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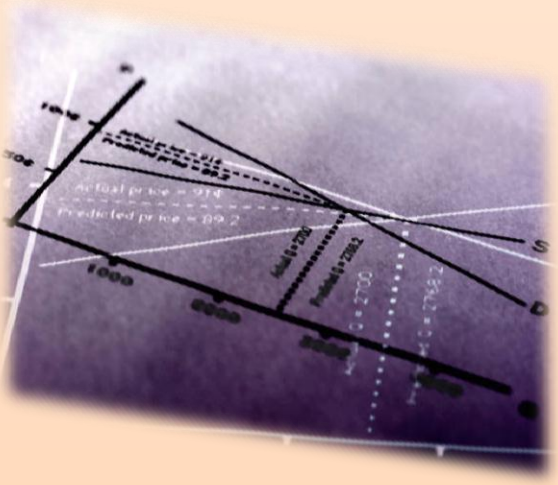
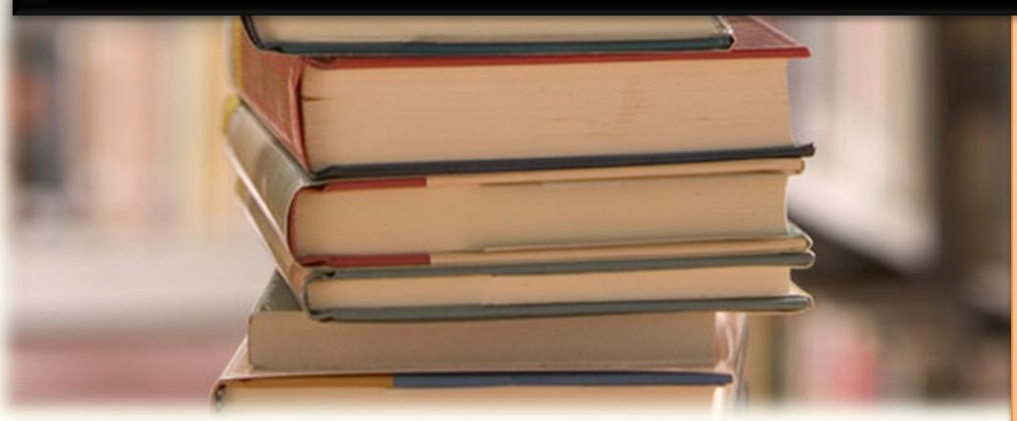


A Sourcebook of Delinquency Interventions



FLORIDA DEPARTMENT OF JUVENILE JUSTICE

Office of Program Accountability
Bureau of Quality Improvement

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Disclaimer

The Sourcebook is not all-inclusive: the information contained within is subject to change without notification. Interventions may be added as empirical evaluations are conducted and supported in the literature. The rankings of the interventions are subject to change--A ranking for a particular intervention may increase as new empirical research is conducted using either a more methodologically rigorous design, or demonstrating the intervention to be more effective than in previous analyses. The ranking of a particular intervention may decrease as new research demonstrates the intervention to be less effective than previously reported. Furthermore, an intervention may be eliminated entirely from the Sourcebook in the event rigorous empirical research demonstrates the intervention to be iatrogenic or potentially harmful to the target population.

New versions of the Sourcebook, as developed, will be posted on the Florida Department of Juvenile Justice website, within the Bureau of Quality Improvement. It is the sole responsibility of the reader to ensure utilization of the most up-to-date version. Additionally, it is the sole responsibility of the reader to obtain the required training, certification, education, and licensure (if applicable) to facilitate any intervention described within. The Florida Department of Juvenile Justice is not liable for any licensure or copyright infringements by any individual or agency engaging in unlawful actions in the facilitation of the interventions within.

Foreword

In 2008, the Programming and Technical Assistance (PTA) Unit compiled a list of delinquency interventions aimed at reducing recidivism and major dynamic risk factors, criminogenic needs, of juvenile offending. These interventions were rank-ordered into three tiers based on the extent to which they had been rigorously evaluated. The first ever *Sourcebook of Delinquency Interventions* separated practices into the categories still used today: Evidence-based Practices, Promising Practices, and Practices with Demonstrated Effectiveness. In recent years, the *Sourcebook* has been updated including this most recent 2013 edition. Several interventions have been added to each tier, and practices have risen in ranking as new empirical evaluations have been conducted which advanced our understanding of an intervention's effectiveness.

The Department continues with efforts to build sustainability of practices through the implementation of the Standardized Program Evaluation Protocol (SPEP) to include: qualified training, proper implementation, fidelity adherence and coaching of evidence-based delinquency interventions and best practices as well as research, development and pilot testing/evaluation.

Since publication of the 2010 Sourcebook, important milestones have been achieved in advancing the implementation of evidence-based and best practices within Florida. The SPEP process will help the Department evaluate the strengths and weaknesses of services with the goal of making them more accountable and effective in areas including: organizational culture, evidence-based delinquency interventions implementation and sustainability, management and staff characteristics, youth risk and needs assessment practices, program characteristics, behavior management strategies, inter-agency communication, and evaluation.

In order to demonstrate the effectiveness of the implementation of evidence-based practices (EBP) within Florida, the provision of those services must be tracked. The Department has developed a module in the Juvenile Justice Information System (JJIS) dedicated to capturing the intervention services each youth receives. The Evidence-based Services Module will collect data related to which specific evidence-based services, if any, that a particular youth receives while under the care and custody of the Department. Furthermore, the module will track the intensity and duration of those services, and whether the youth completed the service. The module will provide the hard empirical data necessary to illustrate to relevant stakeholders the benefits of providing evidence-based interventions to youth.

The goal of the Sourcebook remains to serve as a tool to sustain and advance efforts by providing a catalogue of examined practices by type as defined by The Florida Department of Juvenile Justice.

Jennifer A. Rechichi
Michael Baglivio, Ph.D.

Delinquency Interventions

The purpose of implementing a delinquency intervention is to prevent criminal and antisocial behavior, reduce recidivism for those already in the juvenile justice system, and reduce youths' dynamic/changeable risk factors (termed "criminogenic needs") that are proven to be the major causes of juvenile criminal behavior.

There are three levels at which we define delinquency interventions. The level an intervention is placed within is dependent on the empirical research conducted on that practice, and the results of those analyses. The levels progress in terms of methodological rigor and effectiveness of the practice, with evidence-based practices requiring the highest level of rigor and the highest level of program success with results lasting at least one year from completion. The levels and their respective definitions are as follows:

Practices with Demonstrated Effectiveness: Practices based on general principles, strategies, and modalities reported in criminological, psychological, or other social science research as being effective with a juvenile population. These practices should be outlined in a format that ensures consistent delivery by the facilitator across multiple groups.

Promising Practices: Manualized curricula are those that have been evaluated and found to reduce the likelihood of recidivism or at least one criminogenic need with a juvenile offending population. The evaluation must have used sound methodology, including, but not limited to, random assignment or quasi-experimental design, use of control or comparison groups, valid and reliable measures, and appropriate analysis. Such studies shall provide evidence of statistically significant positive effects. In addition, there must be evidence that replication by different implementation teams at different sites is possible with similar positive outcomes.

Evidence-Based Practices: Treatment and practices which have been independently evaluated and found to reduce the likelihood of recidivism or at least two criminogenic needs, with a juvenile offending population. The evaluation must have used sound methodology, including, but not limited to, random assignment, use of control groups, valid and reliable measures, low attrition, and appropriate analysis. Such studies shall provide evidence of statistically significant positive effects of adequate size and duration. In addition, there must be evidence that replication by different implementation teams at different sites is possible with similar positive outcomes.

Each of the interventions has specific requirements for implementation and facilitation. Many practices, both promising and evidence-based, can be delivered regardless of educational attainment of the facilitator, provided the staff successfully completed training in the specific practice. Furthermore, many promising and evidence-based practices are proprietary, while others are not and are free with the exception of the training cost. The practices vary widely with respect to training cost per participant and certification requirements. Almost all promising and evidence-based practices allow for an individual to attain the status of a qualified trainer, meaning the individual will not only be able to facilitate groups with at-risk youth, but will be able to train other staff to facilitate groups after successful completion of that practice's trainer protocol.

The purpose of this sourcebook is to provide a quick desk reference for interventions examined by the Department of Juvenile Justice, the criminogenic needs those interventions address, contact and training information, and equally as important, the rank of those interventions according to the Department. As new empirical research avails itself, the sourcebook will be updated with either new practices, addition of criminogenic needs addressed by a specific intervention, or a move to a higher ranking for an intervention.

Name of Program and Acronym

Florida DJJ Ranking:	Level of empirical support for the program; based on the three definitions of evidence-based, promising, or practice with demonstrated effectiveness
Program Author:	Person(s) who developed the program
Program Contact:	Contact for program information
Overview:	Brief synopsis of the program/curriculum
Location:	Program contact current location
Proven Recidivism Reduction:	Has the program been proven effective at reducing recidivism? Yes/No
Criminogenic Need:	Targeted criminogenic need(s)
Population:	Targeted segment of Department of Juvenile Justice population
Treatment Setting:	Type of setting program can be implemented
Modality:	How the program/curriculum is delivered
Training:	A description of what type of training is needed to implement the program
Certification:	Type of certification needed to facilitate the curriculum/ certification offered upon training completion
Facilitators:	The education, experience, and discipline training needed to facilitate program/curriculum
Fidelity:	The method to determine the program is implemented as intended
Bibliography:	A reference list identifying the rigorous research conducted on the program. The reference list is not exhaustive, but is meant to provide information as to the types of analyses conducted on the program and results garnered

Evidence-Based Practices

The delinquency interventions that achieve the highest rank are the evidence-based practices. These interventions have been evaluated to the highest degree, often using the "gold standard" of random assignment. For an intervention to be deemed evidence-based, the empirical research must have shown reductions in at least two criminogenic needs, or a reduction in the recidivism rate of the program participants versus the comparison group(s). The effect of the intervention must have been statistically significant and must have lasted for an adequate time period (at least one year for recidivism).

Adolescent Community Reinforcement Approach (A-CRA)

Florida DJJ Ranking: Evidence-based Practice

Program Author: Robert Myers, Ph.D., Jane Ellen Smith, Ph.D., et al.

Program Contact: http://www.chestnut.org

Overview: The Adolescent Community Reinforcement Approach (A-CRA) is a developmentally-appropriate behavioral treatment for youth and young adults 12 to 24 years old with substance use disorders. A-CRA seeks to increase the family, social, and educational/vocational reinforcers to support recovery. This intervention has been implemented in outpatient, intensive outpatient, and residential treatment settings. A-CRA includes guidelines for three types of sessions: individuals alone, parents/caregivers alone, and individuals and parents/caregivers together. According to the individual's needs and self-assessment of happiness in multiple life areas, clinicians choose from a variety of 15 A-CRA procedures that address, for example, problem-solving skills to cope with day-to-day stressors, communication skills, and active participation in positive social and recreational activities with the goal of improving life satisfaction and eliminating alcohol and substance use problems. Practicing new skills during sessions is a critical component of the skills training used in A-CRA. Every session ends with a mutually-agreed upon homework assignment to practice skills learned during sessions. Often these homework assignments include participation in pro-social activities. Likewise, each session begins with a review of the homework assignment from the previous session. A-CRA is designed for weekly sessions over a 90-day period (Fourteen sessions, 60 minutes each, over a three-month period, ten individual sessions with adolescent, two individual sessions with caregiver and two joint sessions. Community contact is added on a case-by-case basis).

Location: 448 Wylie Drive, Normal, IL 61761;
Phone: (309) 451-7700

Proven Recidivism Reduction: Yes

Criminogenic Need: Substance Abuse/Use/Dependence, internalizing and externalizing problems, family problems

Population: Male and Female juveniles (12-22 years old) with Substance Abuse/Use

Treatment Setting: Community-based or residential

Modality: Behavioral therapy

Training: An initial four-day initial training workshop is designed for clinical staff who plan to implement A-CRA/ACC with adolescent treatment participants and/or provide clinical supervision of A-CRA/ACC cases, as well as those in support and administrative roles for programs implementing A-CRA/ACC. The training uses demonstrations to model how A-CRA and ACC are used with adolescents and their families, and participants have an opportunity to practice procedures. Clinical and supervisor trainees are required to participate in a series of coaching calls and reviews of their clinical/supervisory session recordings as they progress through a certification process. Initial training costs: $600 per person.

Certification: Clinical and Supervisor Certification Processes

Facilitators: Clinician/Therapist

Fidelity: *EBTx.org*: Secure website used by clinicians and clinical supervisors to upload recordings of clinical sessions and enter session data. Clinical sessions are reviewed by an expert rater, who provides numeric ratings and narrative feedback. Session data (procedures completed during the session, urinalysis results, etc.) is used for the creation of management reports (used by clinicians, supervisors, and administrators) and the case review report (used by clinicians and clinical supervisors). The EBTx session data can also be used by each site for program evaluation purposes (evaluate number of clients seen, how many sessions each client received, etc.).

Additionally, the developer requires coaching calls, provides session ratings and feedback, requires supervisor supervision session reviews, supervisor ratings reliability, technical assistance, and implementation performance indicator reports and calls.

Bibliography:

For a complete list of references regarding the effectiveness of A-CRA visit: http://www.chestnut.org/Portals/14/PDF_Documents/Lighthouse/acra-acc/A-CRA_ACC_Reference_List_0713.pdf

Dennis, M.L., Godley, S.H., Diamond, G.S., Tims, F.M., Babor, T., Donaldson, J., Liddle, H.A., Titus, J.C., Kaminer, Y., Webb, C., Hamilton, N., & Funk, R.R. (2004). The Cannabis Youth Treatment (CYT) study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment*, *27*, 197-213. doi:10.1016/j.jsat.2003.09.005

French, M.T., Roebuck, M.C., Dennis, M.L., Diamond, G.S., Godley, S.H., Tims, F.M., Webb, C., & Herrell, J.M. (2002). The economic cost of outpatient marijuana treatment for adolescents: Findings from a multisite experiment. *Addiction*, *97*, S84-S97. doi:10.1046/j.1360-0443.97.s01.4.x

Aggression Replacement Training® (ART®)

Florida DJJ Ranking: Evidence-based Practice

Program Author: Goldstein, Arnold P.; Glick, Barry; Gibbs, John C.

Program Contact: bglick01@nycap.rr.com

Overview: Aggression Replacement Training® (ART®) is a multimodal psychoeducational intervention designed to alter the behavior of chronically aggressive adolescents and young children. The goal of ART® is to improve social skill competence, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger-control training, and training in moral reasoning. *Skill-streaming* uses modeling, role-playing, performance feedback, and transfer training to teach prosocial skills. In *anger-control training,* participating youths must bring to each session one or more descriptions of recent anger-arousing experiences (hassles), and over the duration of the program they are trained in how to respond to their hassles. *Training in moral reasoning* is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others and to train youths to imagine the perspectives of others when they confront various moral problem situations.
The program consists of a 10-week, 30-hour intervention administered to groups of 8 to 12 juvenile offenders thrice weekly. The 10-week sequence is the "core" curriculum. During these 10 weeks, participating youths typically attend three 1-hour sessions per week, one session each of skill-streaming, anger-control training, and training in moral reasoning.

Location: G & G Consultant, LLC
106 Acorn Drive, Suite A
Glenville, NY 12303-4702
(518) 399-7933

Proven Recidivism Reduction: Yes

Criminogenic Need: Aggression, Anti-social attitudes, Impulsivity

Population: Male and female juveniles

Treatment Setting: Community-based or Residential

Modality: Cognitive Behavioral in a group format

Training:

1. Five-day 36-40 hour seminar, Group Trainers (Facilitators) Training to deliver the curriculum with youth;

2. Aggression Replacement Training® (ART®) Trainer of Group Trainers (Facilitators) Training: This is a minimum four or five day 32-40 hour seminar (that may include up to 280 hours of additional study depending on participant qualifications), in which participants are provided specific information about adult learners and what trainers must do to train others in Aggression Replacement Training® (ART®). The seminar has specific goals and behavioral objectives for individuals to accomplish before they are designated as Aggression Replacement Training® (ART®) Trainers of Group Trainers (Facilitators). Individuals must first successfully have completed the Aggression Replacement Training® (ART®) Group Trainers (Facilitators) Training and have delivered the Aggression Replacement Training® (ART®) program at least three times to clients with documented supervision of their experiences. Once accepted into this seminar, participants will fully know the contents and skills of each of the Aggression Replacement Training® (ART®) lessons that are delivered to clients. The participants must also prepare to teach the Aggression Replacement Training® (ART®) Group Trainers (Facilitators) Training seminar to a group of their peers under the supervision of a Master Trainer, who is the lead trainer for this seminar.

3. Aggression Replacement Training® (ART®) Master Trainer
Master Trainers are individuals who have at least five years of experience delivering Aggression Replacement Training® (ART®) to clients and at least three years of experience as an Aggression Replacement Training® (ART®) Trainer of Group Trainers (Facilitators). (One of these years may be concurrent with the five years of experience delivering Aggression Replacement Training® (ART®). The Master Training is an individualized training program developed by the Master Trainer Candidate with the guidance and direction of a Master Trainer. The individualized program must be reviewed and approved by Barry Glick, Ph.D., NCC, ACS and the Master Trainer credential must be signed (or co-signed) by Barry Glick, Ph.D., NCC, ACS. A Master Trainer: a) may work independently, providing consultation to agencies and systems in the area of Aggression Replacement Training® (ART®); b) may design variations of the ART® program to meet particular client needs; c) may initiate and/or operate a P***ART***®TC; and d) offer credentials to individuals for both the Aggression Replacement Training® (ART®) Group Trainers (Facilitators) Training and the Aggression Replacement Training® (ART®) Trainer of Group Trainers (Facilitators) Trainer Training.

Certification: Certificate upon completion

Facilitators: No degree requirements

Fidelity: Checklists available

Bibliography:

Barnoski, R. 2004. *Outcome Evaluation of Washington State's Research-Based Programs for Juvenile.* Olympia, Wash.: Washington State Institute for Public Policy.

Coleman, M.; S. Pfeiffer; and T. Oakland. 1991. "Aggression Replacement Training with Behavior-Disordered Adolescents." Unpublished manuscript. Austin, Texas: University of Texas, Special Education Department.

Curulla, V.L. 1990. "Aggression Replacement Training in the Community for Adult Learning-Disabled Offenders." Unpublished manuscript. Seattle, Wash.: University of Washington, Special Education Department.

Glick, Barry. 1996. "Aggression Replacement Training in Children and Adolescents." *The Hatherleigh Guide to Child and Adolescent Therapy* 5:191–226.

Goldstein, A.P., and Barry Glick. 1994. "Aggression Replacement Training: Curriculum and Evaluation." *Simulation and Gaming* 25(1):9–26.

Goldstein, A.P., and Barry Glick. 1996a. "Aggression Replacement Training: Methods and Outcomes." In C.R. Hollin and K. Howells (Eds.). *Clinical Approaches to Working with Offenders.* Chichester, England: John Wiley & Sons.

Goldstein, A.P., and Barry Glick. 1996b. "Aggression Replacement Training: School-Based Instruction in Prosocial Skills." *The Quarterly Journal of the National Association of School Safety and Law Enforcement Officers.*

Goldstein, A.P., and Barry Glick. 1996c. "Aggression Replacement Training: Teaching Prosocial Behaviors to Antisocial Youth." In R. Ross, D.H. Antonowicz, and K. Dhuluval (Eds.). *Effective Delinquency Prevention and Offender Rehabilitation.* Ottawa, Ontario: AIR Training and Publications.

Goldstein, A.P.; Barry Glick; W. Carthan; and D.A. Blancero. 1994. *The Prosocial Gang: Implementing Aggression Replacement Training.* Thousand Oaks, Calif.: Sage Publications.

Goldstein, A.P.; Barry Glick; and J.C. Gibbs. 1998. *Aggression Replacement Training: A Comprehensive Intervention for Aggressive Youth (revised ed.)*. Champaign, Ill: Research Press.

Goldstein, A.P.; Barry Glick; M.J. Irwin; C. McCartney; and I. Rubama. 1989. *Reducing Delinquency: Intervention in the Community.* New York, N.Y.: Pergamon.

Goldstein, A.P.; Barry Glick; S. Reiner; D. Zimmerman; and T. Coultry. 1987. *Aggression Replacement Training.* Champaign, Ill.: Research Press

Aggression Replacement Training

Florida DJJ Ranking: Evidence-based Practice

Program Author: Goldstein, Arnold P.; Glick, Barry; Gibbs, John C.

Program Contact: Mark Amendola, (814) 881-2438

Overview: Aggression Replacement Training consists of three core components:

Skill-streaming uses modeling, role-playing, performance feedback, and transfer training to teach prosocial skills.

Anger-Control Training, in which youths are taught how to respond prosocially to anger-arousing situations.

Moral Reasoning is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others and to train youths in perspective-taking of others when they confront various moral problem situations.
The curriculum consists of a 10-week, 30-hour intervention administered to groups of 8 to 12 juvenile offenders three times per week for ten weeks. Each week one session each of skill-streaming, anger-control training, and moral reasoning are delivered.

Location: 3951 Shamrock Court
Erie, PA
16510

Proven Recidivism Reduction: Yes

Criminogenic Need: Aggression, Anti-social attitudes, Impulsivity

Population: Male and female juveniles

Treatment Setting: Community-based or Residential

Modality: Cognitive Behavioral in a group format

Training: The following outlines our proposed training and fee structure:

1. For an initial three day facilitator training the fee would be $3,500.00 per day. This training should have no more than 15 participants, which may represent 5 staff from three agencies. The total fee for the three day training would be **$10,500.00**
2. A one day booster training of the initial training cohort, between 4 and 6 months after the initial facilitator training, to assure program fidelity. This fee is **$2,750.00**.
3. Each cluster will be assigned a Master Trainer from Educational & Treatment Alternatives Inc. (ETA), for a one-year period, to include phone consultation (up to 20 phone calls), fidelity form review by the Master Trainer and videotape review of the trained facilitators. This is $1,000.00 per cluster for a total of 3 clusters for **$3,000.00**.

