Prevention Strategies:

A Research Guide to What Works

ental Research and Programs, Inc.

CTC Prevention Strategies: A Research Guide to What Works

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This guide is a tool for developing a long-range comprehensive prevention plan, using research-based promising approaches to guide programming decisions.

Once your community has identified gaps in resources and services addressing priority risk factors and protective factors that need to be strengthened, you can use the guide to learn about programs and strategies that have demonstrated effectiveness in reducing those risk factors while enhancing protective factors.

The charts on the following pages provide a quick overview of the Promising Approaches covered in this guide. Although we recommend that you become familiar with the whole guide, these charts can help you identify the specific sections of the guide you need to investigate in depth. The charts list the nineteen risk factors by domain. By locating each of your priority risk factors on the charts, you will be able to determine the program strategies that address that risk factor. The charts can also help you identify strategies that can address several of your priority risk factors. More detailed charts can be found in the Appendix Section.

Further information on how to use the guide can be found in the Introduction section.

Community Domain

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Family Domain

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Individual/Peer Domain

Communities That Care

What is *Communities That Care?*

Communities That Care (CTC) is a comprehensive, research-based community mobilization and planning process that fights youth health and behavior problems by reducing risks while creating bonds between young people and their families, their schools, their communities and their peers. CTC provides the framework for communities to mobilize schools, families, community agencies and organizations, local media, and young people themselves to work toward the common goal of creating a safe, supportive environment for all young people.

CTC is based on over 10 years of extensive research on the factors that place young people at risk for substance abuse, delinquency, teen pregnancy, school dropout, and violence, and on the protective factors that buffer them from exposure to risk. This public health approach to prevention has been used successfully to address such diverse problems as heart disease, preventive dental care, bicycle safety, and smoking.

How does CTC work?

Communities That Care helps mobilize the **whole community** to fight youth problems by building a web of support for young people from birth through adolescence. CTC helps communities:

- involve all the stakeholders in the community in fighting youth problems
- build or strengthen community coalitions to maximize resources
- overcome barriers to prevention
- assess levels of risk and current resources addressing those risks
- prioritize risks for immediate action
- reduce risks while enhancing protection for young people
- evaluate programs, both existing and new, according to research-based criteria
- institutionalize prevention in the community

Communities using the CTC process move through three phases:

Phase One—Introduce and Involve

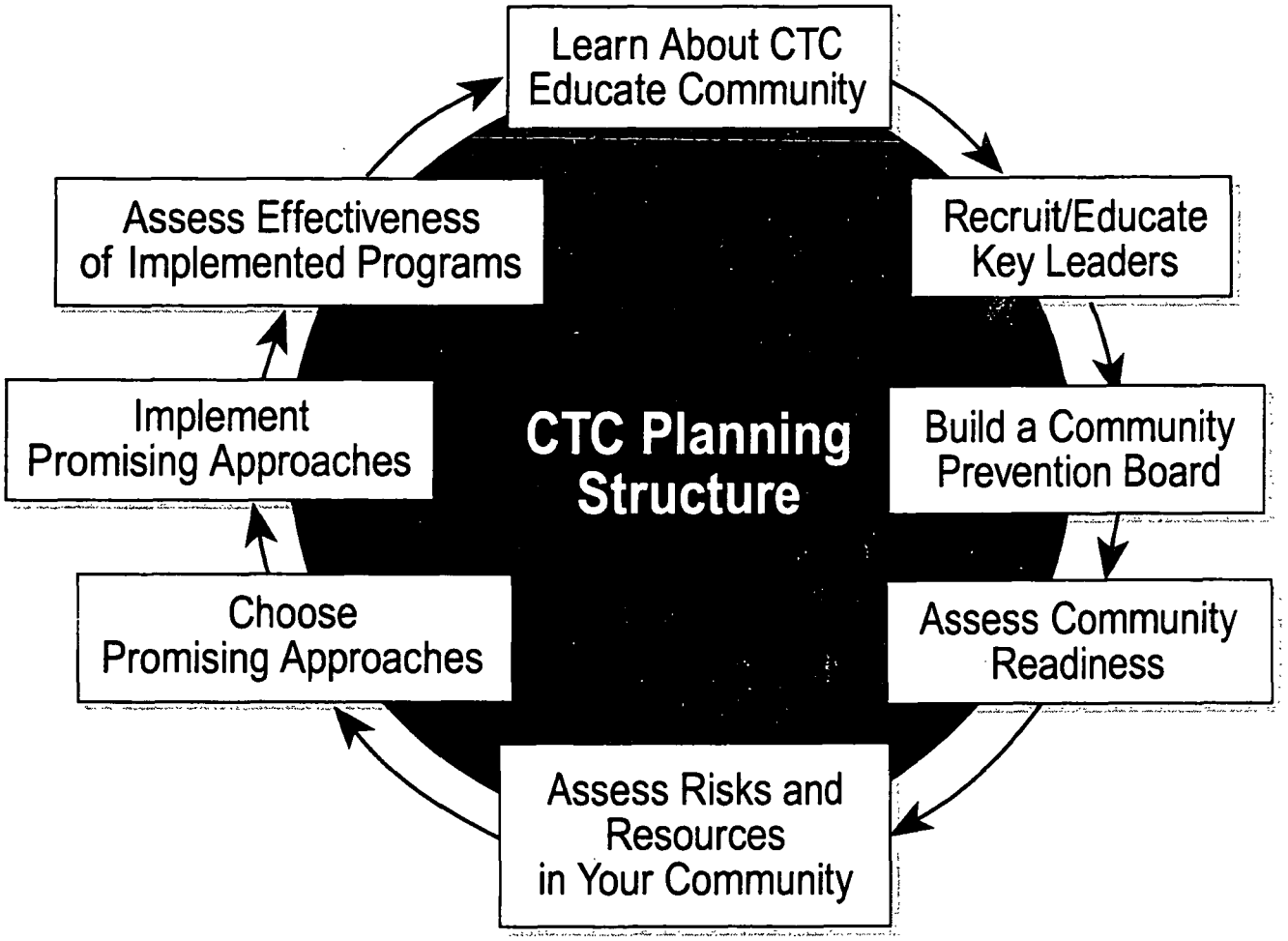
This phase provides the foundation for all the community's prevention efforts. The process of building community support and ownership is as critical to successful prevention as the programs a community implements. It includes 1) involving and educating key community leaders who provide critical leadership, credibility and access to resources, 2) creating a community prevention board, the working group whose members represent all the significant areas affecting young people's lives as well as representing the diversity of the community, and 3) assessing community readiness for risk and protective factor-focused prevention and developing a strategy for addressing readiness issues.

Phase Two—Risk and Resource Assessment

This phase involves 1) collecting and analyzing data on specific risk factors in the community 2) selecting 2-5 priority risk factors on which the community will focus its prevention plan, and 3) collecting and assessing information on existing community resources that may be addressing the priority risk factors. This assessment phase provides the foundation for objective community decision-making as well as establishing baseline data to help evaluate the effects of prevention efforts.

Phase Three—Promising Approaches

In this third phase of CTC communities 1) identify gaps in existing programs and services addressing priority risks, 2) develop a long-range plan for filling these gaps by modifying, strengthening, or expanding existing resources and/or implementing new research-based promising approaches, 3) begin implementing the long-range plan and 4) evaluate the effectiveness of prevention efforts.



Promising Approaches

Introduction to *Prevention Strategies: A Research Guide to What Works*

This guide provides information on research-based strategies that have been found to be effective in each of four areas:

- **Family Focus**
- **School Focus**
- **Community-Based Youth Programs Focus**
- **Community Focus**

The first three areas are presented developmentally, beginning with prenatal and infancy programs through programs for adolescents. The community strategies address the community as the context for behavior and action.

For each strategy described in the four focus areas, the critical components for reducing risk and enhancing protection are highlighted. Where available, specific program examples are described. Some example programs are distributed nationally and contact information is provided for each of these programs. Other promising approaches were developed as part of research projects and are not directly available. For these programs, references are provided so that communities wanting more detailed descriptions can consult the original source. Resource and reference information can be found at the end of each section.

What are Promising Approaches?

Promising Approaches are prevention strategies that have been shown in high quality research tests to be effective in reducing known risk factors and enhancing protective factors for adolescent health and behavior problems.

What criteria were used to select these Promising Approaches?

All of the programs presented in Promising Approaches:

✔ **Address research-based risk factors** for substance abuse, delinquency, teen pregnancy, school dropout, and violence.

✔ **Increase protective factors** by 1) strengthening *healthy beliefs and clear standards* for behavior or, 2) building *bonding* to family, community, school, and/or positive peers by providing *opportunities* for meaningful contribution, teaching *skills* necessary for contributing, and *recognizing* skillful performance.

✔ **Intervene at a developmentally appropriate age.**

✔ **Have shown positive effects in high-quality tests.** These programs have demonstrated significant effects on risk and protective factors in controlled studies or community

trials. Some have also shown positive effects on health and behavior problems.

How can Promising Approaches be used as part of a comprehensive prevention strategy?

To effectively reduce adolescent problem behaviors, communities must design and implement a long-term, comprehensive prevention plan that addresses priority risks for all children–across domains and throughout development. The Promising Approaches outlined in this manual can be used in several ways in designing a comprehensive plan:

- **As a standard by which existing programs can be evaluated.** For example, if your community currently has a program for parents of children in the upper elementary grades, you could assess that program's effectiveness at addressing your priority risks by comparing the information given in this manual about *Preparing for the Drug Free Years* with information about your parent training program.

- **To identify ways to modify or adapt existing programs.** For example, if your community has an existing mentoring program and you want to ensure its effectiveness at reducing risks and enhancing protection, you could use the information given in this manual about *mentoring* to extract the specific components that make mentoring programs effective and apply them to your program.

- **As a source of programs that can effectively fill identified gaps.** For example, if your priority risk factor is Family Conflict and your resource assessment indicated that all of the marital therapy programs in your community are directed at couples who are already experiencing marital difficulty, you may want to use the Premarital Relationship Enhancement Program (PREP) to provide skills for couples *before* they get married.

What kinds of effects have these Promising Approaches achieved?

The programs highlighted in this guide were selected for their effectiveness in addressing known risk factors while enhancing protective factors. Here are some examples of the effects they have produced.

Howard Markman's Prevention and Relationship Enhancement Program (PREP) significantly reduced family conflict and prevented divorce five years later by teaching couples communication skills **before** they got married (page 9).

David Olds' Prenatal/Early Infancy Project, a comprehensive home visitation program for low-income mothers during pregnancy and early infancy, reduced child abuse rates to 4% compared with 19% in the control group. Participants also had twice the rate of high school graduation, increased employment, and delayed subsequent pregnancies (page 11).

David Weikart's High/Scope Perry Preschool Program reduced later violent behavior by 50% and arrests by age nineteen by 40%. The early childhood education program also was followed by better academic achievement, higher rates of high school completion, better employment rates and fewer pregnancies for females (page 21).

Robert Felner's School Transition Environment Project (STEP), a program aimed at easing

the transition from middle school to high school, reduced dropout rates from 43% to 21% and was particularly effective for students who did poorly in school (page 43).

David Hawkins' and Richard Catalano's Seattle Social Development Project, which included parent training and teacher training, produced positive effects on academic achievement and commitment to schooling and significant reductions in school misbehavior, including suspensions and expulsions. The long-term effects of SSDP included significant reductions in violent criminal behavior, teen sexual activity and teen pregnancy (page 55).

Brenna Bry's Behavioral Monitoring and Reinforcement of Attendance, Academic Progress and School Behavior, tested with disruptive 7th grade students, produced significantly better grades and attendance, fewer school problem behaviors, and fewer students with official juvenile records five years after the program ended (page 69).

An evaluation of **New Jersey's Graves Amendment,** which mandated a minimum prison sentence for serious crimes in which a firearm was carried or used, showed lower annual rates of firearm homicides (page 93).

This guide contains additional information about these Promising Approaches and more.

How is the Guide structured?

Promising Approaches are presented by ***focus areas***; 1) Family Focus, 2) School Focus, 3) Community-Based Youth Programs Focus, 4) Community Focus. Each ***focus area*** is then further divided into broad ***strategies***, with ***example programs*** for each of the strategies. The following example will help familiarize you with the Guide's basic structure:

- Each focus area is divided into separate sections for each ***strategy.*** The Family Focus area is divided into five strategies, presented developmentally; 1) Marital Therapy, 2) Prenatal and Infancy, 3) Early Childhood Education, 4) Parent Training, 5) Marital Therapy.

- Turn to page 24 of the Family Focus Tab– Parent Training. The ***strategy*** described here is Parent Training. This page gives an overview of the strategy.

- The first box on page 24 shows the ***risk factors*** that may be addressed by programs within this strategy.

- Following the overview of Parent Training, you will find ***example programs*** within the "Parent Training" strategy, beginning with *The Houston Parent-Child Development Center Program.*

- Above the name of the example program, you will see a developmental bar that highlights the age for which the program is designed. For the Houston Parent-Child Development Center Program, zero to two years is highlighted on the bar.

- The "Social Development Strategy in Action" box highlights the protective factors addressed by the program. The Houston Parent-Child Development Center Program addresses the protective factors of *healthy beliefs and clear standards* and *bonding,* through *opportunities, skills* and *recognition.*

- The description of the program includes the risk factors addressed and outcomes demonstrated by the program.

- Each focus area includes a **Resources and References** section, located at the end of the focus area, right before the next tab. The **Resources** section provides contact information for each promising approach that is available to communities, as well as additional resources where available. Some of the promising approaches described in the Guide were developed as part of research projects and are not directly available. The **References** section provides citations for each promising approach described so that communities interested in additional information can consult the original source.

The last tab in the guide is an appendix section that contains two cross-referenced charts. The first chart displays promising approaches by risk factor addressed. The second chart shows the promising approaches by developmental stage addressed. Both of these charts can help your community ensure that your prevention programming is as comprehensive as possible.

A bibliography in the appendix section provides complete references for the Guide.

Family Focus

The family into which a child is born has the first opportunity to build a web of protection for the child. That web can buffer against risks for problem behaviors. Throughout a child's life, commitment to healthy beliefs and clear standards for behavior learned in the family remains a powerful source for healthy development.

Marital Therapy

Prevention can begin before a child is born–in fact, before the child is even conceived. Skills-based therapy with couples who are not experiencing relationship difficulties can help prevent later family conflict. Longitudinal studies by Howard Markman (1984, 1988, 1993) indicate that the quality of communication before marriage and before the development of distress in the relationship is one of the best predictors of future marital distress. Successful programs teach couples skills for effective communication, constructive handling of disagreements and problem-solving; and provide opportunities to practice new skills with coaching from a therapist/consultant.

Marital therapy can be offered through churches, mental health/counseling agencies, hospitals, community service agencies, university student support programs, or private organizations. Reaching couples at high risk for marital distress may involve expanding such services into community centers, housing communities, neighborhood schools, or other accessible locations. Many churches that offer premarital counseling require such counseling as a prerequisite for being married in the church. Communities may choose to require such training before a marriage license in issued.

Risk Factors That May Be Addressed

Family Conflict

Marital therapy programs must be sensitive to cultural differences in communication styles and marital relationship structures. Recruitment of therapists/group leaders familiar with the population to be served is critical to program success.

Following is an example of an effective marital therapy program.

The Prevention and Relationship Enhancement Program

Protective Factors Addressed: Healthy beliefs and clear standards are established for family communication and problem-solving. Bonding between marital partners through opportunities to contribute to the marital relationship, skills for successful problem-solving and communication, and reinforcement for successful skill mastery.

The Prevention and Relationship Enhancement Program (PREP) is designed to address the **family conflict** risk factor by preventing marital distress and divorced in couples planning marriage.

Program participants attend either six 2 to 2 1/2 hour weekly sessions in groups of four to eight couples or a weekend setting with twenty to forty couples. They hear lectures on communication skills, research personal relationship issues, and privately practice new skills. A communications consultant coaches couples as they master the new skills. Videotapes are also used to teach couples communication skills.

PREP couples reported greater relationship satisfaction, fewer relationship problems, fewer sexual difficulties, less problem intensity, less conflict, less overall negative communication, and greater numbers of problem-solving behaviors. PREP couples also reported fewer instances of physical violence with their spouse than did control couples. At 5-year follow-up, 8% of PREP couples had divorced compared to 19% of control couples (Markman et al., 1993)

Prenatal and Infancy Programs

Prenatal and infancy programs offer support and guidance to parents and their newborn at a critical time of physical growth and psychological development. Currently, up to half of urban newborns are at risk for later developmental and behavioral problems (Chasnoff, Landress, and Barrett, 1990).

Ensuring healthy pregnancies and healthy infants is one of the best antecedents to successful parenting. Nurturing a baby requires energy and demands new skills. Even under the best conditions, parenting a newborn is daunting. Meeting the demands of a high-needs infant can strain the resources of any parent. When that new parent is young, economically insecure, drug-dependent, and/or without the support of a partner or extended family, the task can be overwhelming, leaving the parent without the reserves of emotional and physical energy necessary for creating a nurturing, responsive environment.

New parents are more effective if they are prepared for pregnancy and childbirth and have adequate information about infant care and development. Emotional support, as well as assistance in meeting basic needs (housing, nutrition, child care, etc.), are also critical. Programs offering parent education and support exist in most communities. Research has shown that support for parents at the very beginning can influence the quality of parenting (K.E. Barnard, et al., 1988; Weinraub and Wolf, 1983).

Guidance and support for parents after the baby is born is vital. Many parents have traditional well-child care from physicians or nurse health practitioners. Communities may also have parent groups sponsored by family life programs in colleges and universities. Some school districts offer special programs for teen parents. These resources can help provide information about nurturing the growth and development of children and offer networks of parent peer support.

Risk Factors That May Be Addressed

Favorable Parental Attitudes and Involvement in the Problem Behavior

Family Management Problems

Constitutional Factors

Extreme Economic Deprivation

Academic Failure

Early and Persistent Antisocial Behavior

Low Commitment to School

The most effective approaches during the prenatal and infancy period are comprehensive in scope. They provide a variety of interventions and activities ranging from maternal/child health care to parent education and child cognitive development. Collaborative planning and service delivery involving all the systems serving pregnant women and their infants promotes such a comprehensive approach. Outreach and identification of parents and infants exposed to high risk conditions is critical to successful programs and can best be accomplished by using a collaborative model. Prenatal and early infancy programs should be viewed as the first piece in a developmentally comprehensive strategy. Research shows that the best outcomes are produced by early intervention *and* continuity of care (Horacek et al, 1987).

▶ Routine Prenatal and Perinatal Medical Care

Promoting maternal health through good prenatal care can reduce the chances of preterm births, low birthweight, and fetal exposure to alcohol, tobacco, and illicit drugs, all of which can contribute to the constitutional risk factors that predict increased likelihood of substance abuse, delinquency, and violence.

Routine prenatal medical care should include education for the mother about the physiological and emotional changes of pregnancy, fetal growth and development, and preparation for childbirth. Home visitation by health professionals during pregnancy, with intensive health education for the mother, improves high-risk mothers' health-related behaviors and reduces the rates of pre-term deliveries and low birthweight babies. Health education can also decrease the pregnant mother's use of alcohol and other drugs, which helps to prevent brain damage in the infant (Olds and Kitzman, 1993).

Prenatal education is often available through hospitals with maternity services, or through childbirth educators in the community at large. Through private or public prenatal medical care, a whole range of additional services can often be accessed, such as nursing, social work, nutrition, counseling, and health education. Such prenatal services are often used less readily by women who are young, unmarried, depressed, misusing substances, or who generally lack support. Outreach services, such as public health nurses, school nurses, teachers and counselors are important in identifying underserved pregnant women and helping them access resources.

Routine infant health care should include regular well-baby check-ups, with particular attention to immunizations. Programs aimed at reducing head trauma, either through accident or as a result of child abuse, are also an important part of a comprehensive strategy.

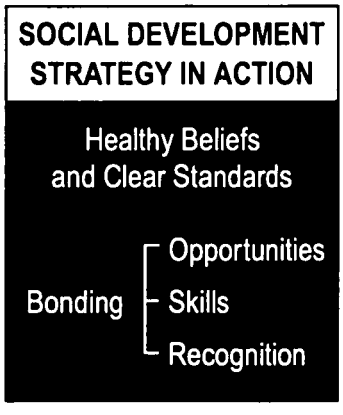
These interventions address the risk factors of **constitutional factors** and **favorable parental attitudes toward the problem behavior.**

Following is an example of an effective comprehensive prenatal/infancy program that includes prenatal and infant health care.

PRENATAL | 0–2 YEARS | 3–5 YEARS | 6–10 YEARS | 11–14 YEARS | 15–18 YEARS

The Prenatal/Early Infancy Project

Protective Factors Addressed: Healthy beliefs and clear standards about maternal/infant health care, parent/infant bonding through opportunities for mothers to contribute to the healthy development of their newborn, skills for maintaining a healthy pregnancy, preparing for labor and delivery, and maintaining their infant's health, and reinforcement for the mother through regular contact with the health professional and the home visitor.



The Prenatal/Early Infancy Project was a comprehensive research project targeting young, unmarried mothers in a semirural Appalachian region of New York that had high rates of poverty and child abuse. The project included multiple interventions, such as home visitations by a nurse from

pregnancy through age two, health education for parents, job and educational counseling, parent training, and social service linkages through referral and advocacy systems. Home visitors encouraged close friends and family members to participate in the home visits and to help mothers with child care and household responsibilities.

The prenatal and infant health care component of the program involved screening and referral, home visits every two weeks during pregnancy, free transportation to well-child care clinics, and continued nurse visitation until the children were two years old. Registered nurses, who had participated in a three- month training program, worked in two-person teams to deliver the program.

This comprehensive program produced significant reductions in the following risk factors: 1) teen mothers and smoking mothers had decreased perinatal difficulties, 2) two years after the program ended, the rate of child abuse and neglect was 4% for project participants compared with 19% for non-participating controls, 3) program participants were twice as likely as controls to graduate from high school, 4) older participating mothers were more likely to be employed, and 5) subsequent pregnancies were delayed. (Olds et al., 1986; Olds & Kitzman, 1993).

This program addressed the risk factors of **extreme economic deprivation, constitutional factors, favorable parental attitudes toward the problem behavior,** and **family management problems.**

▶ Family Support Interventions Using Home Visitors

Home visitors can act as advocates for the family, helping parents obtain needed health and social services. They can also help encourage the mother to pursue her educational and occupational plans. Home visitors may also help parents with child care, transportation to health clinics or early education centers, to help ensure that families are able to take advantage of services. By becoming a friend of the family and developing a trusting, respectful relationship, the home visitor is in a good position to educate parents and reinforce their learning and behavior changes.

The *Prenatal/Early Infancy Project* described in the previous section is also an effective example of a family support intervention using home visitors.

Following are additional examples of effective interventions using home visitors.

PRENATAL | 0–2 YEARS | 3–5 YEARS | 6–10 YEARS | 11–14 YEARS | 15–18 YEARS

The Family Development Research Program

Protective Factors Addressed:
Healthy beliefs and clear standards for children's and mothers' behavior. Bonding between mother and child through opportunities for mother-child interaction and skills for communication. Bonding between parents and the community through opportunities to organize parent activities and critique project plans and advocacy skills. Bonding of children to school through opportunities for involvement in selecting their activities, physical, cognitive, and behavioral skills, and regular recognition from teachers.

The Family Development Research Program used a comprehensive home visitation approach to address the risk factors of **extreme economic deprivation, family management problems, academic failure, low commitment to school,** and **early and persistent antisocial behavior.** The comprehensive home visitation program included home visitation, a formal parent support and advocacy organization, and developmentally appropriate child care for infants and preschoolers. A ten-year follow-up showed positive effects for girls on attendance, academic achievement, self-control, and attitudes toward school, as well as reduced involvement with the juvenile justice system for both boys and girls (Lally, Mangione & Honig, 1988).

The Infant Health and Development Program

The Infant Health and Development Program was an eight-site randomized clinical trial that used a similar intervention for families with low birth weight infants. The comprehensive home visitation program showed positive effects on cognitive development for mothers with a high school education or less. At the end of the program the home environment of program participants was more conducive to child development and program mothers were more likely to be employed (Ramey et al., 1990, Ramey, 1992).

▶ Programs To Enhance Parent-Child Interactions

Many interventions of this type involve structured activities, such as a parent and child playing games together, often coached by a home visitor. Several of the comprehensive programs described in the previous section also include these types of activities. These programs may address the risk of **family management problems.**

The following are examples of programs that enhance parent-child interactions.

PRENATAL | 0–2 YEARS | 3–5 YEARS | 6–10 YEARS | 11–14 YEARS | 15–18 YEARS

The Keys to Caregiving Videotape Series

Protective Factors Addressed: Bonding between infants and mothers through opportunities for mothers to successfully interact with their newborns, caregiving skills, and recognition (attention, calming down) for both the infant and the mother.

SOCIAL DEVELOPMENT STRATEGY IN ACTION

Healthy Beliefs and Clear Standards

Bonding: Opportunities, Skills, Recognition

The Keys to Caregiving Videotape Series was designed for hospital nurses to increase their effectiveness in educating parents about their newborn, with particular attention paid to introducing parents to their infant's capacity for responding to them and their environment.

PRENATAL | 0–2 YEARS | 3–5 YEARS | 6–10 YEARS | 11–14 YEARS | 15–18 YEARS

Promotion of the Use of Front-Pack Infant Carriers

Protective Factors Addressed: Bonding between infant and mother by providing opportunities for the infant to interact with its parent, skills for engaging its parent, and consistent, immediate recognition from the parent.

Promotion of the use of front-pack infant carriers, such as the Snugli or sling-type infant carriers, increases the amount and quality of mother-child interaction. In one experimental study, low-income mothers were assigned to two groups–one group received a Snugli and the other was given a common infant seat where the baby could be safely put down by the mother. After 3 months, mothers using the Snugli were found to be more responsive to their infants than those using infant seats, and at 13 months the Snugli infants were significantly (83% vs. 38%) more securely attached to their mothers (Anisfeld, Casper, Nozyce, & Cunningham, 1990).

