A
Appendices

Appendix A
Programs described by CSMHA (2002)

The symbol * indicates the program is also listed in Table 4.9.

Indicated

Anxiety / Depression

1. Coping Cat (by Phillip Kendall, 1996)
2. FRIENDS (by Paula Bartlett, 1999)
3. Stark School-Based Intervention for Depression (by Kevin Stark)
4. Adolescent Coping with Depression Course (by Peter Lewinsohn)
5. Taking Action Program for Depressed Youth (by Phillip Kendall)

Externalizing Disorders

6. Cognitive-behavioral therapy for impulsive children (by Phillip Kendall & Lauren Braswell, 1993)
7. Teaching Problem Solving to Students with Learning and Behavior Problems (by Phillip Kendall & Nettie Bartel, 1990)
8. Defiant Children (by Russell Barkley, 1998)
9.* Functional Family Therapy (FFT; by James Alexander)
10. Helping the Noncompliant Child (by Rex Forehand & Robert McMahon, 2001)
11. Keeping Your Cool (by Phillip Kendall)
12. Videotape Parent Training (by Carolyn Webster-Stratton)

Selective

Anxiety / Depression

1.* Adolescent Coping with Stress Course (by Peter Lewinsohn)
2.* Family Bereavement Program (by Irwin Sandler)
3. Penn Optimism Program (by Karen Reivich)
4. FRIENDS (by Paula Bartlett, 1999)

Externalizing / Disruptive problems

5. Achieving, Behaving, Caring (ABC; by Pam Kay)
6.* Across Ages (by Andrea Taylor)
7. Behaviorally-Based Preventive Intervention (by Brenna Bry)
8. Coping Power (by John Lochman)
9. Creating Lasting Connections (CLC; by Ted Strader, 1995)
10. FAN Club (by Tena St. Pierre)
11.* Project Towards No Drug Abuse (Project TND; by Steven Sussman)
12.* Reconnecting Youth (by Jerald Herting and Leona Eggert)

Universal

1.* I Can Problem Solve (ICPS; by Roger Spivak and Myrna Shure)
2.* Promoting Alternative Thinking Strategies (PATHS; by Mark Greenberg, 1994)
3. Skillstreaming (by Arnold Goldstein)
4.* Adolescent Transitions Project (by Thomas Dishion)
5.* Project ALERT (by Phyllis Ellickson)
6. Be Proud, Be Responsible (by Loretta & John Jemmott)
7. Behavioral Prevention Project (by Debra Kamps)
8.* Bullying Prevention Program (by Dan Olweus)
9.* Child Development Project (CDP; by Eric Schaps)
10.* Life Skills Training (by Gilbert Botvin)
11.* Linking the Interests of Families and Teachers (LIFT; by John Reid, 2000)
12. Preparing for the Drug-Free Years (PDFY; by J. David Hawkins)
13.* Project Northland (by Cheryl Perry)
14. Project STARR (by Mary Ann Pentz)
15.* Skills, Opportunities, And Recognition (SOAR; by Richard Catalano)
16.* Strengthening Families Program (by Richard Spoth)

Appendix B
WSIPP results of benefit – cost analysis of 61 programs and approaches