4. Each participant should also have the curriculum materials to facilitate the group. We will assure that all materials are on site and the cost of each set is:
    a. Aggression Replacement Training - $25.95
    b. Skillstreaming - New Strategies and Perspectives for Teaching Prosocial Skills (Appropriate age level) $21.95
    c. Skill Cards- Skillstreaming $25.00
    d. Program Forms CD-ROM – Skillstreaming $18.95

Total curriculum materials: (91.85x15) = **$1,033.31**

The total fee for a training with three clusters, followed one year from the initial facilitator training, including materials is **$17,283.31**

It is also important for agencies to develop capacity to train staff to become senior agency ART trainers. The training protocol takes typically one full year for an individual to meet the criteria for a senior trainer. The decision as to who should be selected as a trainer should be a collaborative process. It is critical to choose an individual who will be able to teach the model effectively. The following fee structure is for Train the Trainer:

1. Once a trainer has been identified and selected they would attend a three-day train the trainer workshop. Using the first cohort trained, as an example (15 participants, 3 agencies) agencies could select up to three of those five participants as senior trainer candidates. This would mean no more than 9 participants in the three-day train the trainer workshop. The fee for this $3,500.00 per day or **$10,500.00** for the total three days.

The assigned ETA Master Trainer will work with the candidate prior to the training to assure the candidate is prepared. We will also have a general conference call with all participants to assure all understand their assignments for the three-day training.
2. Following the training, the trainers will conduct on-site agency training within 4 months of the training, with no more than 10 participants. This training will be videotaped and reviewed by an ETA Master Trainer to provide feedback. The agency will also provide videotape of groups conducted by the new trainers to be evaluated by ETA. The year follow-up is $1,000.00 per cluster as with the initial training follow-up. For three clusters that is **$3,000.00**.

The total fee for a train the-trainer-training with three clusters, followed one year from the train the trainer training, is **$13,500.00**

Certification: Certificate upon completion

Facilitators: No degree requirements

Fidelity: Checklists available

Bibliography:

Barnoski, R. 2004. *Outcome Evaluation of Washington State's Research-Based Programs for Juvenile.* Olympia, Wash.: Washington State Institute for Public Policy.

Coleman, M.; S. Pfeiffer; and T. Oakland. 1991. "Aggression Replacement Training With Behavior-Disordered Adolescents." Unpublished manuscript. Austin, Texas: University of Texas, Special Education Department.

Curulla, V.L. 1990. "Aggression Replacement Training in the Community for Adult Learning-Disabled Offenders." Unpublished manuscript. Seattle, Wash.: University of Washington, Special Education Department.

Glick, Barry. 1996. "Aggression Replacement Training in Children and Adolescents." *The Hatherleigh Guide to Child and Adolescent Therapy* 5:191–226.

Goldstein, A.P., and Barry Glick. 1994. "Aggression Replacement Training: Curriculum and Evaluation." *Simulation and Gaming* 25(1):9–26.

Goldstein, A.P., and Barry Glick. 1996a. "Aggression Replacement Training: Methods and Outcomes." In C.R. Hollin and K. Howells (eds.). *Clinical Approaches to Working With Offenders.* Chichester, England: John Wiley & Sons.

Goldstein, A.P., and Barry Glick. 1996b. "Aggression Replacement Training: School-Based Instruction in Prosocial Skills." *The Quarterly Journal of the National Association of School Safety and Law Enforcement Officers.*

Goldstein, A.P., and Barry Glick. 1996c. "Aggression Replacement Training: Teaching Prosocial Behaviors to Antisocial Youth." In R. Ross, D.H. Antonowicz, and K. Dhuluval (eds.). *Effective Delinquency Prevention and Offender Rehabilitation.* Ottawa, Ontario: AIR Training and Publications.

Goldstein, A.P.; Barry Glick; W. Carthan; and D.A. Blancero. 1994. *The Prosocial Gang: Implementing Aggression Replacement Training.* Thousand Oaks, Calif.: Sage Publications.

Goldstein, A.P.; Barry Glick; and J.C. Gibbs. 1998. *Aggression Replacement Training: A Comprehensive Intervention for Aggressive Youth (revised ed.)*. Champaign, Ill: Research Press.

Goldstein, A.P.; Barry Glick; M.J. Irwin; C. McCartney; and I. Rubama. 1989. *Reducing Delinquency: Intervention in the Community.* New York, N.Y.: Pergamon.

Goldstein, A.P.; Barry Glick; S. Reiner; D. Zimmerman; and T. Coultry. 1987. *Aggression Replacement Training.* Champaign, Ill.: Research Press.

Cannabis Youth Treatment (CYT)

Florida DJJ Ranking: Evidence-based Practice

Program Author: Sampl, Susan; Kadden, Ronald

Program Contact: www.samhsa.gov; http://www.chestnut.org/LI/cyt/site_info.html

Overview: MET/CBT5 - This is a five-session treatment composed of two individual sessions of Motivational Enhancement Therapy (MET) and three weekly group sessions of Cognitive-Behavioral Therapy (CBT). The MET sessions focus on factors that motivate participants who abuse substances to change, while in the CBT sessions, participants learn skills to cope with problems and meet needs in ways that do not involve turning to marijuana or alcohol. To be conducted in all four sites, this treatment is designed to be inexpensive and in line with what many parents and insurers are seeking as a basic intervention.

MET/CBT12-session model comprises the complete 5-session model combined with 7 supplemental cognitive behavioral sessions covering additional coping skills, 1 session per week

Location: 1003 Martin Luther King Drive
Bloomington, IL 61701

Proven Recidivism Reduction: Yes

Criminogenic Need: Substance Abuse

Population: Male and female juvenile substance users between the ages of 12 and 18

Treatment Setting: Community-based or Residential

Modality: Cognitive Behavioral using both an individual session and group format

Training: 2-day training

Certification: Certificate upon completion

Facilitators: Recommended bachelor's degree or higher in a mental health field. Florida Statute dictates facilitators of substance abuse treatment must be licensed individuals, or individuals supervised by a licensed individual

Fidelity: No checklists currently available

Bibliography:

Azrin, N.H., Donohue, B., Besalel, V.A., Kogan, E.S., & Acierno, R. (1994). Youth drug abuse treatment: A controlled outcome study. Journal of Child and Adolescent Substance Abuse, 3, 1-16.

Brown, S.A., Myers, M.G., Mott, M.A., & Vik, P.W. (1994). Correlates of success following treatment for adolescent substance abuse. Applied & Preventive Psychology, 3, 61-73.

Brown, S. A., & Vik, P. W. (1994). Adolescent functioning four years after substance abuse treatment. Presented at the Annual Convention of the American Psychological Association, Los Angeles.

Brown, S. A., Vik, P. W., & Creamer, V. A. (1989). Characteristics of relapse following adolescent substance abuse treatment. Addictive Behaviors, 14, 291-300.Brown, S. A., & Vik, P. W. (1994). Adolescent functioning four years after substance abuse treatment. Presented at the Annual Convention of the American Psychological Association, Los Angeles.

Brown, S. A., Vik, P. W., & Creamer, V. A. (1989). Characteristics of relapse following adolescent substance abuse treatment. Addictive Behaviors, 14, 291-300.

Catalano, R. F., Hawkins, J. D., Wells, E. A., & Miller, J. (1991). Evaluation of the effectiveness of adolescent drug abuse treatment, assessment of risks for relapse, and promising approaches for relapse prevention. The International Journal of Addictions, 25, 1085-1140.

Cohen, S. (1980). Cannabis: Impact on motivation, Part I. Drug Abuse and Alcoholism Newsletter, 9(10), Vista Hill Foundation.

Cohen, S. (1981). Cannabis: Impact on motivation, Part I. Drug Abuse and Alcoholism Newsletter, 10, Vista Hill Foundation.

Dennis, M.L. (1998). Global Appraisal of Individual Needs (GAIN) manual. Administration, Scoring and Interpretation, Bloomington, IL: Lighthouse Publications.

Dennis, M.L., Diamond, G., Donaldson, J., Godley, S., Kaminer, Y., Tims, F., and CYT Steering Committee (1998). Research Design and General Protocol for CSAT's Cannabis Youth Treatment (CYT) Cooperative Agreement. Bloomington, IL: Chestnut Health Systems.

Donovan, J. E., & Jessor, R. (1985). Structure of problem behavior in adolescence and young adulthood. Journal of Consulting and Clinical Psychology, 53, 890-904.

Farrell, M. Danish, S. J., & Howard, C. W. (1992). Relationship between drug use and other problem behaviors in urban adolescents. Journal of Consulting and Clinical Psychology, 60, 705-712.

Graham, K., Annis, H.M., Brett, P.J., & Venesoen, P. (1996). A controlled field trial of group versus individual cognitive-behavioral training for relapse prevention. Addiction, 91, 1127-1139.

Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. Psychological Bulletin, 112(1), 64-105.Institute for Social Research (1997). Monitoring the Future Study. Ann Arbor, MI: University of Michigan.

Jessor, R., & Jessor, S. L. (1977). The social-psychological framework. In R. Jessor & S. L. Jessor (Eds.), Problem behavior & psychosocial development: A longitudinal study of youth (pp. 17-42). New York, NY: Academic Press.

Kadden, R.M., Cooney, N.L., Getter, H., & Litt, M.D. (1989). Matching alcoholics to coping skills or interactional therapies: Posttreatment results. Journal of Consulting and Clinical Psychology, 57, 698-704.

Kaminer, Y. (1995). Pharmacotherapy for adolescents with psychoactive substance use disorders. In E.Rahdert & D. Czechowicz (Eds.), Adolescent drug abuse: Clinical assessment and therapeutic interventions (pp. 291-324). NIDA Research Monograph 156. Rockville, MD: National Institute on Drug Abuse.

Kaminer, Y. (1995). Pharmacotherapy for adolescents with psychoactive substance use disorders. In E.Rahdert & D. Czechowicz (Eds.), Adolescent drug abuse: Clinical assessment and therapeutic interventions (pp. 291-324). NIDA Research Monograph 156. Rockville, MD: National Institute on Drug Abuse.

Kennedy, B. P. & Minami, M. (1993). The Beech Hill Hospital/Outward bound adolescent chemical dependency treatment program. Journal of Substance Abuse Treatment, 10, 395-406.

Liddle, H.A., Dakof, G.A., Parker, K., Barrett, K., Diamond, G.S., Garcia, R., & Palmer, R. (1995). Multidimensional family therapy of adolescent substance abuse. Manuscript submitted for publication.

Medtox Diagnostic, Inc. (1997). EZ Screen Urine Testing for THC/Cocaine: Product specifications. Burlington, NC 27214 (1238 Anthony Road): Author.

Musty, R.E., & Kaback, L. (1995). Relationships between motivation and depression in chronic marijuana users. Life Sciences, 56(23/24), 2151-2158.
Office of Applies Studies (OAS; 1995). Drug abuse warning network. Annual medical examiner data 1995, (Series D-1, prepared by CSR Inc.). Rockville, MD: Substance Abuse and Mental Health Services Administration.
Office of Applies Studies (OAS; 1997). National admissions to substance abuse treatment services. The treatment episode data set (TEDS) 1992-1995, (Advanced Report No. 12, prepared by B. Ray, R. Thoreson, L Henderson, & M. Toce). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Rob, M., Reynolds, I., & Finlayson, P.F. (1990). Adolescent marijuana use: Risk factors and implications. Australian and New Zealand Journal of Psychiatry, 24, 47-56.

Schwartz, R.H. (1987). Marijuana: An overview. Pediatric Clinics of North America, 34, 305-317.

Shaffer, D., Fisher, P., & Lucas, C., and NIMH DISC Editorial Board, (1998). Diagnostic Interview Schedule for Children (DISC). New York: Columbia University.

EQUIP

Florida DJJ Ranking: Evidence-based Practice

Program Author: Gibbs, Potter, & Goldstein

Program Contact: Dr. John Gibbs
Department of Psychology
The Ohio State University
142 Townshend Hall
1885 Neil Ave.
Columbus, Ohio
43210-1222
gibbs.1@osu.edu

Overview: EQUIP is intended to encourage and enable juveniles to think and act responsibly using a peer-helping approach. EQUIP is a three-part intervention method for working with antisocial or behavior disordered adolescents. The approach includes training in moral judgment, anger management/correction of thinking errors, and prosocial skills. Youth involved in the EQUIP training program participate in two types of group sessions - Equipment Meetings (in which the leader teaches specific skills) and Mutual Help Meetings (in which the leader coaches students as they use the skills they've learned to help each other). EQUIP is essentially the components of Aggression Replacement Training with a Positive Peer Culture (PPC) overlay.

Location: Department of Psychology
The Ohio State University

Proven Recidivism Reduction: Yes

Criminogenic Need: Aggression, Anti-social attitudes, Impulsivity

Population: Male and female juveniles

Treatment Setting: Community-based or Residential

Modality: Cognitive behavioral in a group format

Training: Contact Bud Potter, M.Ed.
bpotter@aol.com

Certification: Contact Bud Potter, M.Ed.
bpotter@aol.com

Facilitators: No degree requirements

Fidelity: No checklists currently available

Bibliography:

Nas, C., Brugman, D., & Koops, W. (2005). Effects of the EQUIP program on the moral judgment, cognitive distortions, and social skills of juvenile delinquents. *Psychology, Crime & Law,* 11(4): 421-434.

Leeman, L., Gibbs, J., & Fuller, D. (1993). Evaluation of a multi-component group treatment program for juvenile delinquents. *Aggressive Behavior,* 19: 281-292.

Liau, A.K., Shively, R., Horn, M., Landau, J., Barriga, A.Q., & Gibbs, J. (2004). Effects of psychoeducation for offenders in a community correctional facility. *Journal of Community Psychology,* 32: 543-553.

Functional Family Therapy (FFT)

Florida DJJ Ranking: Evidence-based Practice

Program Author: Alexander, James F.

Program Contact: jfafft@psych.utah.edu

Overview: A major goal of Functional Family Therapy is to improve family communication and supportiveness while decreasing the intense negativity so often characteristic of these families. Other goals include helping family members adopt positive solutions to family problems, and developing positive behavior change and parenting strategies. Although originally designed to treat middle class families with delinquent and pre-delinquent youth, the program has recently included poor, multi-ethnic, multi-cultural populations, with very serious problems such as conduct disorder, adolescent drug abuse, and violence.

Location: Functional Family Therapy, LLC
1611McGilvra Blvd. East
Seattle, WA
98112

Proven Recidivism Reduction: Yes

Criminogenic Need: Improve family functioning

Population: Male and female juveniles

Treatment Setting: Community-based, clinical setting

Modality: Family therapy

Training: 3-day clinical training for all FFT therapists in a working group; an externship training for one working group member (will become the clinical lead for the working group); 3 follow-up visits/year (2 days each on-site); and supervision consultations (4 hours of monthly phone consultation).

Certification: Certificate upon completion

Facilitators: Licensed mental health counselors trained in Functional Family Therapy, or non-licensed individuals trained in Functional Family Therapy who receive clinical supervision from licensed mental health counselors

Fidelity: Contact Functional Family Therapy, LLC

Bibliography:

Alexander, J., Barton, C., Gordon, D., Grotpeter, J., Hansson, K., Harrison, R., Mears, S., Mihalic, S., Parsons, B., Pugh, C., Schulman, S., Waldron, H., & Sexton, T. (1998). *Functional Family Therapy: Blueprints for Violence Prevention, Book Three*. Blueprints for Violence Prevention Series (D.S. Elliott, Series Editor). Boulder, CO: Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado.

Aos, Steve, Robert Barnoski, and Roxanne Lieb. 1998. *Watching the Bottom Line: Cost-Effective Interventions for Reducing Crime in Washington.* Olympia, Wash.: Washington State Institute for Public Policy.

Barton, Cole, James F. Alexander, Holly Barrett Waldron, Charles W. Turner, and Janet Warburton. 1985. "Generalizing Treatment Effects of Functional Family Therapy: Three Replications." *American Journal of Family Therapy.* 13(3):16–26.

Gordon, Donald A., Jack Arbuthnot, Kathryn E. Gustafson, and Peter McGreen. 1988. "Home-Based Behavioral-Systems Family Therapy With Disadvantaged Juvenile Delinquents." *American Journal of Family Therapy.* 16(3):243–55.

Gordon, Donald A., Karen Graves, and Jack Arbuthnot. 1995. "The Effect of Functional Family Therapy for Delinquents on Adult Criminal Behavior." *Criminal Justice and Behavior.* 22(1):60–73.

Parsons, Bruce V., and James F. Alexander. 1973. "Short-Term Family Intervention: A Therapy Outcome Study." *Journal of Consulting and Clinical Psychology.* 2:195–201.

Sexton, Thomas L., and James F. Alexander. 2002. *Functional Family Therapy: Principles of Clinical Intervention, Assessment, and Implementation.* Seattle, Wash.: FFT LLC.

LifeSkills Training (LST)

Florida DJJ Ranking: Evidence-based Practice

Program Author: Botvin, Gilbert J.

Program Contact: www.lifeskillstraining.com

Overview: LifeSkills Training (LST) is a research-validated substance abuse prevention program proven to reduce the risks of alcohol, tobacco, drug abuse, and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. This program provides adolescents and young teens with the confidence and skills necessary to successfully handle challenging situations. The curriculum is delivered in 15 sessions plus 3 optional violence prevention sessions.

Location: National Health Promotion Associates (NHPA)
711 Westchester Avenue
White Plains, NY 10604
1-800-293-4969

Proven Recidivism Reduction: Yes

Criminogenic Need: Substance Abuse, Aggression

Population: Male and female juvenile offenders

Treatment Setting: Community-based or Residential

Modality: Skills training in a group format

Training: 2-day Facilitator Training to deliver curriculum with youth
3-day Training of Trainers to be certified to train other staff to facilitate the curriculum (prior to attending master training, facilitators must deliver one full sessions of the curriculum to youth)
The cost for a two-day Core Training Workshop is $4,000.00 (up to 20 participants). Any additional participants over 20 is $200 each. The cost for a Training of Trainers (TOT) Workshop is $1,000.00 (per participant). Please note that travel for both trainees and trainer and training material costs are additional.

Certification: Certificate upon completion

Facilitators: No degree requirements

Fidelity: Fidelity monitoring checklists available through www.lifeskillstraining.com

Bibliography:

Griffin, K. W., Botvin, G. J., & Nichols, T. R. (2006). Effects of a school-based drug abuse prevention program for adolescents on HIV risk behaviors in young adulthood. Prevention Science, 7, 103-112.

Botvin, G.J., Griffin, K.W., Nichols, T.R. (2006). Preventing Youth Violence and Delinquency through a Universal School-based Prevention Approach. Prevention Science, 7, 403-408.

Spoth, R.L., Clair, S., Shin, C., Redmond, C. (2006). Long-Term Effects of Universal Preventative Interventions on Methamphetamine Use Among Adolescents. Archives of Pediatric & Adolescent Medicine.

Griffin, K. W., Botvin, G. J., & Nichols, T. R. (2004). Long-term follow-up effects of a school-based drug abuse prevention program on adolescent risky driving. Prevention Science, 5, 207-212.

Griffin, K.W., Botvin, G.J., Nichols, T.R., & Doyle, M.M. (2003). Effectiveness of a universal drug abuse prevention approach for youth at high risk for substance use initiation. Preventive Medicine, 36, 1-7.

Fraguela, J. A., Martin, A. L., & Trinanes, E. A. (2003). Drug-Abuse prevention in the school: Four-year follow-up of a programme. Psychology in Spain, 7, 29-38.

Zollinger, T. W., Saywell, R. M., Muegge, C. M., Wooldrige, J. S., Cummings, S. F., & Caine, V. A. (2003). Impact of the Life Skills Training curriculum on middle school students tobacco use in Marion County, Indiana, 1997-2000. Journal of School Health, 73, 338-346.

Trudeau, L., Spoth, R., Lillehoj, C., Redmond, C., & Wickrama, K. (2003). Effects of a preventive intervention on adolescent substance use initiation, expectancies, and refusal intentions. Prevention Science, 4, 109-122.

Botvin, G.J., Griffin, K.W., Paul, E., & Macaulay, A.P. (2003). Preventing tobacco and alcohol use among elementary school students through Life Skills Training. Journal of Child & Adolescent Substance Abuse, 12, 1-18.

Spoth, R. L., Redmond, C., Trudeau, L., & Shin, C. (2002). Longitudinal substance initiation outcomes for a universal preventive intervention combining family and school programs. Psychology of Addictive Behaviors, 16, 129-134.

Botvin, G.J., Griffin, K.W., Diaz, T., & Ifill-Williams, M. (2001). Preventing binge drinking during early adolescence: One- and two-year follow-up of a school-based preventive intervention. Psychology of Addictive Behaviors, 15, 360-365.

Botvin, G.J., Griffin, K.W., Diaz, T., & Ifill-Williams, M. (2001). Drug abuse prevention among minority adolescents: Posttest and one-year follow-up of a school-based preventive intervention. Prevention Science, 2(1), 1-13.

Botvin, G.J., Griffin, K.W., Diaz, T., Scheier, L.M., Williams, C., & Epstein, J.A. (2000). Preventing illicit drug use in adolescents: Long-term follow-up data from a randomized control trial of a school population. Addictive Behaviors, 25, 769-774.

Botvin, G.J., Griffin, K.W., Diaz, T., Miller, N., & Ifill-Williams, M. (1999). Smoking initiation and escalation in early adolescent girls: One-year follow-up of a school-based prevention intervention for minority youth. Journal of the American Medical Women's Association, 54, 139-143.

Botvin, G.J., Epstein, J. A., Baker, E., Diaz, T., Ifill-Williams, M., Miller, N., & Cardwell, J. (1997). School-based drug abuse prevention with inner-city minority youth. Journal of Child and Adolescent Substance Abuse, Vol. 6, No. 1, 5-20.

