

PREVENTION AND EARLY INTERVENTION

Commission Member: Jerry Doyle

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Issue 2: Evidence-Based Practices

I. Definitions - What definition of “evidenced-based practices” is most typically used in the prevention and mental health field?

A. One problem in the field (across professions) is that there is no standard definition for “evidence-based” practices or treatment. The American Psychological Association is attempting to arrive at a single/common definition for the mental health field. However, there is consensus that the gold standard includes:

1. Randomized Controlled Trials (RCT)
2. Manuals.
3. Replicated studies.

B. Definition by Oregon State.

1. Level I - Practice, regimen, or service that is supported by scientifically sound randomized controlled studies that have shown consistently positive outcomes (efficacious). Positive outcomes have been achieved in scientifically controlled *and* in routine care settings (effective).
2. Level II - Practice, regimen, or service that is supported by scientifically sound experimental studies that have demonstrated consistently positive outcomes. Positive outcomes have been achieved in scientifically controlled settings *or* routine care settings- not both.
3. Modified from Level I or II practice and applied in a setting or for a population that differs from the original practice.

II. Evidence-Based Practices

A. Why “evidence-based practices?”

1. Governmental organizations at the national level have endorsed the importance of evidence-based practices and programs (National Advisory Mental Health Council, 2001; President’s New Freedom Commission on Mental Health, 2003; U.S. Public Health Service, Office of the Surgeon General, 1999; 2004).
2. Family advocacy groups and patient organizations have become increasingly vocal in advocating for interventions that produce good outcomes plus youth and family satisfaction with the care provided.

B. Resources

1. There are over 800 outcome studies on prevention and health and 250 more on drug abuse prevention. www.effectivechildtherapy.com.
2. The evidence-base for universal prevention indicates addressing drug use, pregnancy, child maltreatment, and health promotion are well documented in the literature. www.oslc.org/spr/apa/summaries.html
3. http://preventionpathways.samhsa.gov/mrepp/adv_search.cfm
4. Web site for the National Registry of Effective Programs and Practices (see www.mentalhealth.samhsa.gov) shows that 91% of those (prevention) programs (i.e., 58 of the 64 programs listed) identify multiple ethnic groups as their target population.
5. http://www.cimh.org/downloads/multicultural/Final%20Summary%20Matrix%2009-15-05%20v%201%20_2_.pdf

- C. Important Features of Effective Family Intervention Programs** (Oregon Research Institute, 2005)
1. Skill-building as an explicit focus, not just education, knowledge, discussion, or support
 - a. Includes skill practice, role-playing, videotaped models, and home practice.
 2. Interactive and collaborative approach, rather than didactic.
 3. Focus on social learning principles, not just parenting strategies.
 4. Explicit education and support related to other issues, including marital adjustment and problem solving.
 5. Start early and capitalize on natural transitions, which are times of opportunity and vulnerability (e.g., birth, preschool).
 6. Build skills in effectively managing children's behavior.
 7. Monitor and supervised activities.
 8. Consistent discipline.
 9. Build positive parent-child relationships.
 10. Self-control for parents.
 11. Consistent parenting between parents.
- D. Examples of programs for Youth (See Attachment A-B)**
- E. Example of programs for Young Adults (See Attachment C-D)**
1. Focus on transitional periods.
 - a. High school to college (e.g., first psychotic break often occurs around age 18 for males).
- F. Older Adults**
1. Example: Prevent alcohol or drug use that would be inappropriate based on the person's condition (e.g., chronic illness such as diabetes, use of medications that interact with alcohol, past problems with alcohol).
 2. Retirement.