	Programs	Benefit – cost estimate per youth	Number of studies	Prevention of				Improved
				Prevention of Crime	Substance Abuse	Teen Pregnancy	Child Abuse & Neglect	Educational Outcomes
Pre-K Education Programs								
1	Early Childhood Education for Low Income 3- and 4-Year-Olds 1	$9,901	106	✔		✔	✔	✔
2	HIPPY (Home Instruction Program for Preschool Youngsters)	$1,476	6					✔
3	Parents as Teachers	$800	8			✔	✔	✔
4	Parent-Child Home Program	($3,890)	6					✔
5	Even Start	($4,863)	2					✔
6	Early Head Start	($16,203)	3					✔
Child Welfare /Home Visitation Programs								
1*	Nurse Family Partnership for Low Income Women	$17,180	15	✔	✔		✔	✔
2	Home Visiting Programs for At-risk Mothers and Children 1	$6,077	25		✔	✔	✔	✔
3	Parent-Child Interaction Therapy	$3,427	1				✔	
4	Healthy Families America	($1,263)	12		✔		✔	✔
5	Systems of Care/Wraparound Programs 1, 2	($1,914)	3					
6	Family Preservation Services (excluding Washington) 1, 2	($2,531)	15					
7	Comprehensive Child Development Program	($37,397)	2					✔
8	The Infant Health and Development Program	($49,021)	1					✔
Youth Development Programs								
1*	Seattle Social Development Project	$9,837	7	✔	✔	✔		✔
2	Guiding Good Choices (formerly PDFY)	$6,918	6	✔	✔			
3*	Strengthening Families Program for Parents and Youth 10-14	$5,805	5		✔			
4*	Child Development Project	$432	4	✔	✔			
5*	Good Behavior Game	$196	1		✔			
6 *	CASASTART (Striving Together to Achieve Rewarding Tomorrows)	($610)	4	✔	✔			
Mentoring Programs								
1 *	Big Brothers/Big Sisters	$48	4	✔	✔			✔
2 *	Big Brothers/Big Sisters (taxpayer cost only)	$2,822	4	✔	✔			✔
3	Quantum Opportunities Program	($15,022)	8	✔		✔		✔
Youth Substance Abuse Prevention Programs								
1*	Adolescent Transitions Program	$1,938	3		✔			
2 *	Project Northland	$1,423	3		✔			
3*	Family Matters	$1,092	2		✔			

WSIPP results of benefit – cost analysis of 61 programs and approaches – continued

	Programs	Benefit – cost estimate per youth	Number of studies	Prevention of				Improved
				Prevention of Crime	Substance Abuse	Teen Pregnancy	Child Abuse & Neglect	Educational Outcomes
4 *	Life Skills Training (LST)	$717	33		✔			
Youth Substance Abuse Prevention Programs (continued)								
5	Project STAR (Students Taught Awareness and Resistance)	$694	6		✔			
6	Minnesota Smoking Prevention Program	$506	2		✔			
7	Other Social Influence/Skill Building Substance Prevention Programs	$485	130		✔			
8 *	Project Towards No Tobacco Use (TNT)	$274	10		✔			
9*	All Stars	$120	13		✔			
10*	Project ALERT (Adolescent Learning Exp. in Resistance Training)	$54	6		✔			
11*	STARS for Families (Start Taking Alcohol Risks Seriously)	($18)	10		✔			
12	D.A.R.E. (Drug Abuse Resistance Education)	($99)	38		✔			
Teen Pregnancy Prevention Programs								
1	Teen Outreach Program	$181	5			✔		✔
2	Reducing the Risk Program	($13)	4			✔		
3	Postponing Sexual Involvement Program	($54)	7			✔		
4	Teen Talk	($81)	3			✔		
5	School-Based Clinics for Pregnancy Prevention 1	($805)	8			✔		
6	Adolescent Sibling Pregnancy Prevention Project	($2,641)	3			✔		
7	Children's Aid Society-Carrera Project	($9,093)	3			✔		
Juvenile Offender Programs								
1	Dialectical Behavior Therapy (in Washington)	$31,243	1	✔				
2*	Multidimensional Treatment Foster Care (v. regular group care)	$24,290	2	✔				
3	Washington Basic Training Camp	$22,364	Not listed					
4	Adolescent Diversion Project	$22,290	4	✔				
5	Functional Family Therapy (in Washington)	$14,315	1	✔				
6	Other Family-Based Therapy Programs for Juvenile Offenders 1	$12,441	6	✔				
7*	Multi-Systemic Therapy (MST)	$9,316	6	✔				
8	Aggression Replacement Training (in Washington)	$8,805	1	✔				
9	Juvenile Offender Interagency Coordination Programs 1	$8,100	4	✔				
10	Mentoring in the Juvenile Justice System (in Washington)	$5,073	1	✔				
11	Diversion Programs with Services (v. regular juvenile court process) 1	$1,865	6	✔				
12	Juvenile Intensive Probation Supervision Programs 1	($1,482)	6	✔				
13	Juvenile Intensive Parole (in Washington)	($5,992)	Not listed					

WSIPP results of benefit – cost analysis of 61 programs and approaches – continued