SOCIAL DEVELOPMENT STRATEGY IN ACTION

Healthy Beliefs and Clear Standards

Bonding: Opportunities, Skills, Recognition

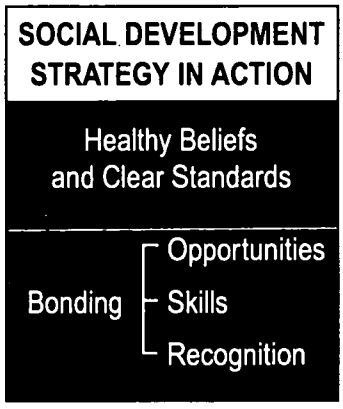
▶ Child Cognitive Development Activities

These programs may be carried out by a home visitor, a parent, or in a developmental daycare center. Activities should emphasize language development through interactive reading or structured play sessions. A toy and/or book- lending library may also be offered. These programs address the risk factors of **academic failure** and **low commitment to school.** Following are examples of programs incorporating child cognitive development activities.

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

The Carolina Abecedarian Project

Protective Factors Addressed: Bonding to school by providing opportunities for involvement in learning activities, developmentally appropriate cognitive skills, and reinforcement from parents, home visitors, or the daycare professional.

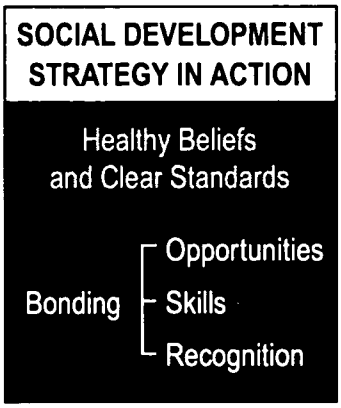


The Carolina Abecedarian Project is a comprehensive, multi-component, program that combines home visitation and parent support groups with developmental day care and a toy-lending library. The daycare, for children from three months to four years of age, employs professional caregivers who provide developmentally appropriate learning activities throughout the day. A toy-lending library allows parents to choose, with guidance from daycare staff, developmentally appropriate toys, complete with guides or instructions, to use at home with their children. This project showed positive effects on reading and math scores in elementary school as well as fewer project students held back a grade (Horacek et al, 1987).

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

The Early Intervention for Preterm Infants Project

Protective Factors Addressed: Bonding between mothers and children through opportunities for mothers to contribute their child's cognitive development, skills for communicating and playing with their child, and recognition from the infant and the home visitor.



The Early Intervention for Preterm Infants project focused on preterm infants of African American teenage mothers. A two-person home visitation team, consisting of a trained psychology graduate student and a teenage, African American work-study student, educated mothers about developmental milestones and infant caretaking practices. The home visitors encouraged mothers to use developmentally appropriate exercises to stimulate sensorimotor and cognitive development. Mothers were also taught to use good communication skills to engage their infants. The project produced significant positive effects on infant cognitive development and mother/infant bonding (Field, et al., 1980).

Early Childhood Education

Early childhood programs promote success in school by preparing preschoolers (ages two to five) and their families for the critical transition into elementary school.

Early childhood programs not only prepare the child for school, they also can help prepare parents to become "parents of students". Early involvement by parents in their child's education can greatly influence a child's later success in school.

Research has shown that early school failure can make it difficult or impossible for a child to catch up later on. Closely related to early school failure is troublesome behavior that parents and teachers find difficult to manage. The precise mechanisms connecting early school failure and early conduct disorders to problems in adolescence are not fully understood.

Risk Factors That May Be Addressed

Family Management Problems

Early and Persistent Antisocial Behavior

Academic Failure

Low Commitment to School

Nevertheless, research indicates that, to reduce academic failure and conduct problems in the early grades, early childhood education should focus on two main elements of preschoolers' development: reading readiness and self-control. Programs that are effective in teaching these skills can take place both at home or in a preschool, daycare center, or kindergarten. Several of the comprehensive programs highlighted in the Prenatal/Early Infancy section also include early childhood education.

▶ Family-Based Programs

Family-based programs should teach parents how to:

- Promote language skills
- Increase clarity of rules, consistency of enforcement of rules, and appropriate consequences for behavior
- Increase the child's self-management skills
- Increase family bonding and attachment by providing opportunities for preschoolers to be involved in developmentally appropriate ways, by teaching cognitive, social and behavioral skills, and by providing consistent reinforcement for successful performance or efforts.

The following are examples of family-based early childhood programs.

PRENATAL | 0–2 YEARS | 3–5 YEARS | 6–10 YEARS | 11–14 YEARS | 15–18 YEARS

Mother-Child Program of Verbal Interaction Project

Protective Factors Addressed: Healthy beliefs and clear standards about the value of educational play. Opportunities for the mother to contribute to her child's cognitive development and skills for successful interaction. Cognitive skills for the child and reinforcement of successful skills by the mother. May enhance intelligence.

SOCIAL DEVELOPMENT STRATEGY IN ACTION

Healthy Beliefs and Clear Standards

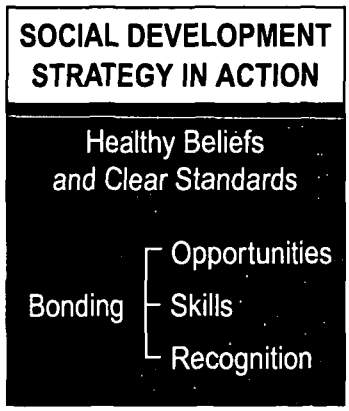
Bonding
- Opportunities
- Skills
- Recognition

This program, which addresses the risk factor of **academic failure**, was tested with low-income, unmarried mothers with a low level of education. Trained "toy demonstrators" conducted weekly or semi-weekly home play sessions involving the mother and child together. Specially designed materials (toys and books) were used to stimulate verbal interaction between the mother and child. When the project was over, the mothers were allowed to keep the toys and books. This project produced long-term positive effects on both academic achievement tests and IQ scores of the program children, measured at fifth and eighth grades. There was also a significant positive effect on IQ score for the siblings of program participants, suggesting improvements in mothers' skills (Madden, et al., 1984; Levenstein, 1992). Over twenty-five replications of this program currently serve an estimated 4,000 mother-child pairs throughout the United States and more programs are in the planning stages.

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

Problem-Solving Techniques in Childrearing

Protective Factors Addressed: Healthy beliefs and clear standards for behavior. Opportunities to contribute to family problem-solving, problem-solving, communication, and social skills, and reinforcement for the child's skills through the attention of the parent.

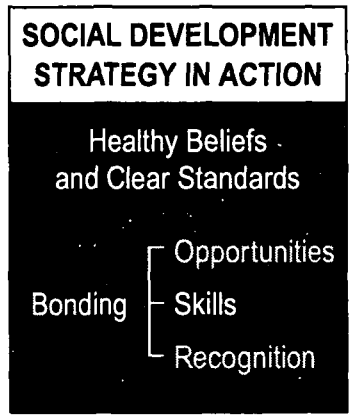


Aimed at parents of young children, this program addresses the risk factors of **early and persistent antisocial behavior** and **family management problems**. The program promotes verbal interaction between the parent and the child, encouraging questioning by the mother and verbal expression by the child. The program also teaches parents how to use a problem-solving approach to discipline. The core of the program is a series of problem-solving games the mother and child play together. Scripts for the games present a series of increasingly difficult problems to solve and ask the child to suggest solutions, potential consequences, and pairing of specific consequences with specific solutions. The scripts also focus on developing language skills, gathering information, and identifying and labeling one's own and others' emotions. The program has been shown to positively affect children's behavior adjustment and use of specific social and problem-solving skills taught through the curriculum (Shure and Spivak, 1982; Shure, 1993).

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

Book Lending Library

Protective Factors Addressed: Healthy beliefs and clear standards about the value of reading. Skills for family reading.



Simply giving favorite books to children to take home and advising parents about ways to use the books with their children appears to be effective in developing pre-reading skills. Encouraging reading can reduce the risk of **academic failure** and **low commitment to school**. (McCormick and Mason, 1987)

▶ Center-Based Programs and Approaches

Early childhood programs based in daycare centers or preschools should:

- Promote language skills and teach beginning reading skills for students who are ready to learn to read.
- Provide clear rules, consistent enforcement of rules, and appropriate consequences for behavior.
- Increase the child's self-management skills.
- Promote bonding to school by providing opportunities for preschoolers to be involved in developmentally appropriate ways, teaching cognitive, social and behavioral skills, and providing consistent reinforcement for successful performance or efforts.

Recent studies show long-term effects of preschool programs (Schweinhart et al., 1993). However, the majority of studies show that consistent early cognitive gains made by preschool youngsters "fade out" by about second grade (Lazar et al., 1982). High-quality educational and social skills development programs are needed throughout a child's schooling to maintain early advantages. Most early childhood education programs offered by public agencies operate for less than three and a half hours per day. A currently debated issue is whether programs should operate on a full school-day schedule (five to six hours) or even an extended day schedule that would match parents' work schedules. Shorter programs cost less, but full-day programs are more convenient for parents, offer greater flexibility in programming, and limit stress associated with moving the child from setting to setting during the day. Research shows that disadvantaged students, in particular, gain from a longer day program, though the evidence is not conclusive. The length of the program should be adequate to allow time for all program components to be implemented effectively.

A wide variety of early education programs are available today, and there are significant differences among them. Some are academic, following a strictly defined curriculum. Others are developmental, encouraging the teacher to assess the child's readiness to learn specific skills. Some are teacher-directed, others student-centered and student-initiated. Some focus on the child, others on the family.

Preschool and kindergarten programs of all types have been shown to be effective in raising test scores, reducing special education placements, and reducing grade retention (Weiss, 1988; Stallings and Stipek, 1986; Karweit, 1989a, 1989b). There is little evidence of the superiority of one program or approach over another. Nevertheless, it is possible to make some general recommendations based on the available research:

- Structured programs, those with a specific set of learning objectives and teaching methodologies, are more effective than unstructured programs such as nursery school models in which the child is encouraged to play freely
- The program should include language-development opportunities, reading instruction for

those who are ready, and social skill-building activities

- Local professionals who have expertise in early childhood education and development and who are aware of the specific needs of the community should assist in selecting programs and curricula

Programs should be politically and culturally acceptable in the community. Programs should be integrated into existing preschool programs and include structured and unstructured play, rest, meals, and other enrichment activities.

Implementation Issues. Identifying, recruiting and retaining families of children with early learning or behavior problems can be a challenge. Some families living in poverty or disorganized or remote neighborhoods may not seek out early childhood education programs, though evaluations show strong positive effects from children living in poverty.

Parents of children at risk can be identified by:

- Searching local birth records for mothers who were single and teenage at the time of birth, whose children would now be two to five years old.

- Seeking referrals from public health nurses or hospitals.

- Seeking referrals from local welfare services

Recruitment is best done by a home visit to explain the services available and the benefits for the child.

Retaining parents in an early childhood education program can also be a challenge. It is more likely that parents will continue to participate if:

- The program helps them overcome obstacles such as baby-sitting needs and transportation to parent meetings

- The parent receives social support for participating. For example, grandparents and friends, including male friends if the child's father is not part of the family, are involved in encouraging the parent to participate

- The training provided by the program is relevant to the parents' needs. In some cases, this includes helping parents address basic survival needs, such as finding jobs or housing

A program that requires parents to attend meetings at some central location and provides little or no support as they try out new practices is likely to be less effective than a design incorporating home visits. Home visits combined with small-group discussions among parents in the community can be effective. Discussions should be led by a trained community outreach worker and should focus on the content of the parent training. Putting parents in touch with needed resources in the community could also be part of these meetings. Group discussions and home visits should support parents in resolving child-rearing, family, education, or work-life problems identified by the parents themselves.

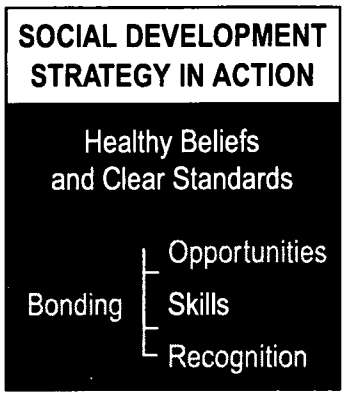
The following are examples of center-based early childhood education programs.

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

The Bereiter-Engleman/DISTAR Model

Protective Factors Addressed: Language skills, enhanced intelligence.

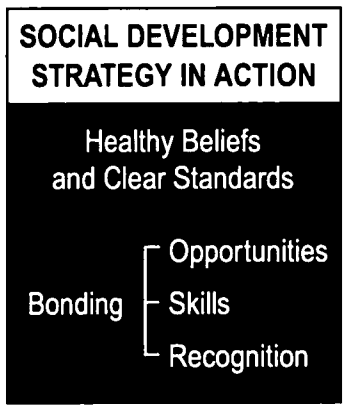
The Bereiter-Engleman/DISTAR model is a highly structured language development approach in which the teacher models the correct use of language and elicits correct responses from children. The program addresses **academic failure** and has shown positive effects on IQ for economically disadvantaged, low IQ preschoolers (Carnine et. al., 1988).



PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

The High/Scope Cognitive Curriculum

Protective Factors Addressed: Healthy beliefs about the value of education and clear standards for behavior. Opportunities for children to initiate their own learning, language skills, recognition and reinforcement from teachers.

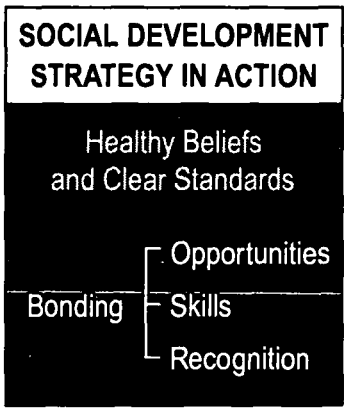


The High/Scope Cognitive Curriculum divides the classroom into language-oriented learning centers that encourage children to use, experience, and discover language through activities and play. By allowing children to be involved in initiating and selecting their own learning activities, this program builds bonding to school and addresses the risk factors of academic failure and low commitment to school. A longitudinal study of the High/Scope Cognitive Curriculum in the Perry Preschool Program showed significant long-term effects. At nineteen years, participants had higher high school grade point averages; had spent less time in special education classes; had higher rates of high school graduation and vocational training; higher rates of employment; and were less likely to have received public assistance. The program reduced later violent behavior by 50% and arrests by age 19 by 40%. Females in the program had fewer pregnancies than those in the control group (Berreuta-Clement et al., 1984; Schweinhart et al., 1993).

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

The Star Model

Protective Factors Addressed: Opportunities for children to contribute to their learning, language skills, reinforcement from teachers and classmates for their storytelling skills.



The Star model is a highly interactive telling and re-telling of stories in which children listen to a story, respond to questions about it, and then retell it in both individual and group situations (Karweit, 1989). By promoting early language development, this program addresses the risk factor of **academic failure**.

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

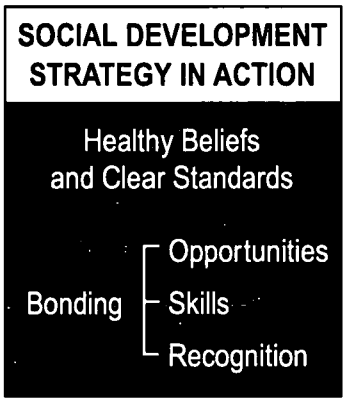
The Brookline Early Education Project (BEEP)

Protective Factors Addressed: Healthy beliefs about the value of education, opportunities for children to be involved in decisions about their learning activities, developmentally appropriate cognitive and social skills.

The Brookline Early Education Project (BEEP) is an example of a comprehensive early education program that addresses the risk factors of **academic failure** and **family management problems**. The program includes home visitation, parent training, book/toy lending library, preschool based on the *High/Scope* curriculum, as well as health and developmental exams by a team of psychologists, nurses and pediatricians. The program demonstrated significant effects on academic achievement as measured in second grade, with 50% fewer program children falling behind academically than control children and significantly fewer program children falling behind in reading than controls (Pierson, D.E., 1988).

Interpersonal Cognitive Problem-Solving (ICPS)

Protective Factors Addressed: Healthy beliefs and clear standards for social behavior; opportunities for children to contribute to the solving of problems; thinking, language, social, and problem-solving skills; reinforcement of new skills by the teacher and other children.



Interpersonal Cognitive Problem-Solving (ICPS), the center-based equivalent of the *Problem-Solving Techniques in Early Childhood* program discussed earlier in this section, addresses **early antisocial behavior** as a risk factor. This program provides teachers with a script composed of thirty-five games that help to develop thinking and problem-solving skills in children. Through enactment and discussion of the games, the children are encouraged to respond with solutions and pair specific solutions with specific consequences. A strong emphasis is placed on the language skills needed for thinking about solutions, consequences, and alternatives. As with the family-based version, children also learn to identify and label emotions as part of solving conflicts and problems. The program has demonstrated significant positive effects on behavioral adjustment (Shure & Spivak, 1982; Shure, 1993).

Parent Training

Parent training provides information and skills to help parents be more effective in raising their children. Parents of children at different ages require information and skills specific to their child's developmental stage. Parent training programs focus on specific ages and specific risk factors. All parent training programs should help parents set clear standards for behavior and promote bonding by increasing opportunities for children to be involved in the family, skills for involvement and recognition for that involvement.

Parent training can be an important part of a comprehensive prevention strategy. Programs designed to support parenting from birth through adolescence can address a number of risk factors and successfully enhance protection for young people. It is important to use programs that address the community's priority risk factors and meet the needs of parents of children at different ages.

Selecting a parent training curriculum is only the first step–the next critical step is implementation. ***Successful Implementation of Parent Training Programs***–A Handbook for Organizing, Staffing, Recruiting and Funding Parent Training Programs is a useful tool for helping communities successfully implement parent training programs (see Resources).

Risk Factors That May Be Addressed

Family Management Problems

Family Conflict

Favorable Parental Attitudes and Involvement in the Problem Behavior

Early and Persistent Antisocial Behavior

Academic Failure

Friends Who Engage in the Problem Behavior

Early Initiation of the Problem Behavior

The following are examples of parent training programs targeting parents of children at different developmental levels.

Many of the comprehensive programs listed in the Prenatal/Early Infancy section of this manual include parent training components.

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

The Houston Parent-Child Development Center Program

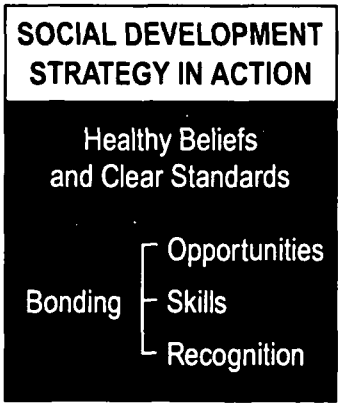
Protective Factors Addressed: Healthy beliefs and clear standards about parenting and the value of education; opportunities for parents to contribute to the healthy development of their child; parenting skills, cognitive and social skills for the child, reinforcement of new parent skills by the home visitor, reinforcement of new child skills by the parent.

The Houston Parent-Child Development Center program, which addressed the risk factors of **academic failure, early antisocial behavior**, and **family management problems**, is a comprehensive, multicomponent family support program tested with Mexican-American families with children ages twelve months through three years. In the first stage of the program (twelve–twenty-four months), parent education was provided by home visitors, with an emphasis on infant development, using the home as a learning environment, and mother-child interaction skills. In the second year of the program (twenty-four to thirty-six months), children attended a developmental daycare while parents attended center-based parent training with emphasis on behavior management, language development through games and toys, parent-child interactions, and child development. The program showed positive immediate and longer-term effects in several areas: 1) program mothers were more affectionate and less controlling, used more praise, were more encouraging of children's verbalizations, and scored higher on mother-child interaction scales, 2) at eight to eleven years old, program children were rated less restless, less impulsive, less disruptive, and got into fewer fights than control children (Johnson, 1991).

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

Parent-Child Interaction Training

Protective Factors Addressed: Healthy beliefs and clear standards for behavior, opportunities for children to participate in their own learning, language and self-control skills, reinforcement of new skills through play sessions with parents. Opportunities for parents to contribute to their child's cognitive and social development, parenting and interaction skills, reinforcement of new parent skills through practice sessions.



Parent-Child Interaction Training, a program that addresses the risk factors of **family management problems** and **early antisocial behavior**, was tested with low-income, predominantly African American parents who rated their preschoolers as having behavioral or emotional problems. Most parents were unmarried and experiencing depressive symptoms. Each of the 5 training sessions includes a 2-hour parent session followed by a modeling and practice session with their children.

The parent sessions included instruction, videos, and role-playing on the following topics:

- giving approval and reinforcement of children's positive behavior
- increasing children's attention to stories that model prosocial behavior
- shaping positive behavior
- giving effective reprimands
- use of "time-out"
- nondirective verbalization of child's behavior during play (using language to "comment" on what the child is doing)
- use of differential attention–attend to prosocial, ignore antisocial behavior
- acting out "modeling plays" that model prosocial behavior using toy people
- planning responses to inappropriate behavior during play sessions.

The play sessions with the child included modeling and practicing in conducting play sessions with their child, including conversation, story reading, and dramatic play. Parents watched the behavior being modeled by a teacher, then the parent repeated the session with coaching from the teacher.

The program showed significant positive effects on program children's attention-deficit/hyperactivity and hostile/aggressive behavior. The mothers who made the most progress in skill development had children who improved the most in behavior (Strayhorn & Weidman, 1991).

PRENATAL | 0–2 YEARS | 3–5 YEARS | 6–10 YEARS | 11–14 YEARS | 15–18 YEARS

The Montreal Longitudinal Study of Disruptive Boys

Protective Factors Addressed: Healthy beliefs and clear standards for behavior, skills for prosocial behavior, recognition of prosocial behavior by parents.

The Montreal Longitudinal Study of Disruptive Boys is a two-year delinquency prevention program that was tested with 7 to 9 year-old boys who had been identified as disruptive. The intervention program was designed to address the risk factors of **family management problems, academic failure,** and **early and persistent antisocial behavior.**

SOCIAL DEVELOPMENT STRATEGY IN ACTION

In addition to school-based social skills training, parent training sessions were provided once every two weeks for the two-year period. The parent training sessions taught parents to:

- use a home reading program with their children
- monitor children's behavior
- give positive reinforcement for prosocial behavior
- effectively discipline their children without being abusive
- manage family crises

The program produced significant positive results in several areas. Program boys were more likely to be at grade level, less likely to be placed in special classes or be retained, less likely to be classified as seriously maladjusted, less likely to be rated as highly disruptive by teachers and less likely to have been involved in delinquent acts by the age of 12 (Tremblay et al., 1992; Tremblay et al., 1995).

The Parents and Children Videotape Series

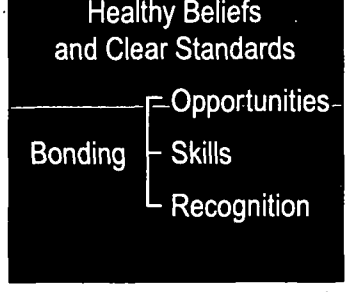
Protective Factors Addressed: Healthy beliefs and clear standards for behavior, opportunities for involvement in family activities, self-control skills, recognition for appropriate behavior.

This program, designed for parents who are having behavior management problems with children ages three to ten, focuses on reducing **family management problems** and **early antisocial behavior** problems through building family management and problem-solving skills. The program's objectives are to teach parents how to:

- Set clear expectations for their children's behavior
- Monitor their children's behavior
- Reinforce positive behavior in their children
- Develop and use effective communication skills
- Use basic problem-solving skills for child management

This program is based on the premise that people change as a result of the interactions they have on a daily basis with one another. Consequently, when children misbehave and families become disrupted, it is necessary to alter both the parents' and the child's behavior. Parents who take this course are able to significantly reduce their children's behavior problems and increase positive social behaviors. Parents have also reported feeling more comfortable about their parenting skills after completing the course (Webster–Stratton, 1984).

SOCIAL DEVELOPMENT STRATEGY IN ACTION



The program consists of ten one and one-half to two hour facilitator-led sessions in two phases. In the first phase, the emphasis is on positive interaction between parents and children (playing together, planning fun activities together, etc.). The second phase emphasizes monitoring, limit-setting and problem-solving. Parents learn to develop a consistent reward structure for appropriate, compliant behavior in children, and to be aware of consistent and moderate punishment to use when children do not behave appropriately. The program emphasizes both communication skills and ways to manage anger, which helps increase positive interaction and bonding in the family.

Each session uses a series of videotapes showing different vignettes of problem situations that commonly arise in families, e.g., getting a child to do a particular task, or a child coming home from school and not getting attention from his or her parent. The workshop leader facilitates a discussion of what kinds of things could be done in the particular situation, and, through the videotapes, the parents get a chance to see both effective and ineffective solutions to problems.

Each session begins with a discussion of the homework assignment from the previous week. New material is presented through the videotaped vignettes for the specific session. Although a detailed workshop leader's guide is provided, the structure of the sessions is flexible enough to allow the leaders opportunities to express their own views on the topics being discussed. Also included in the program materials are manuals

and workbooks for the participants. Program topics include:

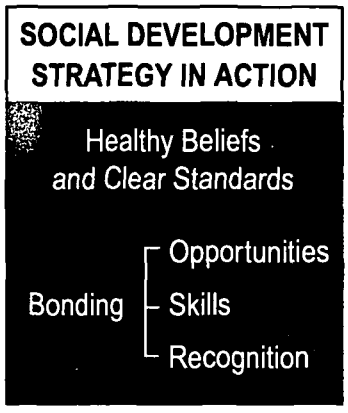
- How to Play with a Child
- Avoiding and Ignoring Misbehavior
- Time Out and Other Penalties
- Preventive Approaches

The *Parents and Children Videotape Series* has shown significant effects in reducing behavior problems and increasing prosocial behaviors, whether used as part of a facilitator-led group discussion, or viewed by parents on their own, without a group discussion (Webster-Stratton, 1984, 1990a, 1990b, 1994; Webster-Stratton et al., 1988, 1989).