III. Implementation examples from other states

- A. Oregon** State legislates the use of evidence-based intervention.
1. In 2003 Oregon legislators adopted a law requiring the state Office of Mental Health, Addiction Prevention Services, Department of Corrections, Oregon Youth Authority, the State Commission on Children and Families, and the Oregon Criminal Justice Commission, to demonstrate that set percentages of their program dollars support evidence-based approaches.
 2. Starting July 1, 2005- The state behavioral health agency will have to show that at least 25% of its program funding supports evidence-based programs; 50% (beginning July 1, 2007), and at least 75% (July 2009 and beyond).
- B. New York** (Noyes-Grosser, et. al, 2005)
1. New York State Department of Health sponsored science-based practice guidelines for children younger than 3 with developmental conditions most often seen in the state's Early Intervention Program.
 2. Guidelines target audience- parents, professionals providing early intervention services, local Early Intervention Program administrators, and primary healthcare professionals.
- C. Illinois-**
1. Developed guidelines for high quality programs for 0-3 age group.
(See Attachment E)

2. Integrate PBIS and Wraparound
 - a. Integrate Wraparound philosophy with Positive Behavioral Interventions and Support in all three-tiers: Universal, Targeted, and Intensive Prevention.
 - b. Emphasis on using data to make decisions.
- D. Iowa** – Iowa Behavioral Alliance
 1. Partnership between the Iowa Dept. of Education, Universities, Iowa Federation of Families for Children’s Mental Health, and other community agencies.
 2. Implemented Positive Behavioral Interventions and Supports (PBIS) in schools and juvenile hall and integrated wraparound planning process for high-end youth.
 3. Outcomes:
 - a. All Iowa children and youth are healthy and socially competent.
 - b. All Iowa children and youth succeed in school, and are prepared for productive adulthood.
 - c. All youth have the benefit of safe and supportive families, schools, and communities.
- E. Washington** – University of Washington, Children’s Hospital/Medical Center, Seattle Public Schools (Vander Stoep, A., et. al, 2005)
 1. Universal School-Based “Emotional Health Check-Up” – Universal approach to screen middle school age youth for “emotional distress”.
 2. Based on results, child/family linked to school counselor, academic support, after school activities, and/or community mental health treatment.
 3. Funding by AETNA Foundation, NIMH, Don Loeb Family.

IV. Collaborative systems

- A. Finding terminology that will encourage cooperation between systems.
 1. “Social emotional competencies” versus “mental health”
- B. Integrating funding and policies.
 1. State Commission (e.g., First 5 and MHSA).
 2. Work with insurance companies to support prevention efforts.
- C. Coordination and partnership between different systems.
- D. Training.
 1. Mentoring and coaching.
 2. Technical assistance
 - a. Collaborate with universities, California Institute of Mental Health.
 3. Supervision
- E. Goodness of fit between policies, practices, and consumers.
- F. Systems-approach versus program-approach.
 1. Fragmented policies lead to fragmented practices.
 2. Health promotion/positive development strategies target an *entire population*, with the goal of enhancing strengths so as to reduce the risk of later problem outcomes and/or to increase prospects for positive development.
 3. Focus on transition periods (e.g., elementary to middle school to high school to college or workforce, parenthood, retirement).

V. Current Efforts in California

A. First 5 Commission

1. Coordinate overlapping efforts with First 5 Commission for the 0-5 age group. **(See Attachment F)**
 - a. School readiness.

B. Behavioral, Developmental, and Emotional Screening and Treatment by Primary Care Providers in Medi-Cal Managed Care (BEST PCP).

1. An example of the integration of PCP and Behavioral/Mental Health.
2. Collaborative effort between California Dept of Health Services and Mental Health in cooperation with California First Five Commission, Other CDHS programs (Maternal and Child Health Branch, Child and Health Disability Prevention Program, Health Care Program for children in Foster Care, and Children's Services); Dept of Developmental Services (EI Program); Education; Social Services; the American Academy of Pediatrics California Chapter; the California Institute of Mental Health; and other project consultants.
3. Project Overview: Two-tiered project to address access to and the delivery of appropriate care that addresses the social emotional development of children ages 0-3 as well as the governmental agency with the responsibility for delivering care.
 - a. Clarify various agency responsibilities for mental health and developmental services for young children enrolled in Medi-Cal managed care.
 - b. Identify policy and service delivery changes needed to improve access, provision, and funding of infant mental health and developmental services.
 - c. Develop and implement a quality improvement project in primary care practices in two counties. The collaborative will seek to improve the identification of at-risk kids, increase the use of existing services, and improve referral and coordination of care for young children in need of more intense services. In particular, the local pilots (Alameda and Inland Empire) will implement screening tools, develop service algorithms and local resource guides, create and promote the use of training curricula and tool kits, and establish measurement criteria in conjunction with project's consultants and an inter-agency work group.

