitimize his child or children.

(2) Complete high school and/or a vocational training program.

(3) Find meaningful employment.

(4) Use the program's extended support network to achieve personal goals.

(5) Develop a sense of empowerment that will help him achieve his life goals.

Program Strategies: Program services are delivered through outreach and counseling. Staff carry pagers and are on call 24 hours a day. Staff work with courts, schools, churches, and other community organizations to reach and impact the teen parents who are called proteges.

Recruitment and Retention: Proteges are recruited through outreach and referrals from juvenile courts, parents, teachers and other school personnel, other proteges, and other agencies.

Staffing: The Institute's 14-person staff consists of professionals and volunteers.

Resources Needed and Materials Available: The resources needed to operate the program include trained and experienced staff with outreach skills, as well as ongoing financial and human resources.

Special Characteristics: The program utilizes the skills and experience of staff members who were teen fathers themselves, in addition to staff members with special expertise. Staff serve as wounded healers, and everyone is considered a protege at some level.

Effectiveness: The 16-year history of the program, as well as ongoing referrals, positive evaluations, financial support, and the transformation of proteges' lives testify to the program's effectiveness. Fathers learn to take responsibility for their lives, the lives of their children, and the mothers of their children. They acquire their GED's or high school diplomas, gain meaningful employment, and establish paternity.

Comments on Implementation/Replication: An expansion committee is leading the program through the initial stages of local, State, and national replication.

22. NEW FUTURES SCHOOL

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Target Population: Pregnant adolescents and adolescent parents.

Program Origin: New Futures School is a comprehensive program for pregnant adolescents and adolescent parents located in Albuquerque, New Mexico. The program was begun in 1976 at the YWCA. Since that time, it has served over 5,000 adolescent parents. As a comprehensive program, it offers educational, health, counseling, vocational and child care services to pregnant adolescents and adolescent parents. It is an alternative school of the Albuquerque Public Schools and is supported by a non-profit, community-based organization--New Futures, Inc.

Program Objectives: The mission of New Futures School is to assist and motivate school-age parents to make responsible, informed decisions, to make progress toward completion of their secondary education, to become more mature, to have healthy pregnancies and families, to become responsible parents (which for some may mean a choice to release for adoption) and to become well-adjusted, contributing, self-sufficient members of their communities.

Program Strategies: The program is very comprehensive and is housed in its own facility. The students helped to determine how the space in the facility should be arranged to meet their needs. This program includes almost all basic services except housing. New Futures provides education, vocational training, child care, health services, job development and job finding, counseling and social services, parent training and child care training, low cost goods sold at a volunteer-run "Dime Store", a library with children's toys and books, and opportunities for self-development through participation in the teenage pregnancy prevention outreach program to high schools. Group health instruction is provided by nurse/health educators. The University of New Mexico School of Medicine's Maternity & Infant Care Project operates a weekly prenatal clinic in this facility for students. New Futures School operates four child care facilities on its premises for children of clients. A Jobs Training class is offered to 30-40 students per year. This program emphasizes job-finding and job-keeping skills. Five Foster Grandparents provide volunteer services for New Futures School.

Recruitment and Retention: No teen mothers requesting services are denied access to the program.

Staffing: A variety of staff with varying areas of expertise participate in this program. As independent consultants or through technical assistance contracts, New Futures staff provide workshops, training and technical assistance to adolescent pregnancy programs and concerned agencies and organizations throughout the United States and Canada. Specialized staffing is needed for the various medical, counseling, and training components of the program, as well as for childcare and other program components.

Resources Needed and Materials Available: The New Futures School is extremely comprehensive in design and implementation. Extensive funding would be required to establish comparable programs.