	Programs	Benefit – cost estimate per youth	Number of studies	Prevention of				Improved
				Prevention of Crime	Substance Abuse	Teen Pregnancy	Child Abuse & Neglect	Educational Outcomes
14	Scared Straight	($11,056)	8	✔				
15	Regular Parole (v. not having parole)	($12,478)	Not listed					
Other National Programs (excluding Washington)								
1*	Functional Family Therapy	$26,216	6	✔				
2	Aggression Replacement Training	$14,846	4	✔				
3	Juvenile Boot Camps	$8,474	10	✔				
4	Juvenile Intensive Parole Supervision	($5,992)	7	✔				

[1] Indicates an approach, not a packaged program
[2] Indicates examined "out-of-home placements"
* Indicates program also listed on 4.9.

Appendix C
Overview of programs (*n*=38) and studies (*n* = 47) by type of problem discovered in the review of literature from 1985 to 1999 conducted by Rones and Hoagwood (2000)

Target	Universal or Indicated	First Author	Name of Program	# of Studies	Results
Emotional and Behavioral Problems (4 citations)					
1*	Universal	Greenberg	PATHS	1	Mixed
2*	Universal	Knoff	Project Achieve	1	Effective
3	Indicated	Catron	Vanderbilt School-Based Counseling Program	2	Mixed/Effective
4	Not specified	Hawkins		1	Effective
Depression (6 citations)					
5	Universal	Klingman	Coping with Distress and Self-Harm	1	Mixed
6	Universal	Clarke	Educational intervention	1	Not Effective
7	Universal	Clarke	Behavioral-skill training	1	Not Effective
8*	Indicated	Clarke	The Coping with Stress Course	1	Effective
9	Indicated	Gillham		1	Effective
10	Not specified	Reynolds		1	Effective
Conduct Problems (22 citations)					
11	Universal	Gottfredson		1	Mixed
12*	Universal	Reid	LIFT	1	Effective
13	Universal	Aber	Resolving Conflicts Creatively Program	1	Mixed
14	Universal	Cunningham	Student Mediated Conflict Resolution	1	Effective
15*	Universal	Dolan./ Kellam	Good Behavior Game	2	Mixed/Effective
16	Universal	Grossman		1	Mixed
17*	Indicated	CPRPG/King	FAST Track	2	Mixed/Effective
18	Indicated	Pepler		1	Mixed
19	Indicated	Tremblay		1	Mixed
20	Indicated	Vitaro		1	Mixed
21	Indicated	Fuchs	Mainstream Assistance Teams	1	Effective
22	Indicated	Bierman		1	Mixed
23	Indicated	Dupper	School Survival Program	1	Not Effective
24	Indicated	Hudley	Attributional retraining	1	Effective
25	Indicated	Lochman	Anger Coping	2	Mixed/Effective
26	Indicated	Rosal	CBT Art Therapy	1	Not Effective
27	Indicated	Suter	Social Activities	1	Not Effective
28	Not specified	Battistich		1	Effective
29	Not specified	Braswell		1	Not Effective

Overview of programs (Rones & Hoagwood) – continued

Target	Universal or Indicated	First Author	Name of Program	# of Studies	Results
Stress (2 citations)					
30	Universal	Henderson	Coping with Kids	1	Effective
31*	Universal	Cecil	Stress Inoculation	1	Effective
Substance Abuse (12 citations)					
32*	Univ/Indic	Botvin	Life Skills Training	4	Mixed/Effective
33	Universal	Dielman	Alcohol Misuse Prev.	1	Mixed
34*	Universal	Ellickson	Project Alert	1	Mixed
35*	Universal	Perry	Project Northland	1	Mixed
36	Universal	Rosenbaum	DARE	2	Not Effective
37*	Universal	Sussman/ Dent	Toward No Tobacco Use	2	Effective
38	Indicated	Hostetler	Project CARE	1	Not Effective

* Program also listed in Table 4.9.

Appendix D
Brief Description of programs listed in Table 4.9

1. **Brief Strategic Family Therapy**
   The program is delivered in sixty to ninety minute sessions over the course of eight to twelve weeks. A counselor meets with the family and develops a therapeutic alliance, diagnoses family strengths and problem relations, develops a change strategy and helps implement those strategies.