C. Riverside County: Riverside Youth Crime Prevention Red Team (2001)

1. Developed a strategic plan for youth violence prevention in the City of Riverside.
2. Example of Recommendations:
 - a. Create a Joint City/County Community Youth Crime Prevention Team that:
 - a) is responsible for implementation of the Youth Crime Prevention Strategic Plan, Goals, and Action Strategies noted in their report;
 - b) Foster partnerships/collaborations;
 - c) ensures coordination among service providers
 - b. Coordinate services for youth 0-10 and their families by establishing case management teams that can share information, ensure a continuum of service and maximize resources.
 - c. Significantly increase the availability of quality child care and Head Start programs.
 - d. Expand the Nurse Visitation Program to include all newborns and their families.
 - e. Expand mental health services availability to children with mental health problems and provided needed support services to their families.
 - f. Enhance school-readiness, which includes social, physical, and emotional well-being and early literacy.

D. Early Mental Health Initiative (EMHI) Statewide Evaluation

1. Based on the School-Based Early Mental Health Intervention and Prevention Services for Children Act: “It is in California’s best interest, both in economic and human terms, to identify and treat minor difficulties that our children are experiencing before those difficulties become major barriers to alter success” (Welfare and Institutions Code, Section 4371.e.).
2. Evaluated short-term, research-based interventions for kindergarten through third grade public school students who were experiencing mild-to-moderate school adjustment difficulties.
3. In FY 2002-03, California Dept of Mental Health awarded 206 EMHI grants to fund services in 496 schools across 113 districts for over 20,000 students.
4. Programs were designed to address:
 - a. Social and emotional development.
 - b. Likelihood that these students will succeed in school.
 - c. Personal competencies related to life success.
 - d. Minimize need for more intensive and costly services as students grow older.
5. Results: Students participating in EMHI-funded services exhibited positive social competence and school adjustment behaviors more frequently and these improvements were maintained two-years following the intervention.

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Attachment A
Examples of Evidence-Based Prevention and Early Intervention Services

Programs with STRONG Evidence-Based

Author/ Founder/ Contact	Practices for Early Intervention	Intervention Focus	Age Group	Location	Evidence- Based	Exemplary Award
Andrea S. Taylor, Ph.D.	Across Age	School and Community-Based Drug Prevention	9 to 13	Philadelphia, PA	Yes	
Craig Ramey, Ph.D.	Carolina Abecedarian Project Care	At-Risk Families with Infants	0 to 5	North Carolina	Yes	
Judith A. Cohen, M.D.; Anthony P. Mannarino, Ph.D.	CBT for child and Adolescent Traumatic Stress (CBT-CATS)	Children Exposed to Traumatic Stress	3 to 18	Nation-wide	Yes	Yes
Esther Deblinger, Ph.D.	CBT for Child Sexual Abuse (CBT-CSA)	Children Exposed to Sexual Abuse	3 to 18	Nation-wide	Yes	Yes
Kerby T. Alvy, Ph.D.	CCIC's Effective Black Parenting	Parent Training	2 to 12	Los Angeles, CA	Yes	
Dr. Lorraine Sullivan, Founder; Arthur J. Reynold, P.I.	Chicago Child-Parent Centers	Child & Parenting Support for At-Risk Youth	3 to 9	Regional (West)	Yes	
Donald Gordon, Ph.D.; Jack Arbuthnot, Ph.D.	Children in the Middle	Child & Family Centered	3 to 15	Nation-wide	Yes	
Lisa H. Jaycox, Ph.D.	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	Reduce Children's Symptoms of Posttraumatic Stress Disorder	10 to 14	Los Angeles, CA	Yes	
Jan Miller-Heyl, M.S.	Dare To Be You (DTBY)	Child, Family, School, & Community	2 to 5	Nation-wide	Yes	Yes
Heidelise Als, PhD	Developmentally Supportive Care: Newborn Individualized Developmental Care and Assessment Program (NIDCAP)	Pre-natal and Low- Birth weight Infants	0 to 5	Nation-wide	Yes	
Gerald J. August, Ph.D.	Early Risers: Skills for Success	Children of High- Risk for Substance Use & Early Development of Conduct Problem	6 to 10	Minneapolis, MN	Yes	
Lynn McDonald, Ph.D., M.S.W.	Family Access to Stabilization and Teaming (FAST)	Family-Focused for Children with Family Crisis	4 to 12	Nation-wide	Yes	Yes
Hill Walker, Ph.D.	First Step to Success	Child-Centered	Pre-K thru 5	Nation-wide	Yes	Yes

