State of the Science and Practice in Parenting Interventions across Childhood

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Literature Review and Synthesis

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Introduction

The current literature review was prepared as part of a project entitled *State of the Science and Practice in Parenting Interventions across Childhood* that was funded by the U.S. Department of Health and Human Services. The project focused on providing a better understanding of how to support parents throughout children's development in order to promote positive adolescent development and reduce risky behaviors in adolescence, particularly sexual risk behaviors. A major task of the project was a literature review that examines what is known about parenting across the developmental stages of childhood and adolescence, how different parenting dimensions or behaviors relate to outcomes for adolescence, and what is known about the strategies and effectiveness of interventions to improve parenting practices. The review draws on two linked research literatures: theoretical and empirical research on children's development and the role played by parental and other influences on that development and on outcomes in adolescence; and evaluative research on programmatic approaches to improving parenting.

Theoretical and Research Framework for the Review

"Parenting is a developmental process; it is formulated over time and amid a system of changing relationships"

Managing to Make It, pp. 103-4

This section of the report reviews what the theoretical and empirical research literature tells us about the links between parenting behavior and adolescent risk-taking behavior. We recognize, at the outset, that many different factors influence the decisions that adolescents make about their lives. The child is born into and grows up surrounded by a web of influences that interact with each other and with him or her. Parental influence, so central in the child's early life, retains its importance as the child moves through school and into adolescence, but must contend with competing influences. Other elements, such as friends and peers, the media, and a variety of environmental factors, as well as the child's own genetic and biological make-up exert considerable influence and interact with each other. Nevertheless, some of the aspects of parenting that were supportive and protective earlier in the child's life continue to shape the adolescent's decisions and actions.

One question posed for the review was "How do early parenting practices relate to later parenting practices and adolescent outcomes?" In this review, we will discuss evidence that supports the argument that the aspects of parenting and family relationships and interactions that are critical to children's well-being in early life continue to be important as the child moves through childhood to adolescence, although the ***expression*** of them may change to adapt to children's developmental needs. We consider the ways in which the characteristics of the child, the parent (or significant adult), the family and the social and economic environment affect youth wellbeing both directly and through their effects on parents' behavior and interactions with the child; and consider evidence that supports the view that there may be critical periods in the child's life when the actions and behavior of parents (or parental figures) have the potential to be most significant.

Adolescent Risk Behaviors as a Public Health Issue

Among the many changes that take place as youth move from childhood to adolescence is an increase in risk-taking and sensation-seeking behavior. For reasons that are not yet completely understood, risk-taking behavior increases in adolescence and decreases as youth move into adulthood. Behaviors such as binge drinking, smoking and drug use, driving recklessly or under the influence of alcohol, engaging in violent and antisocial behavior, and engaging in risky sexual behaviors (sex with multiple partners, casual sex, unprotected sex) pose immediate and longer-term threats to the health and well-being of youth, as well as to others who may be affected by their behavior. Although the rates of some types of risk-taking behavior have dropped, their prevalence remains high and, taken together, they represent a major public health challenge (Steinberg, 2008). The CDC reports that, in 2011, nearly 40% of high-school-age youth did not use a condom the last time they engaged in sexual intercourse and, in the last 30 days, one-quarter rode in a car driven by someone who had been drinking, nearly one-quarter reported multiple episodes of binge drinking, and six percent were regular smokers (CDC 2012). More than 25% of a nationally-representative sample of adolescent girls aged 14-19 had a sexually transmitted infection, according to a second CDC report (Forham et.al., 2008, cited in Coley et al., 2009). Rates of teenage pregnancy and births to teen mothers are also higher than in other developed countries, and are especially high for some minority groups and in areas with high concentrations of poverty. Steinberg (2008) uses evidence from AddHealth to argue that these problems have not been ameliorated by widespread exposure to school-based educational programs designed to reduce smoking, drinking, drug use and unprotected sex.

It seems plausible that interventions to reduce risk behavior would be more effective if based on a clear understanding of the trajectories that lead youth to these behaviors and the characteristics of young people, their families and their surroundings that protect against risky behavior (or, alternatively, place youth at risk). While research has helped our understanding of the precursors of some risk behaviors (violent and anti-social behaviors, for example), the early warning signs and predictors of others, such as risky sexual behavior, are not well understood. By contrast, a substantial body of research exists on the aspects of youth and their environments that are protective against risk behaviors that threaten their well-being (although the interactions among these factors are also not well-understood).

What Characteristics of Adolescents are Associated with Avoidance of Risk Behaviors?

While adolescence is a time of change and exploration and, for many, increased risk-taking, not all youth engage in the kinds of reckless behaviors that pose threats to their future well-being and to the health and safety of others. A number of researchers have attempted to identify the characteristics of young people that armor them against these behaviors. Brody et al., (2004) identify five factors that protect against early alcohol use and initiation of sex: “a planful future orientation; resistance efficacy; negative attitudes toward alcohol use and sexual activity, negative images of drinking youths; and acceptance of parental influence.” These factors emerge from social control theory, social development theory, problem behavior theory and self-control theory and have empirical support. Although Brody’s own work establishes resistance efficacy and acceptance of parental influence as more narrowly protective against alcohol and substance abuse among rural African-American youth (Brody et al., 1998; Brody et al., 2000), a wide range of empirical research supports the hypothesis

that the five factors (or similar factors) are protective across ethnic groups.[1] Adolescents who plan for the future and set goals for themselves, even those who are growing up in high-risk environments, are less likely to experience social and psychological problems (Werner and Smith, 1982, 1992). They are more likely to plan and monitor their own behavior, less likely to abuse alcohol or drugs (Keough, Zimbardo, and Boyd, 1999). The ability to resist pressure from peers, acceptance of parental influence, and negative perceptions of deviant behavior have been identified as protective against both early alcohol use and sexual activity (see, among others, Bogenschneider et al., 1998; Jessor and Jessor, 1997; Lee and Stall, 1993). Similarly, strong theory and empirical research link youths' adjustment to and engagement with school and motivation to succeed academically with both achievement and behavior (Hawkins and Weis, 1985; Andrews and Duncan, 1997; Barber and Olsen, 2003). Youth who are unmotivated and disengaged from school are more likely to drop out of school and/or engage in antisocial and risky behavior (Andrews and Duncan, 1997).

Parenting to Reduce Adolescent Risk Behavior and Promote Positive Outcomes

Although, as we noted earlier, parental influence on children's behavior diminishes somewhat with the onset of adolescence, a substantial body of research supports its continued importance in shaping the behavioral decisions that youth make. This influence manifests itself in a cluster of parent behaviors, parent-child and family interactions and transactions. Although some research (and programming influenced by it) has focused on specific behaviors, such as "parent-child communication," "consistent, positive discipline," there is increasing recognition that a specific behavior is only effective in the context of other behaviors and interactions. At the core of effective parenting of adolescents is a relationship between the parent and child that is warm, trusting and supportive. Parent-child connectedness and positive involvement in children's lives has been shown to be protective against early sexual initiation, and alcohol and cigarette use (Blum, 2002).[2] Similarly, Miller (1998), in a synthesis of the research on family influences on adolescent pregnancy, found that the quality of the relationship between the parent and adolescent influences adolescent sexual risk behavior—positive relationships were associated with reduced risk of teen pregnancy. While offering support for the notion that parental closeness and support influence both adolescents' attitudes towards sex and their sexual behavior, Longmore and colleagues argue that it is parenting strategies (supervision, monitoring) that lay the basic foundation for adolescent decision-making and influence dating and sexual behavior in adolescence(Longmore et al., 2001).[3]

A pattern of behavior that is both demanding and responsive, characterized by Baumrind (1991) as "authoritative" and by Brody et al. (2004) as "involved-vigilant" is, in both paradigms, viewed as the most effective way to parent children in middle childhood and adolescence. A warm and trusting relationship, positive communication and appropriate styles of regulation and control are important

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1 For a summary of this research, see Petraitis et al., 1995.

2 Blum suggests that simply encouraging parents to talk to their teens about the risks of adolescent sex is unlikely to have any impact, if parents are not otherwise positively involved with their children.

3 However, a number of other researchers suggest that continued monitoring in adolescence is critical, citing relationships between low parental monitoring of adolescents and high-risk sexual behavior and early pregnancy (Dornbusch et al., 1985, Luster and Small, 1994. Miller et al., 1997)

factors in parents' ability to instill beliefs and values, foster motivation and help children develop social and intellectual skills (Baumrind, 1989; Steinberg, 1990; Steinberg et.al., 1991). Although many of the early studies of authoritative parenting were based on samples of White middle-class youth, the last of these studies provided convincing evidence that, across ethnic groups, social classes and different family structures, adolescents whose parents demonstrated this pattern of parenting were more successful in school, more self-reliant, reported less anxiety and depression and were less likely to engage in anti-social behavior. Steinberg's operationalization of authoritative parenting demonstrates the challenge that parents face; in the context of an involved and accepting relationship, they must balance firm and clear control with support for the increasing autonomy that is essential to adolescent development and for a democratic approach to family decisions.

Different theoretical frameworks suggest the mechanisms through which parental emotional warmth, responsiveness and support combined with clear communication (of information, rules, values and expectations), non-punitive discipline, monitoring of youth activities and involvement in joint activities encourage the development of prosocial and self-regulation skills that, in turn, help youth to avoid sexual and other problem behaviors. The absence of these skills increases the likelihood of early alcohol use, early sexual activity and other risk behaviors (Jessor and Jessor, 1977; Patterson et al., 1989). Empirical research offers support for these propositions. Authoritative parenting practices have been shown to protect adolescents from problem behavior and to support the development of social competence, adjustment to school and school performance (see, among others, Baumrind, 1991; Simons-Morton and Haynie, 2002; Steinberg et al., 1994; Steinberg, 2001). Brody and his colleagues, in their work with African-American youth specifically, have demonstrated that involved-vigilant parenting practices protect African-American youth from engagement in antisocial activity and promote their development of self-regulation skills (Brody et al., 1999; 2002). Across ethnic and socio-economic groups, research has shown that parents need to be involved with their child, to monitor his or her activities and behavior and to provide effective and consistent discipline (Gorman-Smith et al., 1999; Patterson, 1982; Paterson et al., 1992). Continued emotional support from parents is a strong protective factor and its absence is linked to adolescent substance use and early initiation of sex, among other risk behaviors (Wills et al., 1996; 2004). By itself, parental emotional warmth and support reduces the relationship between cumulative risk factors and negative outcomes for youth (Ackerman et al., 1999).

Coley and her colleagues offer a different perspective on the interaction loop between parents and youth, citing transactional models of problem behavior in which youth, as they begin to engage in problem behavior, disengage from parents. As a consequence, parents become less involved and more negative, possibly leading to escalating problem behavior. However, their research, as well as that of others, does not support the bidirectional models, though it does provide support for the influence of parent involvement in children's lives, through joint activities and routines. Their analysis of growth trajectories of both youth sexual risk behavior and parenting practices, which allowed them to trace the direction of influence, supports the hypothesis that involved parenting and regular family activities are protective against sexual risk behavior in adolescence (Coley et al., 2009).

The aspects of parenting behavior that theory and research have identified as effective and protective in adolescence have their foundation in parenting behavior and interactions in early childhood in two ways. The connections and interactions established in early childhood influence children's responses in later childhood. When parents have established a warm emotional bond and provided clear and consistent messages about rules and expectations, the strong attachment created motivates children to

respond positively to later parental rules and demands, even faced with external pressure to behave in other ways (Furstenberg et al. 2004). In the next section, we discuss what theory and research tells us about the foundational role of parenting in the early lives of children.

Parenting in Early Childhood

In infancy, the role of the caregiver is to establish routines, patterns of interaction and patterns of communication. From the earliest moments of the child's life, attachment theory tells us, the emotional warmth and responsiveness of the parent or primary caregiver is the prime contributor to the child's development of trust, of a sense of self, and of the capacity to engage in future healthy relationships. The theory is supported by decades of research that links maternal verbal and physical responsiveness to secure attachment and accelerated development (see, for example, Bakeman and Brown, 1980; Barnard et al., 1988, Clarke-Stewart, 1973, Ramey et al., 1979, Sroufe, 1985, Yarrow et al., 1975). Even in high-risk families (low socioeconomic status, low social support), the mother's ability to engage her child in positive and stimulating interactions seems to operate as a protective factor (Spieker and Booth, 1988). In the absence of such emotional support, children experience anxiety, which disrupts development (Mahler et al., 1975; Winnicott, 1975; Bowlby, 1969).

In addition, researchers have linked the child's early emotional experiences and social and behavioral adjustment to school success and to later cognitive development, including the development of complex capacities such as reality testing and judgment (Greenspan, 1994; 1996). The psychological research is supported by the work of by neuroscientists like Antonio Damasio on the function of the prefrontal cortex and the consequences of damage to it (Damasio, 1994).

A harbinger of parents' later ability to communicate clear behavioral expectations, rules and boundaries can be found in parents' ability to provide clear cues to their infant and young child about what they are doing and what they want the child to do, and to perceive and respond to cues from the child about his or her needs (Barnard, 1982). Positive communication moves from gestural and language cues in infancy to clarity about expectations, boundaries, and values in early childhood.

From cognitive developmental theory comes Vygotsky's proposition that parents (along with teachers and others later in the child's life) promote children's cognitive development by actively supporting and scaffolding activities that lead the child to think and learn (Vygotsky,1978). Support for learning moves from language and encouraging exploration of the environment in the early years to include supporting the increasing autonomy and decision-making ability that adolescents need as well as for school attachment and educational achievement that can protect against risk behavior

The final element that foreshadows later parenting behavior is so taken for granted that it is seldom mentioned. The vigilance or monitoring behavior that is seen as important in later childhood and adolescence is crucial in infancy and early childhood. The parent or primary caregiver must constantly monitor the child's state and activity, as well as his or her immediate surroundings to determine whether he or she is too hot, too cold, hungry, thirsty, tired, unwell, needing a diaper change or toileting assistance, in a dangerous situation or struggling with a task beyond their ability to complete.

Parenting in Interaction with Characteristics of the Child

The discussions in the preceding sections suggest some convergence on the elements of parenting that provide support for positive development and protect against risky behavior from early childhood through adolescence. While, as we have seen, there is some support for the idea that these elements are important across different ethnic groups, socio-economic strata and family types, we should acknowledge that their relative importance and emphasis may be influenced by characteristics of the child himself or by aspects of the environment.

Although, from Bronfennbrenner's work, we recognize that parental behavior not only shapes but is also shaped by the child's cues or responses, other research suggests in more detail the ways in which this may happen and some implications for parenting strategies. At the most basic level, the science of behavioral genetics has led some researchers to speculate that the emotional and cognitive dispositions that children are born with interact with elements of their environment to enhance or undermine their development (IOM, 2002). Greenspan (1997) argues that the interaction of inborn neurological deficits with environmental stresses and certain types of parent-child relationships increases the likelihood of antisocial behavior. He gives one example of children who crave sensation because they are "underreactive to touch and sound and insensitive to pain" (The Growth of the Mind, p.145). Later, they seek stimulation in risk-taking, but the thrills can result from positive experiences such as exploring or adventure, or negative ones such as gang activity or robbery, depending in large part on the family and community in which the child lives.

Greenspan proposes that these children, as well as active, aggressive children, need a different and more intense type of parenting than other children, beginning in early childhood. The basic elements remain: emotional warmth, but even more of it; limits applied lovingly but very firmly; intimate communication to help the child name feelings, consider consequences and develop compassion for others; and help in controlling physical energy or channeling it into constructive activity. Greenspan proposes four other personality types in addition to the two described here: the highly sensitive child, the inner-focused child, the strong-willed child and the child with attention difficulties. For each, he suggests that some or all of the elements of effective parenting described earlier must be tailored to meet the needs of the child.

As well as adaptation to the child's personality, the expression of these basic behaviors changes in response to the child's developmental needs. As the child develops, parents must balance vigilance and monitoring and the child's need to explore his environment and gradually establish independence. At times of rapid change in the child's development (as a toddler, and then in late childhood/early adolescence), the parent's ability to adapt his or her behavior may be slow to catch up with and adapt to the changes, and the result is conflict between parent and child because of the lack of "developmental fit" (Eccles et al., 1993).

Environmental Moderators of Parenting Effectiveness

The focus of this review is on parenting behavior and its links to adolescent behavior. However, other factors influence children's development both directly and indirectly through their influence on parents' behavior. Bronfennbrenner's developmental-ecological theory (1979) tells us that individual development is influenced by characteristics of the environments that the child experiences as well as by their interaction with one another.

Characteristics of the family unit and the way it functions, that may be beyond the parent's control, affect the child directly, but also constrain the parent's ability to be effective. Low levels of emotional warmth and cohesion among family members, the absence of clear family roles, responsibilities and boundaries and little or no recognition of the importance of family are associated with adolescent risk behavior and delinquency (Farrington, 1994; Gorman-Smith et al., 1996). Parental education levels and financial resources can constrain parents' ability to support their children's learning and education. Lareau (1989) argues that working class and poor parents are at a loss when it comes to interacting with schools and being effective advocates for their children and lack resources to provide educational and cultural experiences outside school.

There is increasing emphasis on the effect of neighborhood and community on both children and their families (Chase-Lansdale and Gordon, 1996; Furstenberg, 1993; Furstenberg et al., 1999; Jarrett, 1995). In high-risk, dangerous neighborhoods, effective parenting may include a higher level of behavioral control than would be necessary in other contexts. Brody et al. (2004) cite pervasive racism as a contributing factor in substance abuse, and compromised psychological functioning that leads to low educational aspirations and the abandonment of life goals among African-American youth. For these youth, effective parenting includes teaching children about the reality of racism while emphasizing the need to strive for success.