PRENATAL | 0–2 YEARS | 3–5 YEARS | 6–10 YEARS | 11–14 YEARS | 15–18 YEARS

How to Help Your Child Succeed in School

Protective Factors Addressed: Healthy beliefs and clear standards about education, opportunities for parents to contribute to their child's educational success, skills for involvement in their child's education, recognition for parents as a valuable partner in their child's education.



This program is for parents of children in the early elementary grades. It is designed to address the risk factor of **academic failure** by helping parents improve their children's academic performance and adjustment to school. Major emphasis is placed on how parents can support their children's schoolwork at home. The program's objectives are to teach parents how to:

- Set up a positive learning environment in the home;
- Be a teacher for their child, assisting the child in learning basic reading and math skills;
- Interact with their child's teachers to support the child's learning
- Support the completion of schoolwork at home to promote their child's school achievement

This program is offered to parents at a critical time in their children's social and academic development—just as the child is entering and making an adjustment to elementary school. In a broad range of socioeconomic groups, parents view a good education as a key to their children's success. However, in many families there may have been little or no opportunity prior to this time to develop the child's academic skills. The program helps parents to understand the importance of the help they can provide at home and how to structure an appropriate environment at home for study and learning.

This program consists of five one and one-half to two-hour sessions designed to be delivered to groups of 10-20 parents by a team of two workshop leaders. Resource materials to help parents understand what their children are being taught in school are provided by the local school district.

Reinforcing at home what the child is learning at school, and developing consistency between home and school, are key aspects of the program. An important strategy in achieving both goals is teaching parents how to interact more effectively with their child's teacher. Parents also learn how to increase the consistency of reinforcement for the child's skill development between home and school.

This, in turn, helps the child to improve skills and work habits.

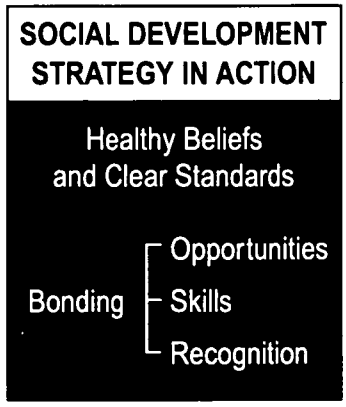
One feature of this program is its use of skill-building games that parents and children can play together. These games help to supplement and strengthen school-based skill building. Other materials for the program include a parent workbook with homework assignments for the parents to carry out with their children between sessions, and a detailed workshop leader's guide.

When used as part of a comprehensive intervention with teachers and parents, this program has been positively correlated with parent reports of frequency of their interaction with teachers, educational expectations for their child, time spent reading with the child, and perceived consistency in views of parents and teachers (Hawkins et al., 1987).

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

Preparing for the Drug-Free Years

Protective Factors Addressed: Healthy beliefs and clear standards for behavior, opportunities for children to be involved in and contribute to the family, skills for family communication and problem-solving, recognition of new skills.



Preparing for the Drug Free Years is for parents of children in the upper elementary to middle school grades (4-8). It addresses the risk factors of **family management problems, family conflict, favorable parental attitudes and involvement in the problem behavior, friends who engage in the problem behavior,** and **early initiation of the problem behavior.** The program's objectives are to:

- Teach parents how to reduce critical risk factors that are especially important during late elementary and middle school years
- Empower parents to set a clear family position on drug use by family members
- Provide parents with skills to help their children refuse offers to use drugs
- Increase family bonding by reducing conflict and by increasing children's involvement in positive family activities

Although similar to other parenting programs in involving parents in setting up clear structures and reinforcements for appropriate behavior, this program includes a specific focus on the prevention of alcohol and other drug use. It provides ways for parents to define and communicate a family position on drug use, while at the same time providing the opportunity for children to be involved in developing the position. It also provides an opportunity for parents and children to learn and practice effective family management skills together.

Facilitated by two co-leaders, at least one of whom should be a parent, the program consists of five two-hour sessions. Videotaped vignettes play a key role in the program, offering portrayals of family situations that pertain to each of the session topics as starting points for group discussion. The videotapes also model specific skills such as refusal skills, effective family management techniques, conflict

management skills, and skills to promote positive bonding within the family.

Tests of *Preparing for the Drug-Free Years* have shown significant positive effects. Parents participating in the program were more likely than control parents to provide reinforcement to their children for prosocial behavior, to monitor their children's whereabouts, and to report more family involvement with their children, both in discussing family issues and in enjoyable family activities. Both mothers and fathers were more likely to demonstrate improved relationship quality with their children and more proactive communication in solving problems (Kosterman et al., 1995; Spoth et al., 1995).

Family Therapy

Research evidence indicates that juvenile delinquency, drug abuse and other forms of self-destructive and antisocial behavior occur in families in repetitive patterns—and that these patterns can be altered by family therapy programs. Although negative family functioning can be a risk factor for children, when families are able to resolve problems successfully, the family can also be a protective environment.

Risk Factors That May Be Addressed

Family Management Problems

Family Conflict

Early and Persistent Antisocial Behavior

Rebelliousness

Research has shown that, through a variety of family therapy approaches, families can be motivated to make enduring positive changes in negative family behavior patterns, reducing **family conflict, early antisocial behavior**, **rebelliousness** and **family management problems.** While there are several kinds of family and marital therapy, the diverse approaches share a focus on changing maladaptive patterns of family interaction and communication.

Selection and implementation of family therapy programs requires the involvement of community clinicians to determine the appropriate program for the target community.

Although this type of intervention typically involves a trained therapist working with multiple family members as a group, the program examples described below follow a specific, time-limited format, with a clear design that remains consistent across families.

Therapists recruited to lead family therapy sessions need to be experienced professionals who focus on families. They should have some background in family systems concepts and methods. Therapists should be skilled in working with families experiencing conflict.

As with other forms of family-focused programs, recruitment for participation in this program may come through agencies and institutions that work with troubled youth and families, such as schools, the juvenile justice system, and social welfare and mental health agencies, as well as from self-referral.

Assessing family members' involvement with alcohol or other drugs and the level of family conflict and dysfunction is important in determining whether group or individual therapy is indicated.

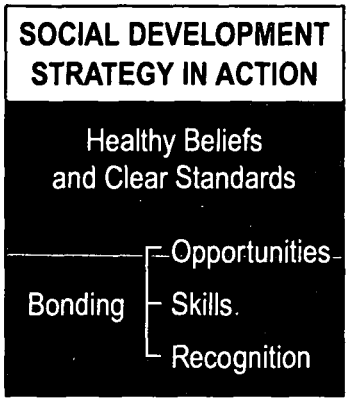
Family therapy is usually more resource-intensive than parent training. It is appropriate for families already experiencing serious difficulties.

Following are examples of effective family therapy programs.

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

Behavioral Systems Family Therapy

Protective Factors Addressed: Healthy beliefs and clear standards for behavior, opportunities for involvement in family decision-making, family interaction skills, recognition of appropriate behaviors with a token economy system.



Behavioral Systems Family Therapy targets families with adolescents who are already exhibiting behavior problems. The program includes eight hours of behavioral therapy delivered over a four-week period. The therapy focuses on helping family members:

- differentiate rules from requests
- reinforce desired behaviors with a token economy system
- improve communication skills

Families are also given a modified therapy manual to work through at home.

This program addresses the risk factors of **early and persistent antisocial behavior, family management problems, family conflict** and **rebelliousness.**

The program was tested in Salt Lake County, Utah with families who were referred to juvenile court for their adolescent's delinquent behavior. Positive results were demonstrated in several areas: 1) significantly better family interaction than controls, 2) significantly lower recidivism, and 3) preventive effects on siblings of the delinquent adolescents, indicated by the fact that only 20% of siblings of program families had juvenile records at the two and one-half year follow-up versus 63% for control families (Klein et al, 1977).

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

Brief Strategic Family Therapy

Protective Factors Addressed: Healthy beliefs and clear standards for behavior, opportunities for positive contribution to the family, communication and conflict resolution skills.

Brief Strategic Family Therapy (Szapocznik et.al., 1989) was selected by a national panel, the Coalition of Spanish Speaking Mental Health Organizations (COSSMHO), as an outstanding family intervention approach for Hispanic youth at high risk of delinquency. The program addresses the risk factors of **early antisocial behavior, family management problems**, and **family conflict.**

Brief Strategic Family Therapy takes place in twelve weekly sessions, lasting about one and one-half hours each.

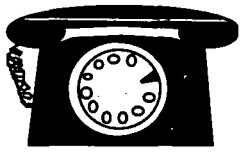
It provides a formal assessment procedure that focuses on six different dimensions of family interaction:

- Structure—leadership of the family, alliances within the family, the flow of communication and patterns of family members' behavior.
- Flexibility—how family members communicate and interact to accomplish needed tasks.
- Resonance—the sensitivity of family members to each other, e.g., their ability to understand what other may be feeling and to listen to each other.
- Developmental stage—how appropriately family members fulfill their roles, e.g., parent, spouse, child, given the developmental stage of different family members (child, adolescent, employed, retired, etc.).
- Identified patienthood—the more the family insists that its entire problem is found in a single person (the "identified patient"), the more difficult it will be to bring about change.
- Conflict resolution—the family's ability to prioritize, express, confront and negotiate difference of opinion, disagreements and conflict.

The use of this assessment can help the therapist implement strategies to correct problems in each of the six areas described above.

Parents in this program reported fewer behavior, personality and inadequacy problems with their children. Participating families also had greater improvements in family structure and organization and better family interaction than controls (Szapocznik et al., 1989).

Resources



Marital Therapy

For more information on the *Prevention and Relationship Enhancement Program* (PREP), contact:

PREP Educational Videos, Inc.
Dr. Howard J. Markman, Director
Center for Marital and Family Studies
University of Denver
Denver, CO. 80028
Phone: (800) 366-0166

Prenatal and Infancy Programs

For more information on the *Keys to Caregiving* videotape series, contact:

NCAST Publications
University of Washington, WJ–10
Seattle, Wa. 98195
Phone: (206) 543-8528

For more information on the *Infant Health and Development Program,* contact:

Donna Spiker, Ph.D.
Infant Health and Development Program
Stanford University
Center for the Study of Youth Development
Building 460, Rm. 110
Stanford, CA 94305-2135
Phone: (415) 723-7809

The Perinatal Resource Center studies and reviews policies and provides interdisciplinary training in the field of perinatal substance abuse and its prevention. For further information, contact:

Office of Substance Abuse Prevention
Perinatal Resource Center
9300 Lee Highway
Fairfax, VA 22031
Phone: (202) 842-8905

For additional information on *prenatal and infant health care,* contact your local hospital or public health department.

Early Childhood Education Programs

For more information on the Mother-Child Home Program, contact:

Phyllis Levenstein, Ed.D
Center for Mother-Child Home Program
3268 Island Road
Wantagh, New York 11793
Phone: (516) 785-7077

For more information on the High/Scope Perry Preschool Program, contact:

High/Scope Educational Research Foundation
600 North River Street
Ypsilanti, MI 48198-2898
Phone: (313) 485-2000

For more information on *Problem-Solving Techniques in Childrearing*, see Raising a Thinking Child, M.B. Shure, Ph.D., Hot and Company, Inc., NY, 1994.

For additional information on *early childhood education programs*, contact:

National Association for the Education of Young Children
1834 Connecticut Avenue N.W.
Washington, DC 20009-5786
(800) 424-2460

Project Head Start
Administration for Children, Youth, and Families
Office of Human Development Services
Department of Health and Human Services
P.O Box 1182
Washington, DC 20013

Local sources to contact:

Regional Office of the U.S. Department of Health and Human Services
Local School District Early Childhood Services

Parent Training

For information on the *Montreal Longitudinal Study of Disruptive Boys*, contact:

Dr. Richard E. Trembley
Professeur Titulaire
University of Montreal Directeur
750 Boulevard Gouin Est
Montreal, Quebec
Canada H2C1A6

For more information on the *Parents and Children Videotape Series*, contact:

Carolyn Webster-Stratton, Ph.D.
Family and Child Guidance
1411 8th Ave. West
Seattle, WA. 98119
(206) 461-3883

For information on *How to Help Your Child Succeed in School* and *Preparing for the Drug-Free Years* contact:

Developmental Research and Programs, Inc.
130 Nickerson Street, Suite 107
Seattle, WA. 98109
Phone: (800) 736-2630

For more information on *Successful Implementation of Parent Training Programs–A Handbook for Organizing, Staffing, Recruiting, and Funding Parent Training Programs*, contact:

Developmental Research and Programs, Inc.
130 Nickerson St., Suite 107
Seattle, WA. 98109
Phone: (800) 736-2630

Local sources to contact:

Regional Office of the U.S. Department of Health and Human Services
Local School District Early Childhood Services

Family Therapy

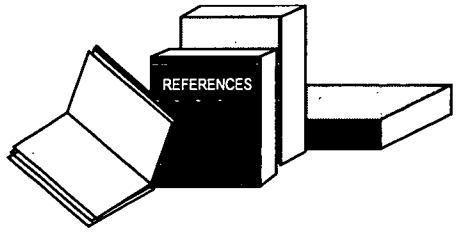
For information on *Behavioral Family Systems Therapy*, contact:

Dr. James F. Alexander
Department of Psychology
University of Utah
Salt Lake City, UT 84112

For information on *Brief Strategic Family Therapy*, contact:

Dr. Jose Szapocznik
University of Miami
Miami, FL
(305) 326-0024

References



For more detailed information on research projects described in this section, see the following references:

Marital Therapy Programs

Prevention and Relationship Enhancement Program (PREP)–Markman, H.J., Renick, M.J., Floyd, F.J., Stanley, D.M., Clements, M. (1993) Preventing marital distress through effective communication and conflict management: A 4- and 5-year follow-up. *Journal of Consulting and Clinical Psychology*, 61(1): 70-77.

Prenatal/Early Infancy Programs

Prenatal/Early Infancy Project–Olds, D.L., Henderson, C.R., Tatelbaum, R., Chamberlain, R. (1986) Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of nurse home visitation., *Pediatrics*, 77:16-28.

Olds, D.L., Kitzman, H. (1993) Review of research on home visiting for pregnant women and parents of young children, *The Future of Children* 3(3), 53-92.

Family Development Research Program–Lally, J.R., Mangione, P.L., Honig, A.S. (1988) The Syracuse University Family Development Research Program: Long-range impact on an early intervention with low-income children and their families. In D. Powell (Ed.) Parent Evaluation as Early Childhood Intervention. *Advances in Applied Developmental Psychology*, vol. 3. New Jersey.

Infant Health and Development Program–Ramey, Craig (1990) Enhancing the outcomes of low-birthweight, premature infants: A multi-site, randomized trial, *Journal of the American Medical Association*, 263(22): 3035-42.

Ramey, C.T., Bryant, D.M., Wasik, B.H., et al., (1992). The Infant Health and Development Program for low birth weight, premature infants: Program elements, family participation, and child intelligence. *Pediatrics* 89, (3) 454-65.

Promotion of the Use of Front-Pack Carriers–Anisfeld, E. Casper, V., Nozyce, M., Cunningham, N. (1990), Does infant carrying promote attachment? An experimental study of the effects of increased physical contact on the development of attachment. *Child Development*, 61:1617-1627.

Carolina Abecedarian Project–Horacek, H.J., Ramey, C.T., Campbell, F.A., Hoffman, K.P., and Fletcher, R.H. (1987) Predicting school failure and assessing early intervention with high-risk children, *Journal of the American Academy of Child and Adolescent Psychiatry*, 26(5), 758-63.

Early Intervention for Preterm Infants Project–Field, T.M., Widmayer, S.M., Stringer, S., and Ignatoff, E. (1980) Teenage, lower-class, black mothers and their preterm infants: An intervention and developmental follow-up, *Child Development*, 51, 26-36.

Early Childhood Education Programs

Mother-Child Home Program of Verbal Interaction Project—Madden, J., O'Hara, J., Levenstein, P. (1984) Home again: Effects of the Mother-Child Home Program on Mother and Child, *Child Development,* 55, 634-47.

Levenstein, P. (1992) The Mother-Child Home Program: Research methodology and the real world. In J. McCord and R.E. Tremblay (Eds.) *Preventing Antisocial Behavior: Interventions from Birth Through Adolescence,* New York: The Guilford Press, 43-66.

Problem-Solving Techniques in Childrearing—Shure, M.B., & Spivack, G. (1982) Interpersonal Problem-Solving in Young Children: A cognitive approach to prevention. *American Journal of Community Psychology* 10:341-356.

Shure, M.B. *Interpersonal Problem Solving and Prevention.* A comprehensive report of research and training. #MH-40801. Washington, D.C.: National Institute of Mental Health, 1993.

Book Lending Library—McCormick, C. & Mason, J. (1987). Intervention procedures for increasing preschool children's interest in and knowledge about reading. In W.H. Teale and E. Sulzby (Eds.), *Emergent literacy: Writing and reading* (pp. 90-115), Norwood, NJ: Ablex.

Bereiter-Engleman/Distar Model—Carnine, D., Carnine, L., Karp, J., & Weisberg, P. (1988) Kindergarten for economically disadvantaged children: The direct instruction component. In C. Warger (Ed.), *A resource guide to public school early childhood programs* (pp. 73-78). Alexandria, VA: Association for Supervision and Curriculum Development.

High/Scope Cognitive Curriculum—Berrueta-Clement, J.R., Schweinhart, L.J., Barnett, W.S., Epstein, A.S., & Weikart, D.P. (1984). *Changed lives: The effects of the Perry Preschool Program on youth through age 19.* Ypsilanti, MI: High/Scope Press, p. 59.

Schweinhart, L.J., Barnes, H.V., and Weikart, D.P. (1993) *Significant benefits: The High/Scope Perry Preschool study through age 27.* Monographs of the High/Scope Educational Research Foundation, no. 10, Ypsilanti, MI: High/Scope Press.

The Star Model—Karweit, N.L. (1989). *The effects of a story reading program on the vocabulary and story comprehension skills of disadvantaged prekindergarten and kindergarten students* (CREMS Report No. 39). Baltimore, MD: Johns Hopkins University, Center for Research on Elementary and Middle Schools.

Brookline Early Education Project—Pierson, D.E. (1988). The Brookline Early Education Project. In R. Price, E.L. Cowen, R.P. Lorion & J. Romoa-McKay (Eds.), *Fourteen Ounces of Prevention: A Casebook for Practitioners.* Washington, DC: American Psychological Association.

Interpersonal Cognitive Problem-Solving (ICPS)—Shure, M.B. & Spivack, G. (1982). Interpersonal Problem-Solving in Young Children: A Cognitive Approach to Prevention, *American Journal of Community Psychology,* 10, 341-355.

Parent Training

Houston Parent-Child Development Center Program—Johnson, D.L. (1991) Primary Prevention of Behavior Problems in Young Children: The Houston Parent-Child Development Center. In R. Price, E.L. Cowen, R.P. Lorion & J. Romoa-McKay (Eds.), *Fourteen Ounces of Prevention,* American Psychological Association, pp. 44-52.

Parent-Child Interaction Training—Strayhorn, J.M. & Weidman, C.S. (1991). Follow-up of one year after parent-child interaction training: Effects on behavior of preschool children. *Journal of American Academy of Child and Adolescent Psychiatry,* 30: 138-143.

Montreal Longitudinal Study of Disruptive Boys-Tremblay, R.E., Vitaro, F., Bertrand, L., LeBlanc, M., Beauchesne, H., Boileau, H. & David, L. (1992). Parent and child training to prevent early onset of delinquency: The Montreal Longitudinal-Experimental Study. In J. McCord & R. Tremblay, *Preventing Antisocial Behavior: Interventions from Birth through Adolescence*, New York: The Guilford Press, 117-138.

Tremblay, R.E., Pagani-Kurtz, L., Masse, L.C., and Pihl, R.O. (1995). A bimodal preventive intervention for disruptive kindergarten boys: Its impact through mid-adolescence. *Journal of Consulting and Clinical Psychology* 63: 560-568, 1995.

Parents and Children Videotape Series–Webster-Stratton, C. (1984) Randomized trial of two parent-training programs for families with conduct-disordered children. *Journal of Counseling and Clinical Psychology*, 52, 666-678.

Webster-Stratton, C. (1990a) Enhancing the effectiveness of self-administered videotape parent training for families with conduct-problem children. *Journal of Abnormal Child Psychology* 18(5): 479-492.

Webster-Stratton, C. (1990b) Long-term follow-up of families with young conduct-problem children: From preschool to grade school. *Journal of Clinical Child Psychology* 19(2): 144-149.

Webster-Stratton, C. (1994) Advancing videotape parent training: A comparison study. *Journal of Consulting and Clinical Psychology* 62(3): 583-593.

Webster-Stratton, C., Kolpacoff, M., Hollinsworth, T. (1988) Self-administered videotape therapy for families with conduct-problem children: Comparison of two cost-effective treatments and a control group. *Journal of Consulting and Clinical Psychology* 56(4): 558-566.

Webster-Stratton, C., Kolpacoff, M., Hollinsworth, T. (1989) The long-term effectiveness and clinical significance of three cost-effective training programs for families with conduct-problem children. *Journal of Consulting and Clinical Psychology* 57(4): 550-553.

How to Help Your Child Succeed in School–Hawkins, J.D., Catalano, R.F., Jones, G.J., and Fine, D. (1987) Delinquency prevention through parent training: Results and Issues from work in progress. In J.Q. Wilson & G.C. Loury (EDS.), *Children to Citizens: Families, Schools, and Delinquency Prevention.* (3) New York: Springer-Verlag, 1987.

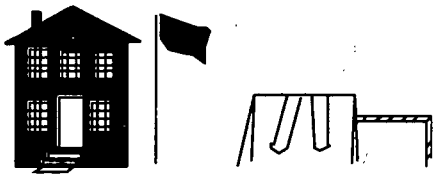
Preparing for the Drug-Free Years–Kosterman, R., Hawkins, J.D., Spoth, R., Haggerty, K.P., and Zhu, K. (1995) Preparing for the Drug Free Years: Effects on videotaped family interactions. Unpublished manuscript. University of Washington's Social Development Research Group.

Spoth, R., Redmond, C., Haggerty, K., and Ward, T. (1995) A controlled parenting skills outcome study examining individual difference and attendance effects. *Journal of Marriage and the Family* 7:449-464.

Family Therapy

Behavioral Systems Family Therapy–Klein, N.C., Alexander, J.F. & Parson, B.V. (1977). Impact of family systems intervention on recidivism and sibling delinquency: A model of primary prevention and program evaluation, *Journal of Consulting and Clinical Psychology* 45: 469-474.

Brief Strategic Family Therapy–Szapocznik, J., Rio, A., Murray, E., Cohen, M., Scopetta, M., Rivas-Vazquez, A., Hervis, O., Posada, V. & Kurtines, W. (1989). Structural family versus psychodynamic child therapy for problematic Hispanic boys. *Journal of Consulting and Clinical Psychology* 57: 571-178.



School Focus

The transition to schooling offers the young child opportunities to interact with a larger group of adults and other children and the need to master a multitude of new social and cognitive skills. Along with the continuing power of the family to shape a child's development, the school now becomes a significant influence in the child's world.

Organizational Change in Schools

Children come to school from a rapidly changing world characterized by growing numbers of single parent families, more families in which both parents work, and greater mobility. The students entering today's school buildings often bring with them greater social, emotional, physical, and educational needs. The world those students will enter after they leave the school system has also changed dramatically. Our increasingly diverse society's transition from the "industrial age" to the "information age" has created a demand for adults with new skills and abilities. Piecemeal efforts to meet these changing demands have seen little success because they ignore the need for basic structural and systemic changes.

Risk Factors That May Be Addressed

Transitions and Mobility

Low Neighborhood Attachment and Community Disorganization

Academic Failure

Lack of Commitment to School

Early and Persistent Antisocial Behavior

Organizational change in schools is particularly important in communities lacking an effective partnership between schools, parents, and the larger community. When significant proportions of students are falling behind academically, fundamental change in how schools are organized to do business may be required.

Systemic changes in schools may involve changes in the organization of the school, decision-making structures, school climate, parent involvement, the development and communication of school policies, and relationships between administrators, teachers, support staff, parents and students.

School organizational change programs require the full commitment of the school's principal, faculty, and parents over a minimum of three years. This does not mean that everyone in the school needs to accept the program without qualms before it is initiated. It will take time to build support. There must be strong leadership, however, among the principal and key faculty members. The principal's own management style will be a particularly important factor—flexibility and a collaborative approach are essential.

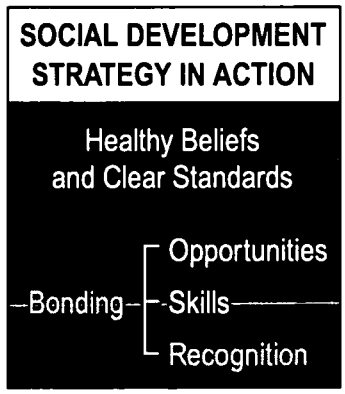
Resources such as special staffing, release time for staff development, special scheduling, and facilities and space will also be needed. To make sure this support is available, a commitment on the part of the district's governing board and superintendent to providing needed resources can be an important factor in initiating the program.

The following are examples of school organizational change programs.

School Development Program

Protective Factors Addressed: Healthy beliefs and clear standards that are consistent across the school environment, opportunities for parents and school staff to contribute to the governance and management of the school, parent involvement skills.