Botvin, G.J., Baker, E., Dusenbury, L., Botvin, E.M. & Diaz, T. (1995). Long-term follow-up results of a randomized drug abuse prevention trial in a White middle-class population. Journal of the American Medical Association, 273(14), 1106-1112.

Botvin, G.J., Schinke, S.P., Epstein, J.A., Diaz, T. & Botvin, E.M. (1995). Effectiveness of culturally-focused and generic skills training approaches to alcohol and drug abuse prevention among minority adolescents: Two-Year follow-up results. Psychology of Addictive Behaviors, 9, 183-194.

Botvin, G.J., Schinke, S.P., Epstein, J.A., & Diaz, T. (1994). Effectiveness of culturally-focused and generic skills training approaches to alcohol and drug abuse prevention among minority youths. Psychology of Addictive Behaviors, 8, 116-127.

Botvin, G.J., Dusenbury, L., Baker, E., James-Ortiz, S., Botvin, E.M. and Kerner, J. (1992). Smoking prevention among urban minority youth: Assessing Effects on Outcome and Mediating Variables. Health Psychology, 11(5), 290-299.

Botvin, G.J., Baker, E., Dusenbury, L., Tortu, S., and Botvin, E.M. (1990). Preventing adolescent drug abuse through a multimodal cognitive-behavioral approach: Results of a three-year study. Journal of Consulting and Clinical Psychology, 58, 437-446.

Botvin, G.J., Batson, H., Witts-Vitale, S., Bess, V., Baker, E., and Dusenbury, L. (1989). A psychosocial approach to smoking prevention for urban black youth. Public Health Reports, 104, 573-582.

Botvin, G.J., Dusenbury, L., Baker, E., James-Ortiz, S., and Kerner, J. (1989). A skills training approach to smoking prevention among Hispanic youth. Journal of Behavioral Medicine, 12, 279-296.

Botvin, G.J., Baker, E., Botvin, E.M., Filazzola, A.D., and Millman, R.B. (1984). Prevention of alcohol misuse through the development of personal and social competence: A pilot study. Journal of Studies on Alcohol, 45, 550-552.

Botvin, G.J., Baker, E., Renick, N., Filazzola, A.D., and Botvin, E.M. (1984). A cognitive-behavioral approach to substance abuse prevention. Addictive Behaviors, 9, 137-147.

Botvin, G.J., Renick, N.L., and Baker E. (1983). The effects of scheduling format and booster sessions on a broad-spectrum psychosocial smoking prevention program. Journal of Behavioral Medicine, 6, 359-379.

Botvin, G.J. and Eng, A. (1982). The efficacy of a multicomponent approach to the prevention of cigarette smoking. Preventive Medicine, 11, 199-211.

Botvin, G.J., Eng, A., and Williams, C.L. (1980). Preventing the onset of cigarette smoking through life skills training. Preventive Medicine, 9, 135-143.

Moral Reconation Therapy

Florida DJJ Ranking: Evidence-based Practice

Program Author: Greg Little (1979)

Program Contact: www.moral-reconation-therapy.com
www.ccimrt.com (training materials)
http://www.moral-reconation-therapy.com/Resources/metaMRTprob.pdf

Overview: MRT was first designed as a program for adults who resided in a prison-based substance abuse therapeutic community. Overall, MRT is a decision-based model designed to help participants re-examine their choices and develop cognitive structures that will improve decision-making skills. Using cognitive-behavioral principles, there are several characteristics that guide MRT practice:

1. Self-assessment of attitudes, beliefs, defense mechanisms, and behavior
2. Current relationship assessment
3. Positive reinforcement
4. Alteration of self-concept in the positive direction
5. Changes in gratification stimuli
6. Enhance moral reasoning

Location: Memphis, TN

Proven Recidivism Reduction: Yes

Criminogenic Need: Antisocial Attitudes

Population: MRT has a juvenile-specific program
Although developed for substance abuse populations, MRT has been extended to the following treatment issues: driving while intoxicated, sex offenders, domestic violence, antisocial thinking

Treatment Setting: Community-based or Residential

Modality: Cognitive behavioral in a group format

Training: Basic MRT training is conducted by Correctional Counseling, Inc. (CCI) of Memphis, TN www.ccimrt.com. Monthly training is held in Memphis. It consists of 32 hours over 5-days. Katherine Burnette typically conducts these trainings. An additional 70 trainings on average are held yearly around the United States by CCI staff and trainers from large state agencies for their own staff. The cost of the training is $600 for the first person of a given agency ($500 for others from the same agency attending the same training) with CEUs offered to those who complete all training. Completion of MRT is required for individuals and agencies to purchase client workbooks. All clients participating in MRT must have an official MRT workbook.

Certification: No certification

Facilitators: No degree requirement

Fidelity: N/A

Bibliography: http://www.moral-reconation-therapy.com/research.html

Little, G. (2004). Treating Juvenile Offenders and At-Risk Youth With MRT®: Comprehensive Review of Outcome Literature. *Cognitive Behavioral Treatment Review*, 13 (2), 1-4.

Burnett, K., Swan, S., Robinson, K., Woods-Robinson, M., Little, G. (2004). Treating Youthful Offenders with Moral Reconation Therapy®: A Recidivism and Pre- Posttest Analysis. *Cognitive Behavioral Treatment Review*, 3/4, 14-15.

Burnett, K., Swan, S., Robinson, K., Woods-Robinson, M., Little, G. (2003). Effects of MRT® on Male Juvenile Offenders Participating in a Therapeutic Community Program. *Cognitive-Behavioral Treatment Review,* 12(2), 2-5.

Multidimensional Family Therapy (MDFT)

Florida DJJ Ranking: Evidence-based Practice

Program Author: Gayle A. Dakof, Ph.D.

Program Contact: http://www.mdft.org/MDFT-Program
(305) 749-9332

Gayle Dakof for costs and training: gdakof@med.miami.edu
(305) 243-3656

Overview: Multi-Dimensional Family Therapy (MDFT) is solution-focused and incorporates a team approach into the substance abuse treatment of adolescents. MDFT focuses on four areas to provide immediate and practical outcomes: the individual adolescent, the adolescent's family members as individuals, the family unit, and how the family unit interacts with the social environment. Multidimensional Family Therapy (MDFT) offers a logically organized program structure that allows for flexibility and customization of all program aspects. Therapists integrate competence-enhancing and problem-solving interventions across four interdependent treatment domains: the adolescent, the parents, the extended family, and extra-familial community systems. Clinician collaboration with each family member and important school or juvenile justice professionals is key to therapeutic success. All treatment domains are addressed during each of the three stages of treatment.

MDFT targets four areas of social interaction:

1. The youth's interpersonal functioning with parents and peers
2. The parents' parenting practices and level of adult functioning independent of their parenting role
3. Parent-adolescent interactions in therapy sessions
4. Communication between family members and key social systems (e.g., school, child welfare, mental health, juvenile justice).

Expectation of Sessions:

3-6 months of treatment with varying sessions of 1-2 hours in length.

Stage 1: Building a Foundation for Change (3 weeks) – Use distress to motivate/focus, create expectations, and visit school/neighborhood

Stage 2: Facilitating Individual and Family Change (5 weeks) – Mobilize, make small steps toward progress, think in stages, use mistakes as opportunities

Stage 3: Solidify Changes and Launch (4 weeks) – Appraise current status honestly, except imperfect outcomes, emphasize all changes made, and assess future needs and next steps.

Location: 6619 South Dixie Highway, #117, Miami, FL, 33143

Proven Recidivism Reduction: Yes

Criminogenic Need: Substance Abuse/Use/Dependence, social skills, family problems, school performance, delinquent peer associations

Population: Male and Female juveniles (11-18 years old) with substance Abuse/Use

Treatment Setting: Community-based or residential

Modality: Behavioral therapy

Training: Multidimensional Family Therapy (MDFT) is committed to thoroughly and successfully training clinicians, and our training system is based on many years of training therapists. It takes approximately six months to train a therapist, and five additional months to train an MDFT supervisor. To begin, programs are provided with written and video training materials so that therapists can familiarize themselves with the model. Next, a certified MDFT trainer comes to the agency site to provide a four day introduction to MDFT. Trainees begin seeing MDFT cases immediately and are guided in this clinical work through weekly consultations with their trainer. Therapist training also involves two additional onsite Intensive Trainings in which trainers visit the agency and review therapists recorded sessions as well as providing live supervision. An additional onsite intensive training is provided as part of supervisor training to facilitate mastery of the MDFT supervision approach. Video recordings of both therapy and supervisions sessions are reviewed and rated for fidelity. Help to select MDFT staff and prevent burnout and turnover are also provided.

Certification: Certification Training and Supervisor Training

Facilitators: Clinician/Therapist

Fidelity: Fidelity monitoring is a component of MDFT Training; Access to the MDFT Clinical Portal (web-based clinical management system); ongoing coaching.

Bibliography:

Liddle, H. A. (2010). Treating Adolescent Substance Abuse Using Multidimensional Family Therapy. In J. Weisz & A. Kazdin (Eds.) *Evidence-based psychotherapies for children and adolescents (2nd edition).* NY: Guilford.

Rowe, C. L. (2012). Family therapy for drug abuse: Review and updates 2003-2010. *Journal of Marital and Family Therapy*, *38*(1), 221-243. doi: 10.1111/j.1752-0606.2011.00280

Rowe, C. L. (2010). Multidimensional Family Therapy: Addressing co-occurring substance abuse and other problems among adolescents with comprehensive family-based treatment. *Child & Adolescent Psychiatric Clinics of North America*, *19*(3), 563-576. doi: 10.1016/j.chc.2010.03.008

Henderson, C. E., Dakof, G. A., Greenbaum, P., & Liddle, H. A. (2010). Effectiveness of Multidimensional Family Therapy with higher-severity substance abusing adolescents: Report from two randomized controlled trials. *Journal of Consulting and Clinical Psychology*, *78*, 885-897. doi: 10.1037/a0020620

Liddle, H. A., Dakof, G. A., Henderson, C. E., & Rowe, C. L. (2011). Implementation outcomes of Multidimensional Family Therapy-Detention to Community: A reintegration program for drug-using juvenile detainees. *International Journal of Offender Therapy and Comparative Criminology*, *55*, 587-604. doi: 10.1177/0306624X10366960

Rigter, H., Pelc, I., Tossmann, P., Phan, O., Grichting, E., Hendriks, V., & Rowe, C. (2010). INCANT: A transnational randomized trial of Multidimensional Family Therapy versus treatment as usual for adolescents with cannabis use disorder. *BMC Psychiatry*, *10*(28). doi: 10.1186/1471-244X-10-28

Henderson, C. E., Rowe, C. L., Dakof, G. A., Hawes, S. W., & Liddle, H. A. (2009). Parenting practices as mediators of treatment effects in an early-intervention trial of Multidimensional Family Therapy. *American Journal of Drug and Alcohol Abuse, 35*, 220-226. doi: 10.1080/00952990903005890

Liddle, H. A., Rowe, C. L., Dakof, G. A., Henderson, C. & Greenbaum, P. (2009). Multidimensional Family Therapy for early adolescent substance abusers: Twelve month outcomes of a randomized controlled trial. *Journal of Consulting and Clinical Psychology*, *77*(1), 12-25. doi: 10.1037/a0014160

Liddle, H. A., Rowe, C. L., & Dakof, G. A. (2007). Clinical and empirical foundations of effective family based treatment for adolescent drug abuse. In E. Gilvarry (Ed.), *Clinics in developmental medicine: Substance misuse in young people* (pp. 185-196). Cambridge University Press.

Liddle, H. A., Dakof, G. A., Turner, R. M., Henderson, C. E., & Greenbaum, P. E. (2008). Treating adolescent drug abuse: A randomized trial comparing Multidimensional Family Therapy and Cognitive Behavior Therapy. *Addiction*, *103*, 1660-1670. doi: 10.1111/j.1360-0443.2008.02274.x

Liddle, H. A., Rowe, C. L., Gonzalez, A., Henderson, C. E., Dakof, G. A., & Greenbaum, P. E. (2006). Changing provider practices, program environment, and improving outcomes by transporting Multidimensional Family Therapy to an adolescent drug treatment setting. *American Journal on Addictions*, *15*, 102-112. doi: 10.1080/10550490601003698

Robbins, M. S., Liddle, H. A., Turner, C. W., Dakof, G. A., Alexander, J. F., & Kogan, S. M. (2006). Adolescent and parent therapeutic alliances as predictors of dropout in Multidimensional Family Therapy. *Journal of Family Psychology*, *20*(1), 108-116. doi: 10.1037/0893-3200.20.1.108

Shelef, K., Diamond, G. M., Diamond, G. S., & Liddle, H. A. (2005). Adolescent and parent alliance and treatment outcome in Multidimensional Family Therapy. *Journal of Consulting and Clinical Psychology*, *73*(4), 689-698. doi: 10.1037/0022-006X.73.4.689

Dennis, M., Godley, S. H., Diamond, G., Tims, F. M., Babor, T., Donaldson, J., Funk, R. (2004). Main findings of the Cannabis Youth Treatment (CYT) randomized field experiment. *Journal of Substance Abuse Treatment, 27*(3), 197-213.

Liddle, H. A., Rowe, C. L., Henderson, C. E., Dakof, G. A., & Ungaro, R. A. (2004). Early intervention for adolescent substance abuse: Pretreatment to post treatment outcomes of a randomized controlled trial comparing Multidimensional Family Therapy and peer group treatment. *Journal of Psychoactive Drugs*, *36*(1), 49-63. doi: 10.1080/02791072.2004.10399723

Rowe, C. L., Liddle, H. A., Greenbaum, P., & Henderson, C. E. (2004). Impact of psychiatric comorbidity on treatment outcomes of adolescent drug abusers. *Journal of Substance Abuse Treatment, 26*(2), 129-140. doi: 10.1016/S0740-5672(03)00166-1

French, M. T., Roebuck, M. C., Dennis, M., Godley, S., Liddle, H. A., & Tims, F. (2003). Outpatient marijuana treatment for adolescents: Economic evaluation of a multisite field experiment. *Evaluation Review*, *27*(4), 421-459. doi: 10.1177/0193841X03254349

Hogue, A., Liddle, H. A., Becker, D., & Johnson-Leckrone, J. (2002). Family-based prevention counseling for high-risk young adolescents: Immediate outcomes. *Journal of Community Psychology*, *30*(1), 1-22. doi: 10.1002/jcop.1047

Liddle, H. A., Rowe, C. L, Quille, T., Dakof, G. A., Mills, D. S., Sakran, E.., & Biaggi, H. (2002). Transporting a research-based adolescent drug treatment into practice. *Journal of Substance Abuse Treatment, 22*(4), 231-24. doi: 10.1016/S0740-5472(02)00239-8

Jackson-Gilfort, A., Liddle, H. A., Tejeda, M. J., & Dakof, G. A. (2001). Facilitating engagement of African American male adolescents in family therapy: A cultural theme process study. *Journal of Black Psychology*, *27*(3), 321-340. doi: 10.1177/0095798401027003005

Liddle, H. A., Dakof, G. A., Parker, K., Diamond, G. S., Barrett, K., & Tejeda, M. (2001). Multidimensional Family Therapy for adolescent substance abuse: Results of a randomized clinical trial. *American Journal of Drug and Alcohol Abuse*, *27*(4), 651-688.

Diamond, G. M., Liddle, H. A., Hogue, A., & Dakof, G. A. (1999). Alliance building interventions with adolescents in family therapy: A process study. *Psychotherapy: Theory, Research, Practice, & Training*, *36*(4), 355-368. doi: 10.1037/h0087729

Diamond, G. M. & Liddle, H A. (1998). Improving an initially poor therapist adolescent therapeutic alliance: A process study. *The Family Psychologist*, *14*, 5-9.

Diamond, G. & Liddle, H. (1996). Resolving a therapeutic impasse between parents and adolescents in Multidimensional Family Therapy. *Journal of Consulting and Clinical Psychology*, *64*(3), 481-488. doi: 10.1037/0022-006X.64.3.481

Schmidt, S. E., Liddle, H. A., & Dakof, G. A. (1996). Changes in parenting practices and adolescent drug abuse during Multidimensional Family Therapy. *Journal of Family Psychology*, *10*(1), 12-27. doi: 10.1037/0893-3200.10.1.12

Multisystemic Therapy (MST)

Florida DJJ Ranking: Evidence-based Practice

Program Author: Henggeler, Scott

Program Contact: http://www.mstservices.com/index.php

Overview: MST is a pragmatic and goal-oriented treatment that specifically targets those factors in each youth's social network that are contributing to his or her antisocial behavior. Thus, MST interventions typically aim to improve caregiver discipline practices, enhance family affective relations, decrease youth association with deviant peers, increase youth association with prosocial peers, improve youth school or vocational performance, engage youth in prosocial recreational outlets, and develop an indigenous support network of extended family, neighbors, and friends to help caregivers achieve and maintain such changes. Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including cognitive behavioral, behavioral, and the pragmatic family therapies.
MST services are delivered in the natural environment (e.g., home, school, community). The treatment plan is designed in collaboration with family members and is, therefore, family-driven rather than therapist-driven. The ultimate goal of MST is to empower families to build an environment, through the mobilization of indigenous child, family, and community resources that promotes health. The typical duration of home-based MST services is approximately 4 months, with multiple therapist-family contacts occurring each week.

Location: MST Services
710 J. Dodds Blvd., Suite 200
Mt. Pleasant, SC 29464

Proven Recidivism Reduction: Yes

Criminogenic Need: Increase family functioning, decrease antisocial peer associations

Population: Male and female juveniles

Treatment Setting: Home-based, school, community

Modality: Individual, family therapy

Training: 5-day Orientation Training, 2-day training for new MST supervisors, 2-day advanced supervisor workshops

Certification: Certificate upon completion

Facilitators: Licensed mental health counselors trained in Multisystemic Therapy, or non-licensed individuals trained in Multisystemic Therapy who receive clinical supervision from licensed mental health counselors

Fidelity: Therapist adherence measures

Bibliography:

An exhaustive list of MST publications can be found at the following site:
http://www.musc.edu/psychiatry/research/fsrc/pubs.htm

Blaske, D. M., Borduin, C. M., Henggeler, S. W., & Mann, B. J. (1989). Individual, family, and peer characteristics of adolescent sex offenders and assaultive adolescents. Developmental Psychology, 25, 846-855.

Borduin, C. M., Henggeler, S. W., Blaske, D. M. & Stein, R. (1990). Multisystemic treatment of adolescent sexual offenders. International Journal of Offender Therapy and Comparative Criminology, 35, 105-114.

Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. Journal of Consulting and Clinical Psychology, 63, 569-578.

Borduin, C. M., & Schaeffer, C. M. (2001). Multisystemic treatment of juvenile sexual offenders: A progress report. Journal of Psychology & Human Sexuality, 13, 25-42.

Brown, T. L., Henggeler, S. W., Schoenwald, S. K., Brondino, M. J., & Pickrel, S. G. (1999). Multisystemic treatment of substance abusing and dependent juvenile delinquents: Effects on school attendance at post treatment and 6-month follow-up. Children's Services: Social Policy, Research, and Practice, 2, 81-93.

Brunk, M., Henggeler, S. W., & Whelan, J. P. (1987). A comparison of multisystemic therapy and parent training in the brief treatment of child abuse and neglect. Journal of Consulting and Clinical Psychology, 55, 311-318.

Burns, B. J., Hoagwood, K., & Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. Clinical Child and Family Psychology Review, 2, 199-254.

Center for Substance Abuse Prevention (CSAP) (2000). Strengthening America's families: Model family programs for substance abuse and delinquency prevention. Salt Lake City, Utah: Department of Health Promotion and Education, University of Utah.

Cunningham, P. B., Naar-King, S., Ellis, D. A., Pejuan, S., & Secord, E. (in press). Achieving adherence to antiretroviral medications for pediatric HIV disease using an empirically supported treatment: A case report. Journal of Developmental and Behavioral Pediatrics.

Curtis, N. M., Ronan, K. R., & Borduin, C. M. (2004). Multisystemic treatment: A meta-analysis of outcome studies. Journal of Family Psychology, 18, 411-419.

Elliott, D. S. (1998). Blueprints for violence prevention (Series Ed.). University of Colorado, Center for the Study and Prevention of Violence. Boulder, CO: Blueprints Publications.

Ellis, D. A., Frey, M. A., Naar-King, S.,Templin, T., Cunningham, P. B., & Cakan, N. (2005). Use of multisystemic therapy to improve regimen adherence among adolescents with type 1 diabetes in chronic poor metabolic control: A randomized controlled trial. Diabetes Care, 28, 1604-1610.

Ellis, D. A., Frey, M. A., Naar-King, S.,Templin, T., Cunningham, P. B., & Cakan, N. (in press). The effects of multisystemic therapy on diabetes stress in adolescents with chronically poorly controlled type 1 diabetes: Findings from a randomized controlled trial. Pediatrics.

Ellis, D. A., Naar-King, S., Cunningham, P. B., & Secord, E. (in press). Use of multisystemic therapy to improve antiretroviral adherence and health outcomes in HIV-infected pediatric patients: Evaluation of a pilot program. AIDS, Patient Care, and STD's.

Ellis, D. A., Naar-King, S., Frey, M. A., Rowland, M., & Greger, N. (2003). Case study: Feasibility of multisystemic therapy as a treatment for urban adolescents with poorly controlled type 1 diabetes. Journal of Pediatric Psychology, 28, 287-293.
Ellis, D. A., Naar-King, S., Frey, M. A., Templin, T., Rowland, M., & Cakan, N. (2005). Multisystemic treatment of poorly controlled type 1 diabetes: Effects on medical resource utilization. Journal of Pediatric Psychology, 30, 656-666.

Farrington, D. P., & Welsh, B. C. (1999). Delinquency prevention using family-based interventions. Children & Society, 13, 287-303.