Even more significant, for the purpose of this review, is the research evidence on the interactions among community characteristics, family functioning and parenting characteristics, and the effects of these interactions on delinquency and risk behavior. Gorman-Smith and her colleagues investigated these questions in their analysis of data from the Chicago Youth Development Study, a longitudinal study of serious delinquent behavior among adolescent African-American and Hispanic males living in 17 inner-city neighborhoods (Gorman- Smith et al., 2000). They found that, while the protective effect of strong family functioning and consistent parenting remained, the effect was lower in the most disadvantaged neighborhoods. Effective parenting practices and cohesive and organized families could reduce but not eliminate the negative effects on youth of stressful neighborhoods.

Parenting During Critical Periods in the Child's Life

As decades of research have made clear, the earliest years of life are a critical developmental period, in which parents or parent surrogates play an essential role. Parental behavior and interactions with their children in the earliest years of life lay the foundation for later emotional and cognitive development, healthy relationships and life success. More recently, attention has focused on transitional periods, most notably the move to middle school, a time when children's school engagement and motivation declines, along with educational achievement. Eccles and her colleagues speculate that the poor fit between the middle school environment, characterized by rules, control and discipline, and the developmental stage of early adolescence, in which youth need to experiment with and assert their individuality may reduce student attachment to school and motivation to succeed academically (Eccles et al. 1996, Roeser and Eccles, 1998). Reduced engagement with school and motivation to succeed makes youth more likely to drop out of school or engage in antisocial and risky behavior (Andrews and Duncan, 1997; Steinberg and Avenovoli, 1998, among others). Effective parenting might ameliorate this effect but, unfortunately, because children are experiencing simultaneous physical, psychological, emotional and cognitive changes, there is often also a poor fit between parenting practices and children's rapidly changing needs. This is typically not the period in childhood on which parent interventions or empirical research has focused, so we have little

information about it, but it is perhaps the last chance we have to improve the adolescent experience in a meaningful way. Even parents who have navigated the early childhood years successfully may struggle to address children's developmental needs and help ease the transition to adolescence.

Recently, attention has focused on adolescence itself as a critical period in children's development, although there is no consensus on how parental behavior and interactions with teens can affect that development. Steinberg (2008), summarizing over a decade of research on brain development, describes continuing significant changes in brain structure and function that continue through adolescence and into young adulthood that seem to have consequences for adolescents' engagement in risk behavior. These changes are not synchronized: that is, the changes in the brain's socio-emotional system in puberty that are believed to lead to increased risk-taking (reward-seeking) precede changes later in adolescence in the brain's cognitive control system that are linked to improvements in the capacity for self-regulation.

Like others he argues that adolescent engagement in risky behavior is not the result of "ignorance, irrationality, delusions of invulnerability, or faulty calculations" (Reyna and Farley, 2006). Rather, the conclusion he draws from the research is that "heightened risk-taking is likely to be normative, biologically driven and, to some extent, inevitable". (Steinberg, p.100). This conclusion leads to some pessimism about the likely effectiveness of interventions that seek to prevent or ameliorate adolescent risk behavior by changing parental awareness and behavior with their children. He acknowledges the link that his own research as well as that of others has established between "authoritative" (warm but firm) parenting and lower levels of adolescent anti-social and risk behaviors. However, the mediating factor may not be increased levels of self-regulation, as many researchers have hypothesized, but external constraints (imposed by parental vigilance) on teens' access to risky situations and harmful substances[4]. While Steinberg goes on to argue that public policy might be better focused on strategies to limit the harmful consequences of risky behavior (raising the price of cigarettes, vigilantly enforcing the laws prohibiting sales of alcohol to minors, expanding access to mental health and contraceptive services), he also highlights our ignorance about the effects of changing the context in which adolescents function on their development of self-regulatory capacity.

Discussion

The evidence that there are parent behaviors and interactions that are important for healthy development from early childhood on seems to hold across socioeconomic and ethnic groups, although it is increasingly clear that they are individualized and responsive to children's temperament and environmental threats.

The research discussed above supports the idea that the basis for effective parenting across developmental stages is a ***warm and supportive relationship*** that lays the foundation on which mutual trust and acceptance can be built. On the parent's part, this means acknowledging and accepting the child's individuality early in life, accepting and supporting the growing child's need for both autonomy and inclusion, and responding positively to the child's efforts. As the child moves into

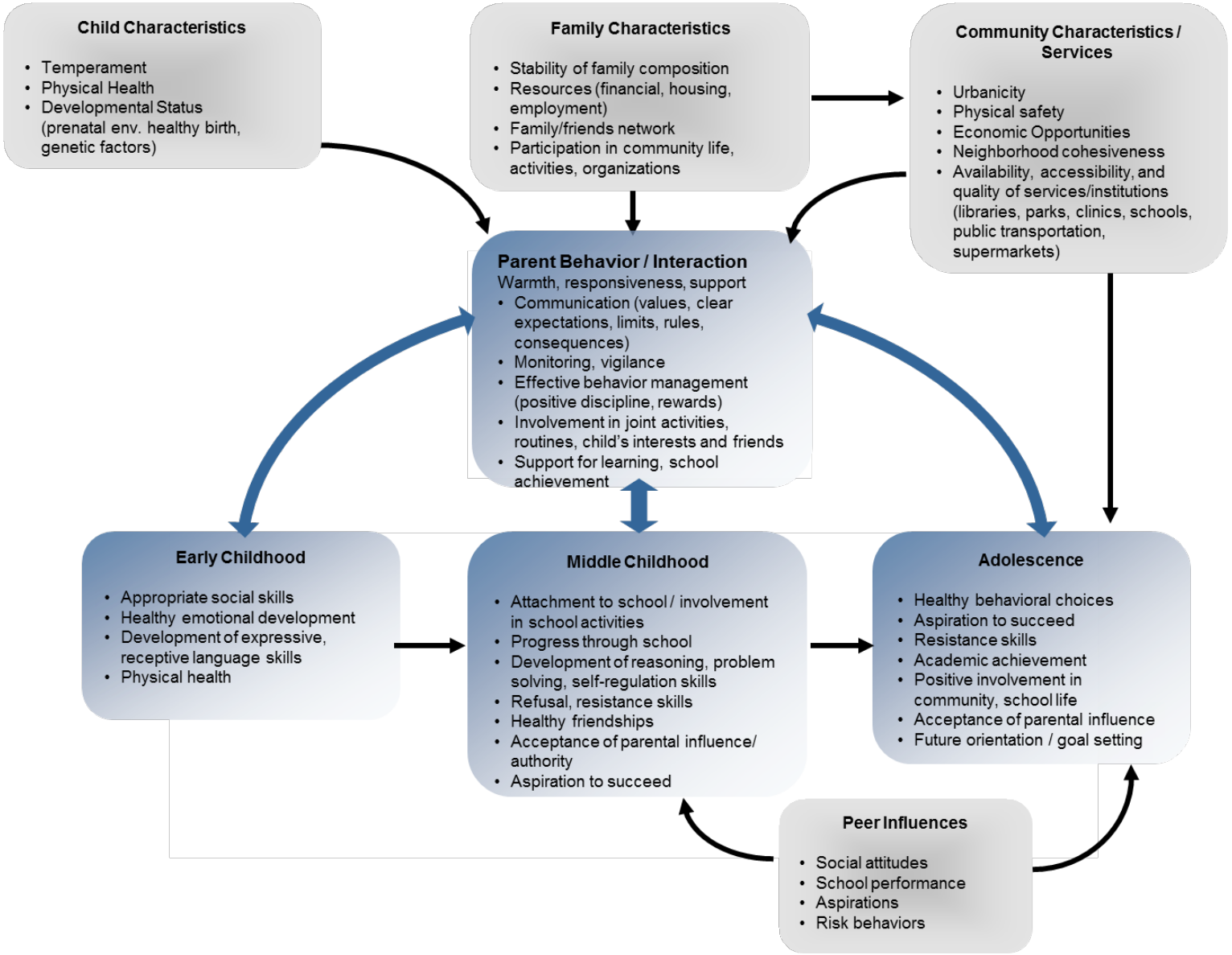
[4] Of course, for maximum effectiveness, vigilance and firm application of family rules build on the foundation of affection and mutual trust established earlier, so that adolescents are more likely to conform to the rules and expectations set by parents and submit to what might otherwise seem unreasonable oversight of their behavior and associations.

adolescence, this foundation allows him or her to acknowledge and accept parental influence and authority, and to play a role in family decision-making. Within this context, ***communication*** is important. Parents communicate rules, values, expectations, and behavioral consequences, provide information and explanations, and encourage questions. The extent and content of the communication may change over time as the child grows, beginning with the effort to help the young child make sense of the world and moving to helping the pre-adolescent make informed and positive decisions. ***Consistent, positive discipline*** that is developmentally-appropriate is a third element of effective parenting over time. A fourth element, ***monitoring*** the child's behavior and activities, focuses on protecting the child's physical well-being in early childhood and expands to include monitoring of friendships and activities that could pose a threat to other aspects of the child's well-being as the child spends more time away from home. Vigilance about associations with anti-social peers and activities may continue to be protective through the adolescent years. A final element is ***involvement in joint activities,*** including daily routines, family meals and recreational and other activities. Exhibit 1 is a visual representation of parental and other influences and the interactions among them and with the child him or herself.

The guidance offered by this research for interventions with parents is less clear. The research does not provide conclusive answers to some questions and does not address others. For example, are all elements of parenting amenable to improvement or only some? Are parenting strategies flexible over time for most parents? Can we improve some aspects of parenting but not others, and does changing a single aspect of parenting by itself affect outcomes for children and youth? To change outcomes for youth, is it necessary to intervene with others in addition to parents—teachers, other adults or the children themselves?

In the absence of clear evidence of the superiority of one strategy over another, programs fall back on theoretical models and test a variety of strategies. In the remainder of this review, we examine a collection of program models that all feature parent training either by itself or as an important component of a larger intervention and that intervene with parents (and often with their children) at different points in the child's development. From their evaluations we hope to derive answers to some of the questions posed above.

Exhibit 1


Child Characteristics
• Temperament
• Physical Health
• Developmental Status (prenatal env. healthy birth, genetic factors)
Family Characteristics
• Stability of family composition
• Resources (financial, housing, employment)
• Family/friends network
• Participation in community life, activities, organizations
Community Characteristics / Services
• Urbanicity
• Physical safety
• Economic Opportunities
• Neighborhood cohesiveness
• Availability, accessibility, and quality of services/institutions (libraries, parks, clinics, schools, public transportation, supermarkets)
Parent Behavior / Interaction
Warmth, responsiveness, support
• Communication (values, clear expectations, limits, rules, consequences)
• Monitoring, vigilance
• Effective behavior management (positive discipline, rewards)
• Involvement in joint activities, routines, child's interests and friends
• Support for learning, school achievement
Early Childhood
• Appropriate social skills
• Healthy emotional development
• Development of expressive, receptive language skills
• Physical health
Middle Childhood
• Attachment to school / involvement in school activities
• Progress through school
• Development of reasoning, problem solving, self-regulation skills
• Refusal, resistance skills
• Healthy friendships
• Acceptance of parental influence/ authority
• Aspiration to succeed
Adolescence
• Healthy behavioral choices
• Aspiration to succeed
• Resistance skills
• Academic achievement
• Positive involvement in community, school life
• Acceptance of parental influence
• Future orientation / goal setting
Peer Influences
• Social attitudes
• School performance
• Aspirations
• Risk behaviors

Interventions to Improve Parenting

The next step in the review was to identify programs or interventions that work with parents to improve parenting strategies, with the goal of preventing or reducing risk behavior in children and youth. Building on the central role that parents and family play in the healthy development of children, many programs and interventions have been developed to support parents' roles in healthy development and in protecting against later negative outcomes for youth. Interventions and programs for parents begin in the prenatal stages and progress to early childhood, early adolescence and middle-childhood, and continue into young adulthood. These interventions vary in many ways: in the types of families served (e.g., parents of children with identified behavior problems, low-income families at risk, parents with children at risk for engaging in high-risk behaviors); emphasize different content (e.g., knowledge of child development, communication, behavior management strategies); and use different settings to deliver the program (e.g., clinics, community agencies, schools, churches, families' own homes). This heterogeneity presents a challenge for any efforts to comprehend or summarize the universe of programs and the extent to which they are able to meet their goals.

Our mandate was not to conduct a meta-analysis or even a comprehensive program-by-program review. Rather, the goal was to conduct a review that would allow us to understand the different strategies and approaches that have been used in intervening with parents and the results associated with those strategies. Therefore, while our search of the literature was broadly encompassing so as not to miss important programs or strategies, it did not involve the level of rigor one would expect from a meta-analysis or more in-depth review.

The first step in conducting the scan of the literature was to define as clearly as possible the parameters of the search, so that the universe of programs/interventions included was also well defined. There is a significant body of research on parenting interventions/education conducted prior to 1999, much of which has been included in meta-analyses or other reviews. Rather than re-reviewing those individual studies, we limited our review to research and evaluations published between 1999 and 2009, the year the review began. In addition, the search was confined to programs that focused on changing parent behaviors, not just attitudes or knowledge; and included programs regardless of the age of the child at the time of the intervention.

Although we were interested in identifying programs that had at least some evidence of effectiveness for closer examination, the review was not designed as a meta-analysis in which the quality of the evidence would be systematically evaluated. For the initial stage of the review, we included programs without regard to their demonstrated effectiveness, but noted statistically-significant outcomes when reported, or the fact of inclusion on one or more of the lists of "effective programs" that have been developed to help practitioners and others interested in implementing a program in their community. These lists include the National Registry of Evidence-based Programs and Practices (NREPP), the Office of Juvenile Justice and Delinquency Prevention's (OJJDP) Model Programs Guide, Blueprints for Violence Prevention, and the Promising Practices Network. Many of the programs appeared on more than one of these lists.

For entirely pragmatic reasons, the review excluded home visiting programs. At the direction of ASPE, programs that rely almost entirely on home visiting, such as the Nurse-Family Partnership, Parents as Teachers, HIPPY or Healthy Start, were excluded from the review, since HHS was

simultaneously conducting a thorough review of this research literature.[5] No other restrictions were placed on the search.

The scan of programs yielded a total of 108 programs (15 of these were adaptations of existing programs to meet the needs of a specific ethnic group, or to make a treatment model appropriate for a lower-risk population). Once this set of programs had been identified, our review proceeded as follows. First, we systematically extracted information on all the programs identified, to allow us to make some broad generalizations about their characteristics and approaches. This description, offered in the next section, provides a background and context for the second step—a closer examination of a subset of programs, discussed later in the review.

Overview of Parenting Interventions

To describe the range of programs that have intervened (or are currently intervening) with parents to prevent negative outcomes for children, we extracted information on the following programmatic characteristics:

- Theoretical basis for the program;
- Program goals (i.e., changing parenting behavior as an end goal or as an intermediate step to improved outcomes for the child);
- Timing of intervention (i.e., the period in the child's life when the program elected to intervene with parents);
- Setting(s) for the intervention;
- Targeting strategy (universal vs. "specific groups");
- Service strategy (intervention directed at parents only vs. parents and children and/or others);
- Evidence of effectiveness (evaluation or inclusion on "effective practices" list; and
- Program impacts (statistically-significant outcomes).

Theoretical Basis for Parenting Programs

Two kinds of theories shape a program's decisions about when, with whom, and how they will intervene. The first deals with how children develop and the influences on that development. The second kind of theory deals with how individuals (adults and children) learn. More than half of the programs reviewed cite one or more developmental theories as a ***framework*** for their intervention. These include: Bronfenbrenner's ecological theory of children's development; social development theory; attachment theory; and general theories of child development. The second type of theory is more likely to shape decisions about how to intervene. Most commonly, programs identify social learning theory (27%) or cognitive behavioral theory (26%) as the foundation for their intervention strategy. Social learning theory posits that individuals learn new behaviors by observing the behavior of others and the outcomes associated with that behavior, but does not necessarily imply changes in

[5] http://homvee.acf.hhs.gov/

behavior as a consequence. Cognitive behavioral theory takes social learning theory a step farther by positing change in cognition as a mediator of behavioral change.

Program Goals

All of the programs included in the review had to have the goal of changing parenting behavior. We were interested in understanding what, if any, additional goals were articulated, since we assume that changes in parenting are intended to have impacts on children's behaviors. Indeed, a majority (though not all) of programs described one or more goals in addition to changing parents' behavior. More than half (54%) of the programs aim to reduce problem behaviors in young children (externalizing, emotional disorders, conduct disorders). Almost 60 percent focus on reducing high-risk behaviors later in the child's life, although only one-quarter of these focus specifically on sexual risk behavior. A substantial proportion (44%) establish positive goals for children and youth, including improved academic achievement. Programs vary greatly in the narrowness or expansiveness of their goals, and this is reflected in the program's scope. At one extreme, an abstinence education program (*Managing Pressures Before Marriage*) seeks to increase communication between parent and child, about pressures to have sex and parental values, through homework assignments linked to a curriculum for children in middle school. *Talking Parents, Healthy Teens* has a similar, narrowly-focused goal. At the other extreme is a program (*Positive Action*) that aims to increase parent-child bonding, improve family interactions, improve academic achievement and attachment to school, and decrease a range of problem behaviors in children and youth across a wide range of ages through a comprehensive intervention with multiple components working directly with parents.

Timing of the Interventions

Because parents face different developmental issues and behavioral challenges at different stages in the child's life, it seemed likely that programs would develop interventions that focus on a relatively narrow child age-range. To the contrary, and supporting the contention made earlier in the paper that a core set of behaviors and interactions constitute effective parenting across the developmental span, programs generally targeted a wide age-range of children. Of the programs that we reviewed, almost one-third (31%) provide the intervention to parents of children ranging in age from 12-18 years. About half intervene with parents of children across even wider age ranges. A minority of programs target more narrowly—parents of children ages 0-5 years (10%) and parents of elementary school-age children (6%).[6] Programs that address issues across a wide range of child ages usually develop modular curricula, with age-specific content.