The School Development Program, developed by Dr. James Comer, was originally tested in two inner-city public elementary schools in New Haven, Connecticut. The program addresses the risk factors of **low neighborhood attachment and community disorganization, transitions, early antisocial behavior, academic failure** and **lack of commitment to school.**



The School Development Program consists of three main components:

Governance and Management Team

This group is made up of the school principal, two teachers selected by the faculty, three parents selected by the school's parent group, and a mental health professional. Charged with the main responsibility for school-site planning and program development, the group meets weekly. The group considers such issues as:

- School-wide needs and goals
- Curriculum
- In-service training
- School climate
- Program implementation
- Resources
- Evaluation

The Governance and Management Team also works closely with the other groups established by the program to plan and carry out school-wide activities over the course of the year.

Mental Health Team

This group includes a classroom teacher, the special education teacher, a social worker, and a school psychologist. It meets weekly to consider individual student behavior problems on a case by case basis, usually as a result of teacher referrals. It also recommends and helps to bring about changes in school policies and procedures that have an impact on the school's social climate and students' well-being (for example, developing an orientation program for new students and their parents to introduce them to the school).

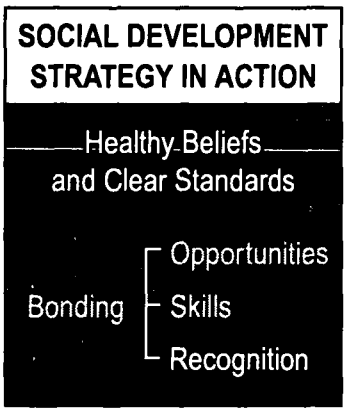
Parent Program

Parental representatives play a key role in the Governance and Management Team. In addition, parents have many opportunities to become involved in the school through social activities, workshops, and as classroom tutors or aides. The program provides a parent handbook describing parental roles and opportunities for involvement.

The program increased parental involvement and showed significant positive effects on middle school grades, academic achievement test scores, and social competence (Comer, 1988).

The Program Development Evaluation (PDE) Method

Protective Factors Addressed: Healthy beliefs and clear standards communicated throughout the school, consistent recognition for appropriate behavior.



The Program Development Evaluation (PDE) Method is a multi-component middle school organizational intervention that addresses the risk factors of **academic failure** and **low commitment to school.** The program has four main program components:

- School discipline policy review and revision to develop school rules that are clear, specific, fairly administered, and coordinated with individual classroom policies. The rules includes provisions for systematically rewarding positive student behavior.

- A behavior tracking system for recording individual students' positive and negative referrals to the office and disciplinary actions. It is used for notifying parents of their child's school behavior.

- Classroom organization and management that focuses on clear and effectively communicated rules, procedures, and instruction; monitoring; activity transitions; fair grading; and frequent and systematic feedback on student academic progress.

- Behavioral modification techniques in which teachers reinforce positive behavior and consistently respond to misbehavior according to the communicated rules and consequences.

These components are implemented in the context of an organizational development process intended to increase school staff commitment to and ownership of the program and equip them with the skills and information to effectively manage program implementation.

The PDE process involves a set of specific steps:

- Determining factors that are causing problems and choosing potential interventions that address those factors.

- Selecting proven (or at least plausible) interventions to bring about the desired outcomes.

- Utilizing information about the factors working both for and against the innovation in group decision-making as part of the planning for program implementation.

- Specifying critical benchmarks, implementation standards, and time-delineated tasks to serve as indicators of progress.

- Monitoring all aspects of program implementation and outcomes to signal needed changes in course.

These steps are carried out by School Improvement Teams of teachers, parents, school administrators and district-level staff. The Team meets regularly to identify priorities, clarify goals and objectives, develop programs that address problem areas, and monitor the process of implementing

programs. The method provides for ongoing scrutiny of changes in school management.

The program produced significantly less classroom disruption, greater classroom organization and clarity of rules (Gottfredson et al., 1993.)

PRENATAL | 0–2 YEARS | 3–5 YEARS | 6–10 YEARS | 11–14 YEARS | 15–18 YEARS

School Transitional Environment Project (STEP)

Protective Factors addressed: Opportunities for positive involvement with peers, reinforcement by the teacher for involvement, supportive environment for young people who are less socially oriented.

***School Transitional Environment Project* (STEP)** is a school organization model that addresses the risk factors of **transitions, academic failure,** and **low commitment to school.**

SOCIAL DEVELOPMENT STRATEGY IN ACTION

Healthy Beliefs and Clear Standards

Bonding: Opportunities, Skills, Recognition

It is designed to facilitate successful adaptation to large middle and high schools, particularly for low-income, minority, and other disadvantaged students who may not be attending schools within their geographic neighborhoods. Incoming students are assigned to units of approximately sixty-five to one hundred students, or "schools within the school". Homerooms and classes in primary academic subjects are composed only of students in the same unit and classrooms for the same unit are located in close physical proximity to each other (e.g., the same wing and floor of a building).

Teachers of the primary academic subjects in a unit also serve as homeroom teachers for students in that unit. Homeroom teachers act as the main administrative and counseling link between the students, their parents, and the rest of the school. STEP homeroom teachers contact parents before the school year begins to explain the program and encourage them to contact program teachers. The program homeroom teachers also have brief counseling sessions with homeroom students approximately once a month.

After a year in STEP, participants join the general student population in their school.

The program has demonstrated significant effects: 1) project students were less likely to drop out of school—21% of the project students compared to 43% of the control group, 2) in the tenth grade, project students had significantly higher grades and fewer absences than controls. Results suggested that the program was particularly effective for those students initially doing poorly in school (Felner and Adan, 1988; Felner et al., 1993).

Classroom Organization, Management and Instructional Strategies

The combined experiences of thirteen years in classrooms has a powerful impact on a child's success in life. Unfortunately, children exposed to the greatest risk often experience early school failure, setting in motion a self-perpetuating downward spiral. Interventions involving classroom organization, management and instructional strategies have the potential to break that cycle of failure. A combination of the successful strategies and techniques outlined below will be most effective in reducing risks as well as in promoting bonding to school.

Risk Factors That May Be Addressed

Early Antisocial Behavior

Academic Failure

Lack of Commitment to School

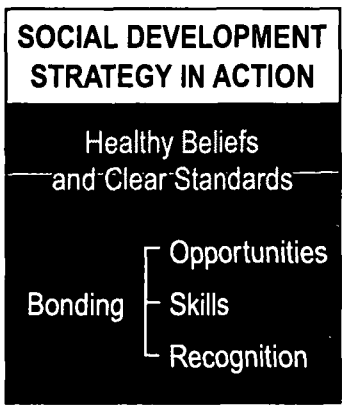
The following are examples of classroom organization, management and instructional strategies.

▶ Classroom Organizational Strategies

Schools have always used a variety of ways of grouping students for instruction, from the one-room schoolhouse where children of all ages and abilities learn together, to the more common placement of children in grade level classrooms based on their age. A number of different classroom organizational strategies have been evaluated. Following are examples of strategies that have been shown to be effective in addressing the risk factors of **academic failure** and **lack of commitment to school.**

PRENATAL | 0–2 YEARS | 3–5 YEARS | 6–10 YEARS | 11–14 YEARS | 15–18 YEARS

Protective Factors Addressed: Opportunities for students to contribute to their classroom, reading and math skills, immediate recognition for skill development.



In several reviews of evaluations of classroom organization, management, and instructional strategies, Robert Slavin and his associates identified a number of effective classroom organizational strategies. ***Reductions in class size*** for kindergarten and first grade show positive effects on students' reading achievement. ***Within class ability grouping*** for math and reading shows promise for improving reading and math scores in the *elementary grades*. However, there is no evidence that smaller class sizes affect achievement in later grades. ***Ability grouping in reading across classes and grades*** has been shown to increase students' reading scores. ***Non-graded elementary schools***, a classroom arrangement in which students are grouped according to their level of academic performance rather than their ages, have been shown to increase students' academic achievement. ***Diagnostic-prescriptive pullout strategies,*** in which students identified as being in need of additional learning support are given individual or small group instruction, show positive effects on academic achievement in reading and math (Slavin, et al. 1987, 1989, 1990; Madden & Slavin, 1989; Gutierrez & Slavin, 1992).

▶ Classroom Strategies for Behavior Management

Behavioral techniques for classroom management, including the establishment of clear rules and directions, use of praise/approval, modeling, token reinforcement, self-reinforcement, and shaping of behavior are effective strategies for promoting positive classroom behavior. In addition, several techniques have demonstrated effectiveness in decreasing disruptive, negative behavior. These include ignoring misbehavior, reinforcement of behavior that is incompatible with the undesired behavior, soft reprimands, time-outs, point loss/fines in token economies, and relaxation methods.

The following are examples of classroom strategies for behavior management.

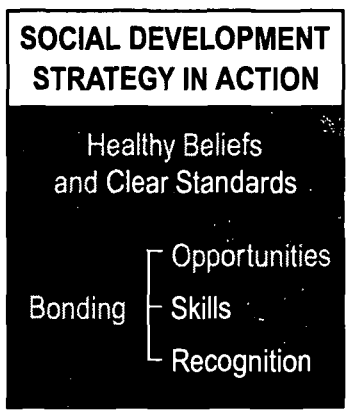
PRENATAL | 0–2 YEARS | 3–5 YEARS | 6–10 YEARS | 11–14 YEARS | 15–18 YEARS

Proactive Classroom Management

Protective Factors Addressed: Clear standards for behavior, skills for self-control and following classroom rules, reinforcement of appropriate behavior.

Proactive classroom management involves training teachers to maximize the time students spend actually involved in learning and to minimize classroom disruptions. When teachers use this approach in the classroom, students learn to manage their own behavior. Teachers learn how to give clear and explicit instructions for student behavior and to recognize and reward attempts to comply. Teachers also learn how to keep minor discipline problems from interrupting the learning process by being pro-active. Specific examples include:

- Starting the school year with clear rules and expectations for behavior.
- Teaching students classroom rules and routines in structured lessons.
- Giving clear directions, and using praise effectively.
- Making smooth transitions between classroom activities to maximize the time spent learning.
- Maintaining a positive classroom environment and maximizing time on task by using classroom control methods least disruptive to instruction.



- Proactive classroom management was tested, in conjunction with interactive teaching practices and cooperative learning, in multi-ethnic public middle school classrooms.

At the end of Grade 6, low-income girls in the project showed greater attachment and commitment to school, higher levels of classroom participation, and lower rates of initiation of alcohol, marijuana, and tobacco use compared to controls. Low-income boys in the project also showed greater attachment and commitment to school and higher levels of classroom participation at the end of Grade 6, as well as higher levels of social skills, better work skills, higher scores on standardized tests, lower levels of interaction with antisocial peers and lower levels of delinquency initiation. Long-term effects of SSDP included significant reductions in violent, criminal behavior, teen sexual activity and teen pregnancy (Hawkins, et al., 1992; O'Donnell, et al., 1995).

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

The Good Behavior Game

Protective Factors Addressed: Healthy beliefs and clear standards for behavior, opportunities to contribute to a "team", skills for self-control and working with peers, recognition for appropriate behavior.

SOCIAL DEVELOPMENT STRATEGY IN ACTION

Healthy Beliefs and Clear Standards

Bonding — Opportunities, Skills, Recognition

The ***Good Behavior Game*** is a behavioral classroom technique designed to address the risk factor of **early antisocial behavior** by decreasing aggressive and disruptive behaviors among first graders. In classrooms, students are assigned to heterogeneous teams, with each team including some students who exhibit aggressive/disruptive behavior. When the *Good Behavior Game* is in progress, teachers assign checkmarks on the blackboard to a team when a member of that team engages in disruptive behavior. At the end of the game period, teams with fewer than five checkmarks earn a reward. In the beginning of the program, game periods are announced, and tangible rewards, such as stickers, are immediately given to team members. As the program progresses, teachers begin the game unannounced and use less tangible rewards, such as extra recess or other special activity. Teams that win most often during the week receive a special reward on Friday.

The *Good Behavior Game* was evaluated with children from low and middle income families of varying ethnic backgrounds in a large urban school district. After one year of the program, students in classrooms that employed the *Good Behavior Game* were evaluated as less aggressive and shy by teachers and peers compared to students in the control group who were not part of the intervention. The most marked results were found for the most aggressive children. Participants were also evaluated when they were in the sixth grade. Highly aggressive boys who had received the intervention in the first grade were found to be less aggressive in the sixth grade than were highly aggressive boys who had not received the intervention. (Kellam and Rebok, 1992)

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

Behavioral Intervention for Middle School Students

Protective Factors Addressed: Healthy beliefs and clear standards for behavior, recognition for appropriate behavior and school performance.

SOCIAL DEVELOPMENT STRATEGY IN ACTION

Healthy Beliefs and Clear Standards

Bonding — Opportunities, Skills, Recognition

Behavioral Intervention for Middle School Students targeted middle school students with academic and behavior problems at school. The intervention addressed the risk factors of **early and persistent antisocial behavior, academic failure** and **low commitment to school.**

Participants' school progress was monitored using school records and weekly reports from teachers on the students' performance and behavior during a two-year study period. Students who exhibited appropriate

school behavior received praise and approval, as well as points to be used toward extra school trips. During the year following the intervention, biweekly follow-up review sessions were provided for the students.

For the evaluation, students in the program were matched to other at-risk students who had received no intervention. At the end of the program, students who had received the intervention had better grades and attendance records than those students who did not have the intervention. During the year after the program, the experimental youths reported less abuse of some types of illegal drugs as well as less criminal behavior. Five years after the program, the students who had received this behavior intervention were two-thirds less likely to have a juvenile record than were those who were not part of the program (Bry, 1982).

▶ Classroom Instructional Strategies

Classroom instructional strategies, including *cooperative learning, one-on-one tutoring, computer-assisted instruction, continuous progress instruction,* and *interactive teaching* address the risk factor of **academic failure**.

As schools are increasingly faced with heterogeneous student populations with diverse needs and abilities, changes in classroom instructional practices are necessary to meet the needs of each individual student and ensure academic success for all children. Effective instructional strategies help teachers systematically plan lessons, maximize time spent on teaching and learning, provide opportunities for all students to be actively involved in their learning, promote positive interactions among students and between students and teachers, monitor students' progress, and provide assistance as necessary to students who have not mastered the material.

PRENATAL | 0–2 YEARS | 3–5 YEARS | 6–10 YEARS | 11–14 YEARS | 15–18 YEARS

Continuous Progress Instruction

SOCIAL DEVELOPMENT STRATEGY IN ACTION

Healthy Beliefs and Clear Standards

Bonding — Opportunities, Skills, Recognition

Protective Factors Addressed:
Opportunities to contribute to their own learning plan, increased academic skills, consistent and immediate recognition for successful performance.

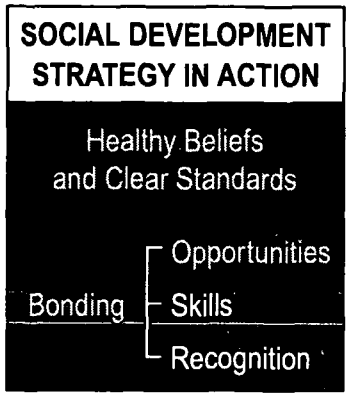
Continuous progress instruction allows students to proceed at their own pace through a defined hierarchy of skills, ensuring mastery of each level before moving on to the next skill. Instruction is delivered to students at the same skill level. Students are tested at each level to assess their readiness to advance to the next skill. Those who fail these mastery tests receive tutoring, corrective instruction in small groups or other instructional assistance to help them master the necessary skills. Continuous progress programs maintain careful records of each student's progress through the curriculum and these records are used to guide instructional decisions. Multiple evaluations of continuous progress programs have shown significant positive effects on **academic achievement**. (Slavin and Madden, 1989).

PRENATAL | 0–2 YEARS | 3–5 YEARS | 6–10 YEARS | 11–14 YEARS | 15–18 YEARS

Computer-Assisted Instruction

Protective factors addressed: Recognition for successful performance, reading and math skills.

Computer-assisted instruction addresses the risk factor of **academic failure.**

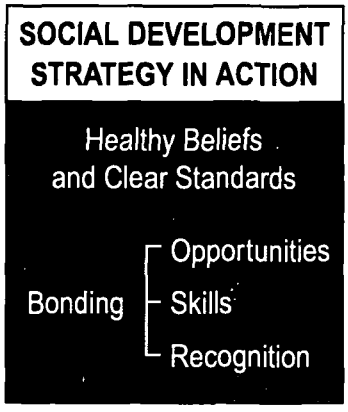


Computer-assisted instruction uses highly-structured computer programs to drill students in basic reading and math skills, often using entertaining games and interesting graphics. These programs provide immediate reinforcement to the student for correct answers and require mastery of a set of skills before moving on to the next level. Most computer programs can be modified by the teacher to focus on the specific skill needs of the student and can track the student's progress, allowing the teacher to diagnose particular skill areas that need attention. *Computer-assisted instruction* has shown positive effects on student's achievement in basic reading and math skills (Madden and Slavin, 1989).

PRENATAL | 0–2 YEARS | 3–5 YEARS | 6–10 YEARS | 11–14 YEARS | 15–18 YEARS

Cooperative Learning Programs

Protective Factors Addressed: Healthy beliefs and clear standards, opportunities to contribute to a prosocial peer group; communication, problem-solving, group process skills, recognition for successful contribution to the group.



Cooperative learning programs involve teachers giving initial instruction to groups of students who are at the same skill level, or to the class as a whole. Students then work in heterogeneous learning teams, helping each other learn and assessing each other's progress in preparing for tests and teacher assessments. This strategy helps the teacher to ensure that all students learn the material.

This method for dividing students into mixed ability learning teams in the classroom has been widely recognized as a way to motivate students and teach both academic and social skills more effectively. Following interactive teaching sessions, teachers use cooperative learning groups to ensure mastery of the material by all students. Cooperative learning strategies:

- Teach positive social skills such as listening, helping, and sharing.
- Create heterogeneous learning teams in the classroom.
- Provide incentives for effective teamwork.
- Provide opportunities for both formal and informal teamwork.
- Help students work together toward mutual goals.

- Reward group efforts, not just individual efforts.

- Develop lesson plans that emphasize cooperation in student teams to master the material.

Cooperative learning has demonstrated positive effects on academic achievement, as well as on attitudes toward school, appreciation of diversity, and acceptance of special education students (Slavin, 1983).

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

Tutoring Programs

Protective Factors Addressed: Opportunities for meaningful involvement with prosocial adults or older peers, increased academic skills, individual recognition from the tutor for skilled performance.

SOCIAL DEVELOPMENT STRATEGY IN ACTION

Healthy Beliefs and Clear Standards

Bonding: Opportunities, Skills, Recognition

Tutoring programs address the risk factors of **academic failure** and **lack of commitment to school**. One-on-one tutoring of elementary school students in reading and math by older students, adult community volunteers, trained paraprofessional, or professional teachers has been shown to produce substantial long-term improvements in student achievement. Both remedial and preventive tutoring programs are effective. Unstructured programs, appear to be as effective as structured programs. In addition, older students who serve as tutors for younger students also showed academic gains as a result of their participation. Several studies of peer tutoring and tutoring by adults have shown positive effects on academic achievement one to two years following tutoring (Coie et al., 1984, Greenwood et al., 1993).

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

Success for All

Protective Factors Addressed: Healthy beliefs about the value of education, opportunities for children to contribute in interactive reading groups, reading skills, immediate recognition for success from the tutor.

SOCIAL DEVELOPMENT STRATEGY IN ACTION

Healthy Beliefs and Clear Standards

Bonding: Opportunities, Skills, Recognition

The ***Success for All*** program was designed to help all children achieve grade level in basic reading, math, and language skills by the third grade. The program is designed to address **academic failure** and **lack of commitment to school** through two basic principles: 1) the prevention of problems by providing good school programs and involving the parents in the prevention effort, and 2) the delivery of unobtrusive, immediate, and intensive intervention when children display learning and school problems. Accordingly, learning problems are addressed before they lead to grade retention and the need for remedial education.

The components of the *Success for All* program include:

- **Reading tutors**–The tasks of the tutors are: (a) to provide one-on-one twenty minute

tutoring sessions for students needing extra assistance (first graders have priority for tutoring), and (b) to assist reading teachers in ninety minute daily reading periods to reduce class size to about fifteen students. The tutoring sessions are out of the classroom. There are six tutors in the school who work with eleven students a day. Each tutor is a certified teacher with experience in special education or primary reading. The goal is to support children's success by reinforcing the classroom curriculum.

- **Reading program**—Students in grades one through three are grouped in performance-based classes for a daily ninety minute reading program. Classes are comprised of fifteen students at the same reading level. On the first level, sessions begin with the teacher reading to the children, followed by a discussion of the story to enhance understanding, listening and using vocabulary. On the second level, lessons use a modified form of the Cooperative Integrated Reading and Composition (CIRC) curriculum which uses cooperative learning reading activities focused on story structure, prediction, summarization, vocabulary, and story-related writing. Progress through the reading program is assessed every eight weeks in order to reassign students to appropriate reading groups, to determine who needs tutoring, and to identify students who need other assistance.

- **Parent education/family support team.** Two social workers and one parent liaison work fulltime in the school to provide parenting education, encourage parents to get involved in their child's education and provide support for their child's progress. When a child has needs or problems at home that may inhibit school progress (nutrition, sleep, truancy), the support team provides assistance.

- **Preschool and kindergarten.** A half-day preschool and full-day kindergarten provide eligible students with developmentally appropriate learning experiences with an emphasis on language skills. Both academic and nonacademic activities are provided.

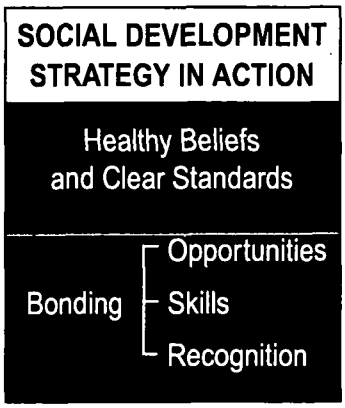
- **Special education.** Efforts are made to provide supplementary help (by tutors) within the context of the classroom.

The program has demonstrated significant effects on reading achievement among urban, low income, predominantly African American students in grades K-3. Third graders in the program group scored 3.6 grade equivalents compared to a score of 2.5 grade equivalents in a control group. The greatest effects were observed in students with the lowest achievement levels at entry. There was also a lower rate of grade retention and a lower rate of referrals to special education in the program group (Slavin et al. 1990).

This comprehensive program illustrates the importance of using multiple preventive strategies.

The Seattle Social Development Project

Protective Factors Addressed: Healthy beliefs about the value of education, opportunities for student participation in the school, opportunities for parent participation in the school, academic and social skills for students, family management and educational support skills for parents, recognition for academic and social skills from parents and teachers, recognition for parent involvement in the school.



The Seattle Social Development Project tested the effects of ***interactive teaching*** as part of a comprehensive, multicomponent strategy to increase bonding to school and family and reduce the risk factors of **antisocial behavior, academic failure, early initiation of problem behaviors** and **family management problems** in low income multi-ethnic urban elementary school children. The objective of the Seattle Social Development Project was to facilitate the development of strong bonds to family, school, and prosocial peers by (1) promoting opportunities for prosocial participation in the family or school, (2) enhancing skills for successful participation in these social units, and (3) increasing the reinforcement from these social units for prosocial involvement in family and the classroom, thereby affecting the processes by which bonding to family and school develop.

The project included the following components:

Teacher Training—Project teachers were trained in three areas:

- **Proactive classroom management**—see description in this section under Classroom Behavior Management Strategies.

- **Interactive teaching** is a method for enhancing the teacher's ability to design lesson plans to motivate students and monitor their learning. The method, which addresses **academic failure** and **lack of commitment to school**, is particularly effective with students who are at high risk for academic failure.

  Specific teaching methods used are:

  – Using a mental set to motivate students to want to learn the material

  – Breaking objectives into small steps (task analysis)

  – Presenting clear information tied to objectives

  – Modeling the use of skills being taught

  – Use of group and individual practice

  – Constantly monitoring the progress of all students and making the necessary adjustments to ensure that all students master the lesson (Rosenshine, 1986).

- **Cooperative learning**—see description earlier in this section.

Teachers in grades one through four in the intervention group were trained in the three instructional

methods. They were observed and given feedback once every three weeks by project staff and school principals. In addition first grade teachers were trained to implement the cognitive problem-solving curriculum developed by Shure and Spivack (see description in the Early Childhood section of this guide).

Child Skills Training—In the first grade, children in the intervention group received cognitive-based social competence training (Shure and Spivack) which was designed to foster the children's competence in communication, decision making, negotiation, and conflict-resolution.

Parent Training—The three components of the parent training included:

- **Catch 'em Being Good** is a seven-session curriculum which was offered in the first and second grades. It taught parents how to (a) monitor and identify desirable and undesirable behaviors in children, (b) teach expectations for behavior, and (c) give positive feedback for desirable behavior and moderate negative consequences for undesirable behavior. The curriculum involves demonstration and modeling of skills, role play, feedback, and homework practice assignments.

- **How to Help Your Child Succeed in School**—See details in the Parent Training section of this guide.

- **Preparing for the Drug (Free) Years**—see details in the Parent Training Section of this guide.

At the end of Grade 6, low-income girls in the project showed greater attachment and commitment to school, higher levels of classroom participation, and lower rates of initiation of alcohol, marijuana, and tobacco use compared to controls. Low-income boys in the project also showed greater attachment and commitment to school and higher levels of classroom participation at the end of Grade 6, as well as higher levels of social skills, better work skills, higher scores on standardized tests, lower levels of interaction with antisocial peers and lower levels of delinquency initiation. Long-term effects of SSDP have included significant reductions in violent, criminal behavior, teen sexual activity and teen pregnancy (Hawkins, et al., 1992; O'Donnell, et al., 1995).