Halliday-Boykins, C.A., Schoenwald, S.K., Letourneau, E.J. (2005). Caregiver-therapist ethnic similarity predicts youth outcomes from an empirically based treatment. Journal of Consulting & Clinical Psychology, 73 (5), 808-818.

Henggeler, S. W. (1993). Multisystemic treatment of serious juvenile offenders: Implications for the treatment of substance abusing youths. In L. S. Onken, J. D. Blaine, & J. J. Boren (Eds.), Behavioral treatments for drug abuse and dependence: National Institute on Drug Abuse Research Monograph 137. Rockville, MD: NIH Publication No. 93-3684.

Henggeler, S. W. & Borduin, C. M., Melton, G. B., Mann, B. J., Smith, L. Hall, J. A., Cone, L. & Fucci, B. R. (1991). Effects of multisystemic therapy on drug use and abuse in serious juvenile offenders: A progress report from two outcome studies. Family Dynamics of Addiction Quarterly, 1, 40-51.

Henggeler, S. W., Clingempeel, W. G., Brondino, M. J., & Pickrel, S. G. (2002). Four-year follow-up of multisystemic therapy with substance abusing and dependent juvenile offenders. Journal of the American Academy of Child & Adolescent Psychiatry, 41, 868-874.

Henggeler, S. W., Halliday-Boykins, C. A., Cunningham, P. B., Randall, J., Shapiro, S. B., & Chapman, J. E. (in press). Juvenile drug court: Enhancing outcomes by integrating evidence-based treatments. Journal of Consulting and Clinical Psychology.

Henggeler, S. W., Melton, G. B., Brondino, M. J., Scherer, D. G., & Hanley, J. H. (1997). Multisystemic therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. Journal of Consulting and Clinical Psychology, 65, 821-833.

Henggeler, S. W., Melton, G. B., & Smith, L. A. (1992). Family preservation using multisystemic therapy: An effective alternative to incarcerating serious juvenile offenders. Journal of Consulting and Clinical Psychology, 60, 953-961.

Henggeler, S. W., Melton, G. B., Smith, L. A., Schoenwald, S. K., & Hanley, J. H. (1993). Family preservation using multisystemic treatment: Long-term follow-up to a clinical trial with serious juvenile offenders. Journal of Child and Family Studies, 2, 283-293.

Henggeler, S. W., Pickrel, S. G., & Brondino, M. J. (1999). Multisystemic treatment of substance abusing and dependent delinquents: Outcomes, treatment fidelity, and transportability. Mental Health Services Research, 1, 171-184.

Henggeler, S. W., Rodick, J. D., Borduin, C. M., Hanson, C. L., Watson, S. M., & Urey, J. R. (1986). Multisystemic treatment of juvenile offenders: Effects on adolescent behavior and family interactions. Developmental Psychology, 22, 132-141.

Henggeler, S. W., Rowland, M. D., Halliday-Boykins, C., Sheidow, A. J., Ward, D. M., Randall, J., Pickrel, S. G., Cunningham, P. B., & Edwards, J. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. Journal of the American Academy of Child & Adolescent Psychiatry, 42, 543-551.

Henggeler, S. W., Rowland, M. R., Randall, J., Ward, D., Pickrel, S. G., Cunningham, P. B., Miller, S. L., Edwards, J. E., Zealberg, J., Hand, L., & Santos, A. B. (1999). Home-based multisystemic therapy as an alternative to the hospitalization of youth in psychiatric crisis: Clinical outcomes. Journal of the American Academy of Child & Adolescent Psychiatry, 38, 1331-1339.

Henggeler, S. W., Schoenwald, S. K., Liao, J. G., Letourneau, E. J., & Edwards, D. L. (2002). Transporting efficacious treatments to field settings: The link between supervisory practices and therapist fidelity in MST programs. Journal of Clinical Child Psychology, 31, 155-167.

Huey, S. J., Henggeler, S. W., Brondino, M. J., & Pickrel, S. G. (2000). Mechanisms of change in multisystemic therapy: Reducing delinquent behavior through therapist adherence and improved family and peer functioning. Journal of Consulting and Clinical Psychology, 68, 451-467.

Huey, S. J. Jr., Henggeler, S. W., Rowland, M. D., Halliday-Boykins, C. A., Cunningham, P. B., Pickrel, S. G., & Edwards, J. (2004). Multisystemic therapy effects on attempted suicide by youth presenting psychiatric emergencies. Journal of the American Academy of Child & Adolescent Psychiatry, 43, 183-190.

Jones, H. E., Wong, C. J., Tuten, M., Stitzer, M. L. (2005). Reinforcement based therapy: 12-month evaluation of an outpatient drug-free treatment for heroin abusers. Drug and Alcohol Dependence, 79, 119-128.

Kazdin, A. E., & Weisz, J. R. (1998). Identifying and developing empirically supported child and adolescent treatments. Journal of Consulting and Clinical Psychology, 66, 19-36.

National Alliance for the Mentally Ill (Fall, 2003). NAMI Beginnings. Arlington, VA: Author.
National Institute on Drug Abuse. (1999). Principles of drug addiction treatment: A research-based guide. NIH Publication No. 99-4180.

National Institutes of Health (2004). Preventing violence and related health-risking social behaviors in adolescents: An NIH State-of-the-Science Conference. Bethesda, MD.
National Mental Health Association (2004). Mental health treatment for youth in the juvenile justice system: A compendium of promising practices. Alexandria, VA: Author.

Ogden, T., & Hagen, K. A. (in press). Multisystemic therapy of serious behavior problems in youth: Sustainability of therapy effectiveness two years after intake. Journal of Child and Adolescent Mental Health.

Ogden, T., & Halliday-Boykins, C. A. (2004). Multisystemic treatment of antisocial adolescents in Norway: Replication of clinical outcomes outside of the US. Child & Adolescent Mental Health, 9(2), 77-83.

Petry, N. M. (2000). A comprehensive guide to the application of contingency management procedures in clinical settings. Drug & Alcohol Dependence, 58(1-2), 9-25.

President's New Freedom Commission on Mental Health (2003). Achieving the promise: Transforming mental health care in America -- Final Report. Rockville, MD: DHHS.
Roozen, H. G., Boulogne, J. J., van Tulder, M. W., van den Brink, W., De Jong, C. A., & Kerkhof, A. J. (2004). A systematic review of the effectiveness of the community reinforcement approach in alcohol, cocaine and opioid addiction. Drug & Alcohol Dependence, 74(1), 1-13.

Rowland, M. R., Halliday-Boykins, C. A., Henggeler, S. W., Cunningham, P. B., Lee, T. G., Kruesi, M. J. P., & Shapiro, S. B. (2005). A randomized trial of multisystemic therapy with Hawaii's Felix Class youths. Journal of Emotional and Behavioral Disorders, 13, 13-23.

Schaeffer, C. M., & Borduin, C. M. (2005). Long-Term Follow-Up to a Randomized Clinical Trial of Multisystemic Therapy With Serious and Violent Juvenile Offenders. Journal of Consulting and Clinical Psychology, 73(3), 445-453.

Schoenwald, S. K., Halliday-Boykins, C. A., & Henggeler, S. W. (2003). Client-level predictors of adherence to MST in community service settings. Family Process, 42, 345-359.

Schoenwald, S. K., Henggeler, S. W., Brondino, M. J., & Rowland, M. D. (2000). Multisystemic therapy: Monitoring treatment fidelity Family Process 39, 83-103.

Schoenwald, S. K., Letourneau, E. J., & Halliday-Boykins, C. (2005). Predicting therapist adherence to a transported family-based treatment for youth. Journal of Clinical Child and Adolescent Psychology, 34, 658-670.

Schoenwald, S. K., Sheidow, A. J., & Letourneau, E. J. (2004).Toward effective quality assurance in evidence-based practice: Links between expert consultation, therapist fidelity, and child outcomes. Journal of Clinical Child and Adolescent Psychology, 33, 94-104.

Schoenwald, S. K., Sheidow, A. J., Letourneau, E. J., & Liao, J. G. (2003). Transportability of multisystemic therapy: Evidence for multilevel influences. Mental Health Services Research, 5, 223-239.

Schoenwald, S. K., Ward, D. M., Henggeler, S. W., Pickrel, S. G., & Patel, H. (1996). MST treatment of substance abusing or dependent adolescent offenders: Costs of reducing incarceration, inpatient, and residential placement. Journal of Child and Family Studies, 5, 431-444.

Schoenwald, S. K., Ward, D. M., Henggeler, S. W., & Rowland, M. D. (2000). MST vs. hospitalization for crisis stabilization of youth: Placement outcomes 4 months post-referral. Mental Health Services Research, 2, 3-12.

Sheidow, A. J., Bradford, W. D., Henggeler, S. W., Rowland, M. D., Halliday-Boykins, C., Schoenwald, S. K., & Ward, D. M. (2004). Treatment costs for youths in psychiatric crisis: Multisystemic therapy versus hospitalization. Psychiatric Services, 55, 548-554.

Sheidow, A. J., & Henggeler, S. W. (in press). Multisystemic therapy with substance using adolescents: A synthesis of research. In N. Jainchill (Ed.), Understanding and treating adolescent substance use disorders. Kingston, NJ: Civic Research Institute.

Stanton, M. D., & Shadish, W. R. (1997). Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. Psychological Bulletin, 122, 170-191.

Timmons-Mitchell, J., Bender, M.B., Kishna, M.A., & Mitchell, C.C. (2006). An independent effectiveness trial of multisystemic therapy with juvenile justice youth. Journal of Clinical Child and Adolescent Psychology, 35, (2), 227-236.

U.S. Department of Health and Human Services (1999). Mental health: A report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health.

U.S. Public Health Service (2001). Youth violence: A report of the Surgeon General. Washington, DC: author.

Van Wijk, A., Loeber, R., Vermeiren, R., Pardini, D., Bullens, R., & Doreleijers, T. (2005). Violent juvenile sex offender compared with violent juvenile non-sex offenders: Explorative findings from the Pittsburgh Youth Study. Sexual Abuse, A Journal of Research and Treatment, 17, 333-***.

Multisystemic Therapy for Youth with Problem Sexual Behaviors (MST-PSB)

Florida DJJ Ranking: Evidence-based Practice

Program Author: Richard J. Munschy, Psy.D.

Program Contact:
http://mstpsb.com
http://www.mstservices.com/
Richard J. Munschy, Psy.D.
Director of Clinical Training; Senior Consultant
MST Associates
10 Lexington Street
New Britain, CT 06052
Phone: (860) 348-1938
Fax: (860) 225-4776
Email: munschy@sbcglobal.net

Overview:

Multisystemic Therapy for Youth With Problem Sexual Behaviors (MST-PSB) is a clinical adaptation of Multisystemic Therapy (MST) that is specifically targeted to adolescents who have committed sexual offenses and demonstrated other problem behaviors. MST-PSB is suitable for use with male and female youth, although the youth included in the studies reviewed for this summary were primarily male. The primary objectives of MST-PSB are to decrease problem sexual and other antisocial behaviors and out-of-home placements. Based in principle on an ecological model, the intervention is directed at youth and their families, with the collaboration of community-based resources such as case workers, probation/parole officers, and school professionals.

Services to youth include a functional assessment in the context of their families, school, community, and social networks and a subsequent treatment plan including individual therapeutic sessions. The specific treatments provided depend on the factors driving the youth's behavior but typically address deficits in overall family relations and the youth's cognitive processes, peer relations, and school performance. Parents participate in family therapy, gain skills to provide guidance to youth, and are encouraged to develop social support networks.

Each therapist provides approximately 5 to 7 months of intensive services to three to five families at a time. Many families require two to four sessions per week during the most active parts of treatment, with some families requiring a higher frequency of sessions based upon clinical need.

Structural/strategic family therapy, safety planning, individual factors, and interventions specific to PSB (e.g., victim clarification, promotion of normative sexual behavior).

Location:
MST Services
710 J. Dodds Blvd., Suite 200
Mt. Pleasant, SC 29464

Proven Recidivism Reduction: Yes

Criminogenic Need: Increase family functioning, decrease antisocial peer associations, reduce substance abuse, (additional risk factor addressed includes the reduction of problem sexual behavior)

Population: Male and female juveniles who have committed sexual offenses and demonstrated other problem behaviors.

Treatment Setting: MST-PSB is delivered in the youth's natural environment (home-based, school, community)

Modality: Individual, family therapy

Training: 5-day Orientation Training, 2-day training for new MST supervisors, 2-day advanced supervisor workshops

Certification: Certificate upon completion

Facilitators: Master's-level therapists trained in a clinical area of the human service field.

Fidelity: Therapist adherence measures
MST-PSB incorporates intensive quality assurance and fidelity measures into all aspects of the treatment delivery system including:

Intensive preliminary training;
Ongoing onsite training;
Weekly case-specific clinical consultation from a qualified MST-PSB expert;
Fully articulated treatment manual;
Therapist and supervisor adherence measures;
6-month program quality assurance reviews

Bibliography: For information about studies contact:

Charles M. Borduin, Ph.D.
Director, Family Assessment Laboratory; Professor
Department of Psychological Sciences
University of Missouri-Columbia
108A McAlester Hall
Columbia, MO 65211-2500
Phone: (573) 882-4578
Fax: (573) 882-7710
Email: BorduinC@missouri.edu

An exhaustive list of MST publications can be found at the following site:
http://www.musc.edu/psychiatry/research/fsrc/pubs.htm

Borduin, C.M., Schaeffer, C.M., & Heiblum, N. (2009). A randomized clinical trial of Multisystemic Therapy with juvenile sexual offenders: Effects on youth social ecology and criminal activity. Journal of Consulting and Clinical Psychology, 77(1), 26-37.

Henggeler, S.W., Letourneau, E.J., Chapman, J.E., Borduin, C.M., Schewe, P.A., & McCart, M.R. (2009). Mediators of change for Multisystemic Therapy with juvenile sexual offenders. Journal of Consulting and Clinical Psychology, 77(3), 451-462.

Letourneau, E.J., Henggeler, S.W., Borduin, C.M., Schewe, P.A., McCart, M.R., Chapman, J.E., et al. (2009) Multisystemic Therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial. Journal of Family Psychology, 23(1), 89-102.

Quality of Research Supplementary Materials:

Borduin, C. M., Henggeler, S. W., Blaske, D. M., & Stein, R. (1990). Multisystemic treatment of adolescent sexual offenders. International Journal of Offender Therapy and Comparative Criminology, 35, 105-114.

Readiness for Dissemination Materials:

Borduin, C. M., Letourneau, E. J., Henggeler, S. W., & Swenson, C. C. (n.d.). Treatment manual for multisystemic therapy with problem sexual behavior youths and their families. Columbia, MO: Author.

Borduin, C., & Munschy, R. (n.d.). Supplemental training: Multisystemic Therapy with problem sexual behavior youths and their families.

Henggeler, S. W., & Schoenwald, S. K. (1998). Multisystemic Therapy supervisory manual: Promoting quality assurance at the clinical level. Charleston, SC: Author.

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). Multisystemic treatment of antisocial behavior in children and adolescents. New York: Guilford Press.

MST Services. (2003). Making the paperwork work for you: A step-by-step guide to completing the documentation used in MST supervision and consultation. Mt. Pleasant, SC: Author.

MST Services. (2004). Multisystemic Therapy: An introductory training [training handouts]. Mt. Pleasant, SC: Author.

MST Services. (2004). Multisystemic Therapy (MST) overview [PowerPoint slides]. Mt. Pleasant, SC: Author.

MST Services. (n.d.). Multisystemic Therapy [DVD]. Mt. Pleasant, SC: Author.

Multisystemic Therapy Readiness for Dissemination
Program Web sites, http://mstpsb.com, http://www.mstservices.com, and http://www.mstinstitute.org/
Schoenwald, S. K. (1998). Multisystemic Therapy consultation manual. Charleston, SC: Author.

Strother, K. B., Swenson, M. E., & Schoenwald, S. K. (2007). Multisystemic Therapy organizational manual. Mt. Pleasant, SC: MST Services

Van Wijk, A., Loeber, R., Vermeiren, R., Pardini, D., Bullens, R., & Doreleijers, T. (2005). Violent juvenile sex offender compared with violent juvenile non-sex offenders: Explorative findings from the Pittsburgh Youth Study. Sexual Abuse, A Journal of Research and Treatment, 17, 333-***.

Parenting with Love and Limits (PLL)

Florida DJJ Ranking: Evidence-based Practice

Program Author: Scott Sells, Ph.D.

Program Contact:
Savannah Family Institute, Inc.
P.O. Box 30381
Savannah, GA 31410-0381
Phone: 912.224.3999
Fax: 770.573.1128
Email: spsells@gopll.com

Overview: *Parenting with Love and Limits®* (PLL) integrates group and family therapy into one system of care for adolescent populations with the primary diagnosis of oppositional defiant or conduct disorder. Parents and teens learn specific skills in group therapy and then meet in individual family therapy to role-play and practice these new skills. This integration of group and family therapy enables parents to transfer these new skills to real-life situations and prevent relapse.

During group therapy, teens and parents participate together in a small group, led by two facilitators that can also include siblings and extended family. The groups consist of no more than six families and no more than 15 people total per group. Six 2-hour classes are held weekly. Parents and teens meet together as a group for the 1st hour. During the 2nd hour, the parents meet in one breakout group with one facilitator leading each breakout and the teens meet in another. During family therapy, teens and parents meet individually with one of the group facilitators in between classes in an intensive 1- to 2-hour session to practice the new skills learned in group. Extensive role-plays are used along with the development of a typed-out, loophole-free contract. Three to four family therapy sessions are recommended for low- to moderate-risk adolescents and up to 20 sessions for moderate- to high-risk offenders within an outpatient or home-based setting.

Location: Savannah, GA

Proven Recidivism Reduction: Yes

Criminogenic Need: Family functioning

Population: Male and female juveniles between 10 and 18 years of age and their parents

Treatment Setting: Community-based

Modality: Group and family therapy

Training: 5-day on site clinical training, monthly phone consultation

Certification: PLL Center of Excellence

Facilitators: Therapists

Fidelity:

Therapist adherence measures, including fidelity checklists, monthly PLL report to track attrition, group protocol checklist, and family therapy protocol checklist

Bibliography:

Sells, Scott P., Smith, Thomas Edward, Rodman, J. (2006). "Reducing Substance Abuse through Parenting With Love and Limits." *Journal of Child and Adolescent Substance Abuse* (15):105-115.

Sells, Scott P. (2004). "Undercurrents: When therapy stalls, it's usually time to look for the family secrets," *Psychotherapy Networker* 28(6):75-81.

Sells, Scott P. (2001). Parenting Your Out-of-Control Teenager. New York: St. Martin's Press.

Sells, Scott P. 1998. "Process-Outcome Research and the Family-Based Model: Refining and Operationalizing Key Theoretical Concepts." In Scott P. Sells. *Treating the Tough Adolescent: A Family-Based Step-by-Step Guide.* New York, N.Y.: Guilford Press, 259–92.

Sells, Scott P., Smith, Thomas Edward, & Newfield, N. (1997). "Teaching Ethnographies in Social Work: A Model Course." *Journal of Social Work Education* 33(1):1-18.

Sells, Scott P., Smith, Thomas Edward, & Moon, S. (1996). "An Ethnographic Study of Client and Therapist Perceptions of Therapy Effectiveness in a University-Based Training Clinic." *Journal of Marital and Family Therapy* 22(3):321-343.

Sells, Scott P., Newfield, N, Smith, Thomas Edward, & Newfield, S (1996). "Ethnographic Research Methods." In D.H. Sprenkle & S.M. Moon (Eds.) *Handbook of Family Therapy Research Methods*. New York: Guilford Press.

Sells, Scott P., Thomas Edward Smith, and Douglas H. Sprenkle. 1995. "Integrating Quantitative and Qualitative Methods: A Research Model." *Family Process* 34:199–218.

Sells, Scott P., Smith, Thomas Edward, & Clevenger, T. (1994). "Ethnographic Content Analysis of Couple and Therapist Perceptions in a Reflecting Team Setting." *Journal of Marital and Family Therapy* 20(3):267-286.

Sells, Scott P., Smith, Thomas Edward, Coe, M. J., Yoshioka, M., & Robbins, J. (1994). "An Ethnography of Couple and Therapist Experiences in Reflecting Team Practice." *Journal of Marital and Family Therapy* 20(3):247-266.

Smith, Thomas Edward, Sells, S. P., Pereira, G. A., Todahl, J., & Papagiannis, G. (1995) "Interpersonal Process Recall." *Journal of Family Psychotherapy* 6(2):49-70.

Smith, Thomas Edward, Jenkins, D. A., & Sells, S. P. (1995) "Reflecting Teams: Voices of Diversity." *Journal of Family Psychotherapy* 6(2):49-70.

Smith, Thomas Edward, Scott P. Sells, Jeffrey Rodman, and Lisa Rene Reynolds. (In press). "Reducing Adolescent Substance Abuse and Delinquency: Pilot Research of a Family-Oriented Psycho-Education Curriculum." *Journal of Child and Adolescent Substance Abuse.*

Winokur-Early, K., Chapman, S., & Hand, G. (2013). Family-focused juvenile reentry services: A quasi-experimental evaluation of recidivism outcomes, *Journal of Juvenile Justice, 2,* 1-22.

Sells, S. P., Winokur-Early, K., & Smith, T. E. (2011). Reducing adolescent oppositional and conduct disorders: An experimental design using Parenting with Love and Limits. *Professional Issues in Criminal Justice, 6,* 9-30.

Kier, L. (2013). *Champaign County Final Report: A Quasi-experimental Design Evaluation of Parenting with Love and Limits with Community-based Alternatives*. Hornsby Zeller Associates, Portland, ME.