Setting for the Interventions

Program services are delivered in a variety of settings, as we anticipated, including schools, community agencies, hospitals and clinics, churches, families' homes, parents' workplaces, among others. Many programs do not specify a setting for the program but rather suggest that program

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[6] This is partly a function of our search criteria, which do not reflect earlier meta-analyses or reviews of early childhood programs. There are many long established interventions with parents of younger children, specifically pre-school age. This distribution of programs most likely is an accurate representation of programs that were considered for the review to be relevant to the interests of preventing adolescent risk taking behaviors.

services could be delivered in different settings, depending on the needs of families in the community. One-quarter of the programs do specify a single setting for the program, most commonly schools or individual homes. Programs with multiple components often deliver them in different settings—for example combining services in schools or community agencies with visits to families' homes. Just over 10 percent of programs are delivered in hospital or clinic settings.

Target Populations

Programs have three choices about targeting services: they can offer a program to all comers, regardless of socio-economic status; they can provide services to parents and families that are considered high-risk (because of poverty, family structure, parental age, immigrant status etc.); or they can target families and children with a specific presenting problem. These three approaches are designated, respectively, "universal," "selected" and "indicated." In the programs reviewed, the largest group (41%) targeted "indicated" populations. Programs in this category serve families in which a child has been identified as having a specific problem (conduct disorders, aggression, mental health problems or chemical dependency). The remaining programs are almost equally divided between "selected" (31%) and "universal" (28%) targeting strategies. Those programs that offered services to "selected" populations, i.e., those considered high-risk, often define the risk in terms of neighborhood poverty, racial or ethnic characteristics, or high rates of problem behavior such as gang activity. One program defined the "selected" population as divorced parents of children between the ages of three and 17 years. Another focused on families living in areas with high rates of gang activity. Universal programs assume that all parents could use some help managing children's behavior effectively or supporting prosocial behavior. However, in practice, many universal programs are implemented only in poor neighborhoods, where a greater proportion of families may be at risk for adverse child outcomes. One exception to this is the Triple P program which, by design, offers services at all three levels and believes that parenting help offered universally establishes norms for parenting behavior that enable parents with more specific needs to reach out for additional help.

Which Family Members are Targets of Program Services?

Although the focus of this review is on "parenting programs," it is important to recognize that this is not necessarily the way that programs view themselves. While an important subset of programs deliver services only to parents, and can be considered "pure" parenting interventions, in most of the programs reviewed, the parent training or education component is one of two or more program components, and not necessarily the most intensive or important.

Of the programs we reviewed, the largest single group (29%) provide services for parents only, with no other program components, while almost half (46%) deliver a parenting component as one of two or more components. The remaining programs, which offer services for parents and their children together are most often clinical, family therapy-based programs, which sometimes work with children alone as well as in combination with parents and other family members, but rarely if ever meet only with parents.

In almost half of the programs reviewed, children are the major focus of program services, but there is a separate component for parents (40%) and, in almost half of these latter, a third component in which children and their parents work together on joint activities.

While the programs themselves, and the research literature on them often say little or nothing about the rationale for these different patterns of service provision, we feel that the patterns reflect slightly different hypotheses about the levers of change in families and children. For this reason, we return to this issue in the next section of the review, which focuses on a subset of the programs in our sample.

The description of programs provided above, while it faithfully reflects the universe of programs that met the search criteria, is of limited value for two reasons. First, it includes many programs that no longer exist and that may only have existed as part of a research project. A later task in this project is to obtain more detailed operational information about programs in the review—information that might assist program planners and other decision makers. This would clearly not be possible in cases where the intervention was implemented only in the context of a research project.

Second, the sample is skewed by the inclusion of a number of programs that are clinical, therapy-based ***treatment*** programs, rather than prevention programs. The most prominent models are Brief Strategic Family Therapy (BSFT) and Multisystemic Therapy (MST), designed to address severe behavior problems, diagnosed substance addiction, and delinquency. Together with their adaptations, they are disproportionately represented in the literature, given the necessarily small numbers of families they can serve, and we believe they are not relevant to the policy issues that the review is intended to address. For a more in-depth examination of prevention strategies and their effectiveness, we eliminated these two types of programs.

A final screen was applied to the remaining sample of programs. To be most useful to program planners and decision makers, a program needs to have some evidence about the kinds of effects it might be expected to achieve. As we noted earlier, in our initial scan, we included programs whether or not there existed evidence of their effectiveness, but noted it when it was present. For this more in-depth review, we included only programs that had some evidence of effectiveness, as demonstrated by their inclusion on one or more lists of "effective practices." This is not a very stringent criterion; the standards of evidence required for inclusion on these lists vary greatly in their rigor.

Review of Program Strategies

For the more in-depth review of programs, one that includes an examination of the activities and strategies they use to achieve their goals and the impacts they achieve, we focused on a subgroup of the programs in our initial sample, using the exclusion and inclusion criteria described above to select them. No further selection was made, once these screens had been applied.

The group of programs thus identified is quite heterogeneous, varying in the ages of the children that the program focuses on, the settings for program activities, the family members and others who are the target of services, among others. In theory, any of these could be used as a way to group programs for analysis and discussion. In practice, as we showed earlier, the age-range of children whose parents may receive services is often quite broad, often more than one setting is used, and programs are often flexible about the setting for services. As we noted earlier, the selection of family members and others as targets for services was intriguing to us because it seemed to embody an hypothesis about how to achieve program goals, though this was only sometimes articulated. We therefore opted to group the programs and interventions in terms of the most basic aspect of their strategy—whether the parenting intervention constituted the entire program or was one of two or more components of a program.

The discussion that follows looks across programs and considers the strategies used by programs in each group to achieve their goals and the outcomes associated with those goals. More detailed information on the programs discussed here can be found in the profiles contained in Appendix B.

We first consider programs that offer services to parents only—"pure" parenting interventions—and then go on to consider programs that serve children and/or other family members and significant adults in addition to offering services for parents. In some cases, these other programs really have children as their primary target but include components for parents and other adults.

Programs Serving Parents Only

One strategy programs use to address the health and development of youth is to focus their efforts solely on parents. These parenting education efforts are intended to assist parents in developing skills to meet their children's needs effectively. This may take the form of providing information to parents, providing role models and opportunities to practice new skills, and emphasizing child-rearing techniques appropriate to the developmental stage of the child. By improving parenting practices, either through changing attitudes, beliefs, or practices, programs address factors that research has related to early outcomes for children and that in turn have been shown to be predictive of longer-term well-being. The assumption that seems to underlie these programs is that working with parents is by itself sufficient to achieve the positive child outcomes they are hoping for.

Programs targeting parents differ in focus, intensity and the specific parent behaviors and child outcomes that they are attempting to change. Programs may target specific parenting practices that the literature suggests may operate as protective factors, such as positive involvement in the child's life, or effective monitoring and supervision or may try to change specific ineffective parental behaviors and interactions, such as negative reinforcement, exchanges of aversive behavior, or lack of communication. These programs, often more universal in nature, may be offered to the general population of parents or a narrower group of parents and children who are considered at-risk. Other programs target families who are at even higher risk, such as foster parents or parents who are recently separated or divorced. They aim to improve specific behavioral outcomes for children by addressing parent management strategies. Indicated programs target parents of children who exhibit aggressive behaviors or who have presented with other behavioral problems. These programs have all placed their bets on changing parenting behaviors as the path to improved outcomes for children.

This section includes a brief review of the following programs that serve parents only:

- Active Parenting Now
- Parenting Wisely
- Saving Sex for Later
- Family Matters
- Talking Parents, Healthy Teens
- Helping Encourage Affect Regulation (HEAR) now Pathways to Competence in Young Children
- Parenting Through Change
- KEEP (Keeping Foster Parents Trained and Supported)

- Positive Parenting Program (Triple P)

The first five of these programs are "universal" programs, that is, they do not target a specific at-risk group, although they are frequently used with at-risk groups. Notably, all but one of the programs can be self-administered in the home by parents themselves, and all but one use electronic media to deliver the curriculum. *Active Parenting Now* and *Parenting Wisely* deliver education and training to parents through videos, in the first case, and interactive, computer-based programs that incorporate videos in the second. Both programs are aimed at parents across a wide range of child ages (5-12 year-olds, and 3-18 year-olds). Both use video enactments of family situations and interactions to illustrate ineffective and more effective ways to handle the situation, highlighting specific parenting skills. The content of the two programs is quite similar, emphasizing communication, effective discipline and behavior management. The intensity of the interventions is somewhat different. *Active Parenting Now* offers 12 hours of video instruction, while *Parenting Wisely* can be completed in 2-3 hours.

The next three "universal" programs target parents of pre-adolescents (*Saving Sex for Later*) and adolescents (*Family Matters* and *Talking Parents, Healthy Teens*) but use quite different strategies to communicate their message, focus on different aspects of youth risk behavior and stress somewhat different aspects of parental behavior. *Saving Sex for Later* and *Talking Parents, Healthy Teens* both focus on preventing adolescent sexual risk behavior, using three brief (30-minute) audio CDs in the first case, and reaching out to parents in the workplace through eight lunchtime workshops in the second. The audio CDs emphasize the importance of communicating values and expectations to children, setting household rules and monitoring children's activities, through stories and scripts that use drama and humor to deliver the messages. The workplace sessions engage parents in discussions that focus on communication, monitoring and remaining involved with adolescent children. *Family Matters* addresses the issue of adolescent smoking and alcohol use in a series of health booklets which are sent to the parent at home and combines information on parenting behaviors such as monitoring activities and behavior and communication with suggestions for activities that parents can engage with their children. A health educator makes follow-up calls to each parent, to answer questions and provide additional information.

The advantages of the use of electronic media and booklets are obvious: they make the fewest demands on parent time, allow parents flexibility in where and when they view or read the materials, and ensure that every parent targeted has at least an opportunity to participate. One disadvantage is that parents will usually if not always miss an opportunity to discuss the materials and messages with other parents. *Active Parenting Now* attempts to address this by setting up group discussions on the Internet, but it is not clear how many parents are interested in or comfortable using this technology.

The next three programs in this category (*HEAR, Parenting Through Change, and KEEP)* are not intended for all parents but are intended to provide information and improve skills for parents whose children exhibit aggression and other behavior problems. The first, *HEAR*, designed for parents of preschool-age children, offers 30 hours of group sessions led by a clinical psychologist, that combine information on children's developmental stages from infancy through adolescence, with role-plays and other exercises to improve parent-child interactions and parental confidence. Parents are given assignments to be completed at home. *Parenting Through Change* and *KEEP* are designed for specific groups of parents or parent surrogates, the first for recently separated parents of boys ages 6-8, the second for foster and kinship parents of children ages 4 to 12. The assumption underlying both

programs is that the life circumstances of children in both groups place them at high risk for internalizing or externalizing behavior and place particular strain on parenting skills. Both programs use weekly small group sessions (14 in one case, 16 in the other) led by professional or trained facilitators and employ videotapes to illustrate challenging situations and demonstrate effective parent responses. The programs both emphasize limit-setting, effective discipline techniques, understanding children's behavior, and managing parents' own stress. Both use role-plays and discussion to encourage parental problem solving and sharing of ideas.

The final program, *Positive Parenting Program (Triple P),* is similar to the other programs in that it serves parents only, but is different in that it offers differing levels of intervention that correspond to gradually narrowing population targets and increasing intensity of services. The first level, Universal Triple P, is intended to provide information on child development and effective parenting to a wide range of parents through social marketing and dissemination of information through community-wide media outlets. Other levels of the intervention provide for progressively greater levels of direct interaction with program staff or health professionals, depending on the needs of parents and the behavioral problems of children. The assumptions underlying the program are: all families can benefit from information about effective parenting strategies; some families need more assistance, but not all of them need the same level of assistance; and service provision should be efficient, i.e., no family should be given more than is needed. Reflecting these assumptions, in addition to the tiering of services, there is considerable flexibility in how the program is delivered within each level.

Programs That Target Parents and Include a Family Activity

The three programs described here also focus on parent education and training, but add a secondary component that usually involves children or youth but does not directly train or educate them. Two are universal programs although, like most of the other universal programs described in the report, they are widely used with low-income families. The third targets families with children who are identified by school staff as at-risk for mental health problems. The programs are:

- R.E.A.L. Men;
- Familias Unidas; and
- F.A.S.T. (Families and Schools Together)

R.E.A.L. Men is unique in its focus on male parents of adolescent boys. The program is designed to delay sexual initiation and prevent sexual risk behavior through the active involvement of fathers in their son's sexual health education. It is delivered in seven two-hour small group sessions, six of which are attended by fathers only; for the seventh meeting, fathers and sons attend together. Dinner is served at each session. During the sessions, fathers are presented with information about adolescent development and sexuality and the importance of monitoring their sons' activities and communicating positive values, practice communication through role-plays and games, engage in discussions, establish personal goals, and are given take-home activities. In a final session, sons join their fathers in a game designed to generate discussion about issues in adolescents' lives, watch a videotape on the same topic and celebrate reaching the end of the program.

Familias Unidas targets Hispanic parents of adolescents in 6th, 7th and 8th grades of school and is built on the assumption that involved and positive parenting, parent-youth communication and family

support will promote healthy adolescent development and prevent substance abuse and unsafe sex. The major component of the program is one-hour parent group meetings, held weekly over a nine-month period.[7] The program moves from building an engaged and supportive parent group to providing information about adolescent functioning and behavior, with opportunities for discussion, to active practice of parenting skills such as communication, monitoring and effective discipline.

In the third stage of the parent sessions, school counselors make home visits to facilitate interaction and discussion between parents and their adolescent children and to connect families more closely to the school world. Finally, the program organizes joint activities that promote positive interactions between parents and children and expose parents to their children's peer networks.

Families and Schools Together (F.A.S.T.), the third program in this group, targets parents with children in the early school grades who are identified by teachers as exhibiting behavior problems or being at-risk for mental health problems. Like the other two programs, it combines an educational activity for parents with an activity that joins parents with children and, in the case of *F.A.S.T.*, with other family members. Unlike the other two, *F.A.S.T.* treats the family activity as equal in importance to the parent education component. It differs in several other ways from the first two programs and, indeed, from many of the programs described in this report. First, it has no set curriculum. Parents select a topic for discussion at each of the 8-10 weekly group meetings. Second, it builds incentives for full participation into the design of the program (aside from meals, other programs do not as a matter of course offer the kinds of incentives for participation that are often offered in experimental research on the program). Unlike many programs that are flexible about the setting in which the program may be delivered, *FAST* is planned as an after-school program in the school setting and a school staff member is part of the team that facilitates the weekly meeting.

At the same time, it has some commonalities with other programs described in this review. It is influenced by some of the same theoretical and empirical research as well as more idiosyncratically by work on adult education and social capital. It uses the strategy of the family group meeting to encourage positive interactions among family members. And it seeks to build protective factors in young people by creating links between parents, between parents and their children, and between parents and schools, and by encouraging parental support for learning.

The three programs in this group use the parent-child activity for somewhat different purposes. *R.E.A.L. Men* uses the final session as a way to jump start discussion of sexual issues through an activity that fathers and sons can engage in together. *Familias Unidas* staff organize activities that link parents to their children and their children's friends, but the type, form and number of activities is unspecified. In *F.A.S.T.*, by contrast, the joint activity that precedes the parent group meeting at each weekly session is carefully scripted and follows the same routine every week: families (not just a parent and child) sit together at their own table to share a meal, after an opening ritual. After the meal, family members play games and engage in joint activities intended to promote positive communication. Like the parent component in *F.A.S.T.*, the joint activity is more about building resilience through a network of positive relationships, than about educating or training parents.

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[7] The program has been tested with considerably fewer sessions.

Combining Parenting Education with an Intervention for Youth

The programs in this group are heterogeneous in several ways. To begin with, they place different emphases on the two program components: some place greater emphasis on addressing issues with children or youth, adding a parent component in support of the youth intervention; others begin with the parents or family and add services for youth; and a third group places roughly equal emphasis on both components. For the most part, the programs deal with parents and youth in groups. However, to a greater extent than we have seen thus far, some programs in this group tailor the intervention in response to individual needs. The group includes universal and selected models as well as programs that offer three levels of services, depending on family needs.

Program discussed here include:

- STARS for Families
- Focus on Youth
- Coping Power
- SAFEChildren
- Adolescent Transitions Program; and
- PATHS with Fast Track

STARS (*Start Taking Alcohol Risks Seriously) for Families*, the only universal program in this category, is a health promotion model intended to reduce the initiation of alcohol among middle and high school youth. Designed to be implemented in schools, the intervention is offered over two years and incorporates three main activities. In the first year, students 11-15 years old participate in a consultation with the school nurse, who delivers a brief health lesson on how to avoid alcohol use. Prior to the intervention, an initial assessment of the individual student's stage of alcohol initiation and readiness for change is conducted. This allows the consultation and subsequent outreach to parents to take into account individual differences in the student's stage of initiation into alcohol consumption. Over a 5-10 week period, parents are sent postcards that provide guidance on how they can help their children avoid alcohol. In the second year, students participate in a follow-up consultation with the nurse. In the third activity, weekly take-home lessons provide activities that parents and children complete together. Like many of the universal interventions, this is relatively "light touch," even though it extends into a second year.

The next three programs all serve a "selected" population but differ in the focus of the intervention, the ages of children and youth who are the targets of the intervention, and the intensity of the parent component. *Focus on Youth* is the only one of the three to focus specifically on sexual risk behavior (as well as substance abuse) in high-risk adolescents. The program for youth is delivered in 8 small-group sessions, in community-based settings, and focuses on decision-making and prevention strategies. A single 90-minute session for parents is conducted in the home, with the adolescent present, and focuses on parental monitoring and communication about sexual risk. A video on these topics is used as the starting point for a discussion between the parent and the adolescent. As with *R.E.A.L. Men,* the assumption underlying the session seems to be that communication needs to be jump-started in the presence of a facilitator who can help guide the conversation.

Coping Power targets a different population and a different problem—pre-adolescent boys who are displaying aggressive behavior in the school setting and who are referred by classroom teachers to the program. The program seeks to improve school behavior and reduce the risk for later substance abuse, as well as covert and overt delinquent behavior, by increasing youths' social competence and ability to regulate their behavior and by supporting parents' positive involvement with their children. Delivered over 15 to 18 months, the program consists of a youth component and a parent component. For youth, the program offers 33-34 small-group sessions, each lasting 40-60 minutes, usually delivered in the school setting. The sessions deal with behavior regulation and anger management, problem-solving, resistance and refusal skills and personal goal-setting.