Classroom Curricula for Social Competence Promotion

Social competence promotion that enhances both social development and academic learning is increasingly recognized as an important part of the basic educational process (Goleman, 1995). Where once skills and attitudes promoting self-discipline, problem solving, self-responsibility, effective communication, cooperation, and helping others were taught at home and through children's participation in the life of the community, now our communities are increasingly fragmented and children are often isolated from positive social influences. Many children come to school from homes and communities that have changed radically in recent decades. Many children spend long parts of each day on their own, without the support and guidance of parents or other positive, caring adults. Increasingly, television and negative peer influences fill the void (Bronfenbrenner, 1986).

School curricula that focus on and support the development of social competence can help. In the primary grades, the focus should be on basic social skills such as sharing, listening to others, and working cooperatively in a group. As students mature, curricula should include a broader range of skills, e.g., how to resist negative peer influences, solve problems, set goals, and provide service to others. Throughout a child's development, social competence development programs support positive social behaviors.

Curricula with a social competence emphasis not only teach specific skills that help students to behave in responsible and healthy ways, they also provide students with a sense of self-efficacy, the feeling and confidence that they know how to accomplish a particular goal and are able to accomplish it. Social competencies can be taught to all students, regardless of their racial/ethnic background, or socioeconomic or at-risk status (Elias and Weissberg, 1990; Jones, 1988; Lemda; et al, 1990; Mirman et al, 1988; Palincsar and Brown, 1985; Presseisen, 1988).

Risk Factors That May Be Addressed

Early and Persistent Antisocial Behavior

Academic Failure

Rebelliousness

Friends Who Engage in the Problem Behavior

Favorable Attitudes Toward the Problem Behavior

Early Initiation of the Problem Behavior

Neighborhood Attachment and Community Disorganization

Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime

Curricula that focus on developing social competencies vary widely in structure and content from one grade level and developmental phase of childhood to another. However, the following components have been identified as important:

- **Focus on skill development.** Programs that are only informational or that rely exclusively on textbooks and lectures may provide students with information about skills, but they do not promote the actual learning and use of those skills.

- **Use effective instructional strategies.** Skill development is the result of learning informa-

tion about the skill, being exposed to modeling of the skill, practicing the skill, receiving feedback on use of the skill, and being reinforced for using the skill. This requires an interactive classroom format in which students participate in learning and trying out new skills and in which the use of those skills is encouraged and reinforced. The classroom is a laboratory for development of skills that can then be used outside the classroom.

- **Accepting classroom climate.** The classroom climate is a particularly important factor in effective social competence promotion. A climate of openness and acceptance encourages students to try out skills that may seem unnatural or unfamiliar. The teacher should model appropriate attitudes and ways of interacting with others. Social competence promotion requires children to work cooperatively together in groups, develop a sense of teamwork, listen to each other more carefully and sensitively, and help each other.

Social competence requires an ability to adapt and integrate feelings (emotions), thinking (cognition), and actions (behavior) to achieve specific goals. The best programs combine skills training in all three areas in an integrated framework. Criteria for selecting a social competence curriculum include determining that the curriculum addresses all three of these areas and explicitly teaches skills in each area.

Emotional skills include:

- Identifying and labeling feelings
- Expressing feeling
- Assessing the intensity of feelings
- Managing feelings
- Delaying gratification
- Controlling impulses
- Reducing stress

Cognitive skills include:

- Self-talk—conducting an "inner dialog" as a way to cope with a topic, a challenge, or to reinforce one's own behavior
- Reading and interpreting social cues—recognizing social influences on behavior and seeing oneself in the perspective of the larger community
- Using steps for problem solving and decision making—setting goals, identifying alternative actions, anticipating consequences, acting, and evaluating consequences
- Understanding the perspective of others
- Understanding behavioral norms (what is and is not acceptable behavior)
- Developing a positive attitude toward life
- Self-awareness—developing realistic expectations in order to predict one's own behavior

Behavioral skills include:

- Nonverbal—communicating through eye contact, facial expressiveness, tone of voice, gestures, style of dress, etc.
- Verbal—making clear requests, responding effectively to criticism, resisting negative influences, expressing feelings clearly and directly, giving and receiving compliments

- Taking action—walking away from situations involving negative influences, helping others.

Social competence promotion programs aim to change students' social behavior over the long-term—improving the conduct of individual students, promoting more positive intergroup relations, and generally affecting the social climate of the school in a positive way. This requires substantial support on the part of the school's administration, faculty, and parents, as well as the community. Many programs that teach social competencies provide opportunities for participation in school events and activities beyond the classroom.

Also important is parental involvement. Curricula should offer regular homework assignments in which parents and their children have opportunities to explore an issue together or talk about and practice a new skill that the child is learning. Parents should also be involved before a curriculum is adopted. They should be informed and consulted as part of the selection process.

A number of studies have shown that school-based social competence programs at the secondary level are more effective when they involve students or peer leaders who teach and model new skills. Botvin and his colleagues (1990) found that social skills training led by peer leaders achieved greater reductions in substance use than did training provided by classroom teachers alone. Peer-led programs are also consistent with the emphasis of the Social Development Strategy on providing opportunities for active involvement to promote bonding to school and on countering negative peer influences to use drugs. They help to establish and support a positive peer norm.

Criteria for Assessing Social Competence Promotion Programs

The following criteria developed by the W.T. Grant Consortium on the School-Based Promotion of Social Competence can be used by communities to assess and select social competence curricula (Hawkins et al., 1992). Social competence programs should:

- Address the needs of an individual school and its students
- Focus on developing specific social competencies and skills in a developmentally appropriate manner
- Teach skills in managing feelings, thinking, and behavior
- Use effective instructional strategies
- Be long-term and coordinated, covering grades K-12
- Include parent involvement and work to be completed at home, preferably involving parents
- Teach specific skills for resisting negative and limiting social influences
- At the upper grade levels, include peer leadership
- Train teachers in implementation methods and provide on-going support and technical assistance
- Be coordinated with more intensive intervention services such as guidance, pre-referral intervention, special education, student assistance counselors, community-based services
- Have clear articulation with other existing subject areas, including some basic academic subject areas and health education
- Contain materials that are clear, up to date, and "user-friendly"
- Show cultural sensitivity to the range of students represented
- Have evidence of effectiveness.

Note: Members of the W.T. Grant Consortium are Maurice J. Elias and Roger P. Weissberg, co-chairs; Kenneth A. Dodge, J. David Hawkins, Leonard A. Jason, Phillip C. Kendall, Cheryl L. Perry, Mary Jane Rotheram-Borus, and Joseph E. Zins.

An effective process for implementing a social competence promotion program requires broader involvement than a quick decision to buy a curriculum package. Effective implementation incorporates the following principles:

- Implementation should be school-wide, coordinated, and long-term.
- Teacher training to deliver the program is a key component.
- On-site follow-up to teacher training, ideally some form of peer coaching, is needed in order to support and strengthen teachers' skills in implementing the program.
- The leadership, commitment, and involvement of the school principal is crucial to the success of the program.
- The program should be well-integrated with the school's other curricula and programs—otherwise, it is likely to be regarded as an afterthought or "frill," rather than a continuing program with real meaning and relevance to the school.
- Parents and the community should be informed about the program, be involved in the selection process, and strongly support it.
- The district administration should be well-informed about the program and consider it a high priority.
- Program evaluation should be planned during initial implementation and should not be an "add-on".

Social competence promotion in schools requires more than just adopting a curriculum or exposing students to a few hours of information classes or a school assembly. It is important to integrate the promotion of social competencies into the daily activities and culture of the school in order to make a long-lasting impact on students' attitudes and behavior (Elias and Weissberg, 1990; Perry et al., 1989).

The following are examples of effective social competence promotion programs.

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

Promoting Alternative THinking Strategies (PATHS)

Protective Factors Addressed: Healthy beliefs and clear standards for behavior, opportunities for positive involvement with prosocial peers, skills for recognizing feelings, self-control and interpersonal problem-solving, recognition of skills mastery.

Promoting Alternative THinking Strategies (PATHS) is an elementary school curriculum designed to prevent violence, aggression, and other behavioral problems by promoting social competence. The program addresses the risk factors of **early antisocial behavior** and **favorable attitudes toward the problem behavior.**

The PATHS curriculum contains three major component areas: self-control, emotional understanding, and interpersonal cognitive problem-solving. A series of structured lessons are taught through pictures and photographs, dialoguing, role-playing, and modeling by teachers and peers. Learning is promoted through the combined use of visual, verbal, and kinesthetic modalities.

SOCIAL DEVELOPMENT STRATEGY IN ACTION

The PATHS Curriculum Kit includes a detailed Instructor's Manual, five-volume curriculum, a set of "feelings" photographs, a set of "feelings" face cards, and a set of posters to use in the classroom.

PATHS has been tested for ten years in the U.S., Canada, The Netherlands, Belgium, and Australia and has demonstrated effectiveness with both hearing-impaired children and hearing children in kindergarten through grade 6. Children who have been through the PATHS program show increased self control, emotional understanding, thinking before acting, and use of effective conflict-resolution strategies (Greenberg and Kusche, 1993). In studies with normal children, there were also significant increases in cognitive skills. The PATHS curriculum has also produced positive effects on classroom atmosphere (Greenberg et al., 1995).

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

The Social Relations Intervention Program

Protective Factors Addressed: Healthy beliefs and clear standards for social behavior, opportunities for prosocial involvement with peers, skills for prosocial involvement, problem-solving, and anger management.

The Social Relations Intervention Program sought to determine the effectiveness of a comprehensive social relations intervention for aggressive and nonaggressive rejected children. The program addresses **early and persistent antisocial behavior**.

SOCIAL DEVELOPMENT STRATEGY IN ACTION

The Social Relations Intervention Program consists of social skill training and cognitive-behavioral training. The training program

consists of twenty-six thirty-minute individual sessions and eight small group sessions for children ages nine to eleven.

The twenty-six session intervention program includes four components:

- **Social problem-solving training.** A seven-session curriculum designed to teach children how to identify problem situations and the goals of the situations, to inhibit impulsive behavior, and to identify possible solutions and their consequences. Sessions deal with issues of peer play, group entry, and anger coping.

- **Positive play training**. A nine-session curriculum designed to help children be better skilled at playing with their peers and maintaining personal relationships. The curriculum deals with physical appearance, communication skills, choice of words in making contact with peers, responses to negative reactions, and negotiation and cooperation strategies.

- **Group entry skill training.** A fourteen-session program designed to help children to be better skilled at joining groups (to identify "climate," rules and leadership of the group, and to match their style of entry to the ongoing play and activities of the group).

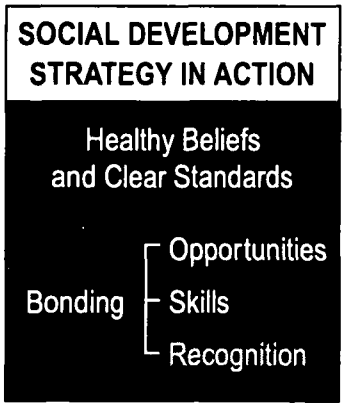
- **Coping with anger.** A four-session curriculum designed to teach children how to identify and reduce impulsive behavior, to use "self-talk" to regulate behavior, and to discuss the concept of "winner" in interpersonal conflicts that involve issues of revenge and dominance.

This program showed significant decreases in aggressive behavior and increased prosocial behavior. These effects held through the one-year follow-up (Lochman et al., in press).

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

The Improving Social Awareness-Social Problem Solving Project

Protective Factors Addressed: Healthy beliefs and clear standards for social behavior, opportunities to contribute to the peer group within the classroom, interpersonal problem-solving skills.



The Improving Social Awareness-Social Problem Solving Project was designed to address the risk factors of **early and persistent antisocial behavior** and **friends who engage in the problem behavior**. The program, for nine to eleven year-olds included the following components:

- **Instructional phase.** The instructional phase consisted of 20 sessions (40 minutes each, twice a week) dedicated to learning the skills involved in problem-solving and learning to use them in problem situations. Teachers used a script for each lesson that followed a set sequence: (a) group sharing of feelings, (b) presentation of the skill, (c) presentation of a sample situation to learn about the skill (story or video), (d) discussion of the situation and skill, (e) role play, and (f) summary and review.

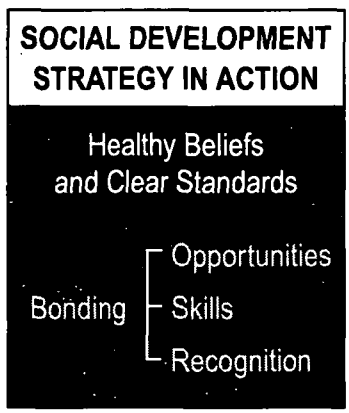
- **Application phase.** The application phase consisted of (a) instructions to teachers in how to mediate students' conflicts by facilitating the students' use of the problem-solving skills they learned in the earlier phase, and (b) instructions for integrating problem-solving situations into the regular classroom routine. Formal application lessons were held once a week, in addition to the informal lessons.

This program produced significant long-term effects (as measured six years after the intervention) on delinquent behavior, aggression, academic achievement, and absenteeism (Elias, 1991).

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

The Intervention Campaign Against Bully/Victim Problems

Protective Factors Addressed: Healthy beliefs and clear standards for behavior.



The Intervention Campaign Against Bully/Victim Problems sought to assess the impact of a nationwide campaign against the bullying problem in Norway. The principles underlying this program include: 1) the importance of creating environments (e.g., school, home) characterized by warm, positive interest and involvement with adults, 2) firm limits on unacceptable behavior, 3) nonhostile, nonphysical sanctions for rules violation, 4) monitoring and surveillance of students, and 5) adults as "authorities." The risk factors addressed in this study included **early and persistent antisocial behavior, family management problems,** and **favorable attitudes towards the problem behavior.**

The main goals of the campaign were to reduce bully/victim problems and to prevent the development of new problems. The specific objectives were as follows: (1) to increase knowledge and awareness of the bullying problem, (2) to actively involve teachers and parents, (3) to develop rules concerning bullying behavior, and (4) to support and protect victims of bullying.

The intervention program was offered to all schools serving grades one through nine. The program targeted teachers, parents, and students and included the following:

- A free thirty-two page booklet which was given to all comprehensive schools. The booklet was for all school personnel, providing information on the bully/victim problem, and suggestions on what to do about reducing and preventing the problem.

- A four-page folder that was given to all families in Norway with school-age children. It consisted of information and advice for parents of bullies, victims, and other children.

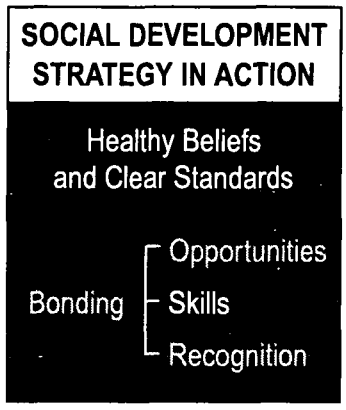
- A twenty-five minute video with stories about the lives of "bullied children" or victims (available for rent or sale).

- A short self-report questionnaire designed to obtain information from students on the bully/victim problem—its frequency and the readiness of students and teachers to deal with the problem. Students were also asked to report on their own involvement in the problem, as bullies or victims.

This program showed significant effects on bullying (50% reduction in students reporting being bullied or bullying others), self-reported antisocial behavior (vandalism, theft, truancy), and satisfaction with school (Olweus, 1991).

The Life Skills Training (LST) Program

Protective Factors Addressed:
Healthy beliefs and clear standards for social behavior, personal and social skills.



The Life Skills Training (LST) Program is a multi-component substance abuse prevention curriculum addressing social, psychological, cognitive, and attitudinal factors that have been shown to be associated with the use of various legal and illegal substances (cigarettes, alcohol, and marijuana). This program addresses the risk factors of **friends who engage in the problem behavior** and **favorable attitudes toward the problem behavior**. The primary objective of the program is to enhance the development of basic life skills, personal competence, and skills relevant to dealing with situations where students are exposed to social influences to smoke, drink, or use drugs.

The prevention program has four components:

- **Problem-specific component.** A four-session curriculum which provides information on the consequences of substance use, drug prevalence rates, norms, the decreasing social acceptability of substance use, the stages of drug use, the physiological effects of cigarette smoking, and advertisement strategies for promoting cigarettes and alcohol. Youth are also taught refusal skills for resisting social influences to use drugs.

- **Personal-Skills and Well-Being.** A four-session curriculum that teaches skills related to decision-making and media influences, a two- session curriculum aimed at self-improvement and self-image, and a two-session curriculum on coping with anxiety.

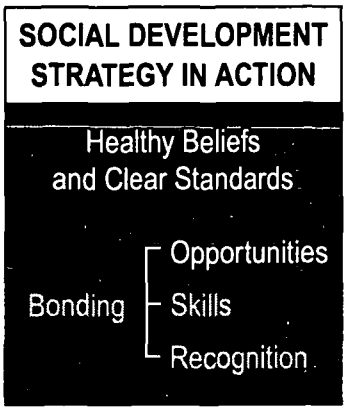
- **Social Skills and Interpersonal Competence.** A six-session curriculum that teaches verbal and nonverbal communication skills; general social skills to reduce shyness, including necessary skills for making social contacts and basic conversational skills with same and opposite sex peers; and assertiveness skills training, including the difference between aggression and assertiveness, verbal and nonverbal assertiveness skills, and how to apply the skills to situations characterized by peer pressure to use drugs.

- **Booster Curriculum:** A ten-session booster curriculum was provided to reinforce the prevention curriculum the year following the intervention. Intervention students also received a five-session curriculum in the ninth grade.

Students exposed to the curriculum were followed through grade twelve to determine long-term effects of participation in the program. The intervention had significant long-term effects on prevalence of cigarette smoking, heavy cigarette smoking, and problem drinking. Students exposed to the curriculum also had significantly lower rates of polydrug (tobacco, alcohol, and marijuana) use. The strongest effects were seen for students who received a complete version of the program—44% fewer drug users and 66% fewer polydrug users (Botvin et al., 1990; Botvin et al., 1995).

Gang Prevention Curricula

Protective Factors Addressed: Healthy beliefs and clear standards for behavior, opportunities for involvement with prosocial peers.



Schools across the country are searching for gang prevention programs aimed at preventing youths from joining gangs and mediating and intervening in crisis conflict situations between existing gangs. Components of gang prevention programs may address such risk factors as **association with delinquent and violent peers, rebelliousness, favorable attitudes toward delinquency, community norms favorable to delinquency,** and **neighborhood disorganization.**

Evaluation of a program consisting of a gang prevention curriculum and after-school recreational activities offered to eighth grade students suggests that this kind of intervention holds promise for preventing at-risk youths from joining gangs, and perhaps associating with delinquent and violent peers more generally.

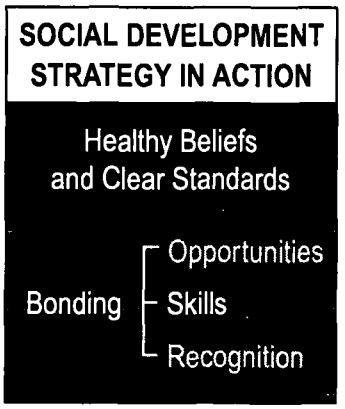
The curriculum included twelve classroom sessions conducted over twelve weeks, including background information on gangs, gang violence, substance abuse in gangs, gang recruitment, methods of resisting recruitment, and consequences of gang membership. Most sessions were led by project staff, but some were led by a prosecuting attorney and by ethnic minority guest speakers from various occupations.

The curriculum was taught to eighth grade students in Chicago middle schools located in lower and lower-middle class areas with high gang activity. After the curriculum ended, youths considered to be at high risk for joining a gang were invited to participate in afterschool recreational activities, including organized sports clinics, competition with youths both in their own and other neighborhoods, job skills/training workshops, educational assistance programs, and social activities.

Project staff and teachers identified youths in experimental and comparison schools who were at risk for joining a gang but were not already gang members (as determined from gang rosters kept by the project's detached street gang workers based on interviews with gang members). The researchers assessed gang membership again at the end of the school year by the same method. Results showed that experimental youths were less likely to become gang members than comparison youths (Thompson and Jason, 1988).

The Alert Drug Prevention Curriculum

Protective Factors Addressed: Healthy beliefs and clear standards about tobacco, alcohol and other drug use, skills for resisting drug use.



The Alert Drug Prevention Curriculum is a junior high school curriculum aimed at helping youth to resist pressure to use drugs and teaching them how drug use can affect them in their daily life and current relationships. The project addresses the risk factors of **friends who engage in the problem behavior, early initiation of the problem behavior,** and **favorable attitudes toward drug use.**

Alert is an eight-session (one session per week) curriculum taught to seventh graders, with three booster sessions taught in the eighth grade. The program was tested using both health educators and trained peer leaders. The curriculum uses interactive discussions, small group exercises, role modeling and skill practice to teach the following components:

- Developing reasons not to use
- Identifying pressures to use
- Countering pro-drug messages
- Understanding the real prevalence of drug use
- Recognizing the benefits of resistance

The curriculum showed significant effects on smoking for students who had never smoked or had experimented with smoking. No effects were found for regular smokers. The most significant effects of the project were on marijuana use, producing lower rates of both initiation and current use (Ellickson and Bell, 1990; Ellickson et al. 1993).

School Behavior Management Strategies

Comprehensive, school-wide strategies for promoting prosocial behavior throughout the school environment ensure a consistent message to students about norms for behavior. They also provide multiple opportunities to learn and practice skills in a variety of contexts and to be recognized for prosocial behaviors by all school personnel.

The following are examples of effective school behavior management strategies.

Risk Factors That May Be Addressed

Early and Persistent Antisocial Behavior

Academic Failure

Lack of Commitment to School

Rebelliousness

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

Structured Playground Activities

Protective Factors Addressed: Healthy beliefs and clear standards for behavior, opportunities for interaction with prosocial adults and peers.

SOCIAL DEVELOPMENT STRATEGY IN ACTION

Healthy Beliefs and Clear Standards

Bonding: Opportunities, Skills, Recognition

Structured playground activities appear to be effective in reducing conflict and aggressive behavior before school and during recess. This strategy addresses the risk factor of **early antisocial behavior.** A playground program evaluated in Tallahassee, Florida consisted of organized games (jump rope, foot races, etc.) for kindergarten through second grade children in the forty minutes before school started. Three aides supervised the activities and used a time-out procedure for students who committed particularly unruly behaviors. For time-out, the student was required to sit quietly on a bench for two minutes. Children were free to participate in the games or choose to play on their own, however, the majority of children participated. The program decreased disruptive incidents by 53% over the baseline period (Murphy et al., 1983).

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

Behaviorally-Based Prevention Program

Protective Factors Addressed: Healthy beliefs and clear standards for behavior, recognition from teachers and parents for prosocial behavior.

SOCIAL DEVELOPMENT STRATEGY IN ACTION

Healthy Beliefs and Clear Standards

Bonding: Opportunities, Skills, Recognition

A *Behaviorally-Based Prevention Program* for low-achieving, disruptive seventh graders with low bonding to their families addressed the risk factors of **rebelliousness, lack of commitment to school**, and **early and persistent antisocial behavior.** The program included the following components:

- **Weekly report cards.** A "weekly report card" was completed for each student, based upon teacher interviews concerning behavior in the classroom—bringing materials to class, tardiness, completion of classroom work.

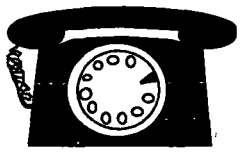
- **Discussion of report cards.** Students met in small groups where the report cards were distributed and discussed in one-on-one sessions. Positive reports elicited praise and approval from program staff, while negative reports elicited discussions of how to make teachers have more positive opinions of them. Points were given based on the weekly reports. Points were taken away for negative behavior during the sessions. Students could "win" an extra field trip away from school with enough points.

- **Parental contact.** Parents were kept informed of students' progress through phone calls, letters, and home visits.

- **Booster sessions.** Booster sessions were given every two weeks following the same format.

At the end of the program participating students had significantly better grades and attendance. In the year after the program ended, program youth had fewer behavioral problems at school (suspensions, academic failure, poor attendance, and tardiness) than controls. Five years after the program, participants were 66% less likely than control youth to have a juvenile record (Bry, 1982).

Resources



Organizational Changes in Schools

For further information about the *School Development Program*, contact:

School Development Program
Child Study Center
Yale University
230 S. Frontage Rd.
New Haven, CT 06510-8009
(203) 785-2548

For further information about the *Program Development Evaluation Method,* contact:

Gary D. Gottfredson
Denise C. Gottfredson
Center for Social Organization of Schools
Johns Hopkins University
3505 N. Charles Street
Baltimore, MD 21218
(301) 338-8466

Also see *A Workbook for Your School Improvement Program* by G.D. Gottfredson, Baltimore: John Hopkins University, 1988.

Classroom Organizational Strategies

For more information on *reduction in class size, within-class ability grouping, ability grouping across classes and grades, non-graded elementary schools,* and *diagnostic-prescriptive pullout strategies,* contact:

Dr. Robert Slavin
Johns Hopkins University
Center for Social Organization of Schools
3505 N. Charles Street
Baltimore, MD 21218

For additional information, contact the Education Department of the nearest college or university.

Classroom Strategies for Behavior Management

For more information on *proactive classroom management,* see *Managing to Teach* (1992) by Carol Cummings, Ph.D. available from:

TEACHING, INC.
P.O. Box 788
Edmonds, WA 98020
(206) 774-0755

For more information on the *Good Behavior Game,* contact:

Dr. Sheppard G. Kellam
Prevention Research Center
Department of Mental Hygiene
Johns Hopkins University
Mason F. Lord Building, Suite 500
Francis Scott Key Medical Center
4940 Eastern Avenue
Baltimore, MD 21224

For additional information, contact the Education Department of the nearest college or university.

