

Empirically-Supported Interventions in School Mental Health

**Center for School Mental Health Assistance
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EMPIRICALLY-SUPPORTED INTERVENTIONS IN SCHOOL MENTAL HEALTH

Introduction

There is a national movement in children's mental health services towards using interventions that have research support for their effectiveness. The reasons for this movement are several. First, there is finally now a convincing body of research demonstrating that effective treatments for certain child and adolescent mental disorders exist. Second, in many settings, the number of sessions allocated for child mental health treatment is limited due to managed care pressures, forcing providers to administer the most effective treatments possible in the least amount of time. Finally, many mental health providers are concerned about the ethics of delivering treatments to children without some evidence that the interventions work.

What does it mean for a particular treatment to be "empirically-supported?" Although there are some discrepancies between scholars as to what the exact criteria should be, all have agreed that in order for a treatment approach to be considered "empirically supported," several things must be true. First, much like the procedure for new drugs being approved for the market, the treatment needs to have undergone several clinical trials in which they were showed to be superior to either no treatment at all or another possible treatment. The gold standard is for the treatment to have been demonstrated effective using a research design including random assignment to the treatment versus no/alternative treatment condition, which virtually ensures that the people served in each treatment condition are equivalent before being treated. In addition, it is also important that the treatment be demonstrated to be effective by someone other than the person(s) who developed the treatment. The American Psychological Association (APA) has created two categories to describe different types of effective treatments: an empirically-supported treatment is one with at least 2 clinical trials using random assignment and at least one trial by someone other than the developer; and a probably efficacious treatment is one with at least 2 less well-controlled clinical trials or trials only by the developer of the treatment. These categories are widely accepted in the field of children's mental health services and will be used throughout this text.

Efforts to Promote the Use of Empirically-Supported Interventions

Many national organizations concerned with children's mental health have reviewed the research pertaining to interventions and have developed lists of approaches that they consider to be effective for various disorders. The goal of these lists is to promote the use of effective treatments by practitioners, administrators, and policy makers. As mentioned above, the APA has been a leader in this effort, particularly Division 12, Section 1 (Child-Clinical Psychology). Other organizations, such as the Institute of Medicine, the Office for Juvenile Justice and Delinquency Prevention (OJJDP), and the Society of Pediatric Psychology, also have weighed in with their choices. The following is a list of the major national dissemination initiatives (i.e., a "list of the lists") for both prevention and treatment approaches:

- American Psychological Association, Division 12 (clinical), Section 1 (child-clinical). Special issue of the Journal of Clinical Child Psychology reviewing effective treatments: 1998, Volume 27 (2); guest editors C.J. Lonigan & J. C. Elbert.
- Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services Administration (SAMHSA): Model Programs for Substance Abuse Intervention. For more information, contact their website: <http://www.samhsa.gov/centers/csap/modelprograms>.
- Collaborative for Academic, Social, and Emotional Learning (CASEL): Reviews universal and selected prevention programs for social and emotional learning (SEL). For more information, contact their website: <http://www.casel.org>.
- Institute of Medicine (IOM) report: Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research (1994; edited by Patricia J. Mrazek & Robert J. Haggerty). Reviews effective preventive interventions across the lifespan. Executive summary of report available for free by writing: Institute of Medicine, Committee on Prevention of Mental Disorders, 2101 Constitution Ave. NW, Washington, DC 20418; full volume available for sale at National Academy Press, 2101 Constitution Ave. NW, Box 285, Washington, DC, 20055 or call (800) 624-6242. You can also read the report at the IOM website: <http://www.iom.edu/> (click on “recent reports”, then scroll down to 1994).
- Office for Juvenile Justice and Delinquency Prevention: Blueprints for Violence Prevention (1998). Sponsored in conjunction with the Center for the Study and Prevention of Violence (CSPV) at the University of Colorado (Director: Delbert Elliott, Ph.D.). Treatments and preventive interventions to address youth aggressive and violent behavior. For more information, contact their website: www.colorado.edu/cspv/blueprints/
- Society of Pediatric Psychology, Special issue of the Journal of Pediatric Psychology reviewing effective psychosocial treatments for pediatric conditions: 1999, Volume 24 (2).