Seven Challenges

Florida DJJ Ranking: Evidence-based Practice

Program Author: Dr. Robert Schwebel

Program Contact: www.**sevenchallenges**.com
Sharon Conner
Director of Program Services
The Seven Challenges, LLC
(520) 405 4559
sconner@sevenchallenges.com

Overview: The Seven Challenges® Program is designed specifically for adolescents with drug problems. The program is designed to motivate a decision and commitment to change, as well as support success in implementing the desired changes. The Program simultaneously helps juveniles address their drug problems as well as their co-occurring life skill deficits, situational problems, and psychological problems.
The seven specific challenges provide a framework for helping youth think through their own decisions about their lives and their use of alcohol and other drugs. Counselors using The Seven Challenges Program teach youth to identify and work on the issues most relevant to them. In sessions, as youth discuss the issues that matter most, counselors seamlessly integrate the seven challenges as part of the conversation.

Location: Tucson, Arizona

Proven Recidivism Reduction: No

Criminogenic Need: Substance Abuse, aggression

Population: Male and female juveniles with substance use/abuse

Treatment Setting: Community-based or Residential

Modality: Group counseling, as well as individual and potentially family sessions

Training: Focus is on an organization as a whole, requiring a top-down support of The Seven Challenges as the substance abuse treatment program for their young clients. They must agree to have all their substance abuse counselors, those supervising the counselors, and others directly involved in providing the services to clients, attend the three-day Initial Training. We do not specify a degree or certification level these participants must have, but rather the focus is on their role within their organization and the training gives them the tools they will need to contribute to the success of the Program implementation and the success of clients in the Program. Following the Initial Training the organization selects someone (often more than one person) to be their Seven Challenges Leader. Leaders attend an additional three-day training where they are taught to supervise Seven Challenges counselors, monitor for Program fidelity, and to train new staff joining their organization. Leaders are generally the organization's clinical director and supervisors. We request Leaders not only have supervisory authority but also have master's degree or higher in a counseling related educational program.

Certification: Initial training, Seven Challenges Leader

Facilitators: See Training section above

Fidelity: Available from Seven Challenges, LLC. New processes were developed to provide ongoing support, and improved and expanded training to clinical leaders within agencies; leaders who could supervise, teach the program to new hires, and sustain the program for the long run. Quality assurance processes have been developed to help agencies upgrade service quality and attain fidelity of implementation. Sharon Conner became the director of Program Services for The Seven Challenges in early 2005. She assists organizations during their process of determining whether the Program is a good fit for their setting and if it is, then how to make a plan and arrangements for successful implementation. Sharon also coordinates the licensing, training, and ongoing support process.

Bibliography:

Stevens, S., Schwebel, R., & Ruiz, B. The Seven Challenges®: An Effective Treatment for Adolescents with Co-occurring Substance Abuse and Mental Health Problems. This research was supported by grants 5KD1-TI11422 from the Substance Abuse and
Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) Adolescent Treatment Models Program.

Smith, D., Hall, J., Williams, J., An, H., & Gotman, N. (2006). Comparative Efficacy of Family and Group Treatment
for Adolescent Substance Abuse. *The American Journal on Addictions,* 15: 131–136.

Stevens, S. (2007). Seven Challenges: Research findings and next steps. Presented at the Joint Meeting on Adolescent Treatment Effectiveness, Washington, D.C.

Dennis, M., & Ives, M. (2005). Traumatic Victimization Among Adolescents Presenting for Substance Abuse Treatment: *It is Time to Stop Ignoring the Elephant in our Counseling Room*. Presentation for the 2005 Joint Meeting on Adolescent Treatment Effectiveness, Washington, DC, March 21-23, 2005. Sponsored by the Center for Substance Abuse Treatment (CSAT), National Institute on Drug Abuse (NIDA), Substance Abuse and Mental Health Services Administration (SAMHSA).

Thinking for a Change (T4C)

Florida DJJ Ranking: Evidence-based Practice

Program Author: Bush, Jack; Glick, Barry; Taymans, Juliana

Program Contact: www.nicic.org

Overview: Thinking for a Change uses a problem-solving program with both cognitive restructuring and social skills interventions bridging the identification of thinking, beliefs, attitudes, and values, to behavior. Thinking for a Change is a 22-lesson curriculum, intended to be delivered twice per week.

Revised in 2012, Thinking for a Change 3.2 uses a problem-solving program with both cognitive restructuring and social skills interventions bridging the identification of thinking, beliefs, attitudes, and values, to behavior. Thinking for a Change is a 25-lesson curriculum, intended to be delivered twice per week.

Thinking for a Change follows the idea that thinking, beliefs, attitudes, and values impact behavior. Effort is focused on helping youth become aware of their thoughts, feelings and beliefs in particular circumstances. If we know what thoughts, feelings, and beliefs a person is experiencing in a particular circumstance, we are more likely to change behavior.

The Thinking for a Change process is divided into three steps:
1. Pay attention to our thoughts and feelings.
2. Recognize when there is risk of our thoughts and feelings leading us into trouble.
3. Use new thinking to reduce the risk.

Location: National Institute of Corrections
Administrative Offices
320 First St., N.W.
Washington, D.C. 20534
(800) 995-6423
(202) 307-3106

Proven Reduction in Recidivism: Yes

Criminogenic Need: Antisocial Attitudes, Values, and Beliefs

Population: Male and female juveniles offenders

Treatment Setting: Community-based or Residential

Modality: Cognitive Behavioral in a group format

Training: 4-Day Facilitator, Additional 4-Day Master Trainer

Certification: Certificate upon completion

Facilitators: No degree requirements

Fidelity: Checklists available

Bibliography:

Milkman, H., & Wanberg, K. (2007). Cognitive-Behavioral Treatment: A Review and Discussion for Corrections Professionals. National Institute of Corrections, NIC Accession Number 021657.

Landenberger, N, & Lipsey, M. (2005). The positive effects of cognitive-behavioral programs for offenders: A meta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology,* 1, pp.451-476.

Golden, L. (2002). Evaluation of the Efficacy of a Cognitive Behavioral Program for Offenders on Probation: Thinking for a Change. Dissertation, University of Texas Southwestern Medical Center at Dallas.

Reeves, D. (2006). Investigation of the impact of a cognitive skills educational program upon adult criminal offenders placed on supervised probation. Unpublished dissertation, Northern Arizona University.

Promising Practices

The delinquency interventions that achieve the rank of promising practices have a significant amount of empirical support. These interventions have been evaluated using either random assignment or the use of control/comparison groups. For an intervention to be deemed a promising practice, the empirical research must have shown reductions of the program participants versus the comparison group(s) in at least one criminogenic need. The effect of the intervention must have been statistically significant.

Brief Strategic Family Therapy

Florida DJJ Ranking: Promising Practice

Program Author: Jose Szapocznik, Ph.D.

Program Contact: http://www.cfs.med.miami.edu
(305) 243-4592

Overview: Brief Strategic Family Therapy (BSFT) is a family-based intervention designed to prevent and treat child and adolescent behavior problems. BSFT targets children and adolescents who are displaying—or are at risk for developing—behavior problems, including substance abuse. BSFT is based on the fundamental assumption that adaptive family interactions can play a pivotal role in protecting children from negative influences and that maladaptive family interactions can contribute to the evolution of behavior problems and consequently are a primary target for intervention. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems. The therapy is tailored to target the particular problem interactions and behaviors in each client family. Therapists seek to change maladaptive family interaction patterns by coaching family interactions as they occur in session to create the opportunity for new, more functional interactions to emerge. Major techniques used are joining (engaging and entering the family system), diagnosing (identifying maladaptive interactions and family strengths), and restructuring (transforming maladaptive interactions). BSFT is a short-term, problem-oriented intervention. A typical session lasts 60 to 90 minutes. The average length of treatment is 12 to 15 sessions over more than 3 months. For more severe cases, such as substance-abusing adolescents, the average number of sessions and length of treatment may be doubled. Treatment can take place in office, home, or community settings.
The average length of treatment is 12 to 15 sessions over more than 3 months

Location: Miami, FL

Proven Recidivism Reduction: No

Criminogenic Need: Family functioning, substance abuse, antisocial peer associations, academic performance

Population: 8 to 17 year old male and female juveniles

Treatment Setting: Community-based or within the home

Modality: Family Therapy

Training: Standard training includes:
3 days of intensive instruction
12 months of phone consultation, including review of videotaped or audio taped sessions
follow-up workshop on skill development

Certification: Certificate from the Center for Family Studies

Facilitators:

Master's level therapists
Bachelor's level clinicians with family therapy experience
Doctoral level supervisors

Fidelity:

12-month phone consultation, review of video/audio taped sessions

Bibliography:

Szapocznik, J., & Williams, R.A. (2000). Brief strategic family therapy: Twenty-five years of interplay among theory, research and practice in adolescent behavior problems and drug abuse. *Clinical Child and Family Psychology Review, 3* (2), 117-135.

Szapocznik, J., & Hervis, O.E. (2000). Brief Strategic Family Therapy: A revised manual. Manuscript in preparation for the National Institute on Drug Abuse Treatment Manual Series, NIDA, Rockville, Maryland.

Briones, Ervin; Robbins, Michael S.; Szapocznik, José. (2008). Brief Strategic Family Therapy: Engagement and Treatment. *Alcoholism Treatment Quarterly,* Vol. 26 Issue 1/2, p81-103.

Santisteban, Daniel A.; Suarez-Morales, Lourdes; Robbins, Michael S.; Szapocznik, José. (2006). Brief Strategic Family Therapy: Lessons Learned in Efficacy Research and Challenges to Blending Research and Practice. *Family Process,* Vol. 45 Issue 2, p259-271.

Marius MN Nickel; Johannes JL Luley; Jakub JK Krawczyk; Cerstin CN Nickel; Christoph CW Widermann; Claas CL Lahmann; Moritz MM Muehlbacher; Petra PF Forthuber; Christian CK Kettler; Peter PL Leiberich; Karin KT Tritt; Ferdinand FM Mitterlehner; Patrick PK Kaplan; Francisco FP Pedrosa Gil; Wolfhardt WR Rother; Thomas TL Loew. (2006). Bullying Girls – Changes after Brief Strategic Family Therapy: A Randomized, Prospective, Controlled Trial with One-Year Follow-Up. *Psychotherapy & Psychosomatics,* Vol. 75 Issue 1, p47-55.

Santisteban, Daniel A.; Perez-Vidal, Angel; Coatsworth, J. Douglas; Kurtines, William M.; Schwartz, Seth J.; LaPerriere, Arthur; Szapocznik, José. (2003). Efficacy of Brief Strategic Family Therapy in Modifying Hispanic Adolescent Behavior Problems and Substance Use. *Journal of Family Psychology,* Vol. 17 Issue 1, p121-133.

Robbins, Michael S.; Bachrach, Ken; Szapocznik, José. (2002). Bridging the research-practice gap in adolescent substance abuse treatment: the case of brief strategic family therapy. *Journal of Substance Abuse Treatment,* Vol. 23 Issue 2, p123.

Coatsworth, J.D., Santisteban, D.A., McBride, C.K., & Szapocznik, J. (2001). Brief Strategic Family Therapy versus community control: Engagement, retention and an exploration of the moderating role of adolescent symptom severity. *Family Process, 40,* 331-332.

Santisteban, D.A., Coatsworth, J.D., Perez-Vidal, A., Mitrani, V., Jean-Gilles, M., & Szapocznik, J. (1997). Brief Strategic Family Therapy with African American and Hispanic high-risk youth. *Journal of Community Psychology, 25,* 453-471.

Santisteban, D.A., Szapocznik, J., Perez-Vidal, A., Murray, E.J., Kurtines, W.M., & LaPerriere, A. (1996). Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness. *Journal of Family Psychology, 10,* 35-44.

Szapocznik, J., Murray, E.J., Scopetta, M., Hervis, O., Rio, A., Cohen, R., Rivas-Vazquez, A., & Posada, V. (1989). Structural family versus psychodynamic child therapy for problematic Hispanic boys. *Journal of Consulting and Clinical Psychology, 57,* 571-578.

Szapocznik, J., Perez-Vidal, A., Brickman, A.L., Foote, F.H., Santisteban, D.A., & Hervis, O. (1988). Engaging adolescent drug abusers and their families in treatment: A strategic structural systems approach. *Journal of Consulting and Clinical Psychology, 56,* 552-557.

Bullying Prevention Program

Florida DJJ Ranking: Promising Practice

Program Author: Dan Olweus, Ph.D.

Program Contact:
Institute of Family and Neighborhood Life
158 Poole Agricultural Center
Clemson University
Clemson, SC 29634
Phone: 864.710.4562
Fax: 864.656.6281
Email: nobully@clemson.edu

Overview: The Bullying Prevention Program is a universal intervention developed to promote the reduction and prevention of bullying behavior and victimization problems. The program is based on an ecological model, intervening with a child's environment on many levels: the individual children who are bullying and being bullied, the families, the teachers and students within the classroom, the school as a whole, and the community. The main arena for the program is the school, and school staff have the primary responsibility for introducing and implementing the program. Schools are provided ongoing support by project staff.

Core components of the program are implemented at the school level, the class level, and the individual level:

School-wide components include the administration of an anonymous questionnaire to assess the nature and prevalence of bullying at each school, a school conference day to discuss bullying at school and plan interventions, formation of a Bullying Prevention Coordinating Committee to coordinate all aspects of school's program, and increased supervision of students at "hot spots" for bullying.
Classroom components include the establishment and enforcement of class rules against bullying, and holding regular class meetings with students.
Individual components include interventions with children identified as bullies and victims, and discussions with parents of involved students. Teachers may be assisted in these efforts by counselors and school-based mental health professionals.

Location: School/classroom-based

Proven Recidivism Reduction: No

Criminogenic Need: Antisocial attitudes, antisocial peer associations

Population: Male and female juveniles 6 to 14 years of age. Program targets students in elementary, middle, and junior high schools. All students within a school participate in most aspects of the program. Additional individual interventions are targeted at students who are identified as bullies or victims of bullying.

Treatment Setting: School setting

Modality: Group and individual counseling

Training: Training for staff and training of trainers

Training for staff:
2-day Training for staff (usually a member of the 8-12 members of an internal Bullying Prevention Coordinating Committee) conducted by certified trainers.
Ongoing telephone consultation for a full school year (at least 10 months) with a certified trainer.

Training of Trainers:
Participation in the 3-day TOT
Participation in a 2-day booster training approximately 8-9 months later Participation in regular phone consultation with an OBPP Training Director (approximately 1 hour per for first 12 months, 30 minutes per month for next 6 months)
A complete set of training materials
Access to the trainer-only section of the OBPP website

Certification: Trainer of trainers

Facilitators: Teachers

Fidelity: Fidelity scales

Bibliography:

Black, S. (2003). An ongoing evaluation of the bullying prevention program in Philadelphia schools: Student survey and student observation data. Paper presented at Centers for Disease Control's Safety in Numbers Conference, Atlanta, GA.

Limber, S. P. (2004b). Implementation of the Olweus Bullying Prevention Program: Lessons Learned from the Field. In D. Espelage & S. Swearer (Eds.) Bullying in American Schools: A Social-Ecological Perspective on Prevention and Intervention (pp. 351-363). Mahwah, NJ: Lawrence Erlbaum.

Olweus, D. (1991). Bully/victim problems among schoolchildren: Basic facts and effects of a school based intervention program. In D. J. Pepler & K. H. Rubin (Eds.), The development and treatment of childhood aggression (pp. 411-448). Hillsdale, NJ: Erlbaum.

Olweus, D. (1993). Bullying at school: What we know and what we can do. Cambridge: Blackwell.

Olweus, D. (2004). The Olweus Bullying Prevention Programme: Design and implementation issues and a new national initiative in Norway. In P. K. Smith, D. Pepler, & K. Rigby (Eds.), Bullying in schools: How successful can interventions be? (pp. 13-36). Cambridge, UK: Cambridge University Press.

Olweus, D., Limber, S. P., & Mihalic, S. (1999). The Bullying Prevention Program: Blueprints for Violence Prevention, Vol. 10. Center for the Study and Prevention of Violence: Boulder, CO.

Dialectical Behavioral Therapy (DBT)

Florida DJJ Ranking: Promising Practice

Program Author: Marsha Linehan, Ph.D. ABPP

Program Contact: Marsha Linehan, Ph.D.
Professor, Department of Psychology
Director, Behavioral Research and Therapy Clinics
Box 351525
University of Washington
Seattle, WA 98195-1525

Overview: Dialectical Behavior Therapy is a therapeutic methodology developed by Marsha Linehan, a psychology researcher, to treat persons with borderline personality disorder. DBT combines standard cognitive behavioral techniques for emotion regulation and reality-testing with concepts of mindful awareness, distress tolerance, and acceptance largely derived from Buddhist meditative practice. DBT is the first therapy that has been experimentally demonstrated to be effective for treating borderline personality disorder. Research indicates that DBT is also effective in treating patients who represent varied symptoms and behaviors associated with spectrum mood disorders, including self-injury. DBT has since been adapted for youth who have difficultly regulating their emotions.

All DBT involves two components:

An individual component in which the therapist and patient discuss treatment target hierarchy. Self-injurious and suicidal behaviors take first priority, followed by behaviors that interfere with therapy. Then there are quality of life issues and finally working towards improving one's life generally. During the individual therapy, the therapist and patient work towards improving skill use. Often, a skills group is discussed and obstacles to acting skillfully are addressed.

The group, which ordinarily meets once weekly for two to two-and-a-half hours, learns to use specific skills that are broken down into four modules: core mindfulness skills, interpersonal effectiveness skills, emotion regulation skills, and distress tolerance skills.

Neither component is used by itself; the individual component is considered necessary to keep suicidal urges or uncontrolled emotional issues from disrupting group sessions, while the group sessions teach the skills unique to DBT, and also provide practice with regulating emotions and behavior in a social context.

Location: Seattle, Washington

Proven Recidivism Reduction: No

Criminogenic Need: While not criminogenic needs, DBT has been shown to reduce suicidal and self-injurious behavior. Recidivism reductions have been found with juvenile populations, though not statistically significant

Population: Male and female juveniles

Treatment Setting: Home-based, school, community

Modality: Individual, group therapy

Training: 5-day Orientation Training, 2-day training for new MST supervisors, 2-day advanced supervisor workshops

Certification:

Facilitators: Therapists trained in DBT. Therapists must be licensed, or supervised by a licensed individual

Fidelity:

Bibliography: A comprehensive list of articles and empirical evaluations by Dr. Linehan on DBT can be found at:
http://depts.washington.edu/brtc/sharing/publications/dr-linehans-publications

Aos, S., Leib, R., Mayfield, J., Miller, M., & Pennucci, A. (2004). *Benefits and costs of prevention and early intervention programs for youth.* Olympia: Washington State Institute for Public Policy.

Drake, E., & Barnoski, B. (2005). *Recidivism findings for the Juvenile Rehabilitation Administration's Dialectical Behavior Therapy program: Final report.* (Document No. 06-05-1202). Olympia: Washington State Institute for Public Policy.

Trupin, E.W., Stewart, D.G., Beach, B, & Boesky, L. (2002). Effectiveness of a Dialectical Behavior Therapy program for incarcerated female juvenile offenders. *Child and Adolescent Mental Health, 7,* 121-127.

Family Behavior Therapy (FBT)

Florida DJJ Ranking: Promising Practice

Program Author: Bradley Donohue, Ph.D.

Program Contact: http://web.unlv.edu/labs/frs/index.html
(702) 557-5111
For training contact: Brad Donohue (702) 895-0181

Overview: Family Behavior Therapy (FBT) is an outpatient behavioral treatment aimed at reducing drug and alcohol use in adults and youth along with common co-occurring problem behaviors such as depression, family discord, school and work attendance, and conduct problems in youth. This treatment approach owes its theoretical underpinnings to the Community Reinforcement Approach and includes a validated method of improving enlistment and attendance.

Participants attend therapy sessions with at least one significant other, typically a parent (if the participant is under 18) or a cohabitating partner. Treatment typically consists of 15 sessions over 6 months; sessions initially are 90 minutes weekly and gradually decrease to 60 minutes monthly as participants progress in therapy. FBT includes several interventions, including:

1. The use of behavioral contracting procedures to establish an environment that facilitates reinforcement for performance of behaviors that are associated with abstinence from drugs;
2. Implementation of skill-based interventions to assist in spending less time with individuals and situations that involve drug use and other problem behaviors;
3. Skills training to assist in decreasing urges to use drugs and other impulsive behavior problems;
4. Communication skills training to assist in establishing social relationships with others who do not use substances and effectively avoiding substance abusers; and
5. Training for skills that are associated with getting a job and/or attending school.

Location: 4505 Maryland Pkwy (CDC 610), Box 455030, Las Vegas, NV

Proven Recidivism Reduction: Yes

Criminogenic Need: Substance Abuse/Use/Dependence, family problems, school attendance

Population: Male and Female juveniles with Substance Abuse/Use

Treatment Setting: Community-based or residential

Modality: Behavioral therapy

Training: Initial 2-day on-site training workshop; 1-day on-site booster workshop; annual case reviews and audiotaped integrity checks.

Certification: Certification Training and Supervisor Training

Facilitators: Clinician/Therapist

Fidelity: Implementation materials include a fully scripted manual for clinicians that adequately facilitate delivery of the treatment strategies. Numerous checklists, detailed documentation forms, and activity sheets are available to provide implementation structure. Initial and follow-up trainings are available for potential implementers in a variety of formats. Extensive implementation support also is available. Protocol adherence checklists, rating forms, and audiotape assessments are provided to support quality assurance.

Annual case reviews and audiotaped integrity checks are required by the developer if certification is desired.

Bibliography: For extensive literature review visit: http://web.unlv.edu/labs/frs/fbt.html#

Azrin, N., Donohue, B., Teichner, G., Crum, T., Howell, J., & DeCato, L. (2001). A controlled evaluation and description of individual-cognitive problem solving and family-behavior therapies in dually-diagnosed conduct-disordered and substance-dependent youth. *Journal of Child & Adolescent Substance Abuse, 11(1),* 1-43.