Classroom Instructional Strategies

For more information on *continuous progress instruction, computer-assisted instruction, tutoring programs, copoperative learning* and the *Success for All* program, contact:

Dr. Robert Slavin
Center for the Education of Students Placed At Risk
3505 N. Charles Street
Baltimore, MD 21218
(410)516-8800

For more information on *cooperative learning* see:

Cooperative Learning: Theory, Research, and Practice by Slavin, R.E. (1990) Englewood Cliffs, NJ: Prentice-Hall.

or contact:

Association for Supervision and Curriculum Development
1250 North Pitt Street
Alexandria, VA 22314-1453
(703) 549-9110

For more information on the *The Seattle Social Development Project,* contact:

Dr. J. David Hawkins
Social Development Research Group
University of Washington
146 N. Canal St., Suite 211
Seattle, WA 98103
(206) 543-7655

For additional information contact the Education Department of the nearest college or university.

Classroom Curricula for Social Competence Promotion

For more information on *Promoting Alternative THinking Strategies (PATHS),* contact:

Developmental Research and Programs, Inc.
130 Nickerson St., Suite 107
Seattle, WA. 98109
(800) 736-2630

Also see *Promoting Social and Emotional Development in Deaf Children: The PATHS Project* (1993) by M.T. Greenberg and C.A. Kusche, Seattle, WA: University of Washington Press.

For more information on *The Intervention Campaign Against Bullying,* contact:

Dr. Dan Olweus
Department of Personality Psychology
University of Bergen, Box 25
N-5014 Bergen, Norway

School Behavior Management Strategies

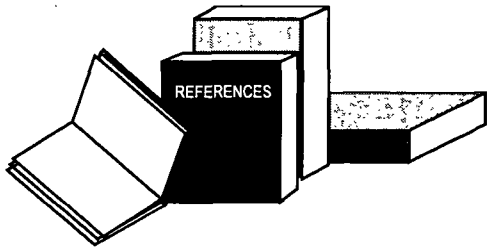
For more information on *Structured Playground Activities,* contact:

Dr. H. Allen Murphy
Department of Psychology
Florida State University
Tallahassee, FL 32206

For more information on the *Behaviorally-Based Prevention Program for Middle School Students,* contact:

Dr. Brenna Bry
Graduate School of Applied and Professional Psychology
Rutgers University
Piscataway, NJ 08855-0819

References



For more detailed information on research projects described in this section, see the following references:

School Organizational Change

School Development Program—Comer, J.P. (1988). Educating Poor Minority Children. *Scientific American* 259(5):42-48.

Program Development Evaluation Method – Gottfredson, D.C., Gottfredson, G.D., Hybl, L.G. (1993). *An approach to reducing risk through school system restructuring.* Paper presented for the Research Partnership Network, Johns Hopkins University, Baltimore, MD.

Gottfredson, D.C. Gottfredson, G.D., Hybl, L.G. (1993). Managing adolescent behavior: A multi-year, multi-school study. *American Educational Research Journal* 30(1):179-215.

School Transitional Environment Project (STEP) –Felner, R.D. & Adan, A.M. (1988). The School Transitional Environment Project: An Ecological Intervention and Evaluation. In R. Price, E.L. Cowen, R.P. Lorion & J. Romoa-McKay (Eds.), *Fourteen Ounces of Prevention: A Casebook for Practitioners.* Washington, DC: American Psychological Association.

Felner, R.D., Brand, S., Adan, A.M., Mulhall, P.F., Flowers, N., Sartain, B., DuBois, D.L. (1993). Restructuring the ecology of the school as an approach to prevention during school transitions: Longitudinal follow-ups and extensions of the School Transitional Environment Project (STEP). *Prevention in Human Services* 10(2):103-136.

Classroom Organization, Management and Instructional Strategies

Reductions in class size— Slavin, R.E. (1990a). Class size and student achievement: Is smaller better? *Contemporary Education* 42:6-12.

Within-class ability grouping—Slavin, R.E. (1987). Ability grouping and student achievement in elementary schools: A best-evidence synthesis. *Review of Educational Research* 57:293-336.

Non-graded elementary schools—Gutierrez, R. & Slavin, R.E. (1992) *Review of Educational Research* 62:333-376.

Diagnostic-prescriptive pullout strategies -Madden, N.A. & Slavin, R.E. (1989) Effective pull-out programs for students at risk. In R.E. Slavin, N.L. Karweit, and N.A. Madden (Eds.), *Effective Programs for Students at Risk.* Boston, MA: Allyn and Bacon.

Classroom Strategies for Behavior Management

Proactive Classroom Management-see Seattle Social Development Project below.

The Good Behavior Game—Kellam, S.G. and Rebok, G.W. (1992). Building developmental and etiological theory through epidemiologically based preventive intervention trials. In J. McCord and R.E. Tremblay (Eds.), *Preventing Antisocial Behavior: Interventions from Birth through Adolescence.* New York, NY: Guilford.

Classroom Instructional Strategies

Continuous progress instruction & computer-assisted instruction—Madden, N.A. & Slavin, R.E. (1989). Effective pull-out programs for students at risk. In R.E. Slavin, N.L. Karweit, and N.A. Madden (Eds.), *Effective Programs for Students at Risk.* Boston, MA: Allyn & Bacon.

Cooperative learning programs—Slavin, R.E. (1983). When does cooperative learning increase student achievement? *Psychological Bulletin* 94: 429-445.

Tutoring programs—Coie, J.D. & Krehbiel, G. (1983). Effects of academic tutoring on the social status of low-achieving, socially rejected children. *Child Development* 55:1465-1478.

Greenwood, C.R., Terry, B., Utley, C.A., Montagna, D., Walker, D. (1993). Achievement, placement, and services: middle school benefits of classwide peer tutoring used at the elementary school. *School Psychology Review* 22:497-516.

Success For All—Slavin, R.E., Madden, N.A., Karweit, N.L., Livermon, B.J., & Dolan, L. (1990b). Success for All: First year outcomes of a comprehensive plan for reforming urban education. *American Educational Research Journal* 27:255-78.

Interactive teaching—Rosenshine, B.J. (1986, April). Synthesis of research on explicit teaching. *Educational Leadership,* pp. 60-69.

Seattle Social Development Project—Hawkins, J.D., Catalano, R.F., Morrison, D.M., O'Donnell, J., Abbott, R.D. & Day, L.E. (1992). The Seattle Social Development Project: Effects of the first four years on protective factors and problem behaviors. In J. McCord and R.E. Tremblay (Eds.), *Preventing Antisocial Behavior: Interventions from Birth through Adolescence.* New York, NY: Guilford.

O'Donnell, J., Hawkins, J.D., Catalano, R.F., Abbott, R.D., Day, L.E. (1995). Preventing school failure, drug use, and delinquency among low-income children: Effects of a long-term prevention project in elementary schools. *American Journal of Orthopsychiatry* 65(1):87-100.

Classroom Curricula for Social Competence Promotion

Promoting Alternative THinking Strategies (PATHS)—Greenberg, M.T. & Kusche, C.A. (1993). *Promoting Social and Emotional Development in Deaf Children: The PATHS Project.* Seattle, WA: 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.

Social Relations Intervention Program—Lochman, J.E., Coie, J.D., Underwood, M.K., & Terry, R. (in press). Effectiveness of a social relations intervention program for aggressive and nonaggressive rejected children. *Journal of Consulting and Clinical Psychology.*

Improving Social Awareness-Social Problem Solving Project—Elias, M.J., Gara, M., Schuyler, T., Brandon-Muller, L.R., & Sayette, M.A. (1991). The promotion of social competence: Longitudinal study of a preventive school-based program. *American Journal of Orthopsychiatry,* 61:409-17.

The Intervention Campaign Against Bully/Victim Problems—Olweus, D. (1991). Bully/victim problems among school-children: Basic facts and effects of a school based intervention program. In D.J. Pepler and K.H. Rubin *The Development and Treatment of Childhood Aggression.* Hilsdale, NJ: Erlbaum.

Life Skills Training Program (LST)—Botvin, G.J., Baker, E., Filazzola, A.D., & Botvin, E.M. (1990). A cognitive-behavioral approach to substance abuse prevention: One-year follow-up. *Addictive Behaviors* 15:47-63.

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.

Gang Prevention Curricula—Thompson, D.W. & Jason, L.A. (1988). Street gangs and preventive interventions. *Criminal Justice and Behavior* 15:323-333.

Alert Drug Prevention Project—Ellickson, P.L., & Bell, R.M. (1990). Drug prevention in junior high: A multi-site longitudinal test. *Science* 247:1299-1305.

Ellickson, P.L., Bell, R.M., McGuigan, K. (1993) Preventing adolescent drug use: long term results of a junior high program. *American Journal of Public Health* 83:856-861.

School Behavior Management Strategies

Structured Playground Activities—Murphy, H.A., Hutchison, J.M., and Bailey, J.S. (1983). Behavioral school psychology goes outdoors: The effect of organized games on playground aggression. *Journal of Applied Behavior Analysis* 16:29-35.

Behaviorally-Based Prevention Program —Bry, B.H. (1982). Reducing the incidence of adolescent problems through preventive intervention: One- and five-year follow-up. *American Journal of Community Psychology* 10:265-276.

Community-Based Youth Programs Focus

As young people move into late childhood and adolescence, their world expands even further. Along with the family and the school, the community becomes a potentially powerful source of support for youth, providing opportunities for young people to be involved and perceived as assets, skills for successful involvement, and recognition for their contributions.

Afterschool Recreation Programs

Significant changes have occurred in the lives of children and families over the past several decades. More children live in families headed by a single parent, two-parent families increasingly have both parents working, extended families and supportive neighbors are less accessible to many families, and more children spend significant amounts of time caring for themselves, and they are doing so at younger and younger ages. Afterschool recreation programs can offer opportunities for youth to interact with prosocial adults and peers and learn new skills in a safe, supportive environment.

Risk Factors That May Be Addressed

Early and Persistent Antisocial Behavior

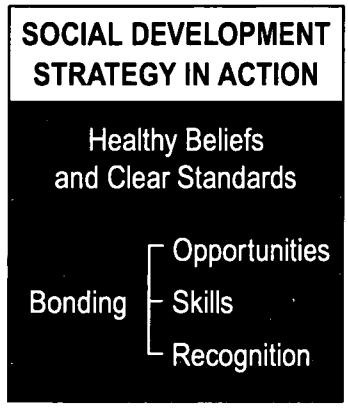
Rebelliousness

Friends Who Engage in the Problem Behavior

Following is an example of an effective afterschool recreation program.

PALS (Participate and Learn Skills)

Protective Factors Addressed: Healthy beliefs and clear standards for behavior, opportunities to contribute to a prosocial peer group, skills for recreational activities, recognition for contribution to the group and skill mastery.



PALS (Participate and Learn Skills) is an afterschool recreation program designed to address the risk factors of **early and persistent antisocial behavior, rebelliousness**, and **friends who engage in problem behaviors**. An evaluation of the program focused on children ages five to fifteen, living in a large publicly-supported housing community. The program was coordinated by two full-time staff located in the community center of the housing community.

PALS emphasized skill development. Over the course of two and one-half years, over forty programs in twenty-five different skill areas were offered. Although many of the programs emphasized sports skills, there were also programs in guitar, ballet, baton, scouting, and other nonsport activities. The program aggressively recruited children to participate and reached seventy-one, sixty, and forty-nine percent of available children over the three years of the project.

Efforts were made to provide opportunities for children to interact with peers in the surrounding community by encouraging participation in on-going leagues or other competitive activities.

The project showed significant effects on juvenile arrest rates during the program period, a 75% decrease in the experimental community compared to a 67% increase in the control community. In addition, reports of delinquent behavior within the housing community declined significantly (Jones and Offord, 1989).

Mentoring With Contingent Reinforcement

As a response to the need by many youth for prosocial adult role models, mentoring programs have become a common strategy for addressing adolescent problem behaviors in many communities. Research on mentoring programs has consistently shown that "relationship-only" mentoring programs, in which mentors develop supportive relationships with mentees in the absence of clear and specific contingencies for behavior, do not have desired effects on academic achievement, school attendance, dropout, school misconduct, or employment. This holds true whether mentors are paid or unpaid and whether mentors are college undergraduates, community volunteers, members of the business community, or school personnel.

Mentoring programs that do show positive effects on behavior problems and school performance involve mentors who provide social and material reinforcement contingent on appropriate and desired behavior in addition to providing supportive relationships. This is consistent with the Social Development Strategy, which says that in order for youth to have healthy behaviors, they must be bonded to adults who promote healthy beliefs and clear standards.

Following is an example of an effective mentoring program.

Risk Factors That May Be Addressed

Early and Persistent Antisocial Behavior

Rebelliousness

Lack of Commitment to School

The Buddy System

Protective Factors Addressed: Healthy beliefs and clear standards for behavior, opportunities for involvement with prosocial adults, social and material reinforcement for appropriate behavior.

SOCIAL DEVELOPMENT STRATEGY IN ACTION

The Buddy System is a mentoring program designed for multi-ethnic youth, to address **early and persistent antisocial behavior, rebelliousness** and **lack of commitment to school.** The Buddy System matches adult mentors with young people ages eleven to seventeen. Mentors meet with the youth individually and as a group and participate in social and recreational activities together. Mentors develop respectful, trusting and affective relationships with the youth.

In an evaluation of the Buddy System, trained mentors were matched with youth who were referred to the program by the schools, courts, police, social welfare agencies, community residents, or parents for behavior problems. The study used three experimental groups and a control group. In the "relationship only" group, mentors established warm and positive relationships with the mentee and spent ten dollars per month on the mentee in a way that was not contingent on the mentee's behavior. In the "social approval" group, mentors responded in a warm and positive way contingent on appropriate and desired behavior, but spent the ten dollars monthly allotment for the mentee in a noncontingent manner. In the "social and material reinforcement" group, mentors provided social approval and the ten dollars monthly allotment contingent on appropriate and desired behavior.

The program showed significant effects on truancy for the "social approval" group and the "social and material reinforcement" group but no positive effects on the non-contingent group (Fo & O'Donnell, 1975).

Youth Employment With Education

Vocational training and employment programs are primarily intended to increase youth employment and earnings, although secondary objectives frequently include improving young people's social and educational functioning.

Vocational training and employment programs have been well evaluated in large-scale evaluations. Youth employment and training programs are generally able to recruit participants successfully from hard to reach populations exposed to multiple risk factors. Program impacts on employment and earnings outcomes are typically positive, although the effects tend to last only for short periods during and immediately after the program. It is important to note that research has shown that long-term impacts on risk and delinquency outcomes appeared only when the program included a significant ***educational component*** and included an array of other support services for youth.

Risk Factors That May Be Addressed

Academic Failure

Rebelliousness

Friends Who Engage in the Problem Behavior

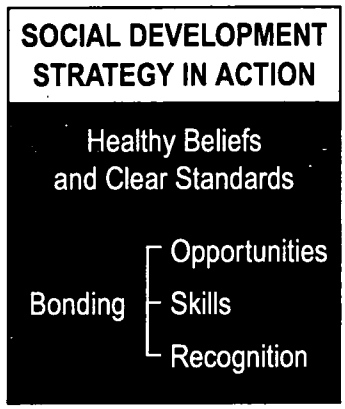
Lack of Commitment to School

Extreme Economic Deprivation

Following is an example of an effective youth employment program.

JOBSTART

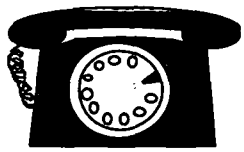
Protective Factors Addressed: Healthy beliefs and clear standards about education and work, opportunities to contribute in the workplace, job, academic, and life skills, recognition for successful contribution.



JOBSTART is a youth employment and education program that addresses the risk factors of **lack of commitment to school, academic failure, rebelliousness,** and **extreme economic deprivation.** The program, which targeted urban, low income, seventeen to twenty-one year-old school dropouts, provided self-paced and competency-based instruction in basic academic skills, occupational skills training for specific jobs, training-related support services (some combination of transportation, child care, counseling, mentoring, tutoring, need-based and incentive payments, work readiness, and life skills instruction), and job placement assistance. The emphasis of these different components varied across program sites.

At the forty-eight month follow-up, significantly more participants (42%) than controls (29%) had earned a GED or high school diploma. Participants were also significantly more likely to have a trade certificate or license. JOBSTART participants who had not been arrested between age sixteen and entry into the program were significantly less likely to be arrested than controls. The program produced significant long-term effects on reducing public assistance for female participants who did not live with their children. (Cave, Bos, Doolittle, and Toussaint, 1993).

Resources



Afterschool Recreation Programs

For more information on the ***PALS*** program, contact:

Dr. Marshall B. Jones
Department of Behavioral Science
M.S. Hershey Medical Center
Hershey, PA 17033

Youth Employment with Education

For more information on ***JOBSTART***, contact:

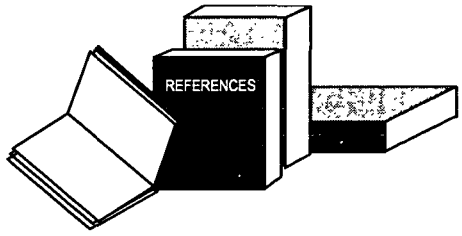
Dr. George Cave
Manpower Demonstration Research Corporation
Three Park Avenue
New York, NY 10016

Mentoring with Contingent Reinforcement

For more information on ***The Buddy System***, contact:

Dr. Clifford R. O'Donnell
Department of Psychology
University of Hawaii
Honolulu, HI 96822

References



For more detailed information on research projects described in this section, see the following references:

Participate and Learn Skills (PALS)—Jones, M.B. & Offord, D.R. (1989). Reduction of antisocial behavior in poor children by nonschool skill-development. *Journal of Child Psychology and Psychiatry and Allied Disciplines* 30:737-750.

The Buddy System—Fo, W.S.O. & O'Donnell, C.R. (1974). The Buddy System: Relationship and contingency conditioning in a community intervention program for youth with nonprofessionals as behavior change agents. *Journal of Consulting and Clinical Psychology* 42:163-169.

Jobstart— Cave, G., Bos, H., Doolitle, F. & Toussaint, C. (1993). *JOBSTART: Final report on a program for school dropouts.* New York, NY: Manpower Demonstration Project.

Community Focus

The community is the context in which families raise their children. Families of all socioeconomic levels, all cultures and races, in all neighborhoods across the country, must recognize the powerful influence of the community on the development of young people. The community context can increase the risks in young people's lives, or, working hand-in-hand with families, schools and youth-serving organizations, can help create a web of protection for youth.

Community Mobilization

Community mobilization is the Social Development Strategy in action. It involves defining and communicating healthy beliefs and clear standards across as many domains as possible–families, schools, media, business, peers, and other community groups–in an "immersion" of young people in the message.

Community mobilization provides opportunities for all members of the community to contribute their unique talents and perspective. Successful mobilization efforts ensure that all community members are given the skills they need to contribute successfully. When involving youth–and adults who may be inexperienced in this type of process–a careful assessment of the skill training needs of these individuals will help ensure their continued involvement. Finally, consistent and appropriate recognition for the contributions of community members will build bonding to the community and to the mobilization group. It is important to remember that recognition for involvement must be perceived as such by the individual. Therefore, recognition efforts must be carefully thought through, sincere, and appropriate to each individual contributor.

Community mobilization efforts in the areas of heart disease and smoking have demonstrated the powerful potential of this strategy to impact individuals' behavior. The Minnesota Heart Health Program and the Stanford Heart Disease Prevention Program were both successful in reducing risks associated with heart disease (Carlaw et al., 1984; Flora et al., 1989). Research in substance abuse prevention suggests that school-based risk reduction programs can have lasting effects if they are part of a comprehensive, community-wide effort directed at reducing risks in all the major social units affecting young people (Hawkins et al., 1992; Johnson et al., 1986; O'Donnell et al., 1995; Pentz et al., 1989). Comprehensive, community-wide prevention strategies can target multiple risk factors across social domains and developmental periods by encouraging involvement by diverse community organizations and social systems. Such an approach improves the ability of prevention efforts to reach those at greatest risk, harnesses the power of culture to affect individual behavior, and can be sustained more effectively over time (Bracht, 1990; Johnson et al., 1990).

Risk Factors That May Be Addressed

Low Neighborhood Attachment and Community Disorganization

Community Laws and Norms Favorable Toward Drug Use, Firearms and Crime

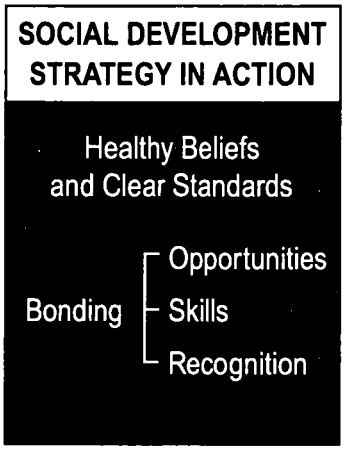
Transitions and Mobility

Although the elements of successful community health promotion continue to be widely explored, several critical elements have emerged from the research. A community development approach, in which local leaders and citizens are mobilized to address community concerns, appears to be more effective than a top-down strategy (Fawcett et al., 1993). The effectiveness of community planning boards as vehicles for mobilizing communities has been demonstrated in risk reductions studies such as the Minnesota Heart Health Project and Project COMMIT (Bracht & Kingsbury, 1990). Community ownership and targeting of local priorities are crucial to community development efforts. Community members are more likely to be actively involved in prevention efforts that they believe are effectively addressing local problem (Wandersman et al., 1987).

Following is an example of an approach for building successful community mobilization efforts.

Communities That Care

Protective Factors Addressed: Healthy beliefs and clear standards for behavior, opportunities to contribute to the community, skills for successful contribution, recognition for prosocial involvement.



The ***Communities That Care*** model builds on the knowledge gained from successful community prevention efforts and provides an effective process for mobilizing communities to address adolescent problem behaviors. *Communities That Care* incorporates the following critical components:

- Involves a broad spectrum of individuals, groups and organizations who represent the diversity of the community.
- Builds support for risk and protective factor-focused prevention from key leaders as well as grassroots community members.
- Promotes widespread communication and collaboration across all domains and disciplines.
- Provides opportunities, skills and recognition to foster bonding to the community.
- Utilizes a data-driven assessment process that empowers community members to collect data on risk, protection and resources.
- Promotes a long-term community commitment to achieving a shared healthy vision for the future.

In addition to the long-term effects of a community's efforts to address specific risk factors, the *Communities That Care* mobilization process itself addresses the risk factors of **low neighborhood attachment and community disorganization** and **transitions and mobility**.

The *Communities That Care* strategy was field-tested in Oregon as TOGETHER! Communities for Drug Free Youth. The purpose of the project was to evaluate the strategy's effectiveness in 1) mobilizing communities to engage in risk-reducing and protection-enhancing prevention efforts without intensive financial backing or external staffing, and 2) training community members to an application level in a risk-focused approach to prevention.

Results from the TOGETHER! project show that multiple communities can be mobilized using the *Communities That Care* strategy and that, with sufficient training, community prevention boards are both willing and able to conduct assessments of risk and protective factors in their community and implement promising risk reduction strategies. Of the forty Oregon communities that initially responded to the invitation to participate in the project, thirty-five completed all three of the *Communities That Care* trainings. Within a year after training, twenty-eight boards had completed risk-focused prevention plans and less than a year into the planning and implementation phase, twenty-seven had begun implementing risk reduction strategies. Four years later, thirty-one boards were still active, and twenty-

eight of them were implementing risk reduction programs (Harachi et al., 1995).

A comparison of the *Communities That Care (CTC)* strategy used in the TOGETHER! project and the Washington State Community Youth Activity Program (CYAP) showed that CTC was more effective in mobilizing communities for the design and implementation of risk reduction strategies. Although both projects were successful in mobilizing community boards to plan and implement prevention activities, the *Communities That Care* process was more successful than the CYAP project at promoting planning and program activities aimed at specific, empirically-based risk factors identified through a community risk assessment process (Arthur et al., 1994).

Community/School Policies

Policies are laws, rules, codes, or standards that guide people's behavior and their interactions with their environment. Community and school policies have the power to shape social, political, cultural, economic and physical influences which affect the behavior of individuals and, consequently, the welfare of the whole community. Policies can be a vital and effective tool for creating positive changes at all levels of a community and are a critical element of comprehensive prevention programs.

Policy change requires the development of new constituencies and collaborative relationships as well as new skills. It means challenging accepted practices and norms. Working with policy issues helps to clarify current community norms and practices that may contribute to adolescent health and behavior problems.

Community prevention groups should begin by identifying and assessing existing policies in the community and in schools. Widespread involvement of diverse community members is critical to effective policy development, including parents and youth, as well as representative from schools, social service agencies, the faith community, health care, media, and local government. Individuals involved in policy development must be provided with the skills they need to be effectively involved.

The following criteria can be used to assess, revise or develop community/school policies (Hawley et al., 1986; Pentz et al., 1989; Moskowitz, 1989; Goodstadt, 1986). Effective policies include:

- **Clear messages**. There should be a strong, clear statement of expected behavior that can be understood by all the individuals to whom the policy applies.

Risk Factors That May Be Addressed

Community Laws and Norms Favorable to Drug Use and Firearms

Availability of Drugs

Availability of Firearms

Favorable Parental Attitudes and Involvement in the Problem Behavior

Friends Who Engage in the Problem Behavior

Favorable Attitudes Toward the Problem Behavior

- **Consistency.** To be effective in creating community-wide changes in norms, policies should be consistent, both within individual organizations, such as schools, and across families, schools, and communities.

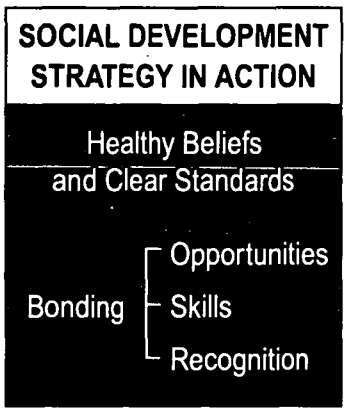
- **Clear and consistent consequences.** Policies must be supported by appropriate consequences for violation that are clearly communicated and consistently applied across families, schools, and communities. In addition to consequences for violation of policies, communities should devise appropriate ways of acknowledging and rewarding those who behave appropriately.