Some good books reviewing this issue that you may also find helpful:

- Christopherson, Edward R. & Mortweet, Susan L. (2001). Treatments that work: Empirically supported strategies for managing childhood problems. Washington, DC: American Psychological Association. Available at the APA website: <http://www.apa.org>.
- Durlak, Joseph A. (1995). School-based prevention programs for children and adolescents. Thousand Oaks, CA: Sage. Available at the Sage Publication website: <http://www.sagepub.co.uk>

Relevance of Empirically-Supported Interventions for School Mental Health Programs

Like any other setting that delivers child and adolescent mental health services, school mental health programs (SMHPs) should be concerned about providing the best interventions possible for the youth they serve. By bringing services to youth in a nonthreatening, naturally occurring setting where many mental health problems are expressed, treatments delivered through SMHPs have the potential to be more effective than those delivered in outpatient clinic settings. However, having a highly innovative and effective *model of service delivery* is not enough to meet youth's mental health needs. We also need to ensure that the *actual interventions* children receive in this setting are as effective as they can be. For many mental health conditions, the research literature can inform SMHP clinicians as to the most effective interventions for youth. Knowledge of empirically-supported interventions can help clinicians make the best decisions as to effective school-wide prevention activities as well.

Review of Empirically-Supported Treatments for Various Disorders

Introduction

The CSMHA has reviewed the literature on empirically-supported interventions for children and adolescents and has developed its own list of treatments that we feel can be adapted for use within SMHPs. We have developed this list by reviewing the treatment approaches identified by the national dissemination initiatives mentioned above and determining what treatments could be delivered within a typical SMHP setting. *The list of treatments below is by no means a comprehensive list of all treatments available for a particular disorder.* Many highly effective interventions, such as home-based family therapies, have been excluded from this list because their method of service delivery is not compatible with most school settings. Readers who are interested in the full range of empirically-supported interventions available to youth should consult the resources provided above.

In addition, it should be noted that not every condition or problem that youth experience has been linked to an empirically-supported intervention. In some cases, effective treatments exist for a particular disorder for youth of a certain age but not for older or younger youth. In other cases, youth's presenting problems are complicated and involve comorbid (i.e., more than one diagnosis) conditions, making it difficult to choose a single empirically-supported approach. Clinicians always need to use empirically-supported interventions in ways that are compatible with their own judgement about a particular case. At the very least, it is hoped that an understanding of the types of approaches that are effective for various conditions can inform this clinical judgement and decision making.

What kinds of treatments are reviewed? The vast majority of the child and adolescent treatments that have received empirical support involve behavioral or cognitive-behavioral interventions. Interventions such as play therapy, insight-oriented talk therapy, or supportive counseling may be of some value to youth with certain problems

or under certain circumstances, but as of now the evidence to support these kinds of treatments is limited at best. This is due in part to the fact that unlike behaviorism, other models of therapy have not been concerned with testing their interventions scientifically. Hopefully, this movement towards “doing what works” will lead to a more rigorous testing of nonbehavioral approaches so that they will begin to be promoted as empirically-supported as well. In the mean time, SMHP clinicians should consider whether or not it is justifiable to deliver untested treatments to youth when more effective approaches exist.

How can I learn how to deliver empirically-supported treatments? Most of the interventions reviewed here and elsewhere have treatment manuals that thoroughly explain how the approach should be implemented. If you have a background in cognitive-behavioral interventions, you will find that most of the manuals combine techniques commonly used by behavior therapists, such as self-monitoring, contingency management, skills training, or rehearsal, in ways that are most beneficial to address a particular problem. If you do not have a background in cognitive-behavioral interventions, most of the manuals provide enough detail that the clinician can usually administer the intervention. It is NOT necessary to have a strong cognitive-behavioral background to administer these treatments!

In the review that follows, we have included a web link or contact information for learning more about each treatment. We have tried to provide advice about how a clinician would go about obtaining and implementing each treatment. Interventions vary in how complicated they are to implement, ranging from simply printing out the manual/curriculum from the internet to contracting with the developer for in-depth training. Clinicians who want training or materials for a particular approach should discuss with their program administrators how to obtain them.

Treatments for Internalizing Disorders: Anxiety and Depression

To date, the treatments that have been demonstrated to be effective with anxious and depressed youth all involve cognitive-behavioral therapy (CBT). Although they vary in their particular sequencing of interventions, most CBT protocols for internalizing disorders involve such specific techniques as self-monitoring of mood and physiological symptoms, engaging in pleasurable activities, use of self-rewards, relaxation and imagery, assertiveness and social skills training, and cognitive restructuring. Many of the treatments for youth with internalizing disorders also include a family component, to address mood/anxiety problems among parents and to teach parents to help children use their new cognitive-behavioral skills.

Anxiety

Coping Cat (by Phillip Kendall, 1996). This 18-session group cognitive-behavioral treatment for anxiety is suitable for children ages 9-13. Single-sex groups of 3-5 youth are recommended to promote discussion of anxiety symptoms and group cohesion. Coping Cat uses the acronym FEAR (Feeling Frightened, Expecting bad things to

happen, Attitudes and Actions that help, Results and Rewards) to help youth remember the cognitive-behavioral steps involved in coping. Three manuals are required to implement the approach, ranging in price from \$13.00-\$22.95 each; an order form for the manuals (published by Workbook Publishers) is available at the website www.childanxiety.org.