The parent component consists of 16 small-group sessions, held over the same 15-18 month period, in community settings and at times that are convenient for parents. The presentations and discussions focus on appropriate and effective discipline and behavior management, and clear communication of rules, expectations and consequences. For both parents and children, the group sessions are augmented by regularly scheduled, brief ***individual*** contacts with children and parents.

The third of the "selected" interventions, *SAFEChildren,* enters children's lives at a much earlier stage and with a very different focus than the other two programs. Targeting families in low-income, inner-city neighborhoods, the program combines an academic tutoring program for children entering first grade with a parent-focused intervention that recognizes the role of inner-city neighborhoods in heightening the risks that families and children face. The program begins as children enter first grade and involves 22 weeks of intervention. For children, the program provides 30 minutes of individual, phonics-based tutoring in reading, twice weekly, over 22 weeks. Group meetings for parents are held weekly, for 22 weeks. The sessions, which combine information, skills practice and group problem-solving, deal with: children's development, parenting skills, family relationships; developing a support network of parents; working with schools; and coping with neighborhood and community problems.

The last two of the programs in this category, *Adolescent Transitions Program* and *PATHS with Fast Track,* take a quite different approach to risk prevention. Both begin with the assumption that all families (in the case of *ATP*) or all children (in the case of *PATHS with Fast Track)* can benefit from some assistance, but perceive the necessity to augment the basic intervention with additional assistance for "selected" and "indicated" families. As we noted at the beginning of this section, programs do not necessarily begin at the same point. *ATP* focuses on the parents of youth 11-13 years of age who are making the transition to adolescence and to high school, and sees parents' ability to manage family interactions and youth behavior effectively as the key to prevention of antisocial and other risk behavior in youth. To this end, for all parents with children in a middle school, the program offers a Family Resource Center, where parents can view videotapes that illustrate effective parenting techniques. At the same time, parents are offered the opportunity to complete a self-assessment, on the basis of which they may be offered individualized help and can work with a program staff member to develop a plan of action. At the "indicated" level, the program provides direct professional help to families who need additional services. The services may be group meetings for parents, family therapy, services for the adolescent, case management or any combination of these for up to a year.

PATHS with Fast Track begins with a classroom-based intervention for children in grades 1 through 10, delivered to all children in a school by a classroom teacher. In the early grades, the program's emphasis is on developing social and emotional competence, ability to self-regulate and social and

problem-solving skills. In later grades, the emphasis shifts to decision making and resistance and refusal skills. The curriculum is delivered two to three times a week in the elementary grades and is most intensive at transition points (entry to school, transition to middle and high school).

For families identified as high-risk on the basis of a screening conducted in kindergarten with both teachers and parents for conduct problems at home and/or at school, *Fast Track* offers additional components. In elementary school, families participate in 2-hour family group meetings, held weekly for 22 weeks in first grade, and less frequently in the remaining elementary school grades. At these sessions, parents and children meet in separate groups for 90 minutes and then participate in 30 minutes of joint activity. The parent groups focus on developing positive school-parent relationships, and effective communication and discipline skills and strategies. The child groups focus on social skills development, including friendship and play, self-regulation, managing anger, and interpersonal problem-solving. Families at the highest risk ("indicated") are offered individualized services, including: home visits to help parents develop problem-solving and family management skills; academic tutoring for children; and classroom-based peer pairing to promote friendships. In first grade, all families receive the same level of individualized services; in subsequent elementary grades, the amount of the three components provided reflects the family's needs and level of functioning.

Adding Group Family Meetings to Parent and Youth Components

The strategy of bringing family members (a parent and child at a minimum) together with other families to share a meal, practice skills and engage in joint activities, before or after adults and children meet in separate sessions to work on family and youth issues is grounded in a variety of theories that link parental influence and interactions with children to the development of protective factors and the reduction of risk behaviors in youth, some of which were cited earlier in the report. They include a theory of social development described by Catalano and Hawkins, itself based on theories of social control and social learning. To illustrate this approach, we have identified three program models:

- Parents Who Care;
- Iowa Strengthening Families Program; and
- The Strong African-American Families Program.

All three programs are universal, target similar age-groups (pre-adolescent to adolescent), and use a similar format. Youth and their parents attend weekly group meetings (5-7, depending on the program) which include time spent in joint activities and separate sessions for youth and parents. *Parents Who Care (PWC)* begins each meeting with a light meal and joint activities, followed by separate sessions and ending with a second joint session; the other two programs begin with separate sessions and end with a joint activity. All three programs have as their ultimate goal the prevention or reduction of risk behaviors such as substance abuse or antisocial behavior and, in the case of the *Strong African-American Families Program,* sexual risk behavior.

To accomplish this goal, all three endeavor to build protective factors in youth both directly, through teaching them decision making, goal-setting, and resistance skills, and indirectly, by teaching parents effective supervision, monitoring, communication and discipline strategies. The *Strong African-American Families Program* adds to these topics, for both parents and youth, a focus on the unique

challenge posed by racism. For parents, the program discusses strategies to help children understand their racial identity and successfully confront the challenge of racism. For youth, the program teaches strategies to counter racism. The joint sessions offer parents and youth an opportunity to practice the skills they have learned in the separate sessions. All of the programs use videotapes to illustrate curriculum topics, demonstrate family interactions and prosocial behavior, as well as role-plays, games and other activities that allow parents and youth to practice skills and encourage family bonding.

Working with Youth, Parents and Others to Prevent Risk Behavior

While the programs described earlier provide services for parents only or for parents and youth (separately and/or as a family unit), all but one the programs described below begin with a youth-focused intervention and add multiple components (for parents, families, teachers and/or community entities) to strengthen the effect of the youth intervention. The group includes universal programs as well as programs that target youth at high-risk for negative outcomes and includes one program that can be implemented either as a universal or targeted program. The programs vary in the point in the child's life when the intervention takes place; some target elementary school age children and address the issue of aggressive behavior in the early school years; others address specific risk behaviors (alcohol use, alcohol, violence) in youth transitioning to adolescence. Rather than focusing on risk, four programs set out to develop resilience and social competence as universal outcomes. In this section, we discuss the following programs:

- Positive Action
- Raising Healthy Children (Seattle Social Development Project)
- LIFT
- Project Northland
- CASASTART
- Early Risers Skills for Success
- The Incredible Years

The first four of these programs are universal interventions, based in schools, but differ from each other in a number of ways. The first three, *Positive Action*, *Raising Healthy Children* and *LIFT*, begin early in the child's school life and emphasize the development of values, skills and behaviors that will support healthy development and protect against risk behavior later. *Project Northland* focuses more narrowly and later in the child's school life to reduce adolescent alcohol abuse. While both *Raising Healthy Children* and *Positive Action* are multi-year interventions that begin in first grade and continue on (through the elementary grades in the case of *Raising Healthy Children* and throughout the child's school life, in the case of *Positive Action*), the *LIFT* intervention begins and ends in first grade.

Positive Action has five major components: a classroom curriculum for grades K-12; school climate development; counseling for individual children, small groups, and classes; parent and family classes; and a community involvement and outreach component. The program allows schools a great deal of flexibility in the selection of components: it is possible to select a curriculum for grades K-6 only for

example, and then combine it with one or more other components. The program provides classes for parents and other family members aimed at helping them understand and support positive actions in their children. *Raising Healthy Children*, which is implemented in the early elementary school grades, has three components: a youth curriculum, delivered in first, second grades and sixth grades, aimed at helping children identify and solve social problems through collaboration and cooperation with their peers. In 6th grade, the curriculum trains students to resist peer pressure to engage in antisocial or risky behavior. Teachers in all the elementary grades and parents of children in 2nd, 3rd, 5th and 6th grades are trained in positive behavior management strategies and skills needed to support children's academic progress. For the later grades, parents are offered five sessions on how to reduce their child's risk for substance abuse. *LIFT*, the briefest of the three, delivers three components to first grade children, to parents, and with teachers and children on the playground. The youth curriculum is delivered in the classroom, in 30-minute sessions offered two or three times weekly for 10 weeks, and focuses on social and problem-solving skills, self-regulation and group cooperation. The parent component is delivered to groups of parents in 90 minute sessions, weekly over a 6-week period. In the classroom component, teachers observe the children during recess and points are awarded for good behavior and subtracted for negative behavior.

Project Northland, the fourth of the universal programs, targets adolescent alcohol use and is delivered in two phases. In both phases, a classroom-based curriculum is augmented with parent education and community outreach. In Phase 1, when students are in grades 6-8, the curriculum for youth deals with communication skills (talking with parents about alcohol), norms for alcohol use, and strategies for effecting changes in programs and policies related to alcohol in their community. Parents receive information and advice on communicating with youth, as well as other parenting skills, through newsletters and homework assignments with scripted activities. Although there is a classroom curriculum for students in grades 10-12, in this phase, the program primarily targets the social acceptability and availability of alcohol in the community.

Two programs, *CASASTART* and *Early Risers Skills for Success,* target youth who are at risk for violence, antisocial and other risk behaviors in adolescence, either because they live in high-risk neighborhoods and manifest one or more individual risk factors (*CASASTART*) or because they manifest aggressive behavior in early childhood (*Early Risers*). While *CASASTART* is school-based, it is not curriculum-based and has no specified set of services. Rather, it is a highly-individualized program for youth 11-13 years old and their families, in which services are tailored to the specific needs of individual families and delivered in a variety of settings including the home. Services for youth include academic tutoring and after-school/summer activities. Services for parents and families include parenting education classes, community events for parents and family therapy. Case managers meet regularly with students, and separately, in the home with parents, to discuss service needs, develop a service plan and monitor progress.

By contrast, *Early Risers* is a carefully-scripted intervention that targets children 6-10 years old who are exhibiting aggressive, disruptive or oppositional behavior. The program works with the children themselves, parents and teachers over a period of two to three years to effect positive change in children's academic competence, self-regulation, social competence and in parental investment in their child. The program has multiple components: a six-week summer program for children, followed by an after-school program during the school year; a component that links family advocates and teachers which begins soon after the beginning of the school year and runs throughout the year; a family program, with separate sessions for parents and children, during the school year, and a family

support program, delivered through six or more home visits. The design of the program calls for participation by children and parents over two or more school years.

Both the parent and youth groups use components of *The Incredible Years* program to address (in the case of parents) effective parenting practices, support for learning, parent stress management and communication and problem-solving skills and(in the case of the children) emotional regulation, conflict resolution, making friends and problem-solving, among other topics.

The last program in this group, *The Incredible Years* presents a challenge to efforts to classify it. It can be a universal or targeted intervention. Unlike the other interventions described here, it is not a single program but rather a set of components each of which can be used in conjunction with one or more of the others, or as a stand-alone intervention. Within the components there is also flexibility: the child training programs can be used by classroom teachers or by therapists working with small groups of children; the parent training programs are intended to be delivered in small groups, but can be adapted for home visits; and the teacher training programs are suitable for classroom teachers or therapists and are also available for self-study. This flexibility has enabled many programs to use one or more of the components to supplement their own programming. The child training curriculum *(Dina Dinosaur*), in particular, has strongly influenced the development of a number of other curricula for similar age-groups.

Intended for children ages 0-12 years their parents and teachers, *The Incredible Years* has three major components: a parent training intervention; a child social skills curriculum; and a teacher training package. Overall, the parent component is designed to teach parents the importance of monitoring, how to use effective discipline and behavior management skills, encourage competent and confident parenting and promote involvement in the child's school experience. Each of the age-specific curricula is designed to be presented in weekly, small-group sessions, each lasting about two hours; the number of sessions varies, depending on the specific curriculum used. The *Dina Dinosaur* curriculum is intended for children 4-8 years old and designed to improve peer relationships and reduce aggressive behavior at home and in school. The curriculum includes 120 lesson plans and is delivered 2-3 times a week during a 15-20 minute circle time discussion, which is followed by small group activities to practice the skills learned. Teachers are trained to deliver the classroom curriculum, to weave the activities throughout the school day and to send home suggestions for activities parents can do with their child. An additional part of the teacher training component is designed to strengthen classroom management strategies and to help teachers promote children's prosocial behavior and reduce aggressive behavior.

Achieving Outcomes

All the programs described earlier share a common goal: to improve aspects of parenting behavior that have been linked theoretically and empirically to more adaptive behavior and fewer risk behaviors in youth. Beyond this basic commonality, programs vary greatly on a number of dimensions. The grouping of programs in the last chapter reflects the most basic of these differences—the choice of which family members are targeted by the intervention. As we have seen, some focus only on the task of changing parents' knowledge, skills and behavior, while others address directly children's knowledge, skills and behavior as well as the interactions among family members and the behavior of other significant adults, such as teachers.

Beyond this major difference in strategy, programs vary greatly on a number of dimensions, including: the extent to which services are directed at families with specific risk factors, as opposed to more general populations; the age-range of children whose families are targeted; the format and setting chosen for the intervention (self-administered, small group, large group, in-home, clinic, school or community setting); the intensity (or intended dosage) of the services; and the specific outcomes that the program seeks to achieve (protective factors such as the parent, child and youth knowledge, skills and behavior that predict or mediate youth risk behaviors, and the risk behaviors themselves). All of this variation would seem likely to influence the outcomes actually achieved both in terms of their range and the extent of the program's effect on them.

While the intent of this report is not to engage in a close examination of the research that supports these programs, we are interested in understanding the linkages within and across program types and the extent to which programs with different foci and strategies produce similar or different outcomes.

Programs that Focus Solely on Parents

As we noted earlier, our review includes both program designed for parents only and programs in which a parent component represents one important part of a larger program. This first group of programs, for which parents are the sole focus, includes programs aimed at a general population (universal), those that target specific groups (selected)[8], and one tiered program that offers services to parents at several levels.

Universal Programs. The universal programs, which include *Active Parenting Now, Parenting Wisely, Saving Sex for Later, Family Matters* and *Talking Parents, Healthy Teens*, focus on parent behaviors in response to normal development in children and, with one exception,[9] deliver information through videotapes or booklets with little or no contact or follow-up by program staff. Two of the programs are offered across a broad age range (3-18 for *Parenting Wisely*, 5-12 for *Active Parenting Now*) while the remaining three target parents of preadolescents and youth in early adolescence. For the first two, program goals focus on improving aspects of parental behavior: communication (setting limits, clear expectations about rules and consequences); support for children's positive development; supervision and monitoring; and effective discipline and problem-solving. In addition, they seek to reduce problem behaviors in children. The programs for parents of older children focus more narrowly on communication about and monitoring of adolescent risk behaviors: smoking and alcohol use, in the case of *Family Matters*, and sexual risk behavior in *Saving Sex For Later* and *Talking Parents, Healthy Teens*. *Family Matters and Saving Sex for Later* also cite reductions in youth risk behavior as goals.

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[8] The IOM definition of prevention components include: *universal* – addressing the entire population with the goal of deterring onset of a problem or behavior through providing individuals with information/skills; *targeted or selected*- targets subsets of the population considered at risk by virtue of their membership in a particular segment of the population, regardless of the degree of risk of any individuals; *indicated* – targets individuals who are exhibiting early signs or consequences of a problem or behavior.

[9] *Talking Parents, Healthy Teens*, which holds lunch-time sessions with groups of parents in the workplace, differs from the other four programs in this respect, but not in the focus of the discussions which is on the importance of parental communication about normative adolescent behavior.

All five programs have had modest success in achieving some of their goals, at least immediately after the program ended. Only two, *Saving Sex for Later and Family Matters*, directly assessed the impact of the program on youth. Both have demonstrated impacts on youth that are sustained for a period of time post-intervention (3-12 months), measured through youth self-report. *Saving Sex for Later* showed impacts on aspects of youth behavior that are seen as mediators of sexual risk behaviors (for example, associations and behaviors disapproved of by parents); *Family Matters* demonstrated impacts on the prevalence of alcohol and tobacco use and on the initiation of smoking. *Saving Sex For Later*, together with *Talking Parents, Healthy Teens* demonstrated effects on the parent behaviors that the program targeted: communication with teens about sexual risk behaviors (increasing the amount and the quality of the communication); increased support from parents as well as increase in the number of rules; and, in the case of Talking Parents, Healthy Teens, direct parental instruction to youth in the use of condoms. Youth reports on these outcomes echoed the parents' reports.

The two video-based programs, *Active Parenting Now* and *Parenting Wisely*, measured outcomes immediately post-intervention, through parent report only. Though both show modest effects on parental knowledge, attitudes and reported behaviors, the specific behaviors affected differ across studies. (For example, one study of *Active Parenting Now* found more positive attitudes toward children, one reported increased knowledge of parenting, and better problem-solving skills, another found improved attitudes toward physical punishment; studies of *Parenting Wisely* show similar variation in outcomes.)

Programs for "selected" or "indicated" parent groups. Unlike the universal programs discussed above, which have quite diverse approaches, the group of programs designed for "selected" groups (KEEP—foster parents, and *Parenting Through Change*—recently separated mothers with young sons, both at high risk for behavior problems in the children they care for) and an "indicated" group (*HEAR* – parents of children actually exhibiting aggressive behavior), share a common approach, as well as common goals. All three aim to reduce behavioral problems in children by improving parenting skills. All bring parents together in small groups for weekly sessions (number of sessions varies from 14-16 and sessions last 90 minutes to two hours). All three use videotapes, role-plays, games, group exercises and group discussions.

Both *KEEP* and *Parenting Through Change* improved parenting skills, specifically by increasing positive reinforcement and decreasing negative disciplinary strategies. For participants in *KEEP*, there was a corresponding reduction in foster parents' reports of child behavior problems. In addition, children in the *KEEP* group had higher rates of reunification with birth parents and fewer placement disruptions than children in the control group. There were no direct effects on children of *Parenting Through Change*. *HEAR* was able to demonstrate significant effects on parents' understanding of child development, satisfaction with and perceived effectiveness in the parenting role, increased involvement with and understanding of her child, effectiveness in setting limits for the child and general feeling of being in control as a parent. There were no significant effects on children's behavior.