- **Communication.** High visibility and broad support are important to effective community/school policies. Media support for prevention efforts can be a valuable tool in communicating policies.

The following policy strategies can be used as part of a comprehensive prevention plan.

Community/School Policies

Protective Factors Addressed: Healthy beliefs and clear standards for behavior, opportunities to contribute to policy-making and/or monitoring, skills for policy-making, and recognition for policy development.



Community Policies

The general thrust of alcohol-related policies in recent years has been to limit the availability of alcohol, particularly the sale of alcohol to minors, and to strengthen penalties for illegal or irresponsible use of alcohol. Some policy areas that have demonstrated effectiveness include:

- **Regulation of Availability.** A number of policy changes have been shown to reduce the availability of alcohol and cigarettes. Minimum age requirements for legal alcohol and tobacco use have been shown to reduce the use of these substances (Cook & Tauchen, 1982; Holder & Blose, 1987; Pentz, Brannon et al., 1989; O'Malley and Wagenaar, 1991). Research on policies regulating how liquor is sold have shown that liquor-by-the-drink sales increased consumption of distilled spirits but not the proportion of drinkers in the population (Holder and Blose, 1987). Moskowitz (1983) found that schools with fewer alcohol retail outlets located within a half mile of the school reported lower rates of alcohol and other drug problems.

- **Taxation.** According to James Mosher (1985), the most neglected policy tool available to the public for the prevention of adolescent drinking problems is the appropriate use of excise taxes. A number of studies have demonstrated the effectiveness of taxation as a prevention strategy. In a study conducted by Levy and Sheflin (1985), a one dollar increase in the tax on alcohol led to a one-half percent decrease in consumption. Cook and Tauchen (1982) also found that an increase in the alcohol tax led to a sharp decrease in consumption as well and cirrhosis mortality. In research focused on teen alcohol consumption, higher taxes were associated with lower teen drinking and alcohol-related traffic fatalities, and higher taxes were more salient than minimum drinking age (Saffer and Grossman, 1987).

- **Responsible Beverage Service.** Responsible beverage service can affect the availability of alcohol to teens. Although many communities have existing policies regulating the serving or sale of alcohol to teens, consistent consequences must be applied to violators. Several California communities have substantially reduced sales to minors by conducting "sting" operations at local alcohol outlets.

School Policies

It is especially important to both the successful development and implementation of school policies to insure clarity, consistency, and coordination. Policies must be integrated throughout the school, at every grade level, in every extracurricu-

lar activity, with the strong support and involvement of parents, teachers, peers and the rest of the community. The most durable effects on substance abuse have been demonstrated for interventions that address policies and norms across schools, families, and the larger community (Johnson et al., 1990; Pentz et al., 1989; Perry et al., 1992; Vartiainen et al. 1990).

PRENATAL | 0–2 YEARS | 3–5 YEARS | 6–10 YEARS | 11–14 YEARS | 15–18 YEARS

Community Laws and Policies Related to Weapons

Protective Factors Addressed: Healthy beliefs and clear standards for behavior.

A variety of laws, regulations, and policies have been enacted with the goal of reducing firearm violence. These interventions address the risk factors of **availability of firearms** and **community laws and norms favorable to crime and violence**.

At both the Federal and State levels, mandatory sentencing laws have been enacted that impose more stringent sentences for offenders who use or carry a firearm during the commission of a felony. An evaluation of the effects of New Jersey's 1981 Graves Amendment, which mandated a minimum prison sentence for any person convicted of one of several serious crimes who carried or used a firearm during commission of the crime. The evaluation found significant decreases in homicides involving firearms after the amendment went into effect (Fife and Abrams, 1989).

A similar statute, the Michigan Felony Firearm Statute, was evaluated for effects on gun homicides. Investigators found an immediate and significant decrease (almost eleven fewer per month) after the statute took effect (Loftin, et. al., 1983).

Community Policing Strategies

The existence of a police force that performs routine crime management and criminal processing helps to prevent crime by enforcing laws and bolstering norms against criminal behavior. However, research shows that simply employing more police and allocating more funds for police services has little or no effect on crime.

Risk Factors That May Be Addressed

Low Neighborhood Attachment and Community Disorganization

Community Laws and Norms Favorable to Crime and Violence

In recent decades, various innovations in policing practices have been used in attempts to reduce crime. Three of these policing strategies have been evaluated and found to have potential as prevention strategies; ***intensified motorized patrol, field interrogation,*** and ***community policing***. On-going evaluations of these and other innovative policing strategies will provide further information on the effectiveness of individual strategies and the particular components of such strategies that are producing significant preventive effects.

Following are examples of promising community policing strategies.

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

Intensified Motorized Patrol

Protective Factors Addressed: Healthy beliefs and clear standards for behavior.

The Kansas City Police Department used ***intensified motorized patrol*** in high gun crime areas in a single patrol beat. A pair of two-officer cars patrolled the target beat between the hours of 7 p.m. and 1 a.m., 7 days a week. The emphasis of the patrol was the enforcement of laws regarding concealed weapons. For twenty-nine weeks, they focused their patrol efforts on gun crime "hot spots" identified through geographic distribution of gun crimes in the area. The patrol units focused exclusively on gun detection through proactive patrol and did not respond to calls for service. An evaluation of the program showed a significant reduction in gun crime in the target area. Pre- and post-intervention community surveys also showed that, following the intervention, residents became less fearful of crime, more satisfied with their neighborhood, perceived less physical and social disorder, and were more likely to say that neighborhood drug problems had gotten better. When the patrols were discontinued, gun crime increased gradually until the intensified patrol was reinstituted six months later, at which time gun crimes began to drop again (Sherman et al., 1995).

This intervention addresses **community laws and norms favorable to crime.**

PRENATAL 0–2 YEARS 3–5 YEARS 6–10 YEARS 11–14 YEARS 15–18 YEARS

Field Interrogations

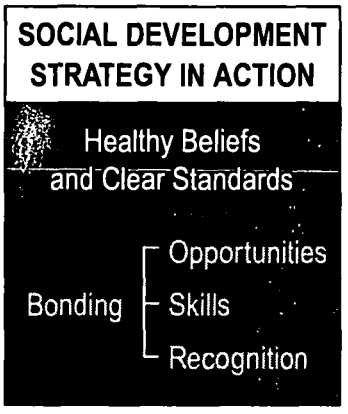
Protective Factors Addressed: Healthy beliefs and clear standards for behavior.

Field Interrogations involve officers stopping persons who appear to be suspicious to question them about their activities and sometimes search them and/or their vehicles. If the officer finds the person's explanations satisfactory, no record of the contact is made. If the explanations are unsatisfactory, the officer may file a field interrogation report on the contact or arrest the individual, given probable cause. This strategy addresses **community laws and norms favorable to crime** and **low neighborhood attachment and community disorganization.**

An evaluation of a field interrogation program in San Diego, California assessed the impact of the program by discontinuing the existing program in one of three areas for a nine month intervention period. The evaluation showed a significant increase in crime in the area in which the program was discontinued and a significant decrease in crime when the program was reinstated. Experience of crime (as a victim or witness), perceptions of the level of crime, and fear of crime by residents increased significantly during the discontinued period (Boydstun, 1975).

Community Policing Strategies

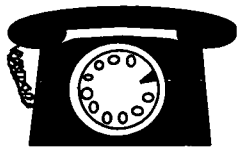
Protective Factors Addressed: Healthy beliefs and clear standards for behavior.



A variety of ***community policing strategies*** have been, and are continuing to be, implemented in communities across the country. Rigorous evaluations of these innovations will provide needed information on their effectiveness in reducing risk factors. A multicomponent policing strategy in Newark, New Jersey combined **foot patrol** with efforts to reduce the physical signs of crime. The program began by establishing a storefront police station in the neighborhood, where officers accepted reports of crime, distributed crime prevention information, provided referrals to other agencies, and communicated informally with residents. A separate group of foot patrol officers enforced disorderly conduct and loitering laws, maintained order on sidewalks and street corners, performed radar checks for speeding, enforced ordinances on public buses, and did road checks to serve warrants and apprehend drunk drivers, persons driving stolen vehicles, and drivers without a license. The program also included cleanup activities such as removing graffiti, improving lighting, repairing streets, and cleaning streets and vacant lots. Cleanup activities were performed by city employees, juvenile offenders doing community service, and community residents. The residents of the target neighborhood were mostly apartment-dwellers and 97% were African-American. Evaluation of the program showed that, compared to a comparison area, resident satisfaction with the neighborhood and with police services increased significantly, while perceptions of neighborhood social disorder and worry about property crime decreased significantly. Analysis showed significant reductions in serious crimes, personal crimes, auto theft, and outdoor offense in the experimental area (Pate et al., 1985).

This intervention addresses the risk factors of **low neighborhood attachment and disorganization** and **norms favorable to crime.**

Resources



Community Mobilization

For more information on *Communities That Care* training and technical assistance, contact:

Developmental Research and Programs, Inc.
130 Nickerson St., Suite 107
Seattle, WA. 98109
(800) 736-2630

Community/School Policies

For training and technical assistance in developing and implementing *school policy change*, contact:

American Council for Drug Education
204 Monroe St., Suite 110
Rockville, MD 20850
(301) 294-0600

For more information on *alcohol-related policies and initiatives*, contact:

Center for Science in the Public Interest
1501 16th St. N.W.
Washington, DC 10036
(202) 332-9110

For more information about training in prevention *policy development* in schools and communities, contact:

James Mosher, Ph.D.
Marin Institute
1040 "B" Street, Suite 300
San Rafael, CA 94901
(415) 456-5692

Community Policies Related to Weapons

For more information on *mandatory sentencing laws for felonies involving a firearm*, contact:

Dr. Colin Loftin
Violence Research Group
Institute of Criminal Justice and Criminology
University of Maryland
2220 Lefrak Hall
College Park, MD 20742-8235

Policing Strategies

For more information on *intensified motorized patrol*, contact:

Dr. John Schnelle
Borun Center, Multicampus Division of Geriatrics
Department of Medicine
University of California, Los Angeles
10833 Leconte Avenue
Los Angeles, CA 90024-1687

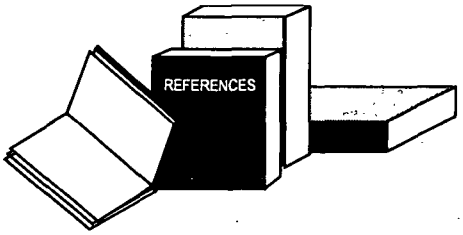
For more information on *field interrogations* and *community policing*, contact:

The Police Foundation
1909 K.Street N.W.
Washington, DC 20006

Pam Cammarata
Community Oriented Policy Services
1100 Vermont Ave. NW
Washington, DC 20530
(202) 514-4101

The Community Policing Consortium
1726 M Street NW, Suite 801
Washington, DC 20036
(202) 833-3305

References



For more information about research projects described in this section, see the following references:

Community Mobilization

Arthur, M.W., Ayers, C.D., Graham, K.A., & Hawkins, J.D. (1994). Mobilizing Communities to Reduce Risks for Drug Abuse: A comparison of two strategies, unpublished manuscript.

Carlaw, R.W., Mittelmark, M.B., Bracht, N., & Luepker, R. (1984). Organization for a community cardiovascular health program: Experiences from the Minnesota Heart Health Program. *Health Education Quarterly, 11, 243-252.*

Flora, J.A., Maccoby, N. & Farquhar, J.W. (1989). Communication campaigns to prevent cardiovascular disease: The Stanford Community Studies. In R.E. Rice and C.K. Atkin (Eds.), *Public Communication Campaigns* (pp. 233-252). Newbury Park, CA: Sage.

Harachi, T.W., Ayers, C.D., Hawkins, J.D., Catalano, R.F., and Cushing, J. (1995). Empowering communities to prevent adolescent substance abuse: Process evaluation results from a risk and protection-focused community mobilization effort. *Journal of Primary Prevention,* 16(3).

Community/School Policies

Cook, P.J. & Tauchen, G. (1982). The effect of liquor taxes on heavy drinking. *Bell Journal of Economics* 13: 379-90.

Fife, D., and Abrams, W.R. (1989). Firearms' decreased role in New Jersey homicides after a mandatory sentencing law. *Journal of Trauma* 29:1548-1551.

Goodstadt, M.S. (1986). Alcohol education research and practice: A logical analysis of the two realities. *Journal of Drug Education* 16:349-365.

Hawley, R.A., Petersen, R.C. & Mason, M.C. (1986). *Curriculum for building drug-free schools.* Rockville MD: American Council for Drug Education.

Holder, H.D., & Blose, O. (1987). Impact of changes in distilled spirits availability on apparent consumption: A time series analysis of liquor-by-the-drink. *British Journal of Addiction* 82:623-31.

Johnson, C.A., Pentz, M.A., Weber, M.D., Dwyer, J.H., MacKinnon, D.P., Flay, B.R., Baer, N.A., & Hansen, W.B. (1990). Relative effectiveness of comprehensive community programming for drug abuse prevention with high-risk and low-risk adolescents. *Journal of Consulting and Clinical Psychology* 58:447-56.

Levy, D. & Sheflin, N. (1985). The demand for alcoholic beverages: An aggregate time-series analysis. *Journal of Public Policy and Marketing* 4:47-54.

Loftin, C., Heumann, M. and McDowall, D. (1983). Mandatory sentencing and firearms violence: Evaluating an alternative to gun control. *Law and Society Review* 17:287-318.

Moskowitz, J.M. (1983). Preventing adolescent substance abuse through drug education. In T.J. Glynn, C.G. Leukefeld, and J.P. Ludford (Eds.), *Preventing adolescent drug abuse: Intervention strategies* (NIDA Research Monograph No. 47, pp. 233-249). Washington, DC: U.S. Government Printing Office.

Moskowitz, J.M. (1989). The primary prevention of alcohol problems: A critical review of the research literature. *Journal of Studies on Alcohol,* 50:54-88.

Mosher, J.F. (1985). Alcohol policy and the nation's youth. *Journal of Public Health Policy,* 6, 295-299.

O'Malley, P.M. & Wagenaar, A.C. (1991). Effects of minimum drinking age laws on alcohol use, related behaviors and traffic crash involvement among American youth: 1976-1987. *Journal of Studies on Alcohol* 52:478-91.

Pentz, M.A., Brannon, B.R., Charlin, V.L., Barnett, E.J., MacKinnon, D.P., & Flay, B. R. (1989). The power of policy: Relationship of smoking policy to adolescent smoking. *American Journal of Public Health* 79:857-62.

Perry, C.L., Helder, S.H., Murray, D.M., & Klepp, K.I. (1992). Community-wide smoking prevention: Long-term outcomes of the Minnesota Heart Health Program and the class of 1989 study. *American Journal of Public Health* 82:1210-16.

Saffer, H. & Grossman, M. (1987). Beer taxes, the legal drinking age, and youth motor vehicle fatalities. *Journal of Legal Studies* 16:351-74.

Vartiainen, E., Pallone, U., McAlister, A., & Puska, P. (1990). Eight-year follow-up results of an adolescent smoking prevention program: The North Karelia Youth Project. *American Journal of Public Health* 80:78-79.

Policing Strategies

Intensified Motorized Patrol- Sherman, L.W., Shaw, J.W., and Rogan, D.P. (1995). The Kansas City Gun Experiment, *Research in Brief.* Washington, DC: National Institute of Justice.

Field Interrogations–Boydstun, J.E. (1975). *San Diego Field Interrogation Final Report.* Washington DC: Police Foundation.

Community Policing Strategies-Pate, A.M., Skogan, W.G., Wycoff, M.A., & Sherman, L.W. (with S. Annan and the Newark Police Department) (1985). *Reducing the "signs of crime": The Newark Experience, Executive Summary.* Washington, D.C. The Police Foundation.

Appendix A: Risk and Protective Factor Charts

The following charts can be used to help identify strategies that you want to incorporate into your comprehensive plan. Strategies are cross-referenced in two ways:

- The **Risk and Protective Factor Cross-Reference Chart** shows the strategies by risk factor addressed within each of the four domains. It can be used to identify all the program strategies that address a particular risk factor and to determine which protective factors are strengthened by each program strategy.

- The **Developmental Cross-Reference Chart** shows the strategies by developmental stage addressed. It can be used to identify all of the strategies that target young people at a given developmental stage.

Risk and Protective Factor Cross-Reference Charts

The Risk and Protective Factor Cross-Reference Chart lists each of the nineteen risk factors and all of the strategies that address each risk factor. For each of the strategies listed, the protective factors addressed are identified, as well as the developmental period for which the strategy has demonstrated effectiveness.

After your community has selected priority risk factors, this chart can be used to identify the promising approaches that address those risk factors and the protective factors addressed by each of the promising approaches.

Risk and Protective Factor Cross-Reference Charts—Community Domain

			Protective Factors					
	Risk Factor Addressed	Program Strategy	Healthy Beliefs & Clear Standards	Bonding	Opport.	Skills	Recog.	Developmental Period
Community Domain	**Availability of Drugs**	Community/School Policies	✔	✔	✔	✔	✔	all
	Availability of Firearms	Community/School Policies	✔					all
	Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime	Classroom Curricula for Social Competence	✔		✔			6-14
		Community Mobilization	✔	✔	✔	✔	✔	all
		Community/School Policies	✔	✔	✔	✔	✔	all
		Policing Strategies	✔					all
	Media Portrayals of Violence							
	Transitions and Mobility	Organizational Change in Schools	✔	✔	✔	✔	✔	6-18
	Low Neighborhood Attachment and Community Disorganization	Community Mobilization	✔	✔	✔	✔	✔	all
		Policing Strategies	✔					all
		Organizational Change in Schools	✔	✔	✔	✔	✔	all
		Classroom Curricula for Social Competence	✔		✔	✔		11-14
	Extreme Economic Deprivation	Prenatal and Infancy Programs	✔	✔	✔	✔	✔	prenatal–3
		Youth Employment with Education	✔	✔	✔	✔	✔	all

Risk and Protective Factor Cross-Reference Charts—Family Domain

			Protective Factors					
	Risk Factor Addressed	Program Strategy	Healthy Beliefs & Clear Standards	Bonding	Opport.	Skills	Recog.	Developmental Period
Family Domain	**Family History of the Problem Behavior**	Prenatal/Infancy Programs	✔	✔	✔	✔	✔	prenatal-2
	Family Management Problems	Prenatal/Infancy Programs	✔	✔	✔	✔	✔	prenatal-2
		Early Childhood Education	✔	✔	✔	✔	✔	3-5
		Parent Training	✔	✔	✔	✔	✔	prenatal-14
		Family Therapy	✔	✔	✔	✔	✔	6-14
	Family Conflict	Marital Therapy	✔	✔	✔	✔	✔	prenatal
		Prenatal/Infancy Programs	✔	✔	✔	✔	✔	prenatal-2
		Parent Training	✔	✔	✔	✔	✔	prenatal-14
		Family Therapy	✔	✔	✔	✔	✔	6-14
	Favorable Parental Attitudes and Involvement in the Problem Behavior	Prenatal/Infancy Programs	✔	✔	✔	✔	✔	prenatal-2
		Parent Training	✔	✔	✔	✔	✔	prenatal-14
		Community/School Policies	✔	✔	✔	✔	✔	all

Risk and Protective Factor Cross-Reference Charts—School Domain

			Protective Factors					
	Risk Factor Addressed	Program Strategy	Healthy Beliefs & Clear Standards	Bonding	Opport.	Skills	Recog.	Developmental Period
School Domain	**Early and Persistent Antisocial Behavior**	Early Childhood Education	✔	✔	✔	✔	✔	3-5
		Parent Training	✔	✔	✔	✔	✔	prenatal-10
		Family Therapy	✔	✔	✔	✔	✔	6-18
		Classroom Organization, Management and Instructional Strategies	✔	✔	✔	✔	✔	6-18
		Classroom Curricula for Social Competence Promotion	✔	✔	✔	✔	✔	6-14
		School Behavior Management Strategies	✔		✔		✔	6-14
		Afterschool Recreation Programs	✔	✔	✔	✔	✔	6-10
		Mentoring with Contingent Reinforcement	✔		✔		✔	11-18
	Academic Failure Beginning in Late Elementary School	Prenatal/Infancy Programs	✔	✔	✔	✔	✔	prenatal-2
		Early Childhood Education	✔	✔	✔	✔	✔	3-5
		Parent Training	✔	✔	✔	✔	✔	prenatal-10
		Organizational Change in Schools	✔	✔	✔	✔	✔	6-18

Risk and Protective Factor Cross-Reference Charts—School Domain

			Protective Factors					
	Risk Factor Addressed	Program Strategy	Healthy Beliefs & Clear Standards	Bonding	Opport.	Skills	Recog.	Developmental Period
School Domain	**Academic Failure** (continued)	Classroom Organization, Management and Instructional Strategies	✔	✔	✔	✔	✔	6-18
		Classroom Curricula for Social Competence Promotion	✔	✔	✔	✔	✔	6-14
		School Behavior Management Strategies	✔		✔		✔	6-14
		Youth Employment with Education	✔	✔	✔	✔	✔	15-21
	Lack of Commitment to School	Early Childhood Education	✔	✔	✔	✔	✔	3-5
		Organizational Change in Schools	✔	✔	✔	✔	✔	6-18
		Classroom Organization, Management and Instructional Strategies	✔	✔	✔	✔	✔	6-18
		School Behavior Management Strategies	✔		✔		✔	6-14
		Mentoring with Contingent Reinforcement	✔		✔		✔	11-18
		Youth Employment with Education	✔	✔	✔	✔	✔	15-21

Risk and Protective Factor Cross-Reference Charts—Individual/Peer Domain

			Protective Factors					
	Risk Factor Addressed	Program Strategy	Healthy Beliefs & Clear Standards	Bonding	Opport.	Skills	Recog.	Developmental Period
Individual/Peer Domain	**Rebelliousness**	Family Therapy	✔	✔	✔	✔	✔	6-14
		Classroom Curricula for Social Competence Promotion	✔	✔	✔	✔	✔	6-14
		School Behavior Management Strategies	✔		✔		✔	6-14
		Afterschool Recreation	✔	✔	✔	✔	✔	6-10
		Mentoring with Contingent Reinforcement	✔		✔		✔	11-18
		Youth Employment with Education	✔	✔	✔	✔	✔	15-18
	Friends Who Engage in the Problem Behavior	Parent Training	✔	✔	✔	✔	✔	6-14
		Classroom Curricula for Social Competence Promotion	✔	✔	✔	✔	✔	6-14
		Afterschool Recreation	✔	✔	✔	✔	✔	6-14
		Mentoring with Contingent Reinforcement	✔		✔		✔	11-18
	Favorable Attitudes Toward the Problem Behavior	Classroom Curricula for Social Competence Promotion	✔	✔	✔	✔	✔	6-14
		Community/School Policies						
	Early Initiation of the Problem Behavior	Parent Training	✔	✔	✔	✔	✔	6-14
		Classroom Organization Management and Instructional Strategy	✔	✔	✔	✔	✔	6-10
		Classroom Curricula for Social Competence	✔	✔	✔	✔	✔	6-14
		Community/School Policies	✔					all
	Constitutional Factors	Prenatal/Infancy Programs	✔	✔	✔	✔	✔	prenatal-2

Developmental Cross-Reference Charts

The Developmental Cross-Reference Chart lists the developmental periods from prenatal through age eighteen. For each of the developmental periods, all of the strategies appropriate for that period are listed, along with the risk and protective factors addressed by each strategy.

After your community has selected priority risk factors, completed an assessment of existing resources addressing priority risks, and identified gaps in existing resources, this chart can be used to identify those strategies that might be used to fill an identified developmental gap.