FRIENDS (by Paula Bartlett, 1999). FRIENDS is a group-administered cognitive-behavioral treatment for anxiety disorders for children ages 7-11. The program is comprised of 10 sessions between 45-60 minutes in length, administered on a weekly basis, with two follow-up booster sessions. There are also four optional parent sessions. Groups should be comprised of 12 or fewer youth. FRIENDS addresses the three major components of chronic anxiety symptoms: mind (i.e., cognition), body (i.e. physiological responses), and behavior (i.e., learning new coping skills). The acronym of FRIENDS is used to help youth remember coping steps for dealing with anxiety symptoms. The FRIENDS approach is well-manualized with easy to reproduce materials. Three manuals are necessary to implement the approach: the group leader's manual, a children's workbook, and a parents' supplement. Manuals are \$65.00 each, and order forms are available at the website: www.australianacademicpress@compuserve.com. To order by phone, dial international 61-7-3257-1176.

Depression

Stark School-Based Intervention for Depression (by Kevin Stark). This 26-session group cognitive-behavioral intervention has been tested and shown to be effective with 4th-7th graders with elevated levels of depression. The treatment components include self-control techniques (e.g., self-monitoring, self-reinforcement), social skills training, assertiveness training, relaxation training, imagery, and cognitive restructuring. A family component, which focuses on increasing positive family activities and training parents to help children use their new skills, is also recommended. The treatment protocol is described in a recent book by Phillip Kendall (2000; Child and adolescent therapy: Cognitive-behavioral procedures) available for \$46.00 from Guilford Press at www.guilford.org. Or, to obtain the full treatment manual, contact Dr. Stark directly at the Department of Educational Psychology, University of Texas-Austin: kevinstark@mail.utexas.edu.

Adolescent Coping with Depression Course (by Peter Lewinsohn). The Adolescent Coping with Depression Course is a psychoeducational, cognitive-behavioral intervention for adolescent depression. The protocol consists of 16 2-hour group sessions conducted over an 8-week period. It is designed for use with groups of 4-8 adolescents in an in-school or after-school program. It can also be adapted for use in individual therapy. The treatment sessions are conducted as a class in which a group leader teaches the adolescents skills for controlling depression. The topics covered include relaxation, engaging in pleasant activities, negative thoughts, social skills, communication, and problem solving. Each adolescent is provided with a Student Workbook which matches closely the course discussions and group activities. The Workbook includes brief readings, structured learning tasks, self-monitoring forms, homework assignments, and

short quizzes. Parents are encouraged to participate in the program by way of nine, 2-hour group sessions that are held at the same time as the adolescent group.

All materials required for administering this intervention (student workbook, leaders' manual, parent workbooks) are available for free download at the Coping with Depression Course website: <http://www.kpchr.org/public/info/newacwd.html>.

Taking Action Program for Depressed Youth (by Phillip Kendall). This manual, although not itself demonstrated as an empirically-supported intervention, uses many of the cognitive-behavioral techniques used in the Stark and Lewinsohn protocols, and is suitable for elementary age children. The therapist manual (\$22.95) and student workbook (\$13.00) are available from Workbook Publishers; print out an order form at www.childanxiety.org.

Treatments for Externalizing Disorders: ADHD, ODD, and CD

As any clinician working with children knows, externalizing behavior problems such as impulsivity, aggression, noncompliance, and oppositionality are very difficult to address. According to the treatment research that is currently available, the only effective psychosocial treatments for these disorders are those that involve behavioral modifications administered consistently in the youth's natural environment by the youth's caregivers – parents and teachers. With the exception of non-comorbid youth with impulse-control problems, individual therapies for youth with externalizing behavior disorders have not been demonstrated to be effective. Moreover, group therapies that involve treating large numbers of these youth at the same time have been shown in many cases to actually make externalizing symptoms **worse**. This is because of a phenomenon that has been called “deviancy training:” groups of antisocial youth tend to teach, encourage, and reward each other for saying and doing antisocial things. In group therapy settings, it is very difficult for group leaders to maintain control over such behaviors; even when group leaders feel they are being successful in creating a prosocial environment, youth often are rewarded by their peers for acting up in group either subtly or after the session concludes.