Special Characteristics: There are two departments of the New Futures School in-school program. The largest and oldest, now called the Perinatal Program, serves the teen who enters during her pregnancy and remains until the end of the semester in which her child is born. (If the child is less than 3 months old at semester's end, the mother may remain through the next semester.) A girl may receive services in this program for only one pregnancy. The second department, called the Young Parents' Center is designed to serve school-age mothers and fathers, who for identified reasons cannot successfully participate in a regular school program in the years following the birth of their child. Enrollment is limited, with students accepted after a screening process. The Young Parents' Center, therefore, serves the most high risk of a high risk group. It, too, offers the full range of educational and support services described. Clients may remain in this program as long as their need exists if they are showing steady progress toward their diploma or GED. Individual contracts may be used to specify expectations and measures of progress.

Prevention Services: New Futures School responds to requests from schools, churches, and community agencies for presentations aimed at reducing pregnancy. The focus of these presentations is on helping teens to understand the realities and responsibilities of teen parenthood, and on leading teens to consider how a teen pregnancy would affect their lives. New Futures students sometimes participate in these presentations. Extensive use is made of the video made by New Futures, Inc., "See What The Future Will Bring." Fifteen hundred to 2,000 teens are reached annually with these presentations.

New Futures, Inc. sponsors training series for parents of pre-teens entitled "Family Talks." The program is designed to assist parents in educating their children about sex. It emphasizes helping children to develop a strong sense of self-worth.

Effectiveness: This school has had impressive results with high-risk pregnant teens and teenage mothers. Almost three-quarters of their students continue on to post-secondary education and child abuse is nonexistent. The program has only been evaluated by non-experimental designs consisting mainly of comparisons of their graduates with local or national statistics. They have found that the services of New Futures School have probable benefits for the participants and for the community, if their students are similar to comparison group norms. The rate of low birth weight babies is less than the national rate for children of teen mothers. Repeat pregnancy rates for clients are less than half of the national rates for teenage pregnancies. A study in 1987 found that 77 percent of New Freedom School students contacted had either completed a secondary education or were still in school. Fifty-four percent of the graduates had gone on to post-secondary education or training. Nationally, less than half of teen parents graduate from high school. Only 16% of the former students were receiving welfare. Perhaps equally important are the observations that clients are better adjusted young women who have learned from their experiences, who face the future with increased confidence and abilities, and who have developed parenting skills which will provide their children with a better chance in life.

Comments on Implementation/Replication: This alternative school in Albuquerque is almost perfect in terms of the comprehensiveness of the services provided and the number of risk factors addressed. The primary barrier to dissemination is the cost of the facility and the fact that the students are put into their own alternative school. Few school districts today have the money to establish a free-standing facility such as New Futures. Most schools today have pregnant students attend the same classes with the rest of the students. Unfortunately, special needs of the pregnant teenager or new mother are difficult to address in a regular school.

23. THE NURTURING PROGRAM

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President

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Target Population: The six Nurturing Programs are each designed for specific groups. There are Nurturing Programs tailored for parents with children from birth to 5 years; for parents with children from age 4 to 12 years; for parents with adolescent children; a program designed specifically for teenage parents and their families; a program for parents who have special learning needs; and a Nurturing Program for foster and adoptive families. The Nurturing Programs were designed for families experiencing serious interaction problems.

Program Origin: The original Nurturing Program was designed to reduce child abuse and neglect by improving child nurturing in abusive parents.

Program Objectives: The Nurturing Programs seek to reduce family dysfunction and to build healthy, positive interactions in the family. The Programs' philosophy is that parenting is learned; the way we raise children will be influenced by the way we were raised.

Program Strategies: The Nurturing Programs address parents' needs for nurturance and reparenting and also provide concurrent nurturing learning experiences for children. Parents and children are taught similar skills and attitudes to maximize learning and maintenance of new knowledge. Each program consists of weekly sessions; these range from 45 minutes (in the program for very young children) to 2 1/2 hours. Overall program lengths also vary. Each session has a particular focus and requires the use of previously learned skills.

Recruitment and Retention: No specific information available.

Staffing: The Programs are designed for skilled professionals and paraprofessionals in social services, mental health, education and other helping professions. Training in group instruction, home visits, and working with children from infancy through adolescence is required. Instructor training workshops are available nationwide; these focus on the nurturing philosophy, results of field testing, and implementing and conducting the weekly sessions. Workshops are generally about 2 days long.