2. **Counselors Care (C-Care) and Coping and Support Training (CAST)**
   C-Care is a 2-hour computer-assisted assessment of risk and protective factors and also includes a brief intervention to provide empathy and support and to build networks and resources. CAST includes 12 small-group sessions held twice weekly for 6 weeks. CAST includes building group support, problem solving, anger management, and building self esteem.

3. **Early Risers: Skills for Success**
   A family advocate visits and consults with the child's teachers, instructs and mentors the child in social skills, and facilitates communication between home and school. The family advocate also makes regular home visits, supports the family in setting goals and planning, and brokers community services.

4. **Family Effectiveness Training**
   This program consists of thirteen weekly family sessions educating and promoting effective parenting skills, communication, conflict resolution, problem solving skills, and substance abuse prevention. Brief strategic family therapy is also employed. This program was developed for use with Hispanic populations.

5. **Multidimensional Treatment Foster Care (MTFC)**
   MTFC is a home-based foster care program which emphasizes behavior management methods to provide adolescents with a structured and therapeutic living environment. Average length of stay is seven months. Services are also offered to biological parents with the ultimate goal of returning the youth back home.

6. **Queensland Early Intervention and Prevention of Anxiety Project (QEIPAP)**
   This cognitive-behavioral school based program consists of weekly group sessions, one to two hours long, over ten weeks. It develops a plan of graduated exposure to fearful stimuli using psychological, cognitive, and behavioral coping strategies. This is a modified form of Coping Cat (Kendall). Parents participate in three sessions teaching child management strategies and exposure techniques.

7. **Multidimensional Family Therapy**
   Multicomponent and multilevel intervention that assesses and intervenes with the adolescent and parent(s) individually, the family as a system, individuals in the family, relative to their interactions with influential social systems that impact youth's development.

8. **Not on Tobacco**
   Ten, fifty-minute weekly sessions using curriculum based on social cognitive theory delivered at school or in the community. Trains youth in self-management, stimulus control, social skills, social influence, stress management, relapse prevention, nicotine withdrawal techniques, weight management, and peer evaluation.

9. **Project EX**
   Eight sessions delivered over six weeks emphasizing coping with stress, nicotine withdrawal, relaxation, avoiding relapse. The program uses motivating activities including games, talk shows, and alternative exercises (yoga).

10. **Reconnecting Youth**
    A semester-long high school class involving skills training in the context of a positive peer culture. Parental involvement is required. School personnel are given guidelines regarding suicidal behavior.

11. **Adolescent Transitions Program (ATP)**
    This program strives to reduce antisocial behavior through 12 weekly, 90-minute group sessions using presentations, videotapes, and tokens. Parents also attend 12 weekly 90-minute group sessions on parent skill building. Additionally, families participate in three individual consultations.

12. **Anger Coping Program**
    An anger management program including weekly 45 to 60 minute groups over 12 to 18 weeks. Lessons focus on improving student perspective-taking skills, affect regulation, self-control, social problem solving, and social skills. Sessions include role play and other activities.

Brief Description of programs listed in Table 4.9 – continued

13. Attributional Intervention (Brainpower Program)
This program aims to reduce aggression by conducting twice-weekly 40-60 minute group sessions over 6 weeks. Groups focus on teaching students about social interactions and correct interpretation of interactions. The program includes role play, story reading, and discussion. Also includes a twelve sessions on attention training.

14. Earlscourt Social Skills Group Program
Program aims to reduce aggression in elementary school students through twice weekly, 75-minute group sessions for 12 to 15 weeks. Sessions teach eight basic skills in program modules, classroom activities, and homework. Training sessions are also offered to parents.

15. Montreal Longitudinal Experimental Study
This program is an effort to reduce aggressive behavior in 7 to 9 year olds. It consists of parent training where each family attends multidisciplinary sessions every two to three weeks on average over two years. Parents receive twenty sessions about ways to improve parenting skills. During social skills training, student groups were involved in several activities: coaching, peer modeling, and role play techniques and met for nine sessions the first year and ten sessions during the second year.