With these cautions in mind, below is a list of empirically-supported treatments for externalizing behavior problems:

Attention Deficit/Hyperactivity

Cognitive-behavioral therapy for impulsive children (by Phillip Kendall & Lauren Braswell, 1993). In this group-administered treatment, youth with impulse-control problems are taught to use a systematic problem-solving process to slow themselves down and brainstorm ways to respond to interpersonal and academic situations more successfully. The problem-solving process is taught primarily through modeling, role-playing, and rewards for use of the new skills. The protocol calls for a minimum of 20, 50-minute sessions (more if participants need more practice in the skills) led by two therapists. An extensive reward system (using “Stop-and-Think Dollars”) is employed to encourage prosocial behavior, and response costs are used for misbehavior.

The treatment is designed for youth ages 9-13. As noted above, this treatment only addresses the impulsive component of ADHD, not noncompliance, disruptive behavior, or aggression that is often found in youth with ADHD; thus, this approach should be used in conjunction with other interventions (e.g., parent training) when other symptoms commonly associated with ADHD are present. A general treatment manual describing the approach is available for \$31.00 Guilford Press (www.guilford.org). The youth Stop-and-Think Workbook (\$13.00) and a more detailed treatment manual for group leaders (\$22.95) are also available from Workbook Publishers; download an order form at www.childanxiety.org.

Teaching Problem Solving to Students with Learning and Behavior Problems (by Phillip Kendall & Nettie Bartel, 1990). This is the classroom-based version of the CBT for Impulsive Children described above. It is meant for youth with problems in impulsivity, self-control, or self-discipline; however, the problem-solving approach is general enough to be used in normal classroom settings and can be beneficial for all youth, even those not presenting with clinical symptoms. The approach can be adapted for almost any age youth. It is comprised of 12 sessions, but more may be required in order for students to master the skills. A reward system is optional in this approach. The teacher/group leader manual is available for \$22.95 at Workbook Publishers; download an order form at www.childanxiety.org.

See also – “Defiant Children” in ODD/CD section below.

Oppositional Defiant / Conduct Disorder

Classroom Behavioral Reward Systems. Classroom behavioral reward systems are an essential part of addressing the conduct problems of youth who show disruptive behavior and oppositionality in the school setting. Unfortunately, there are few specific protocols available for how to reward and punish appropriate and inappropriate classroom behavior for externalizing youth. For a good overview of various strategies, involving response cost systems and token economies, the book Effective school interventions: Strategies for enhancing academic achievement and social competence by Natalie Rathvon (1999) is an excellent place to start. This book is available from Guilford Press at <http://www.guilford.com>.

Defiant Children (by Russell Barkley, 1998). A comprehensive behavioral parent training course for noncompliant and oppositional children ages 3-13. Protocol includes 10 modules that teach parents ways to monitor good and bad behavior, engage in positive interactions with their child, use time-out, use rewards for good behavior, and use a response cost system as punishment for inappropriate behavior. Manual includes many reproducible handouts and is available in English and Spanish. The protocol can be administered to individual parents or groups of parents. Manual available from Guilford Press Publishers for \$37.00 at <http://www.guilford.com>.

Functional Family Therapy (FFT; by James Alexander). This treatment approach has been applied to many types of adolescent behavior problems and has been

evaluated for conduct and substance abuse disorders. It is suitable for youths aged 11-18. The treatment focuses on family engagement and motivation, with interventions designed to overcome hostility and negativity. The course of treatment ranges from 8 to 30 one-hour sessions over approximately three months. For more information visit the website: <http://www.fftinc.com>.

Helping the Noncompliant Child (by Rex Forehand & Robert McMahon, 2001). This parent training manual is designed for oppositional children ages 3 to 8 years old. It focuses on teaching parents to be more effective reinforcement agents and to issue more effective commands. Parents practice their new skills with their child in the Child Game (child-directed play in which the child chooses an activity) and the Parent Game (parent chooses an activity and applies rules/limits for it). The length of treatment is flexible (parents should not continue to a new phase until skills of previous phase are mastered) but the protocol can be completed in 10 sessions. Although this protocol is less extensive than Barkley's "Defiant Children," it is tailored specifically for the younger child and provides a nice discussion of how to deal with problematic situations (e.g., extremely noncompliant children, failure of gains to generalize beyond the practice games). Manual available from Guilford Press Publishers at <http://www.guilford.com>.

Keeping Your Cool (by Phillip Kendall). This cognitive-behavioral intervention is appropriate for dealing with the aggressive behavior problems of youth exhibiting a disruptive behavior disorder. It is suitable for youth ages 10-17. The protocol calls for 17-27 sessions, depending on the youth's progress. It is designed to be administered individually, but can be implemented in small groups if highly monitored (recall the problem of grouping youth with disruptive behavior problems for interventions). The therapist manuals (\$13.00 and \$16.95) and student workbook (\$22.95) are available from Workbook publishing at (610) 896-9797; a video (\$45.00) is also available.