Resources Needed and Materials Used: A variety of instruction manuals, games, audiovisual presentations, dolls, coloring books and other items are available.

Special Characteristics: The Nurturing Programs are based on the following learning principles and goals: a) the family is a system and involvement of all members is essential for change; b) a major focus is to build empathy among all family members; c) parenting exists on a continuum; d) adults, children and adolescents learn on both cognitive and feeling levels; e) a major goal is to increase self-esteem and positive self-concept; and f) all families would prefer to display healthy interaction (rather than abusive, problem interactions) given a chance.

Effectiveness: These programs have been field tested nation-wide; results of such trials are included in program materials. Nurturing Programs use the Adult-Adolescent Parenting Inventory (AAPI) as a pre/post test to measure parenting attitudes.

Comments on Implementation/Replication: This program is fairly easy to replicate because of the standardized materials and manuals. The cost is reasonable for training and materials. It is widely disseminated nationally and internationally. Excellent training manuals and parent handbooks are available as well as videos and films. However, for very high-risk families this program would be more effective if embedded in a more comprehensive social services system.

24. THE STRENGTHENING FAMILIES PROGRAM

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Target Population: This comprehensive program is designed for families of six- to 12-year-old children of dysfunctional families and children of substance abusers. This program has been modified to be appropriate for African-American families and families with low education or reading levels.

Program Origin: This program was developed by Kumpfer and associates in 1983 to prevent children of drug abusers from becoming abusers also. The program has been replicated in Alabama with African-American, alcohol and drug-using, single parent, low income families.

Program Objectives: The primary objectives of this program are to reduce risk factors for drug use in high-risk children, including behavioral problems (depression, aggression, social withdrawal, school failure), emotional problems (depression, anxiety, fear), academic problems, and social problems (shyness, lack of social skills). These risk factors are addressed by improving family relationships, parenting skills, family environment and improving the youth's life skills.

Program Strategies: This 14 week program meets weekly for 2-3 hours. It includes three separate courses: Parent Training, Children's Skills Training, and Family Life Skills Training. This program was designed for children of substance abusers and their parents in treatment (primarily methadone maintenance patients). Given that these are very difficult, high-risk parents and children, the program works with the parents separately, the children separately and then the whole family together. The families arrive at the community center or clinic and are separated into their own groups for the first hour and reunited in the second hour, either with individual therapists, or in small family groups. Many special incentives are built into the program to assure attendance and completion of homework assignments.

Recruitment and Retention: This program includes more special techniques for involving high-risk and hard-to-reach parents than any other program reviewed. Transportation, child care, meals and snacks, fun activities, prizes for completion of homework and attendance are encouraged by this program to reduce barriers to attendance. The program is held in a non-stigmatizing location, such as a community center.

Staffing: This program requires four trainers to run the groups: two Child Skills Trainers and two Parent Skills Trainers. There are no minimum qualifications, but the trainers generally have at least a bachelor's degree and experience in working with high-risk families in mental health settings. Being a parent and having experience in running groups is helpful. Other selection considerations are based on the requirements of target populations. Instructor training requires at least three days, with a maximum of 12 trainees per training group.

Resources Needed and Materials Available: The program is completely standardized in three trainer manuals, a Parent Workbook, and a Children's Handbook, with films and videos available for use in training. The 14 session Strengthening Families Program is now available in both the original version (Kumpfer and DeMarsh, 1983) and a version modified for parents with a second grade reading level. This version is being evaluated with rural, southern African-American substance abusing parents (Kumpfer, DeMarsh, and Child, 1988). This second version contains adaptations of the Bavolek Nurturing Program for the children's groups and contains separate programs for preschoolers, elementary age children and older children. An evaluation package is available that contains a parent interview, child interview, and a follow-up test.