**Examples of Evidence-Based Prevention and Early Intervention Services
Programs with STRONG Evidence-Based**

Author/ Founder/ Contact	Practices for Early Intervention	Intervention Focus	Age Group	Location	Evidence- Based	Exemplary Award
Sheppard G. Kellam	Good Behavior Game	Children with Early High-Risk Behavior	Pre-K to Adolescent	Baltimore, MD	Yes	Yes
Heather B. Weiss, Ed.D.	Harvard Family Research Project	Family-Youth-Community Partnership	Unspecified	Harvard	Yes	
Dr. Emily Vargas Baron, P.I.	Healthy and Fair Start/CE DEN	At-Risk Pregnant Women	0 to 12	Regional	Yes	
Phyllis Kikendall, Primary Contact; Lori Friedman, HFA Research Liason	Healthy Families America	Family-Focused for Prevention of Negative Birth Outcomes	0 to 12	Indiana	Yes	
Robert J. McMahon, Ph.D.	Helping the Noncompliant Child	Parent-Training for Children with Conduct Problems	3 to 8	Nation-wide	Yes	Yes
Elisabeth Eklind, Executive Director of HIppY USA; M. Gayle Hart, National Program Director	Home Instruction for Parents of Preschool Youngsters (HIppY)	Educational Support for Child and Parent Training	3 to 5	International	Yes	
Charlotte Booth, Executive Director; Shelley Leavitt, Ph.D., Asst. Director	Homebuilders	Family-Focused	0 to 18	Federal Way, WA	Yes	
Dale L. Johnson, Ph.D.	Houston Parent-Child Development Programs	Children from Low-Income, Hispanic Families	2 mo to 3 yrs	Houston, TX	Yes	Yes
Michael L. Hecht, Ph.D; Flavio Francisco Marsiglia, Ph.D; Patricia Dustman, Ed.D.	keepin' it REAL	Children of High-Risk for Substance Use	10 to 17	Tempe, AZ	Yes	
Susan Keister, M.A.; Michael Buscemi, M.Ed.	Lions-Quest Skills for Adolescence	Developmental Needs	10 to 14	Nation-wide	Yes	
Howard A. Liddle, Ed.D.	Multidimensional Family Therapy (MDFT)	Family -Centered	11 to 18	Nation-wide	Yes	
David Olds, M.D.	Nurse-Family Partnership (NFP)	At-risk First Time Mothers	Pre-Natal	Nation-wide	Yes	

**Examples of Evidence-Based Prevention and Early Intervention Services
Programs with STRONG Evidence-Based**

Author/ Founder/ Contact	Practices for Early Intervention	Intervention Focus	Age Group	Location	Evidence- Based	Exemplary Award
Dan Olweus; Reidar Thyholdt; Marlene Snyder, Ph.D.	Olweus Bullying Prevention	School Based Program to Prevent Bullying	6 to 15	Nation- wide	Yes	
David Weikart, Ph.D.	Perry Preschool *	Education for Children with Family-Support	3 to 4	Nation-wide	Yes	Yes
Phyllis L. Ellickson, Ph.D.; G. Bridget Ryan	Project ALERT	Reduce the Onset and Use of Substances	11 to 14	State-wide	Yes	
Cheryl Perry, Ph.D.	Project Northland	Behavioral and Environmental Change	10 to 14	State-wide	Yes	
Lori A. Post, P.I.; Chris Maxwell, P.I.; Carol Burton, Program Director	Project SEEK	Children with Parents in Prison	0 to 11	Nation-wide	Yes	
Ellen Morehouse	Project SUCCESS	Children of High - Risk of Substance Use	14 to 18	State-wide	Yes	
Steve Sussman, Ph.D.; Stephen Stephen Hauk	Project Towards No Tobacco Use (TNT)	Classroom-Based	10 to 15	State-wide	Yes	
Myrna B. Shure, Ph.D.	Raising A Thinking Child: I Can Problem Solve*	Parent-Child Interpersonal Cognitive Problem Solving Skills	4 to 12	Philadelphia, PA	Yes	Yes
Ann Standing	Safe Dates	School-Based	12 to 18	State-wide	Yes	
Chudley E. Werch, Ph.D.; Paula Jones	Start Taking Alcohol Risks Seriously (STARS) for Families	Children at Risk of Alcohol Use	11 to 14	Unspecifie d	Yes	
Susan K. Chase; Cindy Coney	Too Good For Drugs (TGFD)	School-Based	5 to 18	State-wide	Yes	