Videotape Parent Training (by Carolyn Webster-Stratton). This treatment is suitable for parents of younger (ages 3-10) children who are exhibiting disruptive behavior problems. The approach combines traditional parent training techniques with videotapes of actors enacting adaptive and maladaptive responses to common stressful child situations. For more information contact Dr. Webster-Stratton at cws@u.washington.edu.

Universal Preventive Interventions

Universal interventions are those designed to lower the risk for a disorder for all youth, not just those exhibiting early symptoms or risk factors. An example of a universal intervention is vaccinating all babies for smallpox. Many universal interventions are broad and target a number of problems rather than a specific disorder per se. For youth, most universal interventions are delivered to whole classrooms at a time, and as such, require the cooperation and participation of classroom teachers and school administrative personnel.

Promotion of Social and Emotional Competence

Many universal prevention programs focus broadly on enhancing children's abilities to identify and manage their emotions and to behave appropriately in interpersonal conflicts. These programs have been classified as promoting social and emotional competence. Social and emotional competence programs have been shown to reduce rates of later oppositional problems and internalizing disorders. All of these curricula are classroom-based and behavioral, involving reward systems to encourage youth to use newly acquired skills.

I Can Problem Solve (ICPS; by Roger Spivak and Myrna Shure). This universal program is designed for ages 4-12 and has shown long-term positive effects in improving aggression, frustration tolerance, and social withdrawal. Lessons are conducted daily for 20- 30 minutes for younger children, and 3 times/week for 40 minutes for older children. A supplemental parents' manual, Raising a Thinking Child, is available to help parents reinforce new skills at home. Separate manuals (\$39.95 each) exist for preschool, kindergarten/early elementary (up to 3rd grade), and later elementary school (grades 3-6); only one manual per group of children is necessary. Training (\$1,000 per site) is recommended for broad-scale (e.g., schoolwide) implementation. Manuals are available at Dr. Shure's website: <http://www.thinkingpreteen.com/links.htm>.

Promoting Alternative Thinking Strategies (PATHS; by Mark Greenberg, 1994). PATHS is one of the most widely used social and emotional competence programs in existence today. It is designed to be taught by the classroom teacher three times per week or more for at least 20 minutes each lesson. More than 130 lessons focusing on self-control, empathy, self-esteem, social problem solving, positive values and attitudes, and critical thinking skills are included. PATHS is designed for youth in grades K – 6. The complete curricula (K-6) costs \$640 and includes a teachers' instructional manual, 6 volumes of detailed lessons, pictures, photographs, posters, feelings faces, and additional materials; evaluation materials are also available. Training of staff is highly recommended (30 people costs \$3,000 for two days), and ongoing support and consultation in the use of PATHS is available at additional cost. Learn more about PATHS and order it at the website: <http://www/dpr.org/PATHS/PATHS.html>.

Skillstreaming (by Arnold Goldstein). This prevention program, designed to enhance youths' social skills, can be used as a universal classroom or a selected small-group intervention. Separate curricula exist for K-6 and 7-12 grades. Instructors can run through the entire protocol or select different component skills to meet the needs of specific youth. Cue cards are used to prompt students to use Skillstreaming strategies. To implement Skillstreaming, a therapists' manual (\$19.95), student workbook (\$12.95), student materials (\$16.95), and student skill cards (\$25.00) are needed. Materials are available through Research Press at www.researchpress.org.

Substance Use, Conduct Problems, & Other High-Risk Behaviors

Adolescent Transitions Project (by Thomas Dishion). This package of interventions is designed for middle school aged youth. A Family Resource Room is established within the middle school from which parent training and other supportive services can be implemented. The primary intervention involves the Family Check-Up, a 4-5 session in-home assessment of the youths' risk for substance abuse and other problems with a detailed parent feedback session designed to motivate families to make preventive changes or seek additional services. Family Check-Ups generally occur in the summer preceding 7th grade and are available to all families who agree to participate. For more information contact Thomas Dishion at TomD@darkwing.uoregon.edu.

Project ALERT (by Phyllis Ellickson). Project ALERT is a 2-year drug prevention curriculum for middle school students (ages 11-14) that has been shown empirically to reduce the onset and regular use of substances. The 14-lesson program (45 minutes per lesson), administered by classroom teachers, is designed to prevent drug use initiation and the transition to regular use. It focuses on "gateway" substances: alcohol, tobacco, marijuana, and inhalants. Project ALERT uses participatory activities and videos to help students establish non-drug norms, develop reasons not to use, and resist pro-drug pressures. Guided classroom discussions, small group activities, role-playing, and parent-involved homework assignments also are used. Teachers can be trained in on-site workshops or at regional centers; all curriculum materials are distributed at the workshops. For more information, contact the website www.projectalert.best.org.