Because we are interested in understanding the extent to which parenting interventions have effects that are sustained beyond the intervention, it is important to note that only one of the eight programs discussed here gathered information on outcomes beyond those gathered at the end of the intervention. It is possible that, in some cases, if the changes in parental behavior were sustained over

time, these might result in positive behavioral changes in children. In addition, many studies had sample sizes that were almost certainly too small to detect small to moderate effects.

Tiered Program. The *Triple P* program presents challenges to any attempt to summarize its effects, since studies have focused on different levels of the tiered intervention and assessed different outcomes. Evaluating the effects of community-wide television series or media campaign in isolation from the other levels of intervention has not so far been undertaken, with the exception of some pre-post studies in Australia. At the next level, however, in which families self-refer for services to address perceived behavior problems in their children, *Triple P* was found to reduce significantly parent-reported levels of dysfunctional parenting and parent-reported levels of child behavior problems. The program also had positive and significant effects on parental mental health, marital adjustment and levels of parental conflict about childrearing issues. To date, various levels of the program have been subjected to evaluations that use RCT designs and have consistently shown significant positive effects on these same outcomes across a variety of different populations.

Of the more than 100 studies of the program, the most ambitious is the evaluation of a trial of the program as a population-based intervention with five levels of services, designed to reduce the incidence of child maltreatment. The outcomes used to measure the program's success were three independently-derived community-level indicators- substantiated child maltreatment, out-of-home placements of children, and child maltreatment injuries. The program had large effects on all three. The program developers argue that official data on child maltreatment represent only the tip of a much larger iceberg, citing data from anonymous telephone surveys of parents in North and South Carolina that indicate a rate of abuse 40 times greater than official reports, and similar across socioeconomic boundaries, unlike official reports. In this view, it is likely that the different levels of the program work to reduce the number of potential or actual occurrences of abuse that go undetected, as well as to reduce the use of harsh disciplinary techniques that may or may not rise to the level of abuse but that may have adverse consequences for children's healthy development.

Programs That Target Parents and Include a Family Activity

Although the three programs in this group add a family component to their core program for parents, in two of them parents and their children are brought together once, for a dinner at the end of the program *(R.E.A.L. Men)* or occasionally, as part of an organized social activity *(Familias Unidas)*. In the third, *F.A.S.T.*, the group family meal is a central part of the program and, ideally, takes place after every parent group session. *Familias Unidas* and *F.A.S.T.* have an ambitious array of goals. Both wish to increase parental investment in their children, improve academic achievement through parental involvement with school and reduce problem behaviors in children. In addition, *Familias Unidas* seeks to prevent substance abuse and unsafe sex. *R.E.A.L. Men*, by contrast, has more narrowly focused goals: to increase fathers' involvement with their sons and to increase communication about sex between male parents and their sons, with the hope that, as a result, youth would delay sexual initiation and more sexually active youth would use condoms.

Of the three, *R.E.A.L. Men* came closest to achieving its goals: both fathers and their sons reported increased communication about sex, and the program reduced the rate of sexual initiation at a three-month follow-up. However, the effect on youth faded at the six-month follow-up. Parents who participated in *Familias Unidas* reported increased involvement with their children but the program

had no impacts on youth outcomes. (However, when paired with *PATH*, a program aimed specifically at youth, the program demonstrated impacts on tobacco and drug use and on sexual risk behaviors.)

F.A.S.T. is a widely adopted program and has been the subject of many small-scale evaluations and at least one large-scale experimental evaluation. The impact of the program varies by study—sometimes parents report lessened social isolation or more involvement with their child. Most frequently, parents report more involvement with their child's school—not surprisingly, since the program is held in the school and a school staff member, usually a teacher, co-facilitates the sessions. Like *Familias Unidas*, the program has been unable to demonstrate strong evidence of impacts on children; although one study found effects on academic competence, measured by teacher report, two more rigorous studies that used more objective measures of achievement (standardized test scores, report card grades) found no effect of the program.

These findings suggest that the parent-child or family activity made little contribution to the effects the program hoped to achieve, although, as a social event, it may have helped to attract parents to the program (and, in the case of *F.A.S.T.*, may have kept them involved over the eight-week period.)

Combining Parenting Education with an Intervention for Youth

Unlike the programs in the first two groups, the programs in this category begin with an intervention for youth and add a parenting component. *STARS* is a universal program; the populations targeted by the other three are "selected" or "indicated," in that two (*SAFEChildren* and *Focus on Youth with ImPACT*) serve high-risk youth and their families, and the third *(Coping Power)* intervenes with youth who are displaying aggressive behavior. The intensity of the parenting component varies considerably across the four programs; for *Focus on Youth with ImPACT*, the parenting component is a single session; in the case of *STARS*, postcards are sent to the home over a period of five to ten weeks and, later, youth are given take-home assignments to complete with their parents. *Coping Power's* parent component is a substantial one, with about half as many (16) sessions for parents as for youth. In *SAFEChildren*, the parent component is as intensive as the youth component; both take place each week over a 22-week period. Both *STARS* and *Focus on Youth* aim squarely at outcomes for youth; in the first case, reducing the initiation of alcohol use and, in the second, reducing adolescent truancy, substance abuse and sexual risk behaviors. Both hope that parents will reinforce the program message. By contrast, *Coping Power* and *SAFEChildren* aim to effect positive youth outcomes by intervening directly and by using parents as change agents, bringing about positive change in parenting that will move youth in the same positive direction.

STARS was able to demonstrate an effect immediately after the intervention: it changed students' intentions with respect to future alcohol use and decreased heavy alcohol use at the end of the first year. The effects were not sustained after the end of the intervention.

In a study of *Focus on Youth*, youth in the program group reported less alcohol and tobacco use than control group youth (who received only the youth program) six months after the program ended.[10]

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[10] In the original study, effects were found on condom use by sexually active youth, but no other significant outcomes; adding the *ImPACT* parent component appears to have strengthened the program considerably. In addition, the study found significantly lower rates of sexual activity and increased condom use. However, all of these outcomes were found for subgroups defined by sexual activity at follow-up.

Two years after the program ended, they had lower rates of school suspension, use of tobacco and other drugs, were less likely to carry a weapon and more likely to know if a sexual partner had used a condom.

SAFEChildren demonstrated overall positive effects on children's academic performance (reading ability) and on parent involvement with school (involvement with school declined significantly in the control group parents but remained stable in the program group). As we will see in the results from studies of other programs, the program had significant additional impacts on youth at higher risk, notably on problem behaviors (aggression), attention and social competence. Impacts were measured six months after the intervention ended.

Like *Focus on Youth*, *Coping Power* has been tested experimentally with and without a parent component and has demonstrated a similar pattern of effects, albeit on a different set of outcomes. Without the parent component, the program produced lower rates of covert delinquent behavior and of parent-rated substance abuse one year after the program ended. The addition of the parent component significantly strengthened the impact of the program on these two outcomes. The program effected small behavioral improvements in boys (rated by teachers), an effect largely influenced by the youth component.

The Adolescent Transitions Program (ATP), which combines a classroom-based intervention for a general population of 6th graders, with more intensive services for higher-risk students and their families, elected to study program impacts only on the 25% of students and families that availed themselves of the additional services—the Family Check-Up and other services—(and their matched controls). Compared with students in the matched control group, adolescents whose parents engaged in the Family Check-Up (selected), some of whom received additional services (indicated), showed less growth in the use of alcohol, marijuana, and tobacco and exhibited fewer problem behaviors between the ages of 11 to 17 and were at reduced risk for diagnosed substance abuse or arrest by age 18.

Fast Track offers two levels of prevention activities (universal and indicated) to promote competency in parents, children and teachers and reduce the prevalence of conduct disorders in early and middle childhood. The evaluation of the program included parents and children at both program levels, and their control group counterparts. After completion of the first grade portion of the program, there were a number of positive impacts on parents and their children. Participant parents were less likely to endorse physical punishment for problem behaviors; mothers were more involved in school activities, used more effective disciplinary techniques, and demonstrated more warmth toward and involvement with their children. Children exhibited less aggressive, disruptive and oppositional behavior at home and in the classroom (as measured by parent and teacher ratings and classroom observations) and were less likely to identify classmates as aggressive, more likely to identify classmates they liked than those they disliked.

Adding Group Family Meetings to Parent and Youth Components

If we compare the findings for the first three groups of programs, it is hard to escape the conclusion that impacts are stronger and more lasting when the program addresses both parents and children directly and indirectly (i.e., with strong interventions for both youth and parents). For the next two program groups, we are interested in looking at whether continuing to add components increases program impacts. Of course, there are many reasons why it might be difficult to answer the question.

Programs with different strategies may serve different populations with different levels and types of risk. They may add components such as a family meal or activity for reasons other than its effect on outcomes of interest—to reduce social isolation or to motivate families to participate, for example.

All three of the programs in this group have the dual goals of building protective factors in youth and reducing the likelihood of risky behaviors in adolescence. All are universal prevention programs and all enlist parents as partners in the effort to achieve the program goals. The intervention strategy is remarkably similar in intensity and content; all three deliver the program across seven weekly sessions, all provide similar information to parents and their children and use a family meal for joint learning and practice. In all three, the strategy implies a partnership model, in which youth and parents work together on similar issues to achieve positive outcomes. *Parents Who Care* and the *Strengthening Families Program (SFP 10-14)* intervene as a child is crossing the threshold into adolescence; the *Strong African-American Families Program (SAAFP)* is designed for youth and their families earlier in the child's development, before the transition to adolescence.

Two years after the end of the intervention, *Parents Who Care* produced significant overall effects on attitudes toward drug use (though not on attitudes about other risk behaviors). However, the program significantly reduced violent and delinquent behavior and delayed initiation of substance abuse and sex among African-American youth. Interestingly, a self-administered version of the program (workbook, video and telephone support from program staff) was almost as effective in producing these outcomes.

The effects of *SFP10-14* were assessed two and six years after the intervention ended, when students were in 8th and 12th grades respectively. The intervention had positive impacts on several parenting competencies—communication, anger management and setting limits, rules. In addition, there were positive impacts on youth refusal skills. Later impacts on school engagement and academic achievement were indirect and mediated by earlier outcomes, making these findings weaker than the earlier findings.

The *SAAFP* focused narrowly on building protective factors that would reduce alcohol use in African-American adolescents. A follow-up study conducted two years after the program ended demonstrated that the program was successful in preventing the initiation of alcohol use and in slowing the increase in use over time among those who used alcohol. Increases in protective factors such as future orientation, negative attitudes towards alcohol and drinkers, and resistance and refusal skills were associated with the effects on alcohol use.

Programs that Work with Youth, Parents and Others

This is the largest of the program groups and includes programs that are universal *(Project Northland, LIFT, Positive Action, and Raising Healthy Children—formerly the Seattle Social Development Project)*, selected *(CasaStart)* and indicated *(Early Risers),* as well as the hard-to-categorize *The Incredible Years.* Some address specific risk behaviors, such as alcohol use, and aggressive behavior and violence; others focus on healthy development as protective against a host of behavioral risks. The age-range of children targeted is wide, from the early school years through adolescence. All bring into the effort to improve child outcomes other actors or environments that influence the child's behavior, usually teachers and other school staff, but sometimes other members of the community.

Across a variety of school settings, and using school-level data, *Positive Action* has replicated earlier evaluation findings of positive and often large impacts on academic performance and on behavior in school that leads to disciplinary referral or suspension, including violence, absenteeism and truancy. These effects are found in the face of probable variation in implementation, which was neither controlled nor examined. Effects found in other, more controlled, studies include reductions in drug, alcohol and tobacco use, overt delinquent behavior, school drop-out, and gang involvement.

Raising Healthy Children (SSDP) is at the other end of the spectrum, with respect to studies of its effectiveness. Although replications of the program are underway, evidence of its effectiveness is derived from a single, rigorous longitudinal study using a quasi-experimental design that tracked outcomes for children and youth over a span of many years (from 2nd grade to age 27), with measurements at regular intervals across that time. In grade 5, parents in the program reported better family management practices, communication and attachment of family members to the family. Fewer students had initiated alcohol use or engaged in delinquent behavior, and more were attached and committed to school. At the end of grade 6, high-risk youth in the program, compared with their counterparts in the control group, were more attached and committed to school and less likely to be involved with antisocial peers. Close to the end of high school, students who had participated in the program were less involved in violent delinquency and sexual activity, less likely to be drinking heavily, and less likely to drive after drinking. By age 21, participants in the program had significantly fewer sexual partners and, among females, a significantly lower likelihood of both becoming pregnant and giving birth. Single adults were significantly less likely to have contracted an STI and more likely to use a condom during intercourse. This outcome was strongest for African-Americans. The study measured 8 different outcomes at age 24 and again at age 27, finding significant effects on educational attainment beyond high school and household income, civic involvement, mental and sexual health. No sustained effects on substance abuse and criminal activity were found.

Project Northland and *LIFT*, though also universal, aimed to reduce specific risk behaviors—in the first case, alcohol use and in the second, antisocial and aggressive behavior. The original study of *Project Northland*, conducted in Minnesota found significant reductions in the onset and prevalence of alcohol use, linked to changes in peer norms (negative views of underage drinking), parent-child communication about the acceptability of underage drinking, and resistance skills. These outcomes, measured at the end of the intervention, when students were in grade 8 were not found at a subsequent follow-up in grade 10 after a two-year period without intervention. A final follow-up in grades 11 and 12, after community-level intervention to restrict access to alcohol by underage youth and to change community norms about underage drinking, was effective in reducing the growth rate of alcohol use, in reducing binge drinking and in restricting access to alcohol. Unfortunately, an adaptation of the program for an urban, disadvantaged community did not replicate the effects found in the original study, although a significant effect was found when use of alcohol, marijuana and tobacco was combined.

LIFT, which like *Positive Action* and *SSDP* engaged teachers as well as children and their parents in the intervention, demonstrated effects on parent and child behaviors at the end of the intervention in first grade, as well as sustained effects on youth in 5th grade. At the end of the intervention, coercive parenting practices decreased and positive and effective parenting increased. At the same time, children's classroom and playground behavior (rated by teachers) improved, with reduced aggression and fewer problems with peers. In fifth grade, program participants were significantly less likely to

have engaged in patterned alcohol use or to have been arrested. Program effects were strongest for children already exhibiting aggressive and antisocial behavior in first grade, and for their parents.

CASASTART seeks to prevent substance abuse and violence among youth, and to improve school grades, attendance and behavior through a multi-component, multi-service strategy. The program had positive impacts on both mediators of youth risk behaviors (participation in positive activities such as sports, school clubs, religious groups, and organized community activities; participation in a drug and alcohol prevention program; more positive peer support; less association with delinquent peers; less pressure from peers to engage in antisocial behavior) and on youth outcomes (use of gateway and/or serious drugs, selling drugs, violent crime) in the year after the program ended. The program looked for "spill-over" effects, since risk behaviors are often clustered, but found no effects on sexual activity, pregnancy or parenthood, dropping out of school or gang membership.

Early Risers targeted children with early onset aggressive behavior, and is the only indicated program in the group. Reflecting its view that early childhood aggression begins a path that leads to serious antisocial behavior and substance abuse, the program intervenes early in the child's life and employs a variety of strategies to achieve its goals. After two years of the program, there were positive effects on children's academic achievement. An effect on self-regulation was found for highly aggressive children; children in the control group declined in their ability to self-regulate while children in the program maintained at the baseline level. After three years, the program demonstrated an effect on children's social skills and academic achievement and on parental discipline practices. The program achieved a significantly greater impact on academic outcomes for mildly aggressive children compared with highly aggressive children and greater impact, albeit not statistically significant, on impulsivity and aggression.[11]

The authors of the two studies make an interesting and important observation: in both the intervention and control groups, children who exhibited mild to moderate levels of aggression improved similarly so that, at the end of the intervention, both groups fell within the normal range. This creates some tension with the underlying assumption that intervention is best undertaken early in the child's life. If that is true, then an intensive program such as Early Risers might be better applied only to those children who exhibit highly aggressive behavior early, since the less aggressive majority seem to have exhibited temporary aggression, perhaps in response to the dislocation of school entry, and then to have moved over a short space of time, into the normative range of behavior.

As with tiered programs, the flexibility of the *Incredible Years* presents a challenge for a summary of its effects. Its components can be used separately or in combination (although they are designed to be used in combination), across a variety of settings, and for universal, selected, or indicated populations. The many studies of the program are notable for their use of multiple methods to assess outcomes, including parent report (using validated measures), teacher report (also with validated measures), and classroom and home observations of child behavior by independent trained observers.

Across a wide range of studies, the program has demonstrated positive significant effects on parent competence and discipline practices, on parent-child attachment, and on teachers' classroom management skills. Across the same wide range of studies, the program has shown positive

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[11] The effect sizes for these variables were .31 and .37, suggesting that the sample sizes may have been insufficient to detect significance at these levels.

significant effects on children's social-emotional competence, school readiness skills, and has reduced aggressive and disruptive behavior. In indicated samples, the program has reduced externalizing behavior and internalizing symptoms. This program is notable for the number of randomized studies that have used experimental designs to evaluate the effects of separate components and of different combinations of components.

Considerations for Decision-makers

As this discussion makes clear, the assessment of program effectiveness is complicated by multiple factors, ranging from the quality of the studies designed to assess effectiveness, the strength and reliability of the measures, what is known about the durability of the effects, and the number of studies of any single program. It is also important to note that programs may have a small number of positive outcomes because they chose to focus the intervention narrowly or because they failed to achieve the goals they set for themselves. These two scenarios have different implications for how one might view the program and its effectiveness. As individuals and organizations consider program models for adoption, they need to be aware of factors that might affect their judgment about the program's likely success. In this final section, we discuss some of these considerations.