Azrin, N., Donohue, B., Besalel, V., Kogan, E., & Acierno, R. (1994). Youth Drug-Abuse Treatment- A Controlled Outcome Study. *Journal of Child & Adolescent Substance Abuse, 3(3),* 1-16.

Azrin, N. H., Acierno, R., Kogan, E. S., Donohue, B., Besalel, V. A., & McMahon, P. T. (1996). Follow-up results of supportive versus behavioral therapy for illicit drug use. *Behavior Research and Therapy, 34(1),* 41-46. doi:10.1016/0005-7967(95)00049-4.

Azrin, N. H., McMahon, P. T., Donohue, B., Besalel, V. A., Lapinski, K. J., Kogan, E. S., Galloway, E. (1994). Behavior therapy for drug abuse: A controlled treatment outcome study. *Behavior Research and Therapy, 32(8),* 857-866. doi:10.1016/0005-7967(94)90166-X.

Donohue, B., Azrin, N., Lawson, H., Friedlander, J., Teichner, G., & Rindsberg, J. (1998). Improving initial session attendance of substance abusing and conduct disordered adolescents: A controlled study. *Journal of Child & Adolescent Substance Abuse, 8(1),* 1-13.

Functional Family Parole (FFP)

Florida DJJ Ranking: Promising Practice

Program Author: James F. Alexander, Ph.D., Doug Kopp

Program Contact: Holly DeMaranville: hollyfft@comcast.net
(206) 369-5894

Overview: FFP is a family-focused, case management model for juvenile justice officers to more effectively work with youth on community supervision. It was developed at the prompting of juvenile justice systems in Washington and Utah in order to offer juvenile offender supervision that is grounded in data and pulls from the existing evidence base of what works with youthful offenders. FFP believes there are more effective strategies to keep kids in the community, thus allowing them to take advantage of the very effective community based interventions that are proven to reduce recidivism.

Heavily informed by the nearly 40 years of process evaluation and outcome research conducted on Dr. Alexander's Functional Family Therapy (FFT), the model is alliance based, using work within the family as a platform to not only better manage crises, but to more effectively refer youth to programs that will match their particular risks and needs.

The FFP model represents a fundamental shift in how aftercare parole services are delivered—from an essentially offender focused approach to one where the focus is on the family in which the success level of a youth's transition and reentry will be shaped.

Phases of FFP:
Phase One: Engage and Motivate
Phase Two: Support and Monitor
Phase Three: Generalize Change

Location: 1251 Northwest Elford Drive
Seattle WA 98177 USA

Proven Recidivism Reduction: No

Criminogenic Need: Recidivism, Family conflict, family communication, parenting, youth problem behavior

Population: Male and female juveniles ages 10-18

Treatment Setting: Transition to community

Modality: Individual, family therapy

Training: Contact FFTinc.

Certification: Certificate upon completion

Facilitators: Therapists trained in FFP

Fidelity: Functional Family Parole Global Rating Measure (FFP-GRM)

Bibliography:

Lucenko, B. A., He, Lijian, Mancuso, D., & Felver, B. (2011). *Effects of Functional Family Parole on re-arrest and employment for youth in Washington State.* Olympia Washington, Juvenile Rehabilitation Administration.

Sexton, T., Rowland, M., & Gruber, J. *Preliminary Results from Client Outcome Measure-Parent (COM-P) for the Washington State Functional Family Parole Project*. February, 2005.

Sexton, T. & Rowland, M. *Preliminary Results from Adherence Ratings for the Washington State Functional Family Parole Project.* April, 2005.

Sexton, T. & Rowland, M. *Changes in Outcomes Across Time for the First Year of the Washington State Functional Family Parole Project*, June, 2005.

Rowland, M., & Sexton, T. *Preliminary Outcome Evaluation of the Washington State Functional Family Parole Project,* March 1, 2007.

Multisystemic Therapy – Family Integrated Transitions (MST-FIT)

Florida DJJ Ranking: Promising Practice

Program Author: Eric Trupin, Ph.D.

Program Contact: Joshua Leblang: jleblang@u.washington.edu
(206) 685-2254

Overview: The Family Integrated Transitions (FIT) program is a manualized family- and community-based treatment specifically designed to address the range of biopsychosocial needs (risk and protective factors) of adjudicated adolescents diagnosed with co-occurring mental health and substance use disorders.

The MST–FIT program begins in a youth's final 2 months in a residential facility and continues for 4 to 6 months during parole supervision.

The MST-FIT intervention is primarily comprised of three components (Multisystemic Therapy [MST], dialectical behavior therapy, and motivational enhancement), plus a parent skills training module. Program components are systematically delivered based on the youth and family's demonstrated needs. The overarching framework of the program is derived from MST, a family-based preservation model for community-based treatment. MST provides the foundation of the intervention, while the other intervention strategies are delivered within the MST framework. MST tailors treatment goals to a youth's individual risk and protective factors within his or her natural environment (i.e., family, school, and community). This treatment component uses therapists to coach caregivers in establishing productive partnerships with schools, community supports, parole, and other systems, and to help caregivers develop skills to be effective advocates for those in their care.

The MST–FIT team consists of 3-4 therapists with backgrounds in children's mental health, family therapy, and chemical dependency and 1 supervisor per team. The team serves four to six families at any given time. Service delivery occurs in the families' homes and communities, and services are available 24 hours a day, 7 days a week.

Location: Division of Public Behavioral Health and Justice Policy, Department of Psychiatry and Behavioral Sciences, University of Washington, 2815 Eastlake Avenue E., Suite 200, Seattle WA 98102

Proven Recidivism Reduction: No

Criminogenic Need: Recidivism, Increase family functioning, decrease antisocial peer associations, improve educational and vocational opportunities

Population: Male and female juveniles ages 12 to 17

Treatment Setting: Residential with transition to community

Modality: Individual, family therapy

Training: Contact MSTservices.com. Example trainings include 5-day Orientation Training, 2-day training for new MST supervisors, 2-day advanced supervisor workshops

Certification: Certificate upon completion

Facilitators: Licensed mental health counselors trained in Multisystemic Therapy, or non-licensed individuals trained in Multisystemic Therapy who receive clinical supervision from licensed mental health counselors

Fidelity: Therapist adherence measures, weekly group supervision with team supervisor, consultation with FIT consultants

Bibliography:

Trupin, E. J., Kerns, S. E., Cusworth Walker, S., DeRobertis, M. T., & Stewart, D. G. (2011). Family Integrated Transitions: A Promising Program for Juvenile Offenders with Co-Occurring Disorders. *Journal of Child & Adolescent Substance Abuse, 20,* 421-436.

Aos, Steve. 2004. *Washington State's Family Integrated Transitions Program for Juvenile Offenders: Outcome Evaluation and Benefit–Cost Analysis.* Olympia, Wash.: Washington State Institute for Public Policy. http://www.wsipp.wa.gov/rptfiles/04-12-1201.pdf

Drake, Elizabeth. 2007. *Evidence-Based Juvenile Offender Programs: Program Description, Quality Assurance, and Cost.* Olympia, Wash.: Washington State Institute for Public Policy. http://www.wsipp.wa.gov/rptfiles/07-06-1201.pdf

Lee, Terry, and Megan DeRobertis. 2006. "Overview of the FIT Treatment Model." *Focal Point* 20(2):17–19.

Public Behavioral Health and Justice Policy. 2008. "Juvenile Rehabilitation Administration: Family Integrated Transitions™ (FIT™) Overview." Accessed July 17, 2012. http://depts.washington.edu/pbhjp/projects/fit.php

Project Toward No Drug Abuse (TND)

Florida DJJ Ranking: Promising Practice

Program Author: Steve Sussman, Ph.D.

Program Contact:
Institute for Health Promotion and Disease Prevention
University of Southern California, Department of Preventive Medicine
1000 South Fremont Avenue, Unit 8, Suite 4124
Alhambra, CA 91803
Phone: 626.457.6635
Fax: 626.457.4012
Email: ssussma@usc.edu

Overview: Project Toward No Drug Abuse (TND) is an interactive program designed to help high school youths (ages 14–19) resist substance use. This school-based program consists of twelve 40- to 50-minute lessons that include motivational activities, social skills training, and decision-making components that are delivered through group discussions, games, role-playing exercises, videos, and student worksheets over a 4-week period. The program was originally designed for high-risk youth in continuation, or alternative, high schools and consisted of nine lessons developed using a motivation-skills–decision-making model. The instruction to students provides cognitive motivation enhancement activities to not use drugs, detailed information about the social and health consequences of drug use, and correction of cognitive misperceptions. It addresses topics such as active listening skills, effective communication skills, stress management, coping skills, tobacco cessation techniques, and self-control—all to counteract risk factors for drug abuse relevant to older teens. The program can be used in a self-instruction format or run by a health educator; 3 times a week over a 4-week period, the length of the program period could be expanded to 6 weeks, teaching 2 lessons per week.

Location: Alhambra, CA

Proven Recidivism Reduction: No

Criminogenic Need: Substance abuse, self-control

Population: Male and female juveniles 14 to 19 years of age

Treatment Setting: Community-based or Residential

Modality: Group counseling.

Training: Certified trainers are health education specialists who have classroom experience with Project TND. Evaluation studies show that the program is effective when implemented by teachers who received a two-day training workshop conducted by a certified TND trainer.

For more information contact Leah Meza:
USC Institute for Prevention Research
1000 S. Fremont Aveue, Unit #8
Alhambra, CA 91803

Phone: (800)400-8461
E-mail: leahmedi@usc.edu

Certification:

In order to be eligible for certification as a Project TND trainer, one must provide verification that he/she has:
-Taught at least half of the Project TND curriculum sessions to the appropriate target group (youth ages 14-18) in a classroom-based setting, ***or*** observed the delivery of at least half of the curriculum sessions to this target group.
-Attended a two-day Project TND training workshop that was conducted by one of our certified trainers.

After meeting the above eligibility criteria, the potential trainer:
-Conducts a two-day Project TND training workshop, with at least 5 attendees, which is observed by one of our certified trainers. Then, he/she is given a "pass" or a "fail" grade. If the potential trainer receives a "pass" grade, he/she is conditionally certified.
-Within close proximity to the first training, the conditionally certified trainer conducts a second training, which is observed by a certified trainer. If the potential trainer receives a second "pass" grade, he/she is fully certified and receives a certificate as such.

Facilitators:

Bachelor's degree

Fidelity:

Contact Dr. Sussman

Bibliography:

Sussman, S, Dent, C., and Stacy, A. (2002). Project Towards No Drug Abuse: A Review of the Findings and Future Directions. *American Journal of Health and Behavior,* 26(5), 354-365.

Sun, W. , Skara, S., Sun, P., Dent, C., and Sussman, S. (2006). Project Towards No Drug Abuse: Long-term substance use outcomes evaluation, *Preventive Medicine,* 42, 188 – 192.

Sussman, S., Dent, C., Stacy, A., and Craig S. (1998). One-Year Outcomes of Project Towards No Drug Abuse, *Preventive Medicine,* 27, 632–642.

Promoting Alternative Thinking Strategies (PATHS)

Florida DJJ Ranking: Promising Practice

Program Author: Carol Kusche, Ph.D. and Mark Greenberg, Ph.D.

Program Contact: http://www.prevention.psu.edu/projects/PATHS.html

Prevention Research Center
Pennsylvania State University
S109 Henderson Building
University Park, PA 16802
Telephone: 814-865-2618
Fax: 814-865-2530

prevention@psu.edu

Overview:

The Promoting Alternative Thinking Strategies (PATHS) curriculum is a comprehensive program that promotes emotional and social competencies and reduces aggression and behavior problems in elementary school–aged children, while simultaneously enhancing the educational process in the classroom. The PATHS preventive intervention program is based on the ABCD (Affective-Behavioral-Cognitive-Dynamic) model of development, which places primary importance on the developmental integration of affect, behavior, and cognitive understanding as they relate to social and emotional competence. A basic premise is that a child's coping, as reflected in his or her behavior and internal regulation, is a function of emotional awareness, affective-cognitive control and behavioral skills, and social-cognitive understanding.

The PATHS curriculum contains numerous lessons (the exact number depends on the curriculum version) that seek to provide children with the knowledge and skills within three major conceptual units: 1) the Readiness and Self-Control "Turtle" Unit, 2) the Feelings and Relationships Unit, and the 3) Problem Solving Unit. The lessons include instruction in identifying and labeling feelings, expressing feelings, assessing the intensity of feelings, managing feelings, understanding the difference between feelings and behaviors, delaying gratification, controlling impulses, reducing stress, self-talk, reading and interpreting social cues, understanding the perspectives of others, using steps for problem-solving and decision-making, having a positive attitude toward life, self-awareness, nonverbal communication skills, and verbal communication skills. The curriculum is designed for use by educators and counselors in a multiyear, universal prevention model that concentrates primarily on school and classroom settings but also includes information and activities for use with parents. Ideally, the program should be initiated at the start of schooling and continued through sixth grade. Teachers generally receive training in a 2- to 3-day workshop and in biweekly meetings with the curriculum consultant.

The PATHS Curriculum consists of an Instructional Manual, six volumes of lessons, pictures, photographs, posters, Feeling Faces, and additional materials. PATHS is divided into three major units: (1) the Readiness and Self-Control Unit, 12 lessons that focus on readiness skills and development of basic self-control; (2) the Feelings and Relationships Unit, 56 lessons that focus on teaching emotional and interpersonal understanding (i.e., Emotional Intelligence); and (3) the Interpersonal Cognitive Problem-Solving Unit, 33 lessons that cover eleven steps for formal interpersonal problem-solving. Two further areas of focus in PATHS involve building positive self-esteem and improving peer communications/relations. Rather than having separate units on these topics, relevant lessons are interspersed throughout the other three units. There is also a Supplementary Unit containing 30 lessons which review and extend PATHS concepts that are covered in the major three units. The PATHS units cover five conceptual domains:

- Self-control,
- Emotional understanding,
- Positive self-esteem,
- Relationships, and
- Interpersonal problem solving skills.

Each of these domains has a variety of sub-goals, depending on the particular developmental level and needs of the children receiving instruction. Taught three times per week for a minimum of 20-30 minutes per day.

Location: University Park, PA

Proven Recidivism Reduction: No

Criminogenic Need: Self-control, aggression

Population: Male and female juveniles 5 to 10 years of age

Treatment Setting: The PATHS Curriculum was developed for use in the classroom setting with all elementary school aged-children.

Modality: Cognitive behavioral in a group/classroom format.

Training: Teachers generally receive training in a 2- to 3-day workshop and in biweekly meetings with the curriculum consultant.
For information on PATHS training contact PATHS Training LLC Phone and FAX: (206) 323-6688 ckusche@comcast.net
Dorothy Morelli
dorothygm@hotmail.com
(615) 364-6606

Certification: Contact the PATHS Training LLC Phone and FAX: (206) 323-6688 ckusche@comcast.net
Dorothy Morelli
dorothygm@hotmail.com
(615) 364-6606

Facilitators: Teachers

Fidelity:

For information on technical assistance with PATHS contact
PATHS Training LLC Phone and FAX: (206) 323-6688 ckusche@comcast.net
Dorothy Morelli - dorothygm@hotmail.com
(615) 364-6606

Bibliography:

Kusche, C. A. & Greenberg, M. T. (1994) The PATHS Curriculum. Seattle: Developmental Research and Programs.

Greenberg, M. T., & Kusche, C. A. (1993). Promoting social and emotional development in deaf children: The PATHS Project. Seattle: University of Washington Press.

Greenberg, M. T., Kusche, C. A., Cook, E. T., & Quamma, J. P. (1995). Promoting emotional competence in school-aged children: The effects of the PATHS Curriculum. Development and Psychopathology, 7, 117-136.

Bierman, K., Greenberg, M. T., & Conduct Problems Prevention Research Group (1966). Social skills in the FAST Track Program. In. R. DeV. Peters & R. J. McMahon (Eds.). Prevention and early intervention: Childhood disorders, substance abuse, and delinquency (pp. 65-89). Newbury Park, CA: Sage.

Greenberg, M. T., & Snell, J. (1997). The neurological basis of emotional development. In P. Salovey (Ed.) Emotional development and emotional literacy (pp. 92-119) . New York: Basic Books.

Greenberg, M. T. (1997). Promoting social and emotional competence: The PATHS Curriculum and the CASEL Network. *Reaching Today's Youth,* 49-52.

Elias, M. J., Zins, J. E., Weissberg, K. S., Greenberg, M. T., Haynes, N. M., Kessler, R., Schwab-Stone, M. E., & Shriver, T. P. (1997). Promoting social and emotional learning: Guidelines for Educators. Alexandria, VA: Association for Supervision and Curriculum Development.

Greenberg, M. T., & Kusche, C. A. (1998). Preventive intervention for school-aged deaf children: The PATHS Curriculum. *Journal of Deaf Studies and Deaf Education,* 3, 49-63.
Greenberg, M. T. & Kusche, C. A. (1998) Promoting Alternative Thinking Strategies. Institute of Behavioral Sciences, University of Colorado.

Kusche, C. A, & Greenberg, M. T. (1998) Integrating emotions and thinking in the classroom. *THINK,* 9, 32-34.

Kusche, C. A., Riggs, R. S., & Greenberg, M. T. (1999). PATHS: Using analytic knowledge to teach emotional literacy. *The American Psychoanalyst,* 33, 1.

Conduct Problems Prevention Research Group. (1999). Initial impact of the Fast Track prevention trial for conduct problems: II. Classroom effects. *Journal of Consulting and Clinical Psychology,* 67, 648-657.

Kusche, C. A., & Greenberg, M. T. (2001). PATHS in your classroom: Promoting emotional literacy and alleviating emotional distress. In J. Cohen (Ed.) Social emotional learning and the elementary school child: A guide for educators (pp. 140-161). New York: Teachers College Press.

Kusché, C. A., & Greenberg, M. T. (in press). Brain development and social-emotional learning: An introduction for educators. In M. Elias, H. Arnold, & C. Steiger, (Eds.), Fostering Knowledgeable, Responsible, and Caring Students. N.Y.: Teachers College Press.

Kusché, C. A., & Greenberg, M. T. (in press) Teaching emotional literacy in elementary school classrooms: The PATHS Curriculum. In M. Elias, H. Arnold, & C. Steiger, (Eds.), Fostering Knowledgeable, Responsible, and Caring Students. N.Y.: Teachers College Press.

Greenberg, M. T., Kusche, C. A., Riggs, N. (2004). The PATHS Curriculum: Theory and research on neuro-cognitive development and school success. In J. E. Zins, R. P. Weissberg, M. C. Wang & H. J. Walberg, H.J. (Eds.). Building academic success on social and emotional learning: What does the research say? (pp. 170-188) New York: Teachers College Press.

Kam, C. M., Greenberg, M.T., & Walls, C. T. (2003). Examining the Role of Implementation Quality in School-Based Prevention Using the PATHS Curriculum. *Prevention Science,* 4, 55-63.

Kam, C., Greenberg, M. T., & Kusché, C. A. (2004). Sustained Effects of the PATHS Curriculum on the Social and Psychological Adjustment of Children in Special Education. *Journal of Emotional and Behavioral Disorders,* 12*,* 66-78.

Stop Now and Plan (SNAP)

Florida DJJ Ranking: Promising Practice

Program Author: Child Development Institute, Toronto, Canada

Program Contact: http://Stopnowandplan.com

Overview: SNAP® is targeted toward children with behavior problems and those most likely to "flip" into the youth justice system by addressing key risks of their antisocial behavior – inadequate impulse control and problem solving skills. SNAP® (Stop Now And Plan) is an award-winning, manualized cognitive behavioral strategy developed at the Child Development Institute more than 30 years ago. SNAP® helps children and parents deal effectively with anger by teaching them to stop and think before they act -- responding in a way that makes their problems smaller, not bigger. With help and practice, children and parents are able to stop, calm down and generate positive solutions at the "snap of their fingers."

Under the SNAP® umbrella, Child Development Institute has developed two gender-specific, multi-component programs to respond to children under 12 in conflict with the law and/or experiencing behavioral problems:

1. SNAP® Boys: This multifaceted, manualized cognitive behavioral program consists of key components including a ***SNAP® Children's Club*** that teaches boys impulse control skills through the use of SNAP® in a structured group setting and a concurrent ***SNAP® Parenting (SNAPP) Group*** that teaches parents effective child management strategies.
2. SNAP® Girls: ***The SNAP® Girls Club*** is a manualized, 12 week, self-control and problem-solving SNAP® group (girls are clustered by age). ***Parent Training Groups (SNAP® Parenting)*** is a manualized 12 week parent group which runs concurrently with the SNAP® Girls Club group. The focus is two-fold: the acquisition of SNAP® self-control/problem solving techniques and effective parenting strategies.

Location: Child Development Institute
46 St. Clair Gardens,
Toronto, Ontario M6E 3V4, Canada

Proven Recidivism Reduction: No

Criminogenic Need: Aggression, rule breaking, conduct disorder, family relationships, peer relationships

Population: Male and female juveniles under 12 years of age

Treatment Setting: Community-based

Modality: Group counseling for youth, family, and youth and family groups

Training:

Contact Nicola Slater:
ccco@childdevelop.ca
(416) 603-1827x3148

Training Modules for the SNAP® Program, the EARL-20B and the EARL-21G are available through the Centre for Children Committing Offences (CCCO) at Child Development Institute (CDI).

Current Training Modules Available:
Core 5-Day Initial SNAP® Training (for new sites looking to implement a full replication model)
2-Day SNAP® Training (for staff at currently licensed SNAP® sites)
SNAP® for Schools (typically a 2-Day Module)
EARL-20B and EARL-21G Training (on how to use our structured professional judgment risk need assessment tools; training available to professionals working with children at risk of engaging in antisocial behavior)

- EARL-20B Training Format 1-Day Sample
- EARL Training Format 2-Day Sample

The maximum number of participants varies from group to group. Given that group practice exercises are a key training component, a minimum number of attendees are required and maximum numbers may be established for optimal learning.