Be Proud, Be Responsible (by Loretta & John Jemmott). This curriculum is designed to prevent HIV and other STD infections by providing youth with information and skills to avoid engaging in high-risk sexual behaviors. It consists of 6 one-hour modules that can be administered as a whole (i.e., in a single day) or in blocks. The intervention is designed for small groups of 6-12 adolescents aged 11-15. The curriculum uses discussion, videotapes, role playing, and performance feedback, and can be administered by professionals or by supervised older adolescents (called "peer facilitators"). The curriculum can be ordered at Select Media, Inc.: (800) 707-6334 or (800) 343-5540.

Behavioral Prevention Project (by Debra Kamps). This multisetting, multimodal intervention combines classroom level interventions (academic tutoring, social skills instruction, and classroom behavior management) with in-home parent support and outreach to address negative peer student and teacher student interactions. It is designed for elementary school students. For more information send an email to csnyder@zoo.uvm.edu or contact the website: <http://www.air.org/cecp/preventionstrategies/behaviorprevention.htm>.

Bullying Prevention Program (by Dan Olweus). This program targets elementary and middle school students, teachers, and parents and is primarily focused on building awareness of bullying and helping students develop cognitive skills for dealing

with bullying. Screening and identification of potential bullies and victims is another component. For more information contact Dan Olweus at Olweus@psych.uib.no.

Child Development Project (CDP; by Eric Schaps). This elementary school-improvement initiative is for grades K – 6 and is designed to improve students' motivation for school and learning and to enhance students' resilience to later substance use. The intervention involves teachers, families, and school administrators and is focused on building a strong sense of community in the school, fostering cross-grade student relationships, and promoting parent involvement in learning. Phase One interventions focus on school climate; Phase Two focuses on curriculum and teaching style changes. To implement the program, school administrators attend a 2-day training and receive materials for use in the school; costs vary depending on the size of the school. For more information, contact Denise Wood, Developmental Studies Center, at (800) 666-7270, ext. 239 or contact the website <http://www.healthorg/features/hry/Programs/2-cdp/cdp.htm>.

Life Skills Training (by Gilbert Botvin). This widely-adopted universal classroom-based intervention is designed to prevent substance use among middle school students by targeting risk factors such as positive expectations for substance use, poor self image, and poor social skills. The program consists of 30 class sessions, each lasting 45 minutes. It can be administered as a concentrated curriculum (e.g., 2-3 times per week for a semester) or as an ongoing intervention throughout grades 6-8. Life Skills Training can be implemented by health educators, classroom teachers, mental health professionals, or older peer leaders. The curriculum is highly structured and user-friendly, with an average cost per student of \$21.00. To purchase curricular materials or to learn more, visit the website: www.lifeskillstraining.com or call (800) 636-3415.

Linking the Interests of Families and Teachers (LIFT; by John Reid, 2000). This universal program is designed for elementary school youth in 1st-5th grades. The 10-week intervention involves parent training (group administered), social skills training, playground behavioral modification program, and techniques to enhance communication between parents and teachers. It is designed to prevent the development of oppositional and conduct problems. For more information, contact John Reid at: johnr@oslc.org.

Preparing for the Drug-Free Years (PDFY; by J. David Hawkins). PDFY is a family competency training program that promotes healthy parent-child interactions designed to reduce children's risk for early substance use. Parents attend 9 weekly sessions focusing on child rearing, reducing family conflict, and positive family activities. Youth attend one session focusing on peer pressure. For more information, visit the Developmental Research and Programs, Inc. website at <http://www.drp.org>.

Project Northland (by Cheryl Perry). Project Northland is a three-year community-wide intervention designed to reduce adolescent alcohol use among 6th – 8th graders. In the first year parents and youth complete homework assignments together that pertain to adolescent alcohol use. The second year involves a peer- and teacher-led

classroom curriculum, and the third year involves youth community activism to address underage drinking. For more information contact the website:

<http://www.colorado.edu/csvp/blueprints/promise/projectNorthland.htm>.

Project STARR (by Mary Ann Pentz). Project STARR is a multi-component (media, school, parents, community leaders, and health professionals), community-wide intervention to prevent substance abuse. It is designed to ease youths' transition from early adolescence through late adolescence and can be implemented fully in the community within 3-5 years. The program involves mass media programming, active social learning techniques in the schools, parent education, and local policy changes. It requires a strong community/school coalition, extensive training, and ongoing technical assistance but results in a consistent community message to avoid drug use. For more information contact Karen Bernstein at (323) 865-0325.