16. Multisystemic Therapy (MST)
This program has a usual duration of 60 contact hours over 4 months. Intervention strategies are integrated into social ecological context and include strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavior therapy.

17. Peer Coping – Skills Training
The program consists of fifty-minute weekly sessions that include discussion, role playing, group activity, and group reward. Each child must master a specific set of performance goals, but the group does not move on until each member masters the goal. Teachers provide positive reinforcement for on-task behavior.

18. Incredible Years
This program uses four formats: eighteen to twenty-two two-hour weekly Dina Dinosaur group therapy for children; sixty Dina Dinosaur lesson plans for the classroom; twelve to fourteen two-hour weekly parenting groups; and fourteen two-hour teacher classroom management sessions.

19. Families and Schools Together (FAST)
Offers multifamily group intervention including support groups (eight to twelve weeks) and meetings with families after they "graduate" from the program.

20. CASASTART (Striving Together to Achieve Rewarding Tomorrows)
Brings together police, school, and community organizations to redirect lives of youth likely to end up in trouble and to reduce illegal drug use and crime in community. Case managers serve as counselor, mentor, advocate, broker, and role model.

21. Leadership and Resiliency Program (LRP)
Requires partnership between high school and a substance abuse/health service agency. Youth attend weekly in-school resiliency groups, participate in weekly community service activities after school and on weekends (including animal rehabilitation), and outdoor activities.

22. Parenting Wisely
This interactive computer-based program teaches parents and their children skills for combating risk factors for substance use and abuse. The highly interactive and nonjudgmental CD-ROM format accelerates learning, and parents use new skills immediately.

23. Project Success
Project success consists of an eight-session substance prevention education program, individual assessment, and eight to twelve individual or group counseling sessions (which vary by topic). Parents attend a workshop on substance abuse prevention/reduction, and students are referred to treatment or other services as needed.

24. Residential Student Assistance Program
A student assistance counselor is placed in an RTC and provides an eight-session substance abuse prevention education program, individual assessments, eight to twelve group counseling sessions, and referral and consultation.

25. Fast Track
The Universal Fast Track program uses the PATHS school-based curriculum for grades 1-5. The Selective/Indicated Fast Track program includes 5 additional components in grade 1, such as parent training, home visits, child social skills training groups, child tutoring in reading, and peer-pairing.

Brief Description of programs listed in Table 4.9 – continued

26. Cognitive Behavioral Therapy for Child Sexual Abuse (CBT-CSA)

The program consists of parallel sessions with the child and non-offending parent and joint parent-child sessions (in later stages of therapy). There are twelve sessions of both individual and group therapy. Parents are also provided with behavioral management training.

27. Trauma Focused Cognitive Behavior Therapy (TF-CBT)

TF-CBT is a treatment intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. The program can be administered in an individual or group format, involving the child only, parent only, or combined treatment.

28. Nurse-Family Partnership Program

Nurse-Family Partnership (NFP) provides first-time, low-income mothers of any age with home visitation services from public health nurses. The visiting nurse develops a therapeutic relationship with the family around areas of health, environment, support, parental roles, and major life events.

29. Across Ages

This program is a community-based prevention program that pairs older adult mentors with adolescents. The program employs mentoring, community service, social competence training, and family activities.

30. PENN Prevention Program

This program is a cognitive behavioral intervention delivered in group settings that meet after school for one and a half hour sessions over a twelve week period. Groups consist of in-session instruction and weekly homework assignments. Topics include a cognitive component and a problem solving/coping component.

31. Primary Mental Health Project

This is an early intervention project where the identified child meets with a trained child associate alone or in small groups once a week for 20-25 sessions. Each session lasts from 25-45 minutes throughout the school year. These meetings encourage expressive play with limits placed on inappropriate behavior.

32. Stress Inoculation Training I

The thirteen sessions include group and individual formats and cover cognitive restructuring, problem solving, and anxiety management. This program also includes teaching cognitive coping skills and relaxation training.

33. Stress Inoculation Training II

In eight sessions, students learn about the process of anxiety arousal and instrumental and cognitive-palliative coping skills such as progressive relaxation, cue-controlled relaxation, and cognitive restructuring.