**Examples of Evidence-Based Prevention and Early Intervention Services
Programs with GOOD Evidence-Based**

Author/ Founder/ Contact	Practices for Early Intervention	Intervention Focus	Age Group	Location	Evidence- Based	Exemplary Award
William Hansen	Adolescent Alcohol Prevention Trial	Prevent the Onset of Adolescent Drug Use	13 to 17	Los Angeles, CA	Yes	
Dr. Teresa LaFromboise, Ph.D	American Indian Life Skills Development	Suicide Prevention Curriculum for American Indian Adolescents	13 to 18	State-wide (Oklahoma)	No	
Dr. JoAnn Pedro-Carrol, Ph.D.	Child of Divorce Intervention Program (CODIP)	School-Based Support Group using a Curriculum to Enhance Adjustment to Divorce	5 to 13	State-wide (New York)	Yes	
Lisa H. Jaycox, Ph.D	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	Reduce Children's Symptoms of Posttraumatic Stress Disorder	10 to 14	Los Angeles, CA	Yes	
Lynne Shanafelt, Managing Dir.; Tim Speth, Research Assoc.	Early Childhood Education and Assistance Program (ECEAP)	Children from Low-Income Families	3 to 4	State-wide (Washington)	Yes	
Susan Gray	Early Training Project	Low-income African American Children	3 to 4	Regional (New England)	Yes	
Bruce Payette, Ph.D	East Texas Experiential Learning Center	Reduce Multiple Risk Factors	12 to 13	State-wide (Texas)	No	
Melody Powers Noland, Ph.D., CHES	Kentucky Adolescent Tobacco Prevention Project	High-Risk group who live in Tobacco-Raising Areas	13 to 14	State-wide	Yes	
Minalee Saks	Make Parenting A Pleasure	Parent-Training	0 to 8	Eugene, OR	Yes	
Ethel Seiderman, M.A.	Parent Services Project	Family-Centered Support	No Age Specified	Bay Area	Yes	
Missouri Educators Founded; Sue Stepleton, CEO	Parents as Teachers (PAT) *	Family-Focused	Pre-Natal to 5	Nation-wide	Yes	

**Examples of Evidence-Based Prevention and Early Intervention Services
Programs with GOOD Evidence-Based**

Author/ Founder/ Contact	Practices for Early Intervention	Intervention Focus	Age Group	Location	Evidence- Based	Exemplary Award
Jeremy P. Shapiro	Peacemakers	Curriculum- Based Violence Prevention Program	9 to 14	State-wide	Yes	
Dr. Howie Knoff	Project ACHIEVE	Child-centered School Achievement	Pre-K to Middle School	Regional (South)	Yes	
Mary Ann Pentz, Ph.D.; Karen Bernstein, MPH	Project STARS/Midwestern Prevention Project	Reduce the use of Cigarettes, Alcohol, and Marijuana Among Adolescents	12 to 14	State-wide (Kansas City)	Yes	
Richard Clayton, Ph.D	Rural Educational Achievement Project (REAP)	Multilevel Approach to Prevention that involves a Universal Prevention Program	9 to 10	Lexington, KY	No	
Sherryl Kraizer, Ph.D.	Schools and Families Educating Children (SAFE Child Program)	Child & Family Centered	1 to 12	Denver, CO	Yes	
Jennifer James, Committee for Children	Second Step Violence Prevention	Child-Centered	4 to 14	Nation-wide	Yes	
John Elder, Ph.D; M.P.H.	Sembrando Salud	Tobacco and Alcohol-Use Prevention for migrant Hispanic Adolescents	11 to 16	San Diego, CA	Yes	
Alice S. Honig, Ph.D.	Syracuse Family Development Research Program (FDRP)*	Parent-Child for Low-Income, Single-Parent, African Amer.	5 to 10	Regional	Yes	Yes