Skills, Opportunities, And Recognition (SOAR; by Richard Catalano). SOAR is the commercially available version of the David Hawkins and Richard Catalano's Seattle Social Development Project. The intervention is a comprehensive school improvement program for middle school aged youth. For more information, contact Developmental Research And Programs, Inc. at <http://www.drp.org>.

Strengthening Families Program (by Richard Spoth). This universal, family-based intervention is designed for youth ages 10-14 and focuses on enhancing parent management skills, parent-child affective relationships, and family communication. The goal is to delay the onset of youth substance use. The intervention lasts 7 weeks and involves both a parent and youth training component. For more information contact Virginia Molgaard at (515) 294-4518 or visit the website: <http://www.colorado.edu/cspv/blueprints/promise/iowa.htm>.

Selected Preventive Interventions

Selected interventions are those designed to alter the development of a disorder among those who are showing early signs of the disorder or who are at high-risk for developing the disorder. Examples of selected interventions would be targeting children who are sad (early sign) but not yet depressed or children with criminal parents (risk factor) who might be at-risk for developing conduct disorder.

Depression

Adolescent Coping with Stress Course (by Peter Lewinsohn). The prevention counterpart of the Adolescent Coping with Depression Course described above. This selected intervention involves a number of cognitive-behavioral techniques for youth who do not yet meet criteria for a depressive disorder but who are at high-risk for developing depression. All materials required for administering this intervention (student workbook, leaders' manual, parent workbooks) are available for free download at the Coping with Depression Course website:

<http://www.kpchr.org/public/info/newacwd.html>.

Family Bereavement Program (by Irwin Sandler). This is a selected intervention for children and adolescents at high-risk for depression due to the death of a caregiver. The program consists of 12 group sessions for children and adolescents to build coping skills and coping efficacy and 12 sessions for parents to build and support effective parenting during grief. Information on the program and the assessment measures are available from the investigator, Irwin Sandler, at irwin.sandler@asu.edu. Manuals for this approach are free but the developer requests that he be contacted to provide phone assistance to those who want to implement the approach.

Penn Optimism Program (by Karen Reivich). This program is designed to combat cognitive distortions and related deficits associated with depression, such as behavior problems and poor peer relations. At-risk youth who might be suitable for the program are those from households with high marital conflict, low family warmth, or elevated depressive symptomatology. Students meet in groups of 10-12 youth for 12 weeks after school (1.5 hours per week). For more information contact Dr. Reivich at Reivich@psych.upenn.edu.

Anxiety

FRIENDS (by Paula Bartlett, 1999). FRIENDS is a group-administered cognitive-behavioral treatment for children ages 7-11 with anxiety disorders or symptoms. The program is comprised of 10 sessions between 45-60 minutes in length, administered on a weekly basis, with two follow-up booster sessions. There are also four optional parent sessions. Groups should be comprised of 12 or fewer youth. FRIENDS addresses the three major components of chronic anxiety symptoms: mind (i.e., cognition), body (i.e. physiological responses), and behavior (i.e., learning new coping skills). The acronym of FRIENDS is used to help youth remember coping steps for dealing with anxiety symptoms. The FRIENDS approach is well-manualized with easy to reproduce materials. Three manuals are necessary to implement the approach: the group leader's manual, a children's workbook, and a parents' supplement. Manuals are \$65.00 each, and order forms are available at the website: www.australianacademicpress@compuserve.com. To order by phone, dial international 61-7-3257-1176.

Aggressive, Disruptive, and other High-Risk Behaviors

Achieving, Behaving, Caring (ABC; by Pam Kay). This program is designed for children in 1st and 2nd grades who showed behavioral or emotional problems in kindergarten. The intervention is focused on developing a working relationship between teachers and parents. Parents and teachers develop mutually agreed upon goals for the youth and with the help of Parent Liaisons (peer parents), communicate and monitor the youths' progress. Parent Liaisons are recruited, trained, supervised, and paid for their participation. Child social skills training can be used to enhance the effectiveness of the program. For more information contact Pam Kay at pkay@zoo.uvm.edu or visit the website: <http://www.air.org/cccp/preventoinstrategies/achievingbehavingcaring.htm>.