Quality of Study Design

Most but not all of the findings described here come from experimental or strong quasi-experimental program evaluations. The various lists of "evidence-based programs" on which the programs appear ensure that some quality criterion has been applied, although these vary by list. However, some of the programs make larger claims about outcomes that are based on much weaker studies, or on flawed analyses of post hoc subgroups. We have avoided citing the most obvious examples of outcomes where this applied, but it remains true that the strength of the evidence varies a good deal.

It is important to note that, even in the case of very well-designed studies, the age of the study and the size and characteristics of the population studied should cause us to view the reported outcomes with some caution. We cannot be sure that outcomes achieved more than 10 years ago could be replicated today; we are even less sure that outcomes for an all-White population of rural Iowan two-parent families can be generalized to any other group.[12]

Measuring Outcomes

Of more concern than the quality of the research design is the dependence on self-report measures to assess outcomes. While some studies use measures that have been validated and repeatedly tested, others use measures developed specifically for a single study to report on similar outcomes. The problem with these measures is that they may be weak enough to obscure the impact of a program; in other cases they may overestimate the effects. In a few cases, researchers have added structured

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[12] Of course, some program developers/researchers are very clear about the limits of their intervention: the authors of the studies of SAAF make it clear that the program works for rural African-American families and may only work for them. Dr. John Jemmott, in an article describing outcomes for an abstinence intervention, suggested that the findings might only be generalized to urban African-American youth willing to come to a class on Saturday mornings.

observations to supplement parent and/or youth report. In others, they have used school records and administrative data to supplement teacher report. We can have more confidence in findings derived from multiple or reliable measures.

Tracing Paths to Outcomes

There is considerable variation across the studies in the choice of what to measure. Some studies measure only mediators such as parent attitudes or behaviors; others move directly to measuring the child or youth outcomes and omit measures of parenting. A few describe a hypothesized pathway leading through parent and youth mediators to outcomes, measure each of the elements in the pathway and, after analyzing and reporting on outcomes, go on to trace the linkages between mediators and outcomes. While these linkages must be viewed as correlational rather than causal, if enough studies used this strategy, we could, over time build an evidence base to support some mediators and eliminate others.

Timing of Measurement

While a majority of studies included at least one post-intervention measurement point, a number measured outcomes only at the end of the intervention. If we accept the logic of most programs that changes in parenting (as well as some intermediate changes in children) precede and influence positive changes in youth behavior, it would seem to be essential to measure child outcomes at some reasonable temporal distance from the intervention, in those cases where the program demonstrates an impact on parent behavior. Some studies that found impacts on parenting but none on child behavior may have underestimated impact solely because of the timing of measurement.

Discussion

If we place programs in the context of the framework described earlier, which draws from both theory and empirical research, we see that, regardless of the characteristics of families targeted or the strategies selected, the assumptions that underlie their efforts can be found within that framework. The organizing principle that parents exert a critical influence on their children from infancy through adolescence together with the specific aspects of parent behavior and interactions that the framework suggests are essential for healthy development are reflected in program goals and strategies. Clearly, not all programs set out to change every aspect of parenting that is seen as important for development but, to a remarkable degree, there is agreement on what those aspects are: parental warmth, responsiveness and involvement; clear communication of rules, boundaries, expectations and consequences; avoidance of harsh discipline, effective and positive behavior management and support for children's development.

Beyond the basic assumptions, almost all programs face a similar set of linked dilemmas: how to engage parents in the program; and how much of the "treatment" could be considered sufficient or meaningful.

Engaging Parents

The challenge for programs begins with recruiting parents. Although we know little about how many parents refuse the offer of services in real-world settings, we have some information from research

studies of the programs. For these studies, parents are either offered services or, in the case of an experimental study, the chance of services and, almost always, monetary and other incentives for participation in the study. In the studies reviewed here, between 30 percent and 77 percent of parents contacted agreed to participate.[13] While the programs that placed the least demands on parents (i.e., sent home booklets or videos, or offered a single session to view a videotape) view these strategies as likely to reach more eligible parents, the evidence from the studies is equivocal on this point. For example, less than two-thirds of the parents recruited for *Saving Sex for Later* agreed to participate; almost the same percentage of foster parents agreed to participate in *KEEP*, which made considerably greater demands on parents, and 77 percent of Head Start parents contacted agreed to participate in The *Incredible Years* Parent Training program, which involved attending 12 group sessions. We do not know how agreement to participate in a research study relates to acceptance of services in normal program operations—rates of acceptance could be higher or lower.[14] What is clear is that in research studies, as in ordinary operations, most programs have no way of understanding the difference between the families they are serving and the families that are rejecting services, either implicitly, by not responding to outreach efforts, or explicitly, by refusing the offer.

Once parents have agreed to participate, programs face the challenge of keeping them actively engaged and ensuring that they attend as many sessions as possible. Programs are sensitive and ingenious in their response to this challenge. Most commonly, they reimburse transportation expenses, provide child care and light meals. Some add a monetary incentive or raffle. Others develop strategies that acknowledge that, even with these supports, parents may face barriers to regular participation. One solution, as we have seen, is to send the materials to parents; indeed, one program (*Parents Who Care*) that compared effects of parent and youth participation in group meetings with the effects of a self-study curriculum with telephone support found similar impacts for both strategies.

Another approach is to take the program to parents' workplace, as in *Talking Parents, Healthy Teens.* Participants in this program attended an average of 7 (out of 8) sessions, a higher rate of participation than was reported for any of the other programs we reviewed. Other programs, such as *KEEP,* make home visits to parents who miss a session, offer individual make-up sessions in person or by phone, or offer an opportunity to attend a different session (*Parenting Through Change*). Other ways used to encourage attendance include: choosing a wide variety of locations across a community for meetings, to minimize travel time for parents; and grouping parents with existing friends, so that they can provide mutual encouragement to attend sessions. In spite of all these efforts, across different program types, about one-quarter of parents never attend a session and, on average, parents attend slightly better than half of the sessions.[15] Researchers have hypothesized different reasons for dropout or partial attendance, but there is ambiguous evidence on the subject. Webster-Stratton (2002) finds that parents with poor parenting skills or with mental health problems are no more likely than other

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[13] Many programs use flyers, advertisements and other outreach methods to find potential participants. In those cases, it is impossible to estimate the percentage of eligible parents who volunteered.

[14] Programs offer a good deal of information on their websites, but information about take-up and participation rates is not given, although it would be helpful for agency staff and others contemplating the purchase of the program or curriculum.

[15] A completely different approach is taken by *Focus on Youth*, which makes participation in the youth component contingent on parents' participation in a single parent-child session. Even so, the program offers flexibility in where that session takes place and attempts to accommodate parents' needs.

parents to drop out or attend sporadically. In *Parenting Through Change,* lower-SES mothers and more coercive mothers were more likely to drop out of the program.

Given that a small percentage of parents attend most or all of the program sessions, programs (and the researchers who study them) have made efforts to determine what level of participation constitutes "meaningful" participation, a term that can mean different things. For some programs, meaningful participation is the level of attendance that represents commitment to what the program is trying to achieve. For most, it represents their best guess about the number of sessions that might be required to produce an effect. The issue of whether session content is more critical than number of sessions is typically not addressed. Nor, for the most part, is the number of sessions based on strong empirical evidence; although researchers continue to link level of participation with impacts, they have not found a way to eliminate selection bias. There might be ways to address this issue that involve natural experiments. Although the number of sessions is not experimentally manipulated, many entities (schools and others) that choose to implement a program elect to deliver fewer sessions than the program recommends. If a program were to systematically gather data on implementation and outcomes from the wide variety of full and partial replicators, we might begin to accumulate evidence about how many sessions and what content is essential to make a difference in outcomes.

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APPENDICES

Appendix A: Search Criteria to Identify Parenting Interventions

Search Terms:
• parenting interventions • parent education • parent education programs • parental mentoring • parent-child communication • parenting programs in schools • parenting programs in community • parenting skills • parent training • parent and adolescent risk behavior • parenting strategies and child outcomes • parenting programs
Databases and Websites:
• ERIC • Ebsco • NREPP (National Registry of Evidence Based Programs and Practices) • PsycINFO • Blueprints (at the Center for the Study and Prevention of Violence at the University of Colorado) • OJJDP (Office of Juvenile Justice and Delinquency Prevention) • Promising Practices Network • Child Trends • iparenting.com • life.family.education • Research from other government agencies and websites (e.g. information from CDC parenting meeting, search of CRISP system, FindYouthInfo.gov, What Works Clearinghouse, USDOE Exemplary and Promising Programs)

Appendix B: Program Profiles

Active Parenting Now is a video-based educational program model that targets parents of 5-12 year olds who want to improve their parenting skills. Delivered in two-hour sessions over six weeks, the program includes information on: parenting styles; communication and how to handle behavior problems, effective discipline techniques; understanding misbehavior and how to handle aversive situations; how to develop character, courage and self-esteem; and parent involvement. The program uses a video that contains scenes of typical family situations depicted by professional actors. Each scene illustrates how different parenting techniques fail to handle a situation and then suggests how the situation might be handled differently, highlighting a specific parenting skill. The program is attempting to affect parenting competencies including knowledge, skills, and beliefs, parent-child relationships.

An accompanying Parent's Guide contains information covered in the videos. It also includes additional resources, practice activities, and homework assignments that provide information and opportunities for practicing the skills. The program is widely used and has been adapted for a variety of populations, including Hispanics, foster parents, and parents and teenagers. It has been delivered to parents in school districts, community settings, and clinics. The program is now available online, combining video, reading and group discussion all administered over the internet. The program website provides additional information on the multitude of settings and populations for which the program has been provided.

The ***Adolescent Transitions Program (ATP)*** is a multi-level, school-based program for the families of youth, 11-13 years of age, who are moving into adolescence and preparing to make the transition to high school. The program is based on the assumption that the best way to reach families who are at-risk because of parents' difficulties with family management and consequent conflict among family members is to base services in the school and to embed them in a program that reaches out to all parents. There are three program levels—universal, selective and indicated—and each of the latter two levels builds on the previous level. The goals of the program are: to prevent the development of antisocial behavior and substance abuse in adolescents by improving parents' ability to manage family interactions and children's behavior.

For all parents with children in the school, the program, in collaboration with school staff, provides a Family Resource Center. A videotape helps parents to identify observable indicators of risk and illustrates effective and ineffective strategies for managing children's behavior, including: positive discipline techniques, the importance of monitoring behavior, limit-setting, and relationship and communication skills. Parents are encouraged to complete a simple rating of their own relationship and family management skills.

At the "selected" level, the program offers the Family Check Up, which provides assessment and professional support for at-risk families. These may self-refer or may be parents of children who have been identified by classroom teachers as demonstrating problem behaviors. The school-home liaison visits the family in their home, meets with parents and children and conducts a 60-minute interview with them. Parents are asked to complete a brief questionnaire and the liaison videotapes the interactions among family members. After examining the child's adjustment to school, to determine whether this contributes to family conflict or is a strength upon which to build, the liaison formulates a tentative plan of action, reviews it with the family and works collaboratively with family members to decide what if any services are needed.

At the "indicated" level, the program provides direct professional help to families, in accordance with the plan developed on the basis of the Family Check Up. Depending on need, parents may: attend a series of 12 group meetings (approximately 10 families in the group; meet individually with program staff up to three times; participate in family therapy once or twice a week for a period of time as short as one month and as long as one year; receive services for the adolescent;[16] receive services to address school-specific problems; and/or receive case management services to integrate program services with other needed services. The parent group sessions follow a curriculum, focus on improving family management and communication skills, and use group exercises, videotapes, role-plays, and discussion, as well as home practice assignments. Individual meetings focus on issues and challenges unique to the family. Family therapy sessions emphasize motivation to change and collaboration.

CASASTART is a school-centered multi-component program model aimed at preventing substance abuse and violence among youth and at improving school attendance, grades and behavior. The program targets neighborhood, peer group, family, and individual risk factors. The model is built on a framework that includes an integrated set of services such as: case management, family services, education services (tutoring/homework assistance), out-of-school/summer activities, mentoring, morale-building incentives, community policing and enhanced enforcement, and criminal and juvenile justice intervention (Harrell 1999). Services are locally developed, providing the ability to tailor services to local needs and cultures and to leverage existing community resources. Broader program goals include fostering partnerships among health and social services agencies, schools, and law enforcement; helping to improve youth relationships with their families; and facilitating family involvement with schools.

The program was originally developed and tested with youth 11-13 and their families in five high-risk communities. To be eligible for the program, youth had to exhibit risk in at least one of 3 domains: school, family, or personal. Each student has a case manager who meets with them regularly—to identify risk and protective factors across multiple environments. Case managers also meet with their families at least once a month and make regular home visits to address the family context and assess what additional services may be needed. Services for families vary, but could include parenting education classes, organized community events for parents, therapeutic services, and other skills training. According to the *CASASTART* website the program is now operating in 121 schools in 49 cities and counties.

Coping Power is based on research findings that youth who display early aggressive behavior are at risk for later poor school adjustment, substance abuse and more serious antisocial behavior. (The research applies specifically to boys; there is little research on the developmental trajectories of girls who display early aggression.) Targeting pre-adolescent boys who are displaying aggressive behavior in the school setting, the program seeks to improve school behavior and reduce substance abuse, as well as covert and overt delinquent behavior, by increasing youths' social competence and ability to regulate their behavior and supporting parents' positive involvement with their children. Developed as a school-based program, Coping Power has been adapted for delivery in mental health settings.

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[16] It is worth noting that the services to youth are provided in conjunction with services to parents and focus on self-regulation, social interaction and communication skills. In earlier versions, the program conducted group sessions with youth but found negative effects of the peer interactions on antisocial and risk behavior.

The program is delivered over 15 to 18 months in its full form and includes a youth component and a parent component. For youth, the program consists of 33-34 group sessions, each lasting 40-60 minutes, usually delivered in the school setting. Groups of 4-6 boys, screened and referred by teachers, meet with two co-facilitators to address and discuss topics that include: behavioral and personal goal-setting; distraction and relaxation strategies to manage anger; organizational, social problem-solving and study skills; dealing with peer pressure; and refusal skills.

The parent component consists of 16 group sessions, held over the same 15-18 month period, with 4-6 single parents or couples, in community settings and at times that are convenient for parents. Topics covered in the parent groups include: identifying targets for children's positive and negative behaviors; appropriate and effective discipline techniques and reward strategies; clear communication of expectations, rules and consequences for violating them; and maintaining communication through weekly family meetings. For both parents and children, the group sessions are augmented by regularly scheduled, brief individual contacts with children and parents.

The ***Early Risers Skills for Success*** program begins with the assumption that aggression in early childhood leads to serious and chronic antisocial behavior and substance abuse in adolescence. The program targets children aged 6 -10 years who exhibit aggressive, disruptive or oppositional behavior, and is designed to alter the hypothesized negative developmental trajectory of these children by effecting positive change in four domains: academic competence; self-regulation; social competence; and parental investment in the child. The program has multiple components: a six-week summer program for children, followed by an after-school program during the school year; the Check and Connect program which begins soon after the beginning of the school year and runs throughout the year; a family program, with separate sessions for parents and children, during the school year, and a family support program, delivered through six or more home visits. The design of the program calls for participation by children and parents over two or more school years.

Program for youth. The summer program for youth runs four full days a week for six weeks and can begin as early as the summer after the kindergarten year. Each day includes: formal academic instruction in reading, language arts, math and computer education; educational enrichment experiences (dance, music, nature and wildlife); social skills training using a "buddy system" which pairs aggressive children with non aggressive peers for activities to promote development of social skills); creative arts, drama and sports activities; and large-group recreation and CORE also includes an after-school program one day a week and a staff-mentoring program during the school year. The program uses behavioral modification techniques across all activities to help children self-regulate their behavior (point system, daily report card).

During the school year, the after-school program meets once a week in groups of 9 to12 children for 45 minutes of formal social skills instruction, 30 minutes of guided homework help, and 15 minutes of fun activities.

Check and Connect. During the school year, family advocates work with classroom teachers to track the progress of individual children in four domains (academic; relations with peers; behavior in the classroom; and emotional regulation), to identify student needs in any of these domains; and to develop individual intervention plans.

Program for families. During the school year, parents and children are invited to attend a series of bi-weekly evening meetings(12 in each of the first two years and six in the third year) that begin and end

with a family activity (a meal, at the beginning, and a parent-child activity at the end) and feature separate, concurrent sessions for parents and children. The parent sessions draw on the Incredible Years Parenting Series and cover topics such as effective parenting practices (rules and limit setting, nonviolent discipline, using praise and rewards, playing with your child), support for learning, parent stress management, communication and problem-solving skills. The child program follows the Incredible Years Dinosaur curriculum and addresses topics such as emotional regulation, conflict resolution, making friends, understanding school rules, and social problem solving through the use of interactive video modeling, fantasy play with puppets, and role-plays.

The final element of the family program involves home visits by family advocates over the school year, with the number and duration of home visits determined by need. Depending on the level of need, family advocates provide emotional support and assistance in collaborative problem-solving, linking to community resources and goal-setting, as well as, for needier families, assistance with basic living issues, crisis management and referrals for more serious health and domestic needs.

Familias Unidas is a parent-centered program that targets Hispanic parents of adolescents in 6th, 7th and 8th grades of school and is built on the assumption that involved and positive parenting, parent-youth communication and family support will promote healthy adolescent development and prevent substance abuse and unsafe sex. The goals of the program are to increase parental investment in their children, reduce adolescent behavior problems and promote attachment to school and academic achievement, with the ultimate goals of preventing substance use and unsafe sex.

The major component of the program involves one-hour parent group meetings, held weekly over a nine-month period.[17] The intervention occurs in three stages: in the first stage, program staff work to ensure that parents are engaged and understand the purpose of the program, and to build a cohesive and supportive parent group. In the second stage, parents are introduced to the three worlds that adolescents inhabit (family, peers and school) and are encouraged to discuss their concerns about them. In the third stage, parents learn parenting skills appropriate for the challenges of each of the worlds: within the family, positive parenting and involvement with the child and effective behavior management; within the world of school, communicating with school staff and monitoring homework; and, within the peer world, monitoring adolescents' social activities and establishing connections with parents of peers. The sessions for parents promote parent involvement through problem posing and participatory exercises. Group discussion helps parents understand their importance in protecting their child from harm.