Attachment B
Evidence-Based Programs for Youth References

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<http://www.helpingamericasyouth.gov>

- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- East Texas Experiential Learning Center
- Get Real About Violence
- Raising a Thinking Child: I Can Problem Solve
- Sembrando Salud
- Syracuse Family Development Research Program (FDRP)

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- Chicago Child-Parent Centers

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- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- Family Access to Stabilization and Teaming (FAST)
- Kentucky Adolescent Tobacco Prevention Project
- Lions-Quest Skills for Adolescence
- Project ACHIEVE
- Project STAR: Students Taught Awareness and Resistance
- Project SUCCESS
- School Violence Prevention Demonstration Program
- Schools and Families Educating Children (SAFE Child Program)
- Sembrando Salud
- Smoking Prevention Mass Media Intervention
- Start Talking Alcohol Risks Seriously (STARS) for Families
- Too Good For Drugs (TGFD)

<http://www.oslc.org/projects.html>

- Linking the Interests of Families and Teachers (LIFT)

<http://www.personal.psu.edu/dept/prevention/CODIP.htm>

- Children of Divorce Intervention Program (CODIP)

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Attachment C
Examples of Evidence-Based Prevention and Early Intervention Services for Adults
Programs with STRONG Evidence-Base

Author/ Founder/ Contact	Practices for Early Intervention	Intervention Focus	Age Group	Location	Evidence- Based
G. Alan Marlatt, Ph.D.; John S. Baer	BASICS: Brief Alcohol Screening and Intervention for College Students	At Risk for Alcohol-related Problems	18 to 24	Seattle, WA	Yes
James Baker; Kim Herbstritt; Robert Voas, Ph.D.	Border Binge- Drinking Reduction	Reducing Alcohol-Related Trauma	24 and under	San Diego & Baja, CA	Yes
Koreen Johannessen; Carolyn Collins, MS	Challenging College Alcohol Abuse	Reduces High-Risk Drinking	18 to 24 and parents	Tucson, AZ	Yes
David L. Snow, Ph.D.; Susan O. Zimmerman, LCSW	Coping with Work and Family Stress	Developing Effective Coping Strategies	18 to 65+	New Haven, CT	Yes
Royer F. Cook, Ph.D.; Rebekah Hersch, Ph.D.; Joel Bennett, Ph.D.	Healthy Workplace	Addresses Unsafe Drinking, Illegal Drug Use, Prescription Drug Abuse & Develop Healthy Lifestyles	18 to 55+	Nation-wide	Yes
Richard H. Price, Ph.D.; Amiram Vinolcur Ph.D.	JOBS	Promoting Reemployment	18 to 65	International	Yes
Joel B. Bennett, Ph.D.; Wayne E.K. Lehman, Ph.D.	Team Awareness (for the Workplace)	Behavioral Risks with Substance Abuse Among Employees	18 to 55+	Fort Worth, TX	Yes
Max A. Heirich, Ph.D.	Wellness Outreach At Work	Risk-Reduction Services to Employees	25 and older	State-wide (Michigan)	Yes
Edna B. Foa, Ph.D.; Elizabeth A. Hembree, Ph.D.; David S. Riggs, Ph.D.	Prolonged Exposure (PE) Therapy for Posttraumatic Stress	Individuals Suffering from PTSD	18 to 70	International	Yes

**Examples of Evidence-Based Prevention and Early Intervention Services for Adults
Programs with GOOD Evidence-Base**

Author/ Founder/ Contact	Practices for Early Intervention	Intervention Focus	Age Group	Location	Evidence- Based
Bess Marcus, Ph.D	Commit to Quit	Handling Stress, Goals, Expectations, and a Path toward Quitting	Women 18 to 65	State-wide	Yes
Herbert H. Severson, Ph.D.	Enough Snuff	Self-Help Tobacco-Use Cessation Program designed for Smokeless Tobacco Users	Men 15 to 65	Nation-wide	Yes
Michael Goldstein, M.D.	Physicians Counseling Smokers	Increase Physicians' Adoption of and Effectiveness at Delivering Smoking Cessation Strategies to their Parents	Unspecified	State-wide	Yes