Across Ages (by Andrea Taylor). Across Ages is a school-sponsored mentoring program for middle school youth ages 10-13. Elders (age 55 and older) serve as mentors to middle school youth and engage them in community service activities. Classroom teachers also provide life-skills training in the classroom. Positive outcomes have been achieved in improving school attendance and academic competence and in decreasing positive attitudes towards drug use. The Across Ages program requires full-time staff to administer the intervention. Training for up to 25 people occurs on-site at a rate of \$1,000/day (2 days required) and is supplemented by ongoing technical assistance by telephone. Manuals that describe the approach also are available for order by emailing Dr. Taylor at andreat46@aol.com.

Behaviorally-Based Preventive Intervention (by Brenna Bry). This selected two-year program is designed for 7th graders who are at high-risk for conduct problems, substance use, or school failure. Youth who are displaying low academic motivation, family problems, or serious/frequent school discipline referrals are appropriate for this intervention. Teachers, school administrative staff, and school counselors work together to monitor student actions and reward appropriate behaviors across 7th and 8th grades. Small group sessions of 3-5 students meet on a weekly basis across the two years for support and role-playing of new skills. For more information, contact Brenna Bry at bbry@rci.rutgers.edu or visit the website <http://www.colorado.edu/cspv/blueprints/promise/preventI.htm>.

Coping Power (by John Lochman). The Coping Power program targets aggressive children in the 4th-6th-grade years. It contains both child and parent treatment components. The Coping Power Child Component is a 15-month program with 33 group sessions. Child Component group sessions take place at children's schools (after school, before school, or during nonacademic homeroom periods) and last 45-50 minutes. A mental health clinician and school personnel co-lead group sessions of four to six children. To include a school staff person in the delivery of the program helps ensure the schools' active acceptance of and involvement in the project. Each child additionally receives a total of 10-12 individual 1/2 hour sessions at their school with an average of one individual session per month. The Coping Power Parent Component consists of 16 parent group sessions over the same 15-month period. Parents meet in groups of 10-12 parents or parent dyads with two co-leaders. The parent component involves parent training and coping skills for parental stressors. For more information about implementing Coping Power, contact Dr. Lochman at jlochman@gp.as.ua.edu

Creating Lasting Connections (CLC; by Ted Strader, 1995). This widescale intervention begins with mobilizing community groups (e.g., schools, churches, recreation centers, court) to identify at-risk families of youth ages 11-15. Families are recruited to participate and are provided with 20 weeks of parent and youth training focused on responding to adolescent crises and connecting to community resources. For more information, contact the Resilient Futures Network at (502) 897-1111 or visit the website: <http://www.healthorg/features/hry/Programs/3-clc/clc.htm>.

FAN Club (by Tena St. Pierre). This program is designed to be implemented in collaboration with the Boys and Girls Club of America (B&GCA) and is focused on preventing youth substance use. The intervention involves 3 tiers of interventions: Start SMART (ages 10-12), Stay SMART (ages 13-15), and SMART Leaders (ages 14-17). Parents of youth involved in the program are given basic support to deal with stressors, and activities are provided to promote family bonding. Educational enrichment activities also are a component. For more information contact the B&GCA Director of Health and Life Skills at (404) 487-5766 or visit the website: <http://www.healthorg/features/hry/Programs/7-fan/fan.htm>.

Project Towards No Drug Abuse (Project TND; by Steven Sussman). This is one of the only selected interventions targeting drug use that is designed for high school (rather than middle school) students ages 14-19. Youth participate in 12 in-class interactive sessions (40-50 minutes each) over the course of 4-5 weeks. The sessions focus on motivation, skills, and decision making. The program can be administered by classroom teachers; a two-day teacher training is recommended. The curriculum includes an implementation manual, student workbooks, a videotape, and pre/post-tests. For more information contact Steven Sussman at ssussma@hsc.usc.edu.

Reconnecting Youth (by Jerald Herting and Leona Eggert). This program is designed to help youth at high-risk for high school dropout to stay in school. The program is a class taken for credit that meets for one hour every day for a whole semester. Students with high absenteeism, low grades, or who are behind in credits are invited, not required, to participate. Classes have a 1:10 teacher: student ratio. The interventions are culturally and developmentally appropriate and are focused on counteracting prevailing norms for high school dropout by using motivational techniques. They involve skills training, self-monitoring, school bonding social activities, enhanced parent-teacher communication, and positive reinforcement. Class leaders can be teachers, health educators, or mental health counselors. Leader training takes about 40 hours. For more information, contact Jerald Herting at herting@u.washington.edu or Nanci Bratcher at (805) 682-6667.

For more information...

For more information about empirically-supported interventions or to receive technical assistance on this topic, contact the Center for School Mental Health Assistance (CSMHA) at 1-800-706-0980 or through email: csmha@psych.umaryland.edu.