Developmental Cross-Reference Chart—Prenatal to 2 Years Old

Developmental Period	Program	Risk Factor Addressed	Protective Factors: Healthy Beliefs & Clear Standards	Bonding	Opport.	Skills	Recog.
Prenatal–2 years	Marital Therapy	Family Conflict	✔	✔	✔	✔	✔
	Prenatal/Infancy Programs	Parental Involvement in the Problem Behavior Family Management Problems Family Conflict Constitutional Factors Extreme Economic Deprivation Academic Failure Family History of the Problem Behavior	✔	✔	✔	✔	✔
	Parent Training	Family Management Problems Family Conflict Favorable Parental Attitudes and Involvement in the Problem Behavior Early and Persistent Antisocial Behavior Academic Failure	✔	✔	✔	✔	✔
3-5 years	Early Childhood Education	Family Management Problems Early and Persistent Antisocial Behavior Academic Failure Low Commitment to School	✔	✔	✔	✔	✔

Developmental Cross-Reference Chart—3 to 10 Years Old

Developmental Period	Program	Risk Factor Addressed	Protective Factors: Healthy Beliefs & Clear Standards	Bonding	Opport.	Skills	Recog.
3-5 years (continued)	Parent Training	Family Management Problems Early and Persistent Antisocial Behavior Academic Failure	✔	✔	✔	✔	✔
6-10 years	Parent Training	Family Management Problems Family Conflict Favorable Parental Attitudes and Involvment in the Problem Behavior Early and Persistent Antisocial Behavior Academic Failure Friends Who Engage in the Problem Behavior Early Initiation of the Problem Behavior	✔	✔	✔	✔	✔
	Family Therapy	Family Management Problems Family Conflict Early and Persistent Antisocial Behavior Alienation and Rebelliousness	✔	✔	✔	✔	✔
	Organizational Change in Schools	Transitions and Mobility Low Neighborhood Attachment and Community Disorganization Academic Failure Lack of Commitment to School	✔	✔	✔	✔	✔

Developmental Cross-Reference Chart—6 to 14 Years Old

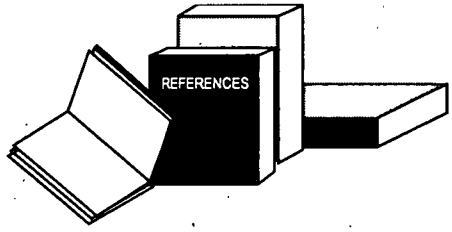
Developmental Period	Program	Risk Factor Addressed	Protective Factors: Healthy Beliefs & Clear Standards	Bonding	Opport.	Skills	Recog.
6-10 years (continued)	Classroom Organization, Management and Instructional Strategies	Early and Persistent Antisocial Behavior Academic Failure Lack of Commitment to School	✔	✔	✔	✔	✔
	Classroom Curricula for Social Competence	Early and Persistent Antisocial Behavior Academic Failure Alienation and Rebelliosness Friends Who Engage in the Problem Behavior Favorable Attitudes Toward the Problem Behavior Early Initiation of the Problem Behavior	✔	✔	✔	✔	✔
	School Behavior Management Strategies	Early and Persistent Antisocial Behavior Academic Failure Lack of Commitment to School Alienation and Rebelliosness	✔		✔		✔
	Afterschool Recreation	Early and Persistent Antisocial Behavior Friends Who Engage in the Problem Behavior	✔	✔	✔	✔	✔
11-14 years	Parent Training	Family Management Problems Family Conflict Favorable Parental Attitudes and Involvement in the Problem Behavior Friends Who Engage in the Problem Behavior Early Initiation of the Problem Behavior	✔	✔	✔	✔	✔

Developmental Cross-Reference Chart—11 to 14 Years Old

Developmental Period	Program	Risk Factor Addressed	Protective Factors: Healthy Beliefs & Clear Standards	Bonding	Opport.	Skills	Recog.
11-14 years (continued)	Family Therapy	Family Management Problems Family Conflict Early and Persistent Antisocial Behavior Alienation and Rebelliosness	✔	✔	✔	✔	✔
	Organizational Change in Schools	Transitions and Mobility Low Neighborhood Attachment and Community Disorganization Academic Failure Lack of Commitment to School	✔	✔	✔	✔	✔
	Classroom Organization, Management and Instructional Strategies	Early and Persistent Antisocial Behavior Academic Failure Lack of Commitment to School	✔	✔	✔	✔	✔
	Classroom Curricula for Social Competence	Early and Persistent Antisocial Behavior Academic Failure Alienation and Rebelliosness Friends Who Engage in the Problem Behavior Favorable Attitudes Toward the Problem Behavior Early Initiation of the Problem Behavior	✔	✔	✔	✔	✔
	Mentoring With Contingent Reinforcement	Early and Persistent Antisocial Behavior Alienation and Rebelliosness Lack of Commitment to School Friends Who Engage in the Problem Behavior Favorable Attitudes Toward the Problem Behavior	✔		✔		✔

Developmental Cross-Reference Chart—15 to 18 Years Old

Developmental Period	Program	Risk Factor Addressed	Protective Factors: Healthy Beliefs & Clear Standards	Bonding	Opport.	Skills	Recog.
15-18 years	Family Therapy	Family Management Problems Family Conflict Early and Persistent Antisocial Behavior Alienation and Rebelliosness	✔	✔	✔	✔	✔
	Organizational Change in Schools	Transitions and Mobility			✔		✔
	Classroom Organization, Management and Instructional Strategies	Early and Persistent Antisocial Behavior Academic Failure Lack of Commitment to School	✔	✔	✔	✔	✔
	Mentoring With Contingent Reinforcement	Early and Persistent Antisocial Behavior Alienation and Rebelliosness Lack of Commitment to School	✔		✔		✔
	Youth Employment With Education	Academic Failure Alienation and Rebelliosness Lack of Commitment to School Extreme Economic Deprivation	✔	✔	✔	✔	✔



Appendix B: References

Anisfeld, E., Casper, V., Nozyce, M., & Cunningham, N. (1990). Does infant carrying promote attachment? An experimental study of the effects of increased physical contact on the development of attachment. *Child Development*, 61, 1617-1627.

Arthur, M.W., Ayers, C.D., Graham, K.A., & Hawkins, J.D. (1994). Mobilizing Communities to Reduce Risks for Drug Abuse: A comparison of two strategies, unpublished manuscript.

Barnard, D. E., Booth, C. L., Mitchell, S. K., & Telzrow, R. W. (1988). Newborn nursing models: A test of early intervention to high-risk infants and families. In E. Hibbs (Ed.), *Children and families: Studies in prevention and intervention* (pp. 63-81). Madison, CT: International Universities Press.

Barnard, K. E., Magyary, D., Sumner, G. A., Booth, C. L., Mitchell, S. K., & Spieker, S. (1988). Prevention of parenting alterations for women with low social support. *Psychiatry*, 51, 248-253.

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.

Bracht, N. and Kingsbury, L. (1990). Community organization principles in health promotion: A five-stage model. In N. Bracht (Ed.), *Heath Promotion at the Community Level*, pp. 66-88, Beverly Hills, CA: Sage.

Brewer, D., Hawkins, J.D., Catalano, R.F., Neckerman, H.J. (1995) Preventing serious, violent, and chronic juvenile offending: A review of evaluations of selected strategies in childhood, adolescence, and the community, in JC Howell, B Krisberg, JD Hawkins, and JJ Wilson (Eds.) *Sourcebook on serious, violent and chronic juvenile offenders.* Thousand Oaks, CA: Sage.

Bronfenbrenner, U. (1986). Alienation and the four worlds of childhood. *Phi Delta Kappan* 67:430-36.

Bry, B.H. (1982). Reducing the incidence of adolescent problems through preventive intervention: One- and five-year follow-up. *American Journal of Community Psychology* 10:265-276.

Carlaw, R.W., Mittelmark, M.B., Bracht, N., & Luepker, R. (1984). Organization for a community cardiovascular health program: Experiences from the Minnesota Heart Health Program. *Health Education Quarterly, 11, 243-252.*

Cave, G., Bos, H., Doolittle, F., Toussaint, C. (1993). JOBSTART: *Final report on a program for school dropouts.* New York, NY: Manpower Demonstration Project.

Chasnoff, I. J., Landress, H. J., & Barrett, M. E. (1990). The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. *New England Journal of Medicine*, 322, 1202.

Coie, J. D., Rabiner, D. L., & Lochman, J. E. (1989). Promoting peer relations in a school setting. In L. A. Bond & B. E. Compas (Eds.), *Primary prevention and promotion in the schools* (pp. 207-234). Newbury Park, CA: Sage.

Comer, J. P. (1988). Educating poor minority children. *Scientific American*, 259(5), 42-48.

Elias, M.J. & Weissberg, R.P. (1990). School-based social competence promotion as a primary prevention strategy: A tale of two projects. In R.P. Lorion (Ed.), *Protecting the children: Strategies for optimizing emotional and behavioral development,* pp. 177-200. New York: Haworth Press.

Elias, M.J., Gara, M., Schuyler, T., Brandon-Muller, L.R., & Sayette, M.A. (1991). The promotion of social competence: Longitudinal study of a preventive school-based program. *American Journal of Orthopsychiatry,* 61:409-17.

Ellickson, P.L., & Bell, R.M. (1990). Drug prevention in junior high: A multi-site longitudinal test. *Science* 247:1299-1305.

Ellickson, P.L., Bell, R.M., McGuigan, K. (1993) Preventing adolescent drug use: long term results of a junior high program. *American Journal of Public Health* 83:856-861. Fawcett, S.B., Paine, A.L., Francisco, V.T., & Vliet, M. (1993). Promoting health through community development. In D.S. Glenwick & L.A. Jason, (Eds.), *Promoting health and mental heal in children, youth and families,* pp. 233-255. New York: Springer.

Felner, R. D., & Adan, A. M. (1988). The school transitional environment project: An ecological intervention & evaluation. In R. Price, E. L. Cowen, R. P. Lorion & J. Ramoa-McKay (Eds.), *Fourteen Ounces of Prevention,* American Psychological Association, pp. 111-122.

Felner, R.D., Brand, S., Adan, A.M., Mulhall, P.F., Flowers, N., Sartain, B., DuBois, D.L. (1993). Restructuring the ecology of the school as an approach to prevention during school transitions: Longitudinal follow-ups and extensions of the School Transitional Environment Project (STEP). *Prevention in Human Services* 10(2):103-136.

Field, T. M., Widmayer, S. M., Stringer, S., & Ignatoff, E. (1980). Teenage, lower-class, black mothers and their pre-term infants: An intervention and developmental follow-up. *Child Development,* 51, 426-436.

Fife, D., and Abrams, W.R. (1989). Firearms' decreased role in New Jersey homicides after a mandatory sentencing law. *Journal of Trauma* 29:1548-1551.

Flora, J.A., Maccoby, N. & Farquhar, J.W. (1989). Communication campaigns to prevent cardiovascular disease: The Stanford Community Studies. In R.E. Rice and C.K. Atkin (Eds.), *Public Communication Campaigns* (pp. 233-252). Newbury Park, CA: Sage.

Fo, W.S.O., O'Donnell, C.R. (1974). The Buddy System: Relationship and contingency conditioning in a community intervention program for youth with nonprofessionals as behavior change agents. *Journal of Consulting and Clinical Psychology* 42:163-169.

Goleman, D. (1995). *Emotional intelligence: Why it can matter more than IQ.* New York: Bantam

Goodstadt, M.S. (1986). Alcohol education research and practice: A logical analysis of the two realities. *Journal of Drug Education* 16:349-365.

Gottfredson, D. C., Karweit, N. L., & Gottfredson G. D. (1989). *Reducing disorderly behavior in middle schools.* Report No. 37. Baltimore, MD: Center for Research on Elementary and Middle Schools, Johns Hopkins University.

Gottfredson, D.C. Gottfredson, G.D., Hybl, L.G. (1993). Managing adolescent behavior: A multi-year, multi-school study. *American Educational Research Journal* 30(1):179-215.

Greenberg, M.T. & Kusche, C.A. (1993). *Promoting Social and Emotional Development in Deaf Children: The PATHS Project.* Seattle, WA: 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.

Greenwood, C.R., Terry, B., Utley, C.A., Montagna, D., Walker, D. (1993). Achievement, placement, and services: middle school benefits of classwide peer tutoring used at the elementary school. *School Psychology Review* 22:497-516.
Gutierrez, R. & Slavin, R.E. (1992) *Review of Educational Research* 62:333-376.

Hawkins, J.D., Catalano, R.F., Brewer, D.D. (1995). Preventing serious, violent and chronic juvenile offending: Effective strategies from conception to age six, in JC Howell, B Krisberg, JD Hawkins, and JJ Wilson (Eds.) *Sourcebook on serious, violent and chronic juvenile offenders.* Thousand Oaks, CA: Sage.

Hawkins, J.D., Catalano, R.F., Jones, G. & Fine, D. (1987). Delinquency prevention through parent training: Results and issues from work in progress. In J. Wilson and G. Loury (Eds.), *From children to citizens: Families, schools, and delinquency prevention* (Vol. 3, pp. 186-204). New York: Springer-Verlag.

Hawkins, J. D., Doueck, H. J., & Lisher, D. M. (1988). Changing teaching practices in mainstream classrooms to improve bonding and behavior of low achievers. *American Educational Research Journal,* 25(1), 31-50.

Hawley, R.A., Petersen, R.C. & Mason, M.C. (1986). *Curriculum for building drug-free schools.* Rockville MD: American Council for Drug Education.

Holder, H.D., & Blose, O. (1987). Impact of changes in distilled spirits availability on apparent consumption: A time series analysis of liquor-by-the-drink. *British Journal of Addiction* 82:623-31.
Hirschi, T. (1969). *Causes of Delinquency.* Newbury Park, CA: Sage.

Horacek, H. J., Ramey, C. T., Campbell, F. A., Hoffman, K. P., & Fletcher, R. H. (1987). Predicting school failure and assessing early intervention with high-risk children. *Journal of the American Academy of Child and Adolescent Psychiatry,* 26(5), 758-763.

Johnson, C.A., Pentz, M.A., Weber, M.D., Dwyer, J.H., MacKinnon, D.P., Flay, B.R., Baer, N.A., & Hansen, W.B. (1990). Relative effectiveness of comprehensive community programming for drug abuse prevention with high-risk and low-risk adolescents. *Journal of Consulting and Clinical Psychology* 58:447-56.

Johnson, D. L. (1991). Primary prevention of behavior problems in young children: The Houston Parent-Child Development Center. In R. Price, E. L. Cowen, R. P. Lorion, & J. Ramoa-McKay (Eds.), *Fourteen Ounces of Prevention,* American Psychological Association, pp. 44-52.

Jones, B. (1988). Toward redefining models of curriculum and instruction for students at risk. In B. Presseisen (Ed.), *At-risk students and thinking: Perspectives from research,* pp. 76-103.

Jones, M.B., Offord, D.R. (1989). Reduction of antisocial behavior in poor children by nonschool skill development. *Journal of Child Psychology and Psychiatry and Allied Disciplines* 30:737-750.

Karweit, N. L. (1989a). Effective kindergarten programs and practices for students at risk. In R. E. Slavin, N. L. Karweit & N. A. Madden (Eds.), *Effective programs for students at risk*, (pp. 103-142). Needham Heights, MA: Allyn and Bacon.

Karweit, N.L. (1989b). *The effects of a story reading program on the vocabulary and story comprehension skills of disadvantaged prekindergarten and kindergarten students* (CREMS Report No. 39). Baltimore, MD: Johns Hopkins University, Center for Research on Elementary and Middle Schools.

Klein, N. C., Alexander, J. F., & Parsons, B. V. (1977). Impact of family systems intervention on recidivism and sibling delinquency: A model of primary prevention and program evaluation. *Journal of Consulting and Clinical Psychology*, 45, 469-474.

Kosterman, R., Hawkins, J.D., Spoth, R., Haggerty, K.P., and Zhu, K. (1995) Preparing for the Drug Free Years: Effects on videotaped family interactions. Unpublished manuscript.

Lally, J. R., Mangione, P. L., & Honig, A. S. (1988). The Syracuse University Family Development Research Program: Long range impact on an early intervention with low-income children and their families. In D. R. Powell (Ed.) *Annual advances in applied developmental psychology: Vol. 3. Parent education as early childhood intervention: Emerging directions in theory, research and practice.* Norwood, NJ: Ablex.

Levy, D. & Sheflin, N. (1985). The demand for alcoholic beverages: An aggregate time-series analysis. *Journal of Public Policy and Marketing* 4:47-54.

Lochman, J.E., Coie, J.D., Underwood, M.K., & Terry, R. (in press). Effectiveness of a social relations intervention program for aggressive and nonaggressive rejected children. *Journal of Consulting and Clinical Psychology.*

Loftin, C., Heumann, M. and McDowall, D. (1983). Mandatory sentencing and firearms violence: Evaluating an alternative to gun control. *Law and Society Review* 17:287-318.

Madden, J., O'Hara, J., Levenstein, P. (1984) Home again: Effects of the Mother-Child Home Program on Mother and Child, *Child Development*, 55, 634-47.

Madden, N.A. & Slavin, R.E. (1989) Effective pull-out programs for students at risk. In R.E. Slavin, N.L. Karweit, and N.A. Madden (Eds.), *Effective Programs for Students at Risk.* Boston, MA: Allyn and Bacon.

Markman, H. J. (1984). The longitudinal study of couples' interactions: Implications for understanding and predicting the development of marital distress. In K. Hohlweg and N. Jacobson (Eds.), *Marital Interaction: Analysis and Modification*, New York, NY: The Guilford Press, pp. 253-281.

Markman, H.J., Renick, M.J., Floyd, F.J., Stanley, D.M., Clements, M. (1993) Preventing marital distress through effective communication and conflict management: A 4- and 5-year follow-up. *Journal of Consulting and Clinical Psychology*, 61(1): 70-77.

Markman, H. J., Renick, M. J., Floyd, F., Stanley, S. M., & Clements, M. (1993). Preventing marital distress through effective communication and conflict management: A 4- and 5- year follow-up. *Journal of Consulting and Clinical Psychology,* 47, 743-749.

McCormick, C., & Mason, J. (1987). Intervention procedures for increasing preschool children's interest in and knowledge about reading. In W. H. Teale and E. Sulzby (Eds.), *Emergent literacy: Writing and Reading* (pp. 90-115). Norwood, NJ: Ablex.

Mirman, J., Swartz, R., & Barell, J. (1988). Strategies to help teachers empower at-risk students. In B. Presseisen (Ed.), *At-risk students and thinking: Perspectives from research,* pp. 138-156. Washington, D.C.: National Education Association/ Research for Better Schools.

Mosher, J.F. (1985). Alcohol policy and the nation's youth. *Journal of Public Health Policy,* 6, 295-299.

Moskowitz, J.M. (1983). Preventing adolescent substance abuse through drug education. In T.J. Glynn, C.G. Leukefeld, and J.P. Ludford (Eds.), *Preventing adolescent drug abuse: Intervention strategies* (NIDA Research Monograph No. 47, pp. 233-249). Washington, DC: U.S. Government Printing Office.

Moskowitz, J.M. (1989). The primary prevention of alcohol problems: A critical review of the research literature. *Journal of Studies on Alcohol,* 50:54-88.

Murphy, H.A., Hutchison, J.M., and Bailey, J.S. (1983). Behavioral school psychology goes outdoors: The effect of organized games on playground aggression. *Journal of Applied Behavior Analysis* 16:29-35.

O'Donnell, J., Hawkins, J.D., Catalano, R.F., Abbott, R.D., Day, L.E. (1995). Preventing school failure, drug use, and delinquency among low-income children: Effects of a long-term prevention project in elementary schools. *American Journal of Orthopsychiatry* 65(1):87-100.Olds, D. L., Henderson, C. R., Tatelbaum, R., Chamberlain, R. (1986). Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of nurse home visitation. *Pediatrics,* 77, 16-28.

Olds, D.L., Kitzman, H. (1993) Review of research on home visiting for pregnant women and parents of young children, *The Future of Children* 3(3), 53-92.

Olweus, D. (1991). Bully/victim problems among schoolchildren: Basic facts and effects of a school based intervention program. In D.J. Pepler and K.H. Rubin *The Development and Treatment of Childhood Aggression.* Hilsdale, NJ: Erlbaum.

O'Malley, P.M. & Wagenaar, A.C. (1991). Effects of minimum drinking age laws on alcohol use, related behaviors and traffic crash involvement among American youth: 1976-1987. *Journal of Studies on Alcohol* 52:478-91.

Pentz, M.A., Brannon, B.R., Charlin, V.L., Barnett, E.J., MacKinnon, D.P., & Flay, B. R. (1989). The power of policy: Relationship of smoking policy to adolescent smoking. *American Journal of Public Health* 79:857-62.

Perry, C.L., Helder, S.H., Murray, D.M., & Klepp, K.I. (1992). Community-wide smoking prevention: Long-term outcomes of the Minnesota Heart Health Program and the class of 1989 study. *American Journal of Public Health* 82:1210-16.

Pierson, D.E. (1988). The Brookline Early Education Project. In R. Price, E.L. Cowen, R.P. Lorion & J. Romoa-McKay (Eds.), *Fourteen Ounces of Prevention: A Casebook for Practitioners.* Washington, DC: American Psychological Association.

Presseisen, B.Z. (1988). Teaching thinking and at-risk students: Defining a population. In B.Z. Presseisen (Ed.), *At-risk students and thinking: Perspectives from research,* pp. 19-37. Washington, D.C.: National Education Association/Research for Better Schools.

Ramey, C. (1990) Infant Health and Development Program. Enhancing the outcomes of low-birth-weight premature infants: A multi-site, randomized trial. *Journal of the American Medical Association,* 263(22), 3035-3042.

Ramey, C.T., Bryant, D.M., Wasik, B.H., et al., (1992). The Infant Health and Development Program for low birth weight, premature infants: Program elements, family participation, and child intelligence. *Pediatrics* 89, (3) 454-65.

Rosenshine, B.J. (1986, April). Synthesis of research on explicit teaching. *Educational Leadership,* pp. 60-69.Slavin, R.E. (1983). When does cooperative learning increase student achievement? *Psychological Bulletin* 94: 429-445.

Saffer, H. & Grossman, M. (1987). Beer taxes, the legal drinking age, and youth motor vehicle fatalities. *Journal of Legal Studies* 16:351-74.

Schweinhart, L.J., Barnes, H.V., and Weikart, D.P. (1993) *Significant benefits: The High/Scope Perry Preschool study through age 27.* Monographs of the High/Scope Educational Research Foundation, no. 10, Ypsilanti, MI: High/Scope Press.

Sherman, L.W., Shaw, J.W., and Rogan, D.P. (1995). The Kansas City Gun Experiment, *Research in Brief.* Washington, D.C.: National Institute of Justice.

Shure, M. B., & Spivack, G. (1982). Interpersonal problem-solving in young children: A cognitive approach to prevention. *American Journal of Community Psychology,* 10, 341-355.

Shure, M.B. *Interpersonal Problem Solving and Prevention.* A comprehensive report of research and training. #MH-40801. Washington, D.C.: National Institute of Mental Health, 1993.

Slavin, R.E. (1987). Ability grouping and student achievement in elementary schools: A best-evidence synthesis. *Review of Educational Research* 57:293-336.

Slavin, R.E. (1990a). Class size and student achievement: Is smaller better? *Contemporary Education* 42:6-12.

Slavin, R.E., Madden, N.A., Karweit, N.L., Livermon, B.J., & Dolan, L. (1990b). Success for All: First year outcomes of a comprehensive plan for reforming urban education. *American Educational Research Journal* 27:255-78.

Spoth, R., Redmond, C., Haggerty, K., and Ward, T. (1995) A controlled parenting skills outcome study examining individual difference and attendance effects. *Journal of Marriage and the Family* 7:449-464.

Stallings, J.A., & Stipek, D. (1986). Research on early childhood and elementary school teaching programs. In M.C. Wittrock (Ed.), *Handbook of research on teaching.* (3rd ed., pp. 727-753). New York: Macmillan.

Strayhorn, J. M., & Weidman, C. S. (1991). Follow-up one year after parent-child interaction training: Effects on behavior of preschool children. *Journal of American Academy of Child and Adolescent Psychiatry,* 30, 138-143.

Szapocznik, J., Rio, A., Murray, E., Cohen, M., Scopetta, M., Rivas-Vazquez, A., Hervis, O., Posada, V. & Kurtines, W. (1989). Structural family versus psychodynamic child therapy for problematic Hispanic boys. *Journal of Consulting and Clinical Psychology* 57: 571-178.

Thompson, D.W. & Jason, L.A. (1988). Street gangs and preventive interventions. *Criminal Justice and Behavior* 15:323-333.

Tremblay, R. E., Vitaro, F., Bertrand, L., LeBlanc, M., Beauchesne, H., Boileau, H., & David, L. (1992). Parent and child training to prevent early onset of delinquency: The Montreal Longitudinal-Experimental study. In J. McCord & R. Tremblay, *Preventing Antisocial Behavior: Interventions from Birth through Adolescence,* New York: The Guilford Press, pp. 117-138.

Tremblay, R.E., Pagani-Kurtz, L., Masse, L.C., and Pihl, R.O. (1995). A bimodal preventive intervention for disruptive kindergarten boys: Its impact through mid-adolescence. *Journal of Consulting and Clinical Psychology* 63: 560-568, 1995.

Vartiainen, E., Pallone, U., McAlister, A., & Puska, P. (1990). Eight-year follow-up results of an adolescent smoking prevention program: The North Karelia Youth Project. *American Journal of Public Health* 80:78-79.Wandersam, A., Florin, P., Friedmann, R., & Meier, R. (1987). Who participates, who does not, and why? An analysis of voluntary neighborhood associations in the United States and Israe. *Sociological Forum,* 2: 534-555.

Warger, C. (Ed.). (1988). *A resource guide to public school early childhood programs.* Alexandria, VA: Association for Supervision and Curriculum Development.

Webster-Stratton, C. (1984). Randomized trial of two parent-training programs for families with conduct-disordered children. *Journal of Counseling and Clinical Psychology,* 52, 666-678.

Webster-Stratton, C., Kolpacoff, M., Hollinsworth, T. (1988) Self-administered videotape therapy for families with conduct-problem children: Comparison of two cost-effective treatments and a control group. *Journal of Consulting and Clinical Psychology* 56(4): 558-566.

Webster-Stratton, C., Kolpacoff, M., Hollinsworth, T. (1989) The long-term effectiveness and clinical significance of three cost-effective training programs for families with conduct-problem children. *Journal of Consulting and Clinical Psychology* 57(4): 550-553.

Webster-Stratton, C. (1990a) Enhancing the effectiveness of self-administered videotape parent training for families with conduct-problem children. *Journal of Abnormal Child Psychology* 18(5): 479-492.

Webster-Stratton, C. (1990b) Long-term follow-up of families with young conduct-problem children: From preschool to grade school. *Journal of Clinical Child Psychology* 19(2): 144-149.

Webster-Stratton, C. (1994) Advancing videotape parent training: A comparison study. *Journal of Consulting and Clinical Psychology* 62(3): 583-593.

Weikart, D. P., Schweinhart, L. J., & Larner, M. B. (1986). A report on the High/Scope Preschool curriculum comparison study: Consequences of three preschool curriculum models through age 15. *Early Childhood Research Quarterly,* 1, 15-45.

Weinraub, M., & Wolf, B. (1983). Effects of stress and social supports on mother-child interactions in single and two-parent families. *Child Development,* 54, 1297-1311.

Weiss, H.B. (1988). Family support and education programs: Working through ecological theories of human development. In H.B. Weiss and F.H. Jacobs (Eds.) *Evaluating Family Programs,* pp. 3-36. New York: de Gruyter.