Special Characteristics: This program was designed as a combination of the most effective family programs: Forehand and McMahon's Helping the Non-compliant Child Program, Patterson's Behavioral Parent Training, Gurney's Family Relationship Enhancement Program, Spivak and Schure's Children's Social Skills Training, Bavolek's Nurturing Program, and Kids Are Special COSA Program.

Effectiveness: The first Strengthening Families Program was found to be effective in improving the child's behavior, improving family functioning and decreasing risk factors of substance abuse, as well as decreasing existing alcohol and tobacco use (Kumpfer, 1986). The second year evaluation of the Strengthening Black Families replication of the program for southern African-Americans shows very positive results, with clinically and statistically significant improvements in the children's behaviors and emotions on the Achenbach Child Behavior Checklist, as well as improvements in family environment on the Moos Family Environment Scale (FES).

Comments on Implementation/Replication: Because the trainer manuals are extremely complete and are low cost, the program is fairly easy to replicate. All handouts and assignments are included in the Parent and Children's Handbooks. There are video tape materials available, and additional videos are being developed.

25. SZAPOCZNIK'S STRUCTURAL FAMILY THERAPY PROGRAM FOR HISPANIC FAMILIES

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Target Population: Hispanic families with high-risk youth experiencing behavioral and alcohol or drug problems. Szapocznik postulates a "high-risk syndrome" for behavior problems in Hispanic families. This syndrome includes current family structural dysfunction, future potential for intergenerational conflict, and future potential for intercultural conflict. Youth from such families are often at high-risk because they have become more acculturated than their parents.

Program Origin: The National Coalition of Hispanic Health and Human Service Organizations (COSSMHO) received funding from OJJDP to select and disseminate a model family strengthening program for Hispanic families. Based on their first year of assessment of potential model programs, their advisory group of Hispanic professionals selected Szapocznik's Structural Family Therapy model for dissemination.

Program Objectives: Six types of family risk categories are addressed by the Structural Family Therapy Program: disorganized families; multi-problem families; inner city families; suburban families; extended families; and blended families. Szapocznik has found that highly acculturated youth of non-acculturated parents are more likely to reject parental authority. These youth also tend to be less bonded to the larger society. Hence, the objectives of this program are to reduce the behavior problem by improving family relationships and parental control of the youth.

Program Strategies: The structural family therapy program uses the family systems strategies employed in family therapy as developed from the work of Minuchin (1974), Haley (1976) and Madanes (1981). This approach views individual pathology as arising from, and being maintained by, interactions between family members. As a naturally occurring system, a family develops habitual patterns in interactions among family members and the environment. A healthy system is one that supports and stimulates the well-being and growth of each individual member. Problems occur when a family's habitual patterns of interacting are not effective in the management of new situations brought into the

family through change in one family member or by some external stress. If the family system is too rigid, it will fail to make needed changes when problems arise.

Recruitment and Retention: Dr. Szapocznik and his associates have emphasized factors that should be considered when recruiting Hispanic families. These principles are built into the COSSMHO programs. (See Number 15 under Family Therapy Programs). The program has developed special recruitment techniques and retention materials that are culturally appropriate for Hispanic families. For example, one strategy is to deal first with the father of the family to insure his cooperation with the family therapy sessions.

Staffing: The Structural Family Program generally requires at least two professional family therapy counselors or trainees, who are at least at the Masters degree level.

Resources Needed and Materials Used: COSSMHO has spent the last year developing an operations manual and a dissemination plan to provide this program to Hispanic counseling centers across the country. A training manual for the therapists is also available. In addition, training by the program developer is recommended.

Special Characteristics: This program was selected by COSSHMO and OJJDP initiative as the best program in the country for strengthening Hispanic families. The sensitivity of this program to cultural bonding and differential acculturation issues as well as the sensitivity to cultural needs in recruitment methods are the outstanding characteristics of this program. A unique aspect of this family therapy model is that it is often implemented in the homes of youth who are already manifesting behavior or drug abuse problems. The program has a high rate of family engagement, because the staff have developed and perfected a strategic structural-systems engagement system (SSSE).