When training is requested by a new SNAP® Affiliate Site, it is advised that key staff of the broader organization attend the first session of the training in order to gain a solid understanding of the SNAP® Model, as well as the context in which this model was created and developed. Full participation is mandatory for any staff members who will be delivering the SNAP® Model and or using the risk assessment tools.

Certification:

Certificate upon completion

Facilitators:

Facilitators trained in SNAP models

Fidelity:

Consultation is negotiated with each SNAP® Affiliate Site on an annual and as-needed basis, and is customized to meet the individual organization's needs. This can be done through face-to-face meetings, or via telephone or video conferencing methods. Clinical teams and supervisors are all invited to be involved in this process, which can also include reviews of live or videotaped SNAP® sessions. Part of this process involves treatment fidelity and integrity checks.

Bibliography:

For a complete list of evaluations contact:
Leena K. Augimeri,
Director, Centre for Children Committing Offences & Program Development Child Development Institute
416.603.1827 ext. 3112
augimeri@childdevelop.ca

Select evaluations of SNAP® Boys:

Hrynkiw-Augimeri, L., Pepler, D., & Goldberg, K. (1993). An outreach program for children having police contact. *Canada's Mental Health, 41,* 7-12.

Day, D. M., & Augimeri, L.A. (1996). *Serving children at risk for juvenile delinquency: An evaluation of the Earlscourt Under 12 Outreach Project (SNAP® ORP).* Submitted to the Department of Justice. Earlscourt Child and Family Centre.

Augimeri, L.K., Farrington, D.P., Koegl, C.J., & Day, D.M. (2007). The SNAP™ Under 12 Outreach Project: Effects of a community based program for children with conduct problems. *Journal of Child and Family Studies*, 16, 799-807.

Augimeri, L.K., Jiang, D., Koegl, C.J. & Carey, J. Differential Effects of the Under 12 Outreach Project (SNAP® ORP) Associated with Client Risk & Treatment Intensity (2006). Program Evaluation Report Submitted to the Centre of Excellence for Child and Youth Mental Health at CHEO.

Augimeri, L.K. (2005). Aggressive and antisocial Young Children: Risk Assessment and Management Utilizing the Early Assessment Risk List for Boys (EARL-20B). Ph.D. Dissertation, Ontario Institute for Studies in Education, University of Toronto, May, 2005.

Koegl, C.J., Farrington, D.P. & Augimeri, L.K. & Day (2008). Evaluation of a targeted cognitive behavioral program for children with conduct problems – the SNAP™ Under 12 Outreach Project: Service intensity, age and gender effects on short and long term outcomes. *Clinical Child Psychology and Psychiatry, 13,* 441-456.

Select evaluations of SNAP® Girls:

Walsh, M. M., Pepler, D. J., & Levene, K. S. (2002). A model intervention for girls with disruptive behavior problems: The Earlscourt Girls Connection. *Canadian Journal of Counseling, 36,* 297-311.

Pepler, D., Levene, K., & Walsh, M. (2004). Interventions for aggressive girls: Tailoring and measuring the fit. In M. M. Moretti & C. L. Odgers (Eds.). *Girls and Aggression: Contributing Factors & Intervention Principles,* Perspectives in Law & Psychology Series, Volume 19 (pp. 41-56). New York: Kluwer Academic/ Plenum.

Walsh, M., Yuile, A., Jiang, D., Augimeri, L.K., Pepler, D. (2007). Early Assessment Risk List for Girls (EARL-21G): Predicting Antisocial Behaviors and Clinical Implications. Manuscript in preparation.

Yuile, A., Walsh, M., Jiang, D., Pepler, D., & Levene, K. (2007). *Risk factors and intervention outcomes for aggressive girls in the SNAP™ Girls Connection: A prospective replication*. Manuscript in preparation.

Strengthening Families Program (SFP)

Florida DJJ Ranking: Promising Program

Program Author: Karol Kumpfer, Ph.D.

Program Contact:

http://strengtheningfamiliesprogram.org
Department of Health Promotion and Education
21901 East South Campus Drive, Room 2142
Salt Lake City, UT 84112
Phone: 8015817718
Fax: 8015815872
Email:

kkumpfer@xmission.com

OR:

Virginia Molgaard , Ph.D.
Institute for Social and Behavioral Research
Iowa State University
ISU Research Park, Bldg. 2, Suite 500
2625 North Loop Drive
Ames, IA 50011-1260
Phone: (515) 294-8762
Fax: (515) 294-3613
Email: vmolgaar@iastate.edu
Website: www.extension.iastate.edu/sfp

Overview: The Strengthening Families Program (SFP) includes a parenting, a youth, and a family component. This skills training program consists of 14 weekly 2-hour skill-building sessions, implementing in groups of 4 to14 families. Parents and youth each work separately in training sessions and then participate together in a joint session practicing the skills they learned in their respective groups. Two booster sessions are used at 6 months to 1 year after the primary course. Youth's skills training sessions concentrate on peer-resistance skills, problem solving, conflict resolution, decision making, and communication skills. Topics in the parental component include setting rules, nurturing, monitoring compliance, and applying appropriate discipline.

Location: Department of Health Promotion and Education
21901 East South Campus Drive, Room 2142
Salt Lake City, UT 84112

Proven Recidivism Reduction: No

Criminogenic Need: Social competencies (e.g., communication, problem solving, peer resistance, and anger control); Family relationships (attachment, harmony, communication, discipline practices, and organization); Substance use

Population: Male and female juveniles up to 16 years of age

Treatment Setting: Community-based

Modality: Individual combined with family skills sessions

Training: 3 days of training from SFP-certified trainers.

Training costs are $3,900 for a two-day SFP group leader training for 35 or fewer trainees or $3300 for a training of 15 or fewer. The training fee includes a SFP master set of course materials on CD for one age-variant and site-limited license to reproduce copies for the agency's own use.

Training and technical assistance provided by:
Henry Whiteside
LutraGroup
5215 Pioneer Fork Road
Salt Lake City, UT 84108
Phone: 8015834601
Fax: 8015815872
Email: lutragroup@att.net

OR:

Catherine Webb
Iowa State University Extension to Families
2625 North Loop Drive
Ames, IA 50011-1260
Phone: (515) 294-1426
Fax: (515) 294-3613
Email: cwebb@iastate.edu
Website: www.extension.iastate.edu/sfp

Certification: Certified SFP Group Leader

Facilitators: Staffing to implement SFP requires a bare minimum of five trained staff: two group leaders for the parents, two for children or teens, and a site coordinator.

Fidelity: Fidelity measures are available from the developer.
Evaluation of implementations is offered through Lutra Group, Inc. Evaluation is comprehensive, normed against a national database, and extremely cost-competitive. All evaluations are supervised by the program developer and data is entered, analyzed and evaluated by staff at the Strengthening Families Program national office. A follow-up on-site visit once implementation has begun is often helpful in assuring fidelity and program effectiveness.

Bibliography:

Aktan, Georgia B., Karol L. Kumpfer, and Christopher W. Turner. 1996. “Effectiveness of a Family Skills Training Program for Substance Use Prevention With Inner City African-American Families.” *Substance Use and Misuse* 31(2):157–75.

Fox, Danielle Polizzi, Denise C. Gottfredson, Karol L. Kumpfer, and Penny D. Beatty. 2004. “Challenges in Disseminating Model Programs: A Qualitative Analysis of the Strengthening WDC Families Project.” *Clinical Child and Family Psychology Review* 7(3):165–76.

Gottfredson, Denise C., Karol L. Kumpfer, Danielle Polizzi Fox, David Wilson, Veronica Puryear, Penny D. Beatty, and Myriam Vilmenay. 2005. “Strengthening Washington, DC, Families Project: A Randomized Effectiveness Trial of Family-Based Prevention.” *Prevention Science* 4:1007–11.

Kumpfer, Karol L. 1998. "Selective Prevention Interventions: The Strengthening Families Program." In Rebecca S. Ashery, Elizabeth E. Robertson, and Karol L. Kumpfer (eds.). *Drug Abuse Prevention Through Family Intervention.* NIDA Research Monograph Series No. 177: U.S. Department of Health and Human Services Pub. No. 99–4135.

Kumpfer, Karol L., and Rose Alvarado. 2003. "Family Strengthening Approaches for the Prevention of Youth Problem Behaviors." *American Psychologist* 58(6/7):457–65.

Kumpfer, Karol L., Rose Alvarado, Paula Smith, and Nikki Bellamy. 2002. "Cultural Sensitivity in Universal Family-Based Prevention Interventions." *Prevention Science* 3(3):241–44.

Kumpfer, Karol L., Rose Alvarado, Connie Tait, and Charles W. Turner. 2002. "Effectiveness of School-Based Family and Children's Skills Training for Substance Abuse Prevention Among 6- to 8-Year-Old Rural Children." *Psychology of Addictive Behaviors* 16(4):65–71.

Kumpfer, Karol L., Rose Alvarado, Henry O. Whiteside, and Connie Tait. 2005. "The Strengthening Families Program (SFP): An Evidence-Based, Multicultural Family Skills Training Program." In José Szapocznik, Patrick H. Tolan, and Soledad Sambrano (eds.). *Preventing Substance Abuse.* Washington, DC: American Psychological Association Books, 3–14.

Practices with Demonstrated Effectiveness

The delinquency interventions that achieve the rank practices with demonstrated effectiveness have empirical support for the principles, theoretical framework, or components of the intervention. The specific interventions have usually not been evaluated using either random assignment or the use of control/comparison groups. For an intervention to be deemed a practice with demonstrated effectiveness, the empirical research must have shown that practices that contain similar components or similar principles have shown reductions of the program participants versus the comparison group(s) in at least one criminogenic need.

ARISE

Florida DJJ Ranking: Practice with Demonstrated Effectiveness

Program Author: Edmund and Susan Benson

Program Contact: www.ariselife-skills.org

824 US Highway 1, Suite 240

North Palm Beach, FL

33408

Overview: ARISE Life-Management Skills Program is a program that trains staff to conduct interactive ARISE Life-Management skill sessions with youth in their care. ARISE provides life-skill lessons including a broad range of topics:

Anger Management
Building Self Esteem
Handling Stress & Worry
Building a Support System
Guns, Drugs and Alcohol
Money Management
The Importance of Staying in School
Violence Reduction
Health Education
Conquering Fear
AIDS Education
Time Management
Nutrition and Exercise

The ARISE Life-Management Skills curricula is based on a cognitive behavior and social learning theory. It uses role playing and modeling to teach youth to control and manage anger, to make choices and changes in their behavior. The curriculum encourages group discussion where opinions are respected. The youth discuss the consequences of their actions and the actions of others in the group; enabling them to see beyond their choices.

Location: North Palm Beach, FL

Proven Recidivism Reduction: No

Criminogenic Need: Dependent on the workbooks chosen

Population: Male and female juveniles

Treatment Setting: Community-based or residential

Modality: Skills training in a group format

Training: ARISE trains line staff, counselors, therapists and educators on how to conduct ARISE Life-Management Skills Lessons with the youth at the facility. All staff learns how to manage a group setting, introduce the topic, and conduct interactive group discussions in a positive environment. Information is delivered in a non-judgmental method.

Certification:

ARISE Life-Skills Instructor
The ARISE Life-Skills Training certifies participants as ARISE Life-Skills Instructors (ALSIs).
Fees depend on the option chosen:
Option 1:
Individuals attend an ARISE scheduled training - seven (7) hours
with no curriculum materials $199.00.
With two (2) ARISE Life Skills Instructor Manuals $249.00.

Option 2:
Two full days: fourteen (14) hours of ARISE Life Management Skills Training and three (3) ARISE Life Management Skills Instructor Manuals**.** $399.00.

Option 3:
Onsite training at your location for a group of up to thirty (30) people $2,500.00 per day plus trainer travel expenses.

ARISE Master Life-Skills Trainer
ARISE Master Life-Skills Trainer is appropriate for building a well-run, structured, results-oriented program. This five-day intensive training certifies participants as ARISE Master Life Skills Trainers and enables them to conduct the ARISE two-day (14 hours) Life Skills Instructor Training to professionally certify their staff and colleagues as ARISE Life Skills Instructors. Graduates have the knowledge and confidence to train others to help troubled youth make fundamental changes in their lives.
Fees: $999 per person

Facilitators:

No degree requirements

Fidelity:

No checklists currently available

Bibliography:

http://www.ariselife-skills.org/Home/EvidenceBasedStudies.aspx

ARISE Life-Skills

Florida DJJ Ranking: Practice with Demonstrated Effectiveness

Program Author: Edmund and Susan Benson

Program Contact: www.ariselife-skills.org

824 US Highway 1, Suite 240
North Palm Beach, FL
33408

Overview: ARISE Life- Skills Program is a program that trains staff to conduct interactive ARISE Life-Skills sessions with youth in their care. The ARISE Life-Management Skills curriculum is based on cognitive behavioral and social learning theory. It uses role playing and modeling to teach youth to make choices and changes in their behavior. The curriculum encourages group discussion where opinions are respected. The youth discuss the consequences of their actions and the actions of others in the group; enabling them to see beyond their choices.

*The ARISE Life-Skills Program is one of the many curricula offered by ARISE. This particular subset of materials has been evaluated by an independent research entity in a quasi-experiment to examine effectiveness, and is therefore presented separately from the other ARISE materials in this Sourcebook.

Location: North Palm Beach, FL

Proven Recidivism Reduction: Yes

Criminogenic Need: Social Skills

Population: Male juveniles

Treatment Setting: Community-based or residential

Modality: Skills Training in a group format

Training: 2-day training ARISE Life-Skills Group Facilitator Training in which ARISE trains line staff, counselors, therapists and educators on how to conduct ARISE Life- Skills Lessons with the youth at the facility. All staff learns how to manage a group setting, introduce the topic, and conduct interactive group discussions in a positive environment. Information is delivered in a non-judgmental method.

A 5-day Life-Skills Master Training (Train the Trainer) certifies participants as ARISE Master Life Skills Trainers and enables them to conduct the ARISE two-day (14-hour) Life Skills Group Facilitator Training to professionally certify their staff and colleagues as ARISE Life Skills Group Facilitators. Graduates have the knowledge and confidence to train others to help troubled youth make fundamental changes in their lives.

Certification:

The ARISE Life-Skills Training certifies participants as ARISE Life-Skills Group Facilitators Fees depend on the option chosen:

Option 1: Individuals attend a training at an ARISE training location- fourteen (14) hours $299 per person.

Option 2: Onsite training at your location for a group of up to twenty (20) people $2,000.00 plus trainer travel expenses.

ARISE Master Life-Skills Trainer
ARISE Master Life-Skills Trainer is appropriate for building a well-run, structured, results-oriented program. This five-day intensive training certifies participants as ARISE Master Life Skills Trainers and enables them to conduct the ARISE two-day (14 hours) Life Skills Instructor Training to professionally certify their staff and colleagues as ARISE Life Skills Instructors. Graduates have the knowledge and confidence to train others to help troubled youth make fundamental changes in their lives.
Fees: $999 per person

Facilitators:

No degree requirements; ARISE Life-Skills training is required.

Fidelity:

No checklists currently available.

Bibliography:

http://www.ariselife-skills.org/Home/EvidenceBasedStudies.aspx

Justice Research Center, Inc. (2011). *ARISE: Providing valuable life skills and staff training to at-risk youth and the adults who care for them.* (Available at: http://at-riskyouth.org/about/evidence-based-studies/).

Big Brothers Big Sisters Mentoring Program

Florida DJJ Ranking: Practice with Demonstrated Effectiveness

Program Author: Big Brothers/Big Sisters

Program Contact: http://www.bigbrothersbigsisters.org

Overview:

The Big Brothers Big Sisters Mentoring Program is designed to help participating youth ages 6-18 ("Littles") reach their potential through supported matches with adult volunteer mentors ages 18 and older ("Bigs"). The program focuses on positive youth development, not specific problems, and the Big acts as a role model and provides guidance to the Little through a relationship that is based on trust and caring. The Big and Little agree to meet two to four times per month for at least a year, with get-togethers usually lasting 3 or 4 hours and consisting of mutually enjoyable activities.

Volunteers applying to be a Big are screened by local Big Brothers Big Sisters of America (BBBSA) agencies for potential safety risks, ability to commit the necessary time, and capability of forming positive relationships with youth. Approved volunteers undergo training, which includes presentations on the developmental stages of youth, communication and limit-setting skills, tips for building relationships, and recommendations on the best way to interact with their matched Little, whose racial, ethnic, or socioeconomic background may differ from that of the Big.

In matching Bigs and Littles, BBBSA agencies often consider practical factors, such as gender, geographic proximity, and availability, as well as the match preferences of volunteers, youth, and parents. Volunteers indicate the type of youth they would like to be matched with, noting age, race, and the types of activities they expect to engage in with the youth. Youth and their parents state their preference for volunteers, noting such factors as age, race, and religion, and youth also provide their activity preferences. Matching policies may vary across local BBBSA agencies, but in all cases, the parent must approve the match.

BBBSA staff and national operating standards guide implementation staff in screening, orienting, and training volunteers and youth and in creating and supervising the matches. The mentoring program emphasizes supervision to facilitate effective matches. For example, national requirements specify that organizations implementing the program must contact the parent, youth, and volunteer within 2 weeks of the match; maintain monthly telephone contact with the volunteer during the first year of the match; and maintain monthly contact with the parent and/or youth. In addition, implementers must contact the youth directly at least four times during the first year of the match; after the first year, contact with the participants can be reduced to once per quarter. Staff from local BBBSA agencies also support the match by providing guidance if problems arise in the Big-Little relationship.

Location:

Big Brothers Big Sisters of America
230 North 13th Street
Philadelphia, PA

Proven Recidivism Reduction: No

Criminogenic Need: Family Relationships; School Competence/Achievement; Aggression; Drug Use Initiation

Population: Male and Female "at-risk" juveniles 10-16 years of age

Treatment Setting: Community-based

Modality: Individual mentoring

Training: Membership fee required (includes standards of practice, affiliation agreement, parent and volunteer orientation guides, information for onboarding program staff, child protection materials, information for program performance managers, information on agency development for regional staff, and surveys): Varies depending on site resources (minimum of $150,000 per year for 3 years).

Role-specific training for various levels of staff: included with membership fee.

Certification: Contact the developer

Facilitators: No degree requirements

Fidelity: Available from the developer at: http://www.bigbrothersbigsisters.org

Bibliography:

Grossman, J. B., & Tierney, J. P. (1998). Does mentoring work? An impact of the Big Brothers Big Sisters program. Evaluation Review, 22(3), 403-426.

Tierney, J. P., Grossman, J. B., & Resch, N. L. (1995, November). Making a difference. An impact study of Big Brothers Big Sisters. Philadelphia, PA: Public/Private Ventures.

Corrective Thinking (Truthought)

Florida DJJ Ranking: Practice with Demonstrated Effectiveness

Program Author: Rogie Spon

Program Contact: Truthought LLC
www.truthought.com

Overview: The Corrective Thinking curriculum has a foundation in the work of Yochelson and Samenow (1977). All individuals have errors in thinking. A person who is responsible has the ability to identify their erroneous thought patterns and alter their cognitions while the irresponsible person will inflate their thinking errors and engage in criminal conduct. The Truthought method attempts to recognize problematic thoughts and behavior while generating positive solutions. The program concentrates on the identification of inappropriate thinking and how to adjust these thought patterns. Thinking barriers are then substituted with correctives. The curriculum involves youth in activities which identify nine thinking barriers and associated correctives.

Location: Roscoe, IL

Proven Recidivism Reduction: No

Criminogenic Need: Antisocial attitudes

Population: Male and female juveniles 12 years of age and older

Treatment Setting: Community-based or residential

Modality: Cognitive behavioral in a group format

Training: 3-day Truthought Certification Training (21 hours)

Certification: Certified Truthought Corrective Thinking Practitioner (TCTP)

Facilitators: No degree requirements

Fidelity: No checklists available, check Truthought website for updates

Bibliography:

Hubbard, D., & Latessa, E. (2004). Final Report: Evaluation of Cognitive-Behavioral Programs for Offenders: A Look at Outcome and Responsivity in Five Treatment Programs. Ohio Office of Criminal Justice Services.

Hubbard, D. (2002). Cognitive-Behavioral treatment: An analysis of gender and other responsivity characteristics and their effects on success in offender rehabilitation. Unpublished dissertation, University of Cincinnati.

Hudson, J. (2001). Perceived factors leading to a lack of recidivism among juvenile offenders. Unpublished Master's thesis, Northern State University.

Crossroads Juvenile Offender Curricula

Florida DJJ Ranking: Practice with Demonstrated Effectiveness

Program Author: National Curriculum and Training Institute, Inc. (NCTI)

Program Contact: www.NCTI.org

Phone: 1-800-622-1644

Overview: NCTI curricula and delivery techniques are designed to foster positive, pro-social behavior change in offenders. NCTI offers Cognitive Based Life Skills and Offense Specific Curricula.

Sample Crossroads Juvenile curricula include:

Cognitive Life Skills- In order for some young offenders to make behavior changes that will enable them to turn their lives around, they require an extended, more comprehensive program to help overcome negative habits and behavior. Cognitive Life Skills is that program.

Anger Management- The Anger Management program is designed to teach youth personal skills to deal responsibly with stress and frustration. It also demonstrates to them the need to acknowledge the consequences of their behavior.

Shoplifting- Understanding why a person shoplifts and learning to behave differently when similar circumstances arise, is the focus of this program. Youthful offenders will learn how certain attitudes can override a person's sense of right and wrong and cause behavior that is contrary to his or her beliefs.

Curfew- The Crossroads Curfew program is based on a foundation of values, attitudes and behavior. The program addresses a range of issues commonly encountered by adolescents. Offenders learn how to avoid negative peer influences, handle stress, take responsibility for themselves, and balance their need for freedom with a respect for authority and the law.