34. Coping with Stress Course

This program promotes adaptive coping for adolescents with depressive symptomatology through 15 group sessions, each 45 minutes long, which take place after school. Groups employ cognitive interventions through the use of cartoons, role play, and group discussions.

35. First Step to Success

This program uses a modified CLASS program (Hops & Walker) which works in conjunction with the existing academic program. Behavioral criterions for the students are set daily. The program usually lasts approximately two months. The home intervention portion of the program, "HomeBase", is a six-week program involving a home visit and assessment. Parents are taught to reward appropriate behaviors.

36. Functional Family Therapy (FFT)

FFT is a prevention/intervention program for youth who have demonstrated the maladaptive, acting out behaviors and related syndromes. Intervention consists of 8-26 hours of direct service time with youth and family, depending on the severity of disruptive behaviors. FFT consists of five phases: engagement, motivation, assessment, behavior change, and generalization.

37. Social Relations Program

This program includes twenty six, 30-minute individual sessions and eight small group sessions covering four areas: social problem solving, positive play training, group-entry skills training, and anger control.

Brief Description of programs listed in Table 4.9 – continued

38. Children in the Middle

This program was designed for use with court-mandated/recommended training. Parents attend one or two sessions for two to three hours per session, where they view videotapes and participate in discussions. Children attend six to ten sessions for thirty to forty-five minutes per session, where they view child-centered videos. Both parents and children complete workbooks.

39. Children of Divorce Coping Program (CODIP)

This program strives to ease impact of parental separation or divorce on elementary school children through 10 to 16 sessions emphasizing support and skill building through group support, discussion, building problem solving skills, and enhancing positive self and family perceptions.

40. Children of Divorce Parenting Program

Parents divorced within two years attend 10 group and 2 individual sessions to learn about spending quality tie with their children, listening to their children, and using anger management skills to reduce interpersonal conflict.

41. Family Bereavement Program

The Family Bereavement Program consists of two parts. The Family Grief Workshops include 3 sessions connecting bereaved families and educating them on the grief process. The Family Advisor Program includes 12 sessions focused on changing parental demoralization, parental warmth, stable positive events, and negative stress events.

42. Big Brothers/Big Sisters

Big Brothers/Big Sisters screen and match adult mentors with youth from low-income, single-parent families for the purposes of developing and maintaining supportive relationships. Mentors meet with the assigned child several times a month over the course of at least one year.

43. Dare to be You

Families attend a twelve-week workshop series and semi annual twelve-hour boosters. The curriculum teaches self-responsibility, personal and parenting efficacy, communication/social skills, and problem solving and decision making skills. Teachers and childcare providers are also trained, as well as community staff involved with the family.

44. Project Achieve

This program involves strategic planning and organizational development to influence school reform. Teachers take part in training programs, parents participate in a home-school collaboration effort, and students receive "stop and think" curriculum.

45. SAFE Children: Schools and Families Educating Children

SAFE Children consists of a twenty-week family group curriculum including information dissemination, group discussion, family activities, and assignment of between-session activities. Also includes twice-weekly individual tutoring (heavily phonics based).

46. Strengthening Families Program (SFP)

SFP consists of fourteen two-hour sessions and behavioral skills training program. Parents meet separately with two group leaders during the first hour while children meet with two children's trainers. For the second hour families engage in structured family activities, practice therapeutic play, and reinforce positive behaviors.

47. All Stars

This is a school or community-based program designed to delay the onset of drug use, violence, and premature sexual activity. A highly interactive program, All Stars involves 9 to 13 lessons during its first year, and 7 to 8 booster lessons in its second year. This program uses small group activities, group discussions, games, and art activities.

48. Keepin' it REAL (Refuse, Explain, Avoid, Leave)

This program is a ten-lesson classroom curriculum accompanied by five videos demonstrating resistance strategies and illustrates skills taught in the lessons. Worksheets, role-play, games, and discussion are also used. One monthly booster session during the eight months after the program was completed is recommended.

49. Project ALERT

Project ALERT consists of eleven weekly lessons that motivate students against drug use, teaches skills and strategies to resist pro-drug pressures, and establishes non-drug