In the third stage of the parent sessions, school counselors make home visits to facilitate interaction and discussion between parents and their adolescent children and to connect families more closely to the school world. Finally, the program organizes activities that expose parents to their children's peer networks, encourage supervision and promote positive peer associations.

Families and Schools Together (F.A.S.T.) is a program that targets families with children in the early elementary school grades. Unlike many programs that are flexible about the setting in which the program may be delivered, *FAST* is planned as an after-school program in the school setting. The program combines interactive sessions for parents with a family meal and activities.

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[17] The program has been tested with considerably fewer sessions.

The program assumes that families are stressed and need support. It uses the strategy of the family group meeting to encourage positive interactions among family members. And it seeks to build protective factors in young people by creating links between parents, between parents and their children, and between parents and schools, and by encouraging parental support for learning.

Children who could benefit from FAST are identified by school staff who screen children for mental health problems and may also be asked to identify bullies, troublemakers or children who are hard to teach.[18] The program begins with a home visit to recruit the family, followed by 8-10 weekly family group meetings (up to 12 families). Each weekly group meeting lasts about 2.5 hours and follows a standard agenda, beginning with an opening tradition and 45 minutes of a family meal and structured communication activities and games. Each family occupies a table (unlike most programs, *FAST* encourages the presence of multiple family members, including older and younger children, as well as parents and adult relatives). This is followed by a one-hour parent meeting, in which parents select the topics for discussion and *FAST* staff guide the discussion. Developmentally-appropriate activities are provided for children during the parent meeting. After a brief (15-minute) period for one-on-one coaching in parent-child communication, in the context of play (for younger children) or a discussion (for middle-school children), the session ends with a closing ceremony. *FAST* promotes full participation through a fixed lottery in which every family wins a prize in the course of the 8-10 weeks, and the winner is announced at the closing ceremony.

After graduating from *FAST*, families are invited to join *FASTWORKS*, a school-based collective of former *FAST* parents that meets monthly for two years, and is intended to sustain the supportive relationships developed during the earlier *FAST* sessions. While some elements of the *FAST* program continue during this period, for the most part families plan the content of the sessions to meet the needs of the group. Rather than rewarding individual families for attending, *FASTWORKS* provides a small monthly budget ($100) and the group decides how it should be spent. Across the two elements of the program, it is estimated that approximately 40% of program content is specified (and fidelity of implementation is assessed); the remaining 60% is decided by parents and staff of individual programs.

Family Matters is an intervention intended to reduce the prevalence of cigarette smoking and alcohol use among adolescents ages 12-14. It is intended for use with a broad range of parents and can be delivered in the home. Parents receive a series of health booklets, delivered successively through the mail, and follow-up telephone calls from health educators. Each booklet contains information and activities to be completed by the parent with their child. The content of the booklets is based on social and behavioral theories, and includes a combination of information on: parenting skills, such as supervision, communication, and monitoring; the importance of family and family influences; rule setting; and peer and media influence. The booklets suggest activities to be completed by the parent and child together. Follow-up phone calls by a health educator are intended to ascertain the status of completion of each booklet and to answer questions or provide additional information about the program.

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[18] The *FAST* program is widely implemented and collects data on participants from individual programs. Data from 53 programs in 13 states show the average child in *FAST* is 8 years old, at least one year behind their expected grade level and is rated by parents and teachers as exhibiting significant behavior problems in the classroom and at home.

Focus on Youth is a risk reduction program model that is part of the CDC's DEBI (Diffusion of Effective Behavioral Interventions) project. The program model is intended to help reduce sexual risk behaviors among high risk youth, as well as substance abuse and truancy. The program has two components: a curriculum delivered to youth and a parent session delivered in the home (ideally) or a community setting.[19] The eight-session curriculum is designed to be delivered by two trained facilitators in community settings with small "friendship" or venue-based groups. Participants are taught the SODA (Stop, Options, Decide, Action) decision making model, which is employed throughout the sessions. The curriculum uses interactive activities such as games, role plays, discussion and community projects to teach prevention knowledge and skills.

The program model also includes a parent session, (formerly called ImPACT, but now embedded in the *Focus on Youth* program model), dealing specifically with parent/child communication. This one ninety minute session is delivered in the home with the program facilitator, the parent, and youth participant. The session includes a video featuring individual interviews, parent-child conversations, and youth discussions, and is focused on parental monitoring and communication. There are also messages about the importance of protection from HIV/AIDS. After the video, there are opportunities for discussion, role play activities, and a condom demonstration. The session is intended to be offered early in the program, preferably before the program begins or by the third session for youth. Parents are informed of the session during the orientation session and encouraged to schedule the session as soon as possible.

This program is a risk reduction program model that is part of the CDC's DEBI (Diffusion of Effective Behavioral Interventions) project. The program model is intended to help reduce sexual risk behaviors among high risk youth, as well as substance abuse and truancy. The program has two components: a curriculum delivered to youth and a parent session delivered in the home (ideally) or a community setting.[20] The eight-session curriculum is designed to be delivered by two trained facilitators in community settings with small "friendship" or venue-based groups. Participants are taught the SODA (Stop, Options, Decide, Action) decision making model, which is employed throughout the sessions. The curriculum uses interactive activities such as games, role plays, discussion and community projects to teach prevention knowledge and skills.

The program model also includes a parent session, (formerly called ImPACT, but now embedded in the *Focus on Youth* program model), dealing specifically with parent/child communication. This one ninety minute session is delivered in the home with the program facilitator, the parent, and youth participant. The session includes a video featuring individual interviews, parent-child conversations, and youth discussions, and is focused on parental monitoring and communication. There are also messages about the importance of protection from HIV/AIDS. After the video, there are opportunities for discussion, role play activities, and a condom demonstration. The session is intended to be offered early in the program, preferably before the program begins or by the third session for youth. Parents are informed of the session during the orientation session and encouraged to schedule the session as soon as possible.

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[19] The program has been used with youth as old as 20.

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The ***Helping Encourage Affect Regulation (HEAR)*** program (currently available as the Pathways to Competence for Young Children) aims to reduce aggression and behavior problems in preschool-age children (already exhibiting such behaviors) by providing parents with information and skills to enhance a number of developmental capabilities in their young children. In group sessions led by a clinical psychologist, parents receive instruction on development, starting in infancy and progressing through adolescence. Social and emotional topics covered include: development, body image, attachment, play and imagination, language and communication, self-regulation, morality and a sense of conscience, emotion regulation, concentration and problem solving, and social competence, empathy and caring behavior.

The program is designed to be offered over 15 weeks in which parents attend 2-hour group meetings each week. Activities include role-plays with other adults, group exercises, and assignments to be completed at home. The program aims to reduce the incidence of behavioral problems among children, increase parenting knowledge and competencies, and improve attitudes toward parenting and their children. The program specifically targets parental perceptions and interactions with their child, emphasizing parent-child relational differences and not just improved parenting knowledge and confidence. Designed for parents of aggressive and noncompliant children, the program has also been used with parents suffering from depression, parents involved with child protective services, and parents who have experienced spousal abuse.

The Incredible Years is not a single program but rather a set of components each of which can be used in conjunction with one or more of the others, or as a stand-alone intervention. Within the components there is also flexibility: the child training programs can be used by classroom teachers or by therapists working with small groups of children; the parent training programs are intended to be delivered in small groups, but can be adapted for home visits; and the teacher training programs are suitable for classroom teachers or therapists and are also available for self-study. This flexibility has enabled many programs to use one or more of the components to supplement their own programming. The child training curriculum *(Dina Dinosaur*), in particular, has strongly influenced the development of a number of other curricula for similar age-groups.

Begun as a parent training program, its goals have expanded to include:

- Develop competent and confident parents;
- Promote children's emotional and social competence;
- Prevent, reduce and treat children's aggression and uncooperative behavior;
- Strengthen teachers' classroom management strategies; and
- Promote collaboration between parents and schools to encourage involvement and consistency between home and school.

Intended for children ages 0-12 years, the Incredible Years has three major components: a parent training intervention; a child social skills curriculum; and a teacher training package.

Parent training. There are four versions of the parent training component: BASIC, for parents of children below three years of age; BASIC for parents of 3-6 year olds: BASIC for elementary school children (6-12 years); and Advanced for the latter age group. Overall, the component is designed to teach parents the importance of monitoring, how to use effective discipline and behavior management

skills, encourage competent and confident parenting and promote involvement in the child's school experience. For parents of very young children, parent training teaches them to observe and interpret the child's cues, provide nurturing and responsive care as well as physical and verbal stimulation. Parents of toddlers learn the importance of child-directed play and participation in it, how to encourage language development, how to provide social and emotional coaching, praise and encouragement, positive discipline, how to set appropriate behavioral limits; and how to manage behavior problems.

For parents of school-age children, the BASIC curriculum teaches parents how to strengthen children's social skills and ability to regulate their behavior, and how to help them get ready for and participate in school. How to play with children, the use of praise and incentives and positive discipline techniques continue to be emphasized. The Advanced curriculum for parents of children 6-12 deals with effective communication, anger management, problem-solving and teaching children to solve problems. Each of the curricula is designed to be presented in weekly, small-group sessions, each lasting about two hours; the number of sessions varies, depending on the specific curriculum used. The format of the sessions is the same: skills are introduced, then practiced. Videotaped vignettes that demonstrate aspects of parent-child interaction are viewed and discussed. Parents engage in role-play and receive feedback. Since not all parents can attend group sessions, a home visiting option is provided.

Child social skills training. The *Dina Dinosaur* curriculum is intended for children 4-8 years old and designed to improve peer relationships and reduce aggressive behavior at home and in school. The curriculum includes 120 lesson plans and is delivered 2-3 times a week during a 15-20 minute circle time discussion, which is followed by small group activities to practice the skills learned. Puppets, videos and games are used to illustrate: making friends and learning school rules; understanding and managing feelings; problem-solving; communicating with peers and friends; social skills (taking turns, trading, asking, ignoring, sharing, helping, complimenting), and how to do your best in school. Teachers are trained to deliver the classroom curriculum, to weave the activities throughout the school day and to send home suggestions for activities parents can do with their child.

The curricula are also designed to be delivered by a therapist in small-group sessions held weekly for 18-20 weeks, and are meant to be offered in parallel with the parent training.

Teacher training. The Teacher Classroom Management Program is designed to strengthen classroom management strategies and to help teachers promote children's prosocial behavior and reduce aggressive behavior. Sessions deal with: the importance of attention, encouragement and praise; motivating children through incentives; preventing problem behavior; reducing inappropriate behavior; promoting children's problem-solving skills and helping them to build positive relationships. The training is also available for therapists working with small groups of children.

What is remarkable about the three components is the consistency of the messages and skills taught: parents learn positive strategies to manage their own and their child's behavior; teachers learn positive techniques to manage their own behavior and that of children in the classroom; and children learn to manage their own behavior and to interact positively with their peers, using the techniques of encouragement and positive reinforcement that adults are trained to use with them.

KEEP (Keeping Foster Parents Trained and Supported) provides 16 weeks of training, supervision and support in behavior management to foster and kinship parents of children ages 4-12 years. The

goal of the intervention is to reduce child problem behaviors through strengthening foster parents' skills, reduce placement disruption, and increase positive placement changes (reunification or permanent adoption). Groups meet weekly for 60-90 minutes (in groups of 6-10). The groups are led by trained facilitators who lead discussions and provide instructions on specific skills. Topics covered during the group sessions include: cooperation, understanding behaviors, limit setting, discipline techniques, avoiding power struggles, promoting school success, promoting positive peer relations, and managing stress.

Videotaped examples are included to illustrate key concepts and particularly challenging situations. There are opportunities for role-plays and skills practice with feedback from the group, and there are home practice assignments in which parents implement behavior management methods discussed and practiced in the group. Facilitators call parents once a week to check in and obtain information on youth behaviors and parents' level of stress. If parents miss a meeting, the facilitator delivers the material during a home visit.

KEEP is a less intensive version of the Multidimensional Treatment Foster Care (MTFC) program, which has been used with foster care providers caring for adolescents referred by juvenile justice as an alternative to placement in group or residential care. MTFC has also been adapted for use with children with severe mental health disorders who are being discharged from inpatient psychiatric care and with high-risk preschoolers in foster care.

LIFT is a multimodal preventive intervention that aims to address antisocial behavior and subsequent delinquency. It is intended to be a universal intervention, delivered to first grade students in school settings. The intervention targets social interactional processes related to child antisocial behavior through components delivered to young children, parents, and on the playground. These settings (school and home) provide the best opportunities for working with multiple agents (parents and teachers) who are involved with children and have opportunities to interact in a way that may or may not reinforce coercive behaviors. The three components, designed as separate interventions, are intended to be complementary.

Students in first grade receive training in social and problem solving skills focused on listening, emotion recognition and management, and group cooperation. The classroom curriculum is delivered in group settings in 30 minute sessions offered two times a week for 10 weeks. As part of the class, students are divided into small groups of 4 or 5 students. Students participate in the classroom activities together as a group. Each session includes direct instruction, group discussions, and individual skill practice within a small and large group. Linked to the child training is a playground intervention delivered during school recess. This intervention (a version of the *Good Behavior Game*) immediately follows the classroom curriculum. During recess, group members have opportunities to earn points toward both a classroom and group reward through display of appropriate behavior (such as sharing, cooperating) and limited aversive behavior (hitting or pushing). Teachers distribute points through observation, and at the end of the period points are counted—points for displays of negative behavior are subtracted from points earned for good behaviors.

The parent management training component is designed to improve parent skills in consistent and effective positive reinforcement, discipline, and monitoring. The curriculum is designed for delivery to parent groups during weekly sessions of 90 minutes over 6 weeks. Meetings were offered in neighborhood school classrooms and intended to emphasize the importance of parent to parent and parent to teacher communication. A phone and answering machine installed in each intervention

classroom encouraged non-threatening communication (teachers could leave daily messages about homework and class activities). Parent and teacher communication was also encouraged through the use of weekly newsletters that teachers sent home summarizing the specific LIFT program that week and providing suggestions for complementary parent-child activities.

Parents Who Care is a 5- or 6-session universal prevention program, developed for older youth aged 12 -16 and their families. The program's goals are: to build protective factors in youth by teaching parents strategies for positive engagement with their children, for offering opportunities to participate in and contribute to their families and for using rewards and recognition to promote family cohesion. At the same time, *PWC* is intended to reduce risk behavior by teaching parents effective supervision, monitoring and discipline strategies, and by teaching youth resistance, goal-setting and decision-making skills. Intended outcomes include changes in: parent and sibling drug use; parental attitudes toward drug use; family management practices; family involvement, communication and conflict; family bonding; and youth association with antisocial peers.

The program sessions, which are 2-2.5 hours long, are held weekly. Youth attend the sessions with one or both of their parents and a light dinner is served. Family members stay together for the first part of the session to view a videotape component of the seven-unit curriculum. Parents and children separate into different groups to practice specific skills, then meet together in the larger group to engage in structured family interactions. Families are given homework and receive the curriculum workbook and videotapes. Program managers are encouraged to offer financial aid for child care and transportation.

The content of the curriculum offered to both youth and parents includes: knowledge and understanding of both risk and protective factors and strategies for reducing one and developing the other; problem-solving strategies; effective parenting and communication; anger management; supporting and encouraging children's struggle to become independent; contributing to the family; setting clear family policies on health and safety issues and consequences for prohibited behaviors; appropriate supervision and monitoring; refusal skills; and how to ask for help. Session leaders, who work in pairs, have prior experience conducting workshops for parents or teens.

The program has also been tested as a self-administered curriculum with weekly telephone support from program staff. Families received written instructions about how to use the workbook and videos, as well as a checklist of 62 activities to complete as a family. A family consultant contacted families once a week to discuss completed activities, motivate parents, and help solve problems that parents encountered in implementing the program with their adolescent children. Family consultants had prior clinical experience with families with adolescent children. Although this model produced outcomes similar to those found in the original model (see discussion of outcomes below), it does not appear to be disseminated.

Parenting Through Change is an intervention to address internalizing and externalizing conduct behaviors and associated problems and to promote healthy child adjustment through changes in parenting behaviors and interactions. Recently separated mothers who have sons in grades 1-3 participate in 14 weekly group sessions led by professionals to learn effective parenting practices including skill encouragement, limit-setting, problem solving, and positive involvement. The program also includes a 30-minute videotape depicting families using effective parenting practices to help their children adjust to the divorce transition. The sessions address parenting practices such as discipline, monitoring, contingent encouragement and problem-solving, together with other issues relevant to

divorcing women (including managing interpersonal conflict and emotions). Participants are taught specific skills and provided opportunities to apply them using classroom examples.

Parenting Wisely is a set of interactive, computer-based training programs for parents of children ages 3-18. Based on social learning, cognitive, behavioral, and family systems theories, the programs aim to increase parental communication and disciplinary skills. The program addresses parenting skills such as monitoring, communication, problem solving and conflict resolution, discipline practices, and reinforcement. These practices have been shown to be effective in improving child behaviors.

Parents view the self-instructional program on either an agency's computer or laptop or at home on a personal computer. During each of the sessions, users view a video enactment of a typical family struggle and then choose from a list of solutions representing different levels of effectiveness, each of which is portrayed and critiqued through interactive questions and answers. The whole program can be completed in 2-3 hours. There are also workbooks containing program content and exercises to promote skill building and practice.

The program has been used in a variety of settings, including: family-centered substance abuse services, community health care clinics (inpatient and outpatient), community substance abuse treatment services, and school-based programs. It has been used internationally as well, including with youth offender teams, mental health centers and community health centers. The various populations receiving the program include substance-abusing parents and their children, low-income ethnic minority families (Portuguese, Hispanic, Asian, African American, African Caribbean), and juvenile offenders.