Attachment D
Evidence-Based Programs for Adults: References

<http://www.ilir.umich.edu/wellness/aboutus.html>

- Wellness Outreach At Work

<http://modelprograms.samhsa.gov>

- Border Binge-Drinking Reduction Program
- Challenging College Alcohol Abuse
- Coping with Work and Family Stress
- Healthy Workplace
- Prolonged Exposure Therapy for Posttraumatic Stress
- Commit to Quit
- Enough Snuff

BASICS: Brief Alcohol Screening and Intervention for College Students: Dimeff, L.A., Baer, J.S., Kivlahan, D.R., & Marlatt, A.G., (2002). Brief alcohol screening and intervention for college students (BASICS): A harm reduction approach. *Journal of Psychiatry & Law*, 30(2), 275-278.

Commit to Quit: Marcus, B.H., King, T.K., Albrecht, A. E., Parisi, A.F., & Abrams, D.B. (1997). Rationale, design and baseline data for commit to quit: An exercise efficacy trial for smoking cessation among women. *Preventive Medicine: An International Journal Devoted to Practice and Theory*, 26(4), 586-597.

Enough Snuff: Severson, H.H., Akers, L., Andrews, J.A., Lichtenstein, E., & Jerome, A. (2000). Evaluation two self-help interventions for smokeless tobacco cessation. *Addictive Behaviors*, 25(3), 465-470.

JOBS Program: Vinokur, A.D., VanRyn, M., Gramlich, E.M., & Price, R. H. (2001). Long-term follow-up and benefit-cost analysis of the jobs program: A preventive intervention for the unemployed. *Journal of Applied Psychology*, 76(2), 213-219.

Physicians Counseling Smokers: Park, E.R., DePue, J.D., Goldstein, M.G., Niaura, R., Harlow, L.L., Willey, C. & et al. (2003). Assessing the transtheoretical model of change constructs for physicians counseling smokers. *Annals of Behavior Medicine*, 25, 120.

Team Awareness (for the Workplace): Bennett, J.B., Lehman, W.E.K., & Reynolds, S.G. (2000). Team awareness for workplace substance abuse prevention: The empirical and conceptual development of a training program. *Prevention Science*, 1(3), 157-172.

Attachment E
Illinois Proposed Framework for High Quality Prevention Services

Modified version. Guidelines adapted by the Illinois Early Learning Council 0-3 Program Quality & Quality Assurance Workgroup.

I. Guidelines for High Quality Programs

Program models implemented must be those that are based in research and have shown to improve outcomes for at-risk infants, toddlers, and their families. The models should address the following principles, parameters and best practices:

A. Program Principles of High Quality Programs (for children birth to five and their families):
Focused on prevention and promotion of optimal well-being. Programs shall support the promotion of early learning and of health and well-being in the child, parents and family in order to prevent, detect, and address problems at their earliest stages.
Family-centered. Staff and families shall work together in relationships based on respect, and the program shall build on family strengths and support parents as the primary nurturers, educators, and advocates for their children.
Intensive and comprehensive. Programs shall offer services of sufficient intensity and comprehensiveness to meet families' needs.
Individualized. Programs shall be flexible enough to meet the needs of individual family members and children.
Relationship-based. Programs shall support and enhance strong, caring relationships which nurture the child, parents, family and care-giving staff, maintaining relationships with caregivers over time and avoiding the trauma of loss experienced with frequent turnover of key people in the children's life.
Culturally competent. Programs shall demonstrate an understanding of, respect for, and responsiveness to the home culture and home language of every child.
Community-based. Programs should be embedded in their communities and contribute to the community-building process.
Voluntary. Services are offered on a voluntary basis.
Accessible. Services are provided in a way that overcomes potential barriers to participation, such as lack of English proficiency, lack of transportation, and need for non-traditional service hours.
Well coordinated. Service providers should regularly communicate and coordinate their services on behalf of individual families such that families who receive multiple services or who participate in multiple programs should experience a comprehensive system of services.