Drugs and Alcohol- This program is based on research that has identified a range of problems that are most commonly present when experimentation with drugs and/or alcohol begins. The program focuses on the areas of self-esteem, interpersonal relationships, work ethic, self-direction and alternatives.

Gang Involvement- Gang involvement is one of the most dangerous steps young people can take towards ruining their lives and their futures. This dynamic, interactive program helps gang members and at-risk youth examine their reasons for being in a gang or desiring to join. Alternative methods of achieving social and/or economic goals are explored, as are the consequences of gang membership.

Misdemeanor Offenses- The program builds a foundation based on values, attitudes and behavior. The broad scope addresses issues most commonly encountered by these individuals. Participants learn how to avoid negative influences, handle stress effectively and take responsibility for themselves.

Parenting- The program helps parents determine the reasons why their children are misbehaving, and teaches parenting based on consequences for actions.

Truancy- There are two levels of Truancy curricula aimed at helping youth understand the relevance of school and prompting them to set concrete goals for graduation. Youth learn skills that are necessary to be successful in school. Youth explore the effects today's choices have on their future. The techniques of setting and reaching goals are also taught to assist youth in becoming successful in school.

Location: NCTI, 319 East McDowell Rd.,
Suite 200 • Phoenix, AZ 85004-1534

Proven Recidivism Reduction: No

Criminogenic Need: Dependent on curriculum selected (see sample curricula above)

Population: Male and female juveniles offenders

Treatment Setting: Community-based or Residential

Modality: Cognitive Behavioral in a group format

Training: NCTI requires Certification Training to ensure fidelity in the delivery of the curricula. The American Probation and Parole Association (APPA) in partnership with the National Curriculum and Training Institute®, Inc. (NCTI) present Facilitator Certification Training to deliver cognitive behavior change curricula.

Certification: Certified Cognitive Facilitator

Facilitators: No degree requirements

Fidelity: Checklists available

Bibliography:

Morrow, P.K. (1996). A research study to determine the effect of the Crossroads Program on offenders supervised by the Maroicopa County Adult Probation Department. A master's thesis to the University of Phoenix.

National Curriculum and Training Institute. (2007). NCTI/Maricopa County Juvenile Probation Department: Cognitive Based Life Skills Programs Intervention Study 2003-2004/2006-2007 Longitudinal Recidivism Review.

Girls Circle

Florida DJJ Ranking: Practice with Demonstrated Effectiveness

Program Author: Beth Hossfeld and Giovanna Taormina

Program Contact: http://www.girlscircle.com/

Overview: Girls' Circle is a structured support group for girls from 9-18 years that integrates relational theory, resiliency practices, and skills training in a specific format designed to increase connection, strengths, and competence in girls. It is designed to foster self-awareness and self-confidence, help girls maintain authentic connection with peers and adult women in their community, counter trends toward self-doubt, and allow for genuine self-expression through verbal sharing and creative activity.

Location: Cotati, CA

Proven Recidivism Reduction: No

Criminogenic Need: Attachment to school, Alcohol use, Self-harming behavior, Self-efficacy

Population: Female juveniles age 9-18

Treatment Setting: Community-based or Residential

Modality: Group counseling; Gender-specific approach

Training: Both the Initial and Advanced Facilitator Trainings are two full days, from 8:00am-4:30pm and attendance on both days is mandatory for certification.

Certification: Facilitator, Advanced Facilitator

Facilitators: No degree requirement

Fidelity: No fidelity checklists currently available

Bibliography:

Hossfeld, B., (2006). Developing Friendships and Peer Relationships: Building Social Support with the Girls Circle Program. In C. LeCroy, & J. Mann, (Eds.), *Handbook of Prevention and Intervention Programs for Adolescent Girls*, Hoboken, NJ: Wiley & Sons.

Rough, J., & Matthews, G. (2005). *Understanding the Intervention of Girls Circle on Friendship Quality and Self-Efficacy: A Replication and extension.* Unpublished manuscript, Dominican University of California, San Rafael.

Steese, S., Dollette, M., Phillips, W. Hossfeld, B., & Taormina, G. (2006). Understanding Girls' Circle as an Intervention on Perceived Social Support, Body Image, Self-Efficacy, Locus of Control and Self-Esteem. *Adolescence,* Vol. 41 (161).

Girls Moving On

Florida DJJ Ranking: Practice with Demonstrated Effectiveness

Program Author: Marylyn VanDieten, Ph.D.

Program Contact: www.Orbispartners.com

Overview: Moving On™ focuses on responsivity issues for women offenders. The structured program provides women with alternatives to criminal activity by helping to identify and mobilize both personal and community resources. The program is based on an educational and cognitive skills-building approach and can be delivered over 9 – to –13 weeks in small groups or on an individual basis by trained correctional practitioners.

Location: Toronto, Canada

Proven Recidivism Reduction: No

Criminogenic Need: Gender-specific services/responsivity issues

Population: Female juveniles

Treatment Setting: Community-based or Residential

Modality: Cognitive Behavioral using both an individual session and group format

Training: 5-day training

Certification: Certification available

Facilitators: No degree requirement

Fidelity: Fidelity checklists, participant satisfaction and feedback surveys

Bibliography:

Gehring, K., Van Voorhis, P., and Bell, V. (2008). A Quasi Experimental Study of "Moving On": A Gender-Responsive Program for Women Offenders. Paper presented at the American Society of Criminology Conference, St. Louis, MI.

Gehring, K., Van Voorhis, P., and Bell, V. (2010). "What Works" for female probationers? An evaluation of the Moving On program. University of Cincinnati.

Impact of Crime: Addressing the Harm to Victims and the Community

Florida DJJ Ranking: Promising Practice

Program Author: Florida Department of Juvenile Justice

Program Contact: Residential Services, Florida Department of Juvenile Justice

Overview: Restorative Justice is based on the belief that crime is more than just a legal definition, but rather crime affects the victim, the offender, their families, and the community. The harm caused brings with it the moral responsibility to all involved. The main focus of Restorative Justice is to help offenders understand the harm they have created, and then assisting them in taking personal accountability for their actions. Together, the victim, offender, and the community arrive at a viable solution to the repair the harm caused and the offender, once the harm is repaired, is subsequently reintegrated back into the community.

Impact of Crime: Addressing the Harm to Victims and the Community is a revised curriculum that was updated in 2009. The revised Impact of Crime is a victim impact/restorative justice curriculum consisting of 7 Chapters taking approximately 24 sessions to facilitate. Impact of Crime groups should consist of 5-12 youth. Facilitators are encouraged to bring in victim impact speakers throughout the course of the curriculum.

Location: Tallahassee, FL

Proven Recidivism Reduction: No

Criminogenic Need: Antisocial Attitudes; Social Skills; Aggression

Population: Male and female juveniles

Treatment Setting: Residential

Modality: Skills training in a group format

Training: Standard training includes:
31/2 -day facilitator training (24 training hours credit)

Certification: Certificate upon completion from Residential Services

Facilitators: No degree requirements

Fidelity: Checklists available

Bibliography:

Baglivio, Michael, & Jackowski, Katherine. (2013). Evaluating the effectiveness of a victim impact intervention through examination of changes in dynamic risk scores. *Criminal Justice Policy Review*, June 7, 2013, doi: 10.1177/0887403413489706.

New Freedom / Phoenix

Florida DJJ Ranking: Practice with Demonstrated Effectiveness

Program Author: Paul Alton, Ed.D.

Program Contact:
www.newfreedomprograms.com
www.phoenixcurriculu.com
www.gangprograms.com

New Freedom A.R. Phoenix Resources, Inc.
79 Pine Street #246
New York, NY
10005

Overview: New Freedom/Phoenix sources build on cognitive-behavioral (CBT), motivation enhancement (MET), risk factors management, relapse prevention, and social learning treatment concepts.

These materials provide a logical progression, addressing defensiveness, then cognitive change issues, addressing thoughts and feelings. When the client is ready to learn new approaches, the resources provide guidance in mastering new problem solving, thinking, and coping skills. A critical goal is increasing self-confidence and resilience (self-efficacy) in addressing client-specific risk factors - a critical part of the relapse prevention.

New Freedom/Phoenix curriculums utilize workbooks that stress skill development through the use of activities and homework. The reading level of the material is 4-6th grade. Materials address cognitive change, problem identification, problem solving, and coping skills. New Freedom/Phoenix programs can be tailored specifically to the needs of a site or custom designed.

Location: New York, NY

Proven Recidivism Reduction: No

Criminogenic Need: Antisocial attitudes, delinquent peer influence, substance abuse

Population: Male and female juveniles

Treatment Setting: Community-based or Residential

Modality: Cognitive behavioral in a group format

Training: Training is provided through newfreedom@inch.com

Certification: N/A

Facilitators: No degree requirements

Fidelity: Fidelity checklists/ pre-post tests are available

Bibliography: Check www.newfreedomprograms.com for updates

Reasoning and Reacting

Florida DJJ Ranking: Practice with Demonstrated Effectiveness

Program Author: Elizabeth Fabiano, M.C.A. & Frank Porporino, Ph.D.

Program Contact: http://www.t3.ca

Overview: Reasoning and Reacting is based conceptually on the R&R Revised program, although it was designed specifically for at-risk adolescents and youthful offenders. In 60 structured, one-hour sessions, the program attempts to replace entrenched adolescent thinking patterns with cognitive skills that can promote pro-social behavioral choices. A major emphasis on the program is on teaching youth to become more reflective rather than reactive, more anticipatory and prepared in their responses to potential problems, and more flexible, open-minded, reasoned and deliberate in their thinking in general. The program focuses on modifying the often impulsive, illogical, and sometimes very rigid thinking of many youth by teaching them, in short, to first "reason" before "reacting". It is being implemented broadly as a prevention program throughout the educational system in Norway and as an intervention for delinquent youth in Canada, the US and Scotland.

Location: Ottawa, Canada

Proven Recidivism Reduction: No

Criminogenic Need: Antisocial attitudes

Population: Male and female juveniles 14 to 18 years of age

Treatment Setting: Community-based or Residential

Modality: Cognitive Behavioral in a group format

Training: Contact T3 Associates

Certification: Contact T3 Associates

Facilitators: No degree requirements

Fidelity: No checklists available at this time

Bibliography:

Wilson, R. (2005). Are cognitive problem-solving skills programs really not working? A response to 'evaluating evidence for the effectiveness of Reasoning and Rehabilitation Program'. *The Howard Journal,* 44(3), 319-321.

Wilkinson, J. (2005). Evaluating evidence for the effectiveness of Reasoning and Rehabilitation Program. *The Howard Journal,* 44(1), 70-85.

Ross, R., Fabiano, E., and Ewles, C. (1988). Reasoning and Rehabilitation. *International Journal of Offender Therapy and Comparative Criminology,* 32, 29-35.

Pullen, S. (1996). Evaluation of the Reasoning and Rehabilitation Cognitive Skills Development Program as Implemented in Juvenile ISP in Colorado. Prepared by the Colorado Division of Criminal Justice.

Skillstreaming the Adolescent

Florida DJJ Ranking: Practice with Demonstrated Effectiveness

Program Author: Goldstein, Arnold & McGinnis, Ellen

Program Contact: http://www.skillstreaming.com/

Phone: (217) 352-3273; 1-800-519-2707

Overview: *Skillstreaming the Adolescent* employs a four-part training approach—modeling, role-playing, performance feedback, and generalization—to teach essential prosocial skills to adolescents. The curriculum provides a complete description of the Skillstreaming intervention, with instructions for teaching 50 prosocial skills.

Skill Areas

- Classroom Survival Skills
- Friendship-Making Skills
- Skills for Dealing with Feelings
- Skill Alternatives to Aggression
- Skills for Dealing with Stress

Location: Research Press
Dept. 11W
P.O. Box 9177
Champaign, IL 61826
U.S.A.

Proven Recidivism Reduction: No

Criminogenic Need: Antisocial Attitudes, Values, and Beliefs

Population: Male and female juveniles offenders

Treatment Setting: Community-based or Residential

Modality: Cognitive Behavioral in a group format

Training: Curriculum and implementation materials available from Research Press.
In-service training or workshops can be provided. For more information and available dates, please contact:
Mark Amendola
Perseus House
1511 Peach Street
Erie, Pennsylvania 16501
U.S.A.
Phone 814-480-5900, ext. 288
E-Mail: mamendola@perseushouse.org

Sheldon Braaten Ph.D.
Behavioral Institute for Children and Adolescents
1711 County Road B West, Suite 110S
Roseville, Minnesota 55113
U.S.A.
Phone: 651-484-5510
E-Mail: info@behavioralinstitute.org

Certification: None

Facilitators: No degree requirements

Fidelity: Checklists available

Bibliography:

Lipsey, M.W. (2009). The Primary Factors that Characterize Effective Interventions with Juvenile Offenders: A Meta-Analytic Overview. *Victims and Offenders,* 4: 124-147.

Landenberger, N, & Lipsey, M. (2005). The positive effects of cognitive-behavioral programs for offenders: A meta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology,* 1, pp.451-476.

Berlin, R.J. (1979). *Teaching acting-out adolescents prosocial conflict resolution with Structured Learning Therapy.* Unpublished
doctoral dissertation, Syracuse University.

Goldstein, A.P. (1981). *Psychological skill training: The Structured Learning technique.* New York: Pergamon.

Strong African American Families (SAAF)

Florida DJJ Ranking: Practice with Demonstrated Effectiveness

Program Author: Dr. Grange

Program Contact: http://www.cfr.uga.edu/saaf1

Dr. Christina Grange at 1-888-542-3068 or cgrange@uga.edu

Overview: Strong African American Families (SAAF) is a culturally tailored, family-centered intervention for 10- to 14-year-old African American youths and their primary caregivers. The goal of SAAF is to prevent substance use and behavior problems among youth by strengthening positive family interactions, preparing youths for their teen years, and enhancing primary caregivers' efforts to help youths reach positive goals.

Facilitators administer SAAF through seven 2-hour sessions using separate skill-building curricula for youths and primary caregivers. Sessions can be implemented at any time during the week, including weekends. During the first hour of each session, youths and primary caregivers meet separately with facilitators. Topics addressed in the youth sessions include the importance of following house rules; adaptive ways of responding to racism; the formation of goals for the future and plans to attain them; and skills for resisting early sexual involvement, substance use, and other risk behaviors. The primary caregiver sessions address ways in which the caregivers can monitor their children's behavior; encourage adaptive strategies for their children to respond to racism; and develop adaptive communication skills for discussing sex, substance use, and other risk behaviors. During the second hour of each session, youths and primary caregivers meet as a family with the facilitator and build on what was learned in the separate sessions. In the family sessions, facilitators work with families to build family-based strengths for supporting the youth's goals, enhancing racial pride, and improving communication and support.

SAAF is usually offered at schools and community facilities, and it should be implemented by trained facilitators who have experience working with families and youths. In the study reviewed for this summary, the intervention was provided to 5th-grade students and their primary caregivers.

Location: Center for Family Research, University of Georgia

Proven Recidivism Reduction: No

Criminogenic Need: Criminal behavior (self-reported); Alcohol use

Population: Male and female African American juveniles and caregivers

Treatment Setting: Community-based

Modality: Group format

Training: Standard training for $7,000 includes:
3-day, on-site facilitator training for up to 30 participants; SAAF Program Pack (includes program materials on CD-ROM, training materials, and promotional video and session-specific information on DVDs); technical assistance and consultation

Certification: Contact the developer

Facilitators: No degree requirements

Fidelity: Available from the developer at: http://www.cfr.uga.edu/saaf1

Bibliography:

Brody, G. H., Chen, Y.-F., Kogan, S. M., Murry, V. M., & Brown, A. C. (2010). Long-term effects of the Strong African American Families program on youths' alcohol use. Journal of Consulting and Clinical Psychology, 78(2), 281-285.

Brody, G. H., Kogan, S. M., Chen, Y., & Murry, V. M. (2008). Long-term effects of the Strong African American Families program on youths' conduct problems. Journal of Adolescent Health, 43(5), 474-481.

Brody, G. H., Murry, V. M., Gerrard, M., Gibbons, F. X., Molgaard, V., McNair, L., et al. (2004). The Strong African American Families program: Translating research into prevention programming. Child Development, 75(3), 900-917.

Brody, G. H., Murry, V. M., Kogan, S. M., Gerrard, M., Gibbons, F. X., Molgaard, V., et al. (2006). The Strong African American Families program: A cluster-randomized prevention trial of long-term effects and a mediational model. Journal of Consulting and Clinical Psychology, 74(2), 356-366.

The Council for Boys and Young Men (Previously Boys Council)

Florida DJJ Ranking: Practice with Demonstrated Effectiveness

Program Author: Beth Hossfeld, R. Gibraltarik, M. Bowers, & G. Taormina

Program Contact: http://www.oncirclefoundation.org
(415) 419-5119

Overview: A strengths-based group approach to promote boys' and young men's safe and healthy passage through pre-teen and adolescent years. The Council meets a core developmental need in boys for strong, positive relationships. In a structured environment, boys and young men gain the vital opportunity to address masculine definitions and behaviors and build their capacities to find their innate value and create good lives - individually and collectively. In a safe and action-oriented context, boys can identify the positive and not-so-positive definitions about being male today. They are invited to define the "male box" that shapes and constricts their growth. The Council lets boys examine the messages that define being male, and gives boys new and different options for self-expression and team experiences, promoting skill building and safe, healthy, positive, strong and diverse identities.

Each week, a group of six to ten (6-10) boys of similar age and development meet with one or two facilitators for 1.5 to 2 hours. These meetings are held for ten weeks or more. Each of the group sessions are expected to proceed in order with the following: An opening ritual, theme introduction, warm-up activities, a "council" type check-in opportunity, experiential activities that address gender relevant topics, a reflection and group dialogue component, and a closing ritual.

There are three distinct *The Council* curriculum guides -- Standing Together: A Journey into Respect (for Ages 9 – 14), Growing Healthy, Growing Strong (for Ages 9 – 14), and Living a Legacy: A The Council Rite of Passage (for Ages 14 – 18). The curricula differ only in their respective 10-week themes and activities.

Location: 734 A Street, Suite 4, San Rafael, CA 94901

Proven Recidivism Reduction: No

Criminogenic Need: Increased school engagement, antisocial attitudes, self-efficacy

Population: Male juveniles age 9-18

Treatment Setting: Community-based or residential

Modality: Group counseling format; Gender-specific approach

Training: The Council for Boys and Young Men Facilitator Trainings are two full days, from 8:30am-4:30pm (13 hours of training) and attendance on both days is mandatory for certification.

Certification: Facilitator

Facilitators: No degree requirement

Fidelity: No fidelity checklists currently available

Bibliography:

Gray, M. (2012). "Man Up": A Longitudinal Evaluation of Adherence to Traditional Masculinity among Racially/Ethnically Diverse Adolescent Inmates. Doctoral dissertation, Portland State University.

Gray, M., Braun, M., Galvez, G., Leach, A., Finney, B., Garcia, T., Boal, A., & Mankowski, E. (2008). *An Evaluation of Boys Council: Final Report.* Portland State University, Department of Psychology.

Hossfeld, B., Gibraltarik, R., Bowers, M., and Taormina, G. (2008). Boys Council Facilitator Manual: Promoting Resiliency in Adolescent Boys. Boys Council, A Division of GCA/Tides: Cotati, CA.

Mankowski, E., Gray, M. Viola, W., Vance, K., Lenseigne, L., Wheeler, J., Miles, R., & Jones, C. (2011). *The Council for Boys and Young Men: An Assessment of Effectiveness in the Ohio Department of Youth Services, Final Phase II Report.* Portland State University, Department of Psychology.

YouthBuild

Florida DJJ Ranking: Practice with Demonstrated Effectiveness

Program Author: **YouthBuild USA**

Program Contact: **www.youthbuild.org/start**

Boston (617) 623-990;
South Carolina (843) 569-2662;
Illinois (773) 329-3450

Overview: Founded in 1990, YouthBuild USA is a national non-profit organization. YouthBuild is a youth and community development program that simultaneously addresses core issues facing low-income communities: housing, education, employment, crime prevention, and leadership development.

The YouthBuild intervention consists of the following four components: Education, counseling, job skills, and construction.

The intervention is a 9- to 24-month, full-time YouthBuild program where youth spend half of their time learning construction trade skills by building or rehabilitating housing for low-income populations; the other half of their time is spent in a YouthBuild classroom earning a high school diploma or equivalency degree. Personal counseling and training in life skills and financial management are provided. The students are part of a mini-community of adults and youth committed to each other's success and to improving the conditions in their neighborhoods.

Participants attend an alternative school to work towards a GED or high school diploma as part of the intervention.
Participants also work on construction/renovation of houses in low income areas.

Location: Somerville, MA

Proven Recidivism Reduction: Yes

Criminogenic Need: Educational attainment, Employment

Population: 16-24 years old low income youth involved in the juvenile justice system

Treatment Setting: Community-based/ alternative school/ construction

Modality: Job skills training, alternative school education, construction site, counseling components

Training: Visit **www.youthbuild.org/start** for start-up information and requirements.

Certification: Potential providers are required to procure funding (competitive grants) and be a recognized YouthBuild site.

Facilitators: Must be a recognized YouthBuild site.

Fidelity:

Start-up assistance available from:
YouthBuild Fee for Service
58 Day Street
Sommerville, MA, 02144
www.youthbuild.org/start

Bibliography:

Cohen, M.A., & Piquero, A.R. (2008). Costs and Benefits of a Targeted Intervention Program for Youthful Offenders: The YouthBuild USA Offender Project.

Social Policy Research Associates. (2009). *Evaluation of the YouthBuild Youth Offender Grants.* Prepared for the U.S. Department of Labor, Employment and Training
Administration, Office of Policy Development and Research, by Social Policy Research Associates. Available at: http://wdr.doleta.gov/research/FullText_Documents/Evaluation%20of%20the%20YouthBuild%20Youth%20Offender%20Grants%20-%20Final%20Report.pdf.