Effectiveness: The Structural Family Therapy Program has been rigorously evaluated in a number of studies and found to be effective in reducing recidivism among youthful offenders and in improving family relationships. Structural family therapy has been successfully applied to the prevention of substance abuse in high risk families, such as low income Hispanic families. COSSMHO has endorsed the structural family therapy model and are implementing it in a number of Hispanic mental health centers nationally.

Comments on Implementation/Replication: One possible barrier to dissemination is access to high quality family therapy professionals or trainees for staffing the program. In addition, this program requires the supervision of Dr. Szapocznik or his staff for program implementation. They are currently writing an operations manual to help disseminate the model. As more therapists are trained in the model, the program will be easier to disseminate. The strategy of imbedding the structural family therapy program within a comprehensive Hispanic family service agency should improve this program's effectiveness. This program has been used primarily with Hispanic families, but has also been used with African American families.

26. TREATMENT FOSTER CARE PROGRAM (TFCP)

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Target Population: The program provides 6-month placements for 12 to 18 year-old adolescents who have been committed to the Oregon State Training schools or are at risk of commitment because of delinquency. The Treatment Foster Care Program is essentially a parent training program that focuses on foster parents as well as the natural parents of these adolescents.

Program Origin: This therapeutic or treatment oriented foster care program was developed by Patricia Chamberlain and John Reid at the Oregon Social Learning Center in 1983. It was designed as one of 13 statewide diversion programs funded by the Oregon State Children's Services Division (CSD).

Program Objectives: The program philosophy is that the "conduct of youngsters can be altered by the circumstances that influence them; and second, that their natural or aftercare placement families can be helped to support positive social behaviors so that community adjustments can be made, reducing the likelihood of institutionalization." The most global long-range goal is for the participants to avoid institutionalization. Reduction of delinquency, improvements in school attendance and completion, reduction in substance abuse, and improved adjustment in the community are all treatment goals. Intermediate objectives include improving the parenting skills of the teenager's natural, step, or adoptive family; the teenager's prosocial skills are also targeted.

Program Strategies: Program staff use a "high impact model" for working with chronic delinquents who had been removed from their house by the courts. The foster parents learn problem solving, communication skills, and behavior management practices, such as supervision/monitoring, encouragement, and limit setting. They implement an individualized daily point program for each youth and use allowance and privileges to reward good behaviors.

Recruitment and Retention: Referrals come from state juvenile courts, attorneys, parole officers, and CSD workers.

Staffing: Foster parents are screened, selected and trained in a twenty-hour pre-service training and orientation. They are then supervised and supported by daily telephone calls and weekly foster parent groups. The foster parent training is conducted by an experienced foster parent and other program staff.

Resources Needed and Materials Available: This foster care program is part of the larger comprehensive service tracking and monitoring system created for these delinquents. This system includes a case manager who coordinates all services with the probation officers, school, foster parents, and individual and family treatment staff, and child advocate. The cost for this and the services referenced below is a flat $10,000 capitation per child for the 6 months of services. The cost (ca. 1990) for the foster parent program is $500 to $700 compared to $1000 for hospitalization. Program materials include a foster parent manual and video vignettes for training. There are also published journal articles describing the program.

Special Characteristics: Other services provided for the foster parents include respite families, daily telephone contacts, crisis backup, and regular and on-call consultation with the case manager. The youths have regular home visits beginning after the third week of the program. The natural parents participate in family therapy once per week.

Effectiveness: This program is very effective in reducing delinquency and recidivism in delinquent youths. Compared to residential care and institutionalization, the program has been shown to be effective and cost effective.

Comments on Implementation/Replication: In-home crisis family preservation programs should be considered before out-placement. It is recommended that Alexander's Functional Family Therapy or Szapocznik's Structural Family Therapy be combined and conducted in the home as an adjunct to this program. The program director recommended a Family Resource Enhancement Program with aftercare supports for the natural families after the six months of foster care treatment. Big Brothers/Big Sisters would be helpful, since most of the youth are from single-parent families. Transportation and money for continued community opportunities would also be helpful.