B. Parameters

The specific “best practices” will be determined by the program goals. Structure and activities should be linked to expected outcomes and through a “logic model” that is developed for each program. The logic model should include long-term expected outcomes, shorter-term measurable indicators of participant outcomes (including a plan for when and how to measure these indicators), and a description of program activities that are expected to lead to these outcomes. The logic model must be regularly reviewed and updated to reflect current program realities and used to continually improve service provision.

The parameters of a program that should be addressed in a logic model include:

- Target population (who will be served by program)
- Array of services and programs that families will have access to
- Coordination with other services, including outside agencies
- Method and timing of assessment
- How appropriate services will be matched to participant need
- Intensity of services (frequency, duration)
- Staff disciplines, qualifications and training
- Caseloads for staff
- Supervision for staff

C. Common Best Practices

There are nine best practices identified in the literature that are applicable to all programs and service systems:

1. **Methods and approaches** – The curriculum or approach chosen must reflect the centrality of adult/child interactions in the development of infants and toddlers and the holistic and dynamic nature of child development. The approach should support and demonstrate respect for families’ unique abilities as well as their ethnic, cultural, and linguistic diversity. The approach must address all domains of infant and toddler development including, but not limited to, physical, social, emotional, and cognitive development.
2. **Periodic assessment** - As infancy and early childhood are times of such rapid growth and development, assessments (or screenings) must be completed at regular intervals to ensure that children and families are receiving appropriate services.
3. **Inclusion of parents/other family members** - As infants and toddlers are profoundly influenced by their parents and other family members, all services should include their families.
4. **Transition planning** – Transitions (e.g., from hospital to home, from a prevention program into a more intensive intervention program or from a program for birth to five years into kindergarten) must be carefully planned to ensure continuity of services for the child and family.
5. **Staff knowledgeable about very young children** – Birth to five prevention services must be provided by staff who are knowledgeable about infant and toddler development and who are experienced in working with children this age and their families.
6. **Staff supervision and training** – Staff who work with very young children and their families must be provided adequate supervision and on-going training opportunities in this rapidly developing and changing field.
7. **Multidisciplinary coordination** – Services (and assessments) must be provided in a coordinated fashion (for families involved with more than one service provider).

8. **Staff/family ratios** – Staff must have reasonable caseloads or class sizes to devote adequate time to planning and building strong relationships with children and families.
9. **Intensity of services** – Services must be offered on an intensive basis to meet the needs of at-risk families and with increasing or decreasing frequency as appropriate to meet the changing needs of families.

II. **Four Approaches for Service Expansion and Improvement**

Based on demonstrated community needs and demonstrated competence in delivering programs and services to families with infants and toddlers, entities should aim to accomplish one of the following:

1. Increase availability of high quality prevention programs and services (increase the number of spaces in existing programs using research-based models described below).
2. Raise the quality of existing early childhood programs and services to meet standards outlined in nationally recognized research-based, high quality models (described below).
3. Provide enhanced services to children and families through existing high quality programs already implementing a research-based model.
4. Pilot and evaluate innovative model programs, with basis in research, for expecting parents, infants, toddlers, and their families.

III. **Administration and Infrastructure**

The following recommendations are to ensure that attention to program quality is built into the foundation from program inception and quality is continually and consistently maintained and improved.

A. **Monitoring, Training, Technical Assistance, & Consultation**

In order to make the best use of scarce resources, program should use and build on the existing infrastructure and systems of monitoring, training, and support for infant and toddler services.

- There will be **appropriate staff** within the governance structure to coordinate with existing entities to monitor, train, and provide technical assistance.
- **Funding will be allotted for program start-up** for one-time costs that are incurred as agencies initiate new services.
- More **intensive technical assistance** should be available to new programs just beginning to implement approved program models with intensity decreasing over time so that as new programs are funded they can receive this intensive assistance.
- **Program quality/compliance** - Programs must meet standards outlined in this framework. Programs found to be non-compliant will be put on probation and will receive additional technical assistance to create and implement corrective actions within a specified time frame. Programs not implementing corrective actions in a timely manner will be de-funded.

B. **Resource Development**

- A system should be developed for addressing resource development in communities with great need, but lacking in quality resources or providers.