PATHS (Promoting Alternative Thinking Strategies) with Fast Track merges an intervention designed for an indicated population *(Fast Track)* with a universal classroom-based curriculum (*PATHS*) to produce a three-tiered school-based prevention program. The program is designed to run from first through 10th grade, most intensively at transition points in the child's school life (entry to school, transition to middle school from elementary school). The hypothesis that underlies the program is that improving children's social, emotional and academic competence, parents' effectiveness, the school and classroom environment and communication between home and school will help to prevent antisocial behavior in adolescence.

In elementary school, the universal intervention (*PATHS*) consisted of a curriculum delivered by classroom teachers two to three times a week in grades one through five. The goal of this component is to increase children's social and emotional competence. The curriculum focuses on emotional awareness and understanding, self-regulation, peer social skills, and social problem-solving. In the early school grades, the emphasis is on adaptation to school rules and routines as well as developing positive relationships with peers. The later grades emphasize decision-making, study, resistance and problem-solving skills. Initial training and ongoing support for teachers are designed to enhance the effect of the curriculum by helping the teacher to create a healthy and supportive classroom environment in which children can effectively utilize the skills they have learned.

For families identified as high-risk on the basis of a screening conducted in kindergarten with both teachers and parents for conduct problems at home and/or at school, *Fast Track* offers additional components during the elementary, middle and high school years. In elementary school, at the standard indicated level, families participate in 2-hour family group meetings, held weekly for 22

weeks in first grade, biweekly for 14 sessions in second grade, monthly for 8 sessions a year in grades 3-5. At these sessions, parents and children meet in separate groups for 90 minutes and then participate in 30 minutes of joint activity. The parent groups focus on developing positive school-parent relationships, and effective communication and discipline skills and strategies. The child groups focus on social skills development, including friendship and play, self-regulation, managing anger, and interpersonal problem-solving. The joint sessions are intended to provide opportunities for parents to practice skills they have learned, with guidance from program staff.

At the third intervention level, families are offered individualized services, including: home visits to assist parents' development of problem-solving and family management skills; academic tutoring for children; and classroom-based peer pairing to promote friendships. In first grade, all families receive the same level of individualized services; in subsequent elementary grades, the amount of these three components provided reflects the family's needs and level of functioning. In grade 4, a mentoring component is added to support the child's identity development.

In grades 6-10, *Fast Track* continues to provide both standard group and individualized services to high-risk families, although youth group activities are de-emphasized. Curriculum-based parent and youth group sessions are offered in grades 5-7 to assist youth in the transition to middle school, but the major focus of the program in this phase is on individualized services that reflect the family's needs.

Positive Action is a multi-year school-based character education program, based on theories of self-concept, learning behavior, and school ecology, and designed to achieve the goals of positive character development, improved academic achievement and prevention of problem behavior. The program has five major components: a classroom curriculum for grades K-12; school climate development; counseling; family; and community. Supplementary modules on conflict resolution and drug education are also available for use in schools. The program allows schools a great deal of flexibility in the selection of components: it is possible to select a curriculum for grades K-6 only for example, and then combine it with one or more other components. The expected outcomes are reduction in disruptive behaviors and other disciplinary problems, decreased substance use, violence and suspensions, and improved academic achievement.

Classroom curriculum. The curriculum consists of a series of scripted 15-20-minute lessons to be delivered almost daily (over 140 lessons per grade), that use different teaching strategies to accommodate a variety of learning styles. Through stories, role-play, modeling, question and answer, games, music, posters and manipulatives, students learn how to use positive actions, to manage their thoughts actions and feelings, and to treat others the way they themselves wish to be treated.

School climate development. This component, which the school principal oversees, is designed to reinforce the classroom curriculum by engaging the entire school population in a variety of positive actions and activities that promote improved behavior and academic performance.

Counseling. The school counselor is encouraged to play a critical role in school-climate change, and to teach and reinforce Positive Action concepts with individual children, small groups, classes, parents and community members.

Parents and Families. Through classes for parents or for the whole family, the program teaches about positive actions and their effects on self-concept, behavior and achievement. A Family Kit allows families to learn positive actions together at home.

Community. The community component suggests ways for students and school staff to engage in community-wide positive actions as well as ways to reach out and engage groups such as businesses, local government, social service agencies and media outlets.

Positive Parenting Program (Triple P) targets families with at least one child, from newborn to twelve years (it has recently added services for families with teenaged children), and offers five tiered levels of intervention to address families' differing needs, with the goal of improving parenting practices, preventing child maltreatment, and its negative effects on children's development. The five levels of intervention correspond to gradually narrowing population targets and increasing intensity of services. The assumptions underlying the program are: all families can benefit from information about effective parenting strategies; some families need more assistance, but not all of them need the same level of assistance; and service provision should be efficient, i.e., no family should be given more than is needed. Reflecting these assumptions, in addition to the tiering of services, there is considerable flexibility in how the program is delivered within each level.

Level 1: Universal Triple P. At this level, the program employs health promotion and social marketing strategies to disseminate as widely as possible information that can help parents understand their child's development, their own role in supporting and encouraging development, and how they might respond effectively to common behavior problems, many of which are part of normal development. The strategy is intended to normalize parenting difficulties and eliminate any perceived stigma attached to seeking help with them. Information can be disseminated through community-wide media outlets, through public service announcements on TV and radio, newspaper columns, interviews, current affairs programs. A telephone information line can offer additional information for parents and, like all the other sources, suggest where parents might go to receive additional help.

Level 2: Selected Triple P. At this level, the program is designed to offer information and advice for parents with a specific concern about their child's behavior. Professional staff in primary care services (defined as services and programs that operate community-wide, have regular contact with parents, are easily accessible to them, and are seen as credible and have no stigma attached to them) have periodic discussions with parents about how to manage specific childrearing problems, offer parenting tip sheets and/or videos and suggest resources if parents need additional help. These discussions may be with individual parents, or may take the form of presentations to a group of parents, or a mix of both. The group seminars consist of three 90-minute presentations: The Power of Positive Parenting; Raising Confident, Competent Children; and Raising Resilient Children. Professional staff are present at the seminars to offer additional help if needed. A similar seminar series is offered for parents of teens.

Level 3: Primary Care Triple P. This level of services is for parents who require active skills training in addition to the information offered at the prior levels. Brief individual counseling sessions (four 15-30 minutes) combine practical advice about managing behavior problems with skills coaching. This involves identifying the history and nature of the problem, collaborative development of a parenting plan, modeling responses to the behavior, having parents rehearse responses and then evaluate their response. A similar intervention is offered for parents of teens.

Level 4: Standard, Group and Self-Directed Triple P. This level of services is for parents of children with more severe behavioral problems who require intensive training in positive parenting skills. The individual or standard version involves 10 sessions, each lasting about one hour, in the home or in a clinic, in which professional staff provide information, model positive parenting techniques, have

parents practice them, observe the interaction and provide feedback, encourage goal-setting and self-evaluation of progress, and suggest homework tasks. Variations are: eight group sessions with 8-10 parents; and self-directed study by individual parents using a self-help workbook. Either approach may be supplemented with periodic telephone contact and consultation. Group sessions may be provided for parents of teens.

Level 4 Specialist Services: Stepping Stones Triple P. Specialist services provide positive parenting information and skills training for parents of pre-adolescent children with a disability through 10 individualized sessions.

Level 5: Enhanced Triple P. Services at this level are designed to help families with concurrent child behavior and family problems such as parent depression or parental conflict, who are at risk for child maltreatment. Delivered as an intensive, individually-tailored set of up to 11 sessions in the home, the program addresses not only the positive parenting skills that are the focus of the four levels that precede this one, but also includes three sessions that help parents identify dysfunctional thinking patterns and learn personal coping skills, such as relaxation. For two-parent families and develop plans for personal coping strategies.

Project Northland is a multi-component multi-year intervention intended to reduce alcohol use among adolescents. The program addresses the social, environmental, and intrapersonal factors associated with alcohol use among adolescents through multiple phases. Phase 1 includes: a curriculum delivered in school to students in grades 6-8; parent involvement programs; peer leadership opportunities; and community task forces. During Phase 2, when the student cohort is in grades 11-12 there is a curriculum delivered in the class, parent education, print media, youth development, and community organizing. The content and structure of these activities are designed to be consistent with the developmental stage of the adolescents.

As part of Phase 1, students receive education on skills to communicate with their parents about alcohol, to deal with peer influences and normative expectations about alcohol, and to understand methods that bring about community-level changes in alcohol-related programs and policies. To support these efforts, factors in the social environment are also addressed through parenting education (focused on communication and other parenting skills through the use of newsletters, homework assignments, and scripted activities to be completed with youth); peer education (in which peer leader and teacher-led sessions address peer influences and social norms); and community norms (through community task force engagement in local alcohol related ordinances and broader awareness efforts). Phase 2 is essentially a community level intervention that targets the social acceptability and commercial availability of alcohol. This phase of the intervention relies heavily on the media and community to reinforce the earlier messages delivered primarily in the schools to youth.

Raising Healthy Children (formerly the Seattle Social Development Project) is a universal, multi-component intervention for children in the elementary school grades. The program is guided by the social development model set forth by Catalano and Hawkins (1996), which itself is grounded in social control and social learning theories. The model suggests that schools and families that offer supportive environments and opportunities for active involvement, promote the acquisition of skills and competencies, and encourage effort produce youth who are strongly attached to these social units, and that these strong bonds protect youth against risky and socially unacceptable behavior in adolescence.

The program is designed to intervene early in the child's school life in order to increase prosocial bonds, strengthen children's attachment and commitment to school and, in adolescence, improve school achievement and reduce delinquency, violence and risky sexual and other behaviors. The program has three components: a curriculum for children in grades 1 and 6; teacher training for all classroom staff in the elementary school; and parent training when their children are in grades 1,2, 3, 5 and 6.

Youth component. In first grade, children receive a cognitive and social skills curriculum, which teaches them the skills needed to identify problems, then to generate, choose and implement a solution. The curriculum promotes collaboration and cooperation among children through involvement in small learning groups and other social activities. In 6th grade, students receive training in resisting peer pressure to engage in antisocial or problem behavior.

Teacher component. Although children receive a specific curriculum in only two grades, teachers in all grades receive five days of in-service training in positive classroom management; interactive teaching; and cooperative learning.

Parent component. When children are in 1st grade, parents are offered seven sessions dealing with the skills they need to manage children's behavior positively. In 2nd grade, and again in 3rd grade, parents are offered four sessions on the skills they need to support children's academic progress. In 5th and 6th grade, parents are offered a five-session curriculum on how to reduce their child's risk for substance abuse.

R.E.A.L. Men is an HIV-prevention program for fathers of adolescent boys. The program's goals are to delay sexual activity and increase condom use among sexually-active youth by encouraging fathers to communicate with their sons about sexual issues. To achieve these goals the program seeks to promote fathers' involvement in their sons' sexual education and increase communication on sexual topics.

The program is delivered in seven two-hour sessions, six of which are attended by fathers only; for the seventh meeting, fathers and sons attend together. Dinner is served at each session. During the sessions, fathers are presented with information through lectures and videotapes, practice behavior through role-plays and games, engage in discussions, establish personal goals, and are given take-home activities. Topics covered in the sessions include: fathers' role in educating their sons about sex; adolescent development; HIV/AIDS transmission and prevention; and the importance of parental monitoring. Later sessions deal with communication with youth, how fathers can talk to their sons about puberty, peer pressure, values, and general sexual topics. In the final session, sons join their fathers in a game designed to generate discussion about issues in adolescents' lives, watch a videotape on the same topic and celebrate reaching the end of the program.

SAFEChildren combines an academic tutoring program for children entering first grade with a parent-focused intervention that recognizes the role of inner-city neighborhoods in heightening the risks that families and children face. The program begins as children enter first grade and involves 22 weeks of intervention, with the goals of: increasing parenting knowledge and family cohesion; generating more positive attitudes toward academic achievement and involvement with school on the part of both parents and children; and improving children's social competence and academic achievement.

For children, the program provides 30 minutes of individual, phonics-based tutoring in reading, twice weekly, over 22 weeks (the phonics-based tutoring program used was developed for the *Fast Track* intervention).

Group meetings for parents are held weekly, for 22 weeks. The sessions combine provision of information, skill practice and group problem-solving exercises. Topics addressed include: parenting skills; understanding and managing challenges presented by developmental changes; family relationships; developing a support network of parents; working with schools; and coping with neighborhood and community problems. Parents are given homework assignments in the form of exercises to do at home to apply what they learn in the sessions.

Saving Sex for Later is an intervention for parents of pre-adolescents (10-13 yrs) intended to delay early sexual initiation among youth. The program consists of three 25-minute audio CDs designed to help parents identify "teachable moments" through role-model stories. The messages emphasize communication with their sons and daughters about values and expectations, setting household rules and responding appropriately to their children's development. The program is based on social development theory, which underscores the role parents play in shaping adolescent behavior. The videos include stories and scripts developed around three families, one African American, one Hispanic, and one Caribbean, who grapple with issues in stories that use drama and humor to address different themes along a development progression (puberty, relationships, peer pressure). Key messages are summarized and information about additional resources is provided.

STARS (Start Taking Alcohol Risks Seriously) for Families is a brief health promotion program intended to reduce the initiation of alcohol among at-risk middle and high school youth. The model has been tested in both urban and rural settings. This universal intervention is offered over two years and incorporates three main activities. In the first year, students 11-15 receive a health consultation with the school nurse who delivers a brief health lesson on how to avoid alcohol use. Parents receive corresponding postcards in sets of 1or 2 per week for 5 to 10 weeks. The cards provide guidance on how parents can help their children avoid alcohol. In the second year, students receive a follow-up consultation with the nurse. The final activity is weekly take home lessons in which parents and children complete prevention activities. These activities include a contract that students sign for alcohol avoidance.

This model, while a universal intervention, takes into account individual differences of youth in terms of their stage of initiation for consuming alcohol, allowing for prevention messages and strategies to be tailored accordingly. Prior to the intervention, an initial assessment of the individual student's stage of alcohol initiation and readiness for change is conducted. This assessment is based on data collected from the Youth Alcohol and Drug Survey. This stage-based approach is informed by the Multi-Component Motivational Stages (McMOS) prevention model (which is itself informed by the Transtheoretical stages of change model), which acknowledges the role that the media, interpersonal and environmental factors play in influencing behavior. Youth progress through stages of initiation, and change is influenced by risk and protective factors. This recognition allows for mapping the content and strategies to the specific individual stage status. Parents receive messages that are relevant to their child. The program is also available in Spanish, and has been tested on rural, urban, and high risk families and youth.

The Strengthening Families Program: For Parents and Youth (SFP 10-14) is a universal prevention program that targets youth aged 10-14 years. The program's objectives are to: improve

parenting competencies and youth social competencies as pathways to the ultimate goal of reducing substance abuse and behavior problems during adolescence. Positive impacts on these parental and youth mediating factors, and the subsequent reduction of specific risk behaviors in later adolescence, are the intended outcomes of *SFP 10-14*.

The program consists of seven weekly two-hour sessions, in which the first hour is spent in separate youth and parent activities, and the second hour in a joint session of supervised family activities. Four booster sessions for youth and parents are held 6-12 months after the end of the initial seven sessions. All parent sessions and some of the youth and family sessions feature videotaped demonstrations of prosocial behavior. The curriculum topics for parent groups include: nurturing youth; setting rules and explaining consequences of breaking them; effective monitoring and discipline; encouraging good behavior; and protecting against substance abuse. Later booster sessions for parents deal with managing stress and parental disagreement. Sessions for youth deal with: goal-setting; stress and anger management; decision-making, communication and peer resistance skills. Booster sessions address making good friends and handling conflict, as well as reinforcing earlier lessons. In the joint sessions, parents and youth practice respectful listening and clear communication. Games are used to promote empathy for each other and develop problem-solving skills.

The Strong African-American Families Program (SAAFP) is a universal prevention program, built on existing models such as the *Strong Families Program* and similar family-centered interventions, and tailored to meet the unique challenges that face African-American families. The program's objectives are to promote positive family interactions, prepare youth for the teen years and strengthen parents' ability to help youth make a successful transition to adolescence, with the ultimate goals of decreasing the use of drugs and alcohol and postponing sexual involvement.

Like the other program models described here, the *SAAFP* uses a set of seven two-hour weekly meetings to deliver its curriculum, through a combination of family-, parent- and youth-centered sessions. The two-hour sessions begin with separate, concurrent sessions for children and parents, followed by a family session in which parents and their children practice the skills they have learned. Sessions with parents deal with many of the same topics addressed by other similar programs, including: authoritative and affectionate parenting practices; monitoring and discipline strategies; supporting youth goals and promoting independence; strategies for communicating about sex; and the importance of establishing clear expectations about substance abuse. Unique to this program, however, is parent training in how to help their children understand their racial identity and successfully face the challenges of racism. Leaders of the parents' sessions use videotapes to deliver information and illustrate family interactions, then guide discussion in the group.

Sessions for youth deal with: the importance of having and following family rules; understanding their own strengths; strategies to use when encountering racism; future goal-setting and planning; peer resistance skills; and knowledge of and attitudes toward substance use. Videotapes are used in some sessions to illustrate peer interactions but, for the most part, youth are actively engaged in activities and role-plays related to the session topics. In the joint family sessions, parents and youth practice positive communication and engage in activities designed to increase family bonding.

Talking Parents, Healthy Teens is an intervention that reaches out to parents of 11-16 year olds in their workplace and that specifically addresses adolescent sexual health. A series of 8 weekly workshops are held during the lunch hour and include group instruction and free lunch. Talking Parents, Healthy Teens aims to change parenting behaviors in ways that will lead to changes in

adolescent behaviors. The program addresses skills (communication, monitoring, and involvement); intentions (to talk about sex, monitor their activities and behaviors and stay involved); and environmental barriers and facilitators (such as community norms) that influence talking about sex.

During the sessions, participants engage in a series of activities such as role-play, videotaped interactions, discussion, games, and take-home assignments to be completed with their children. Program developers realized that the inconvenience of traveling to other settings could be a potential barrier to parent participation and that holding the meetings during lunch accommodates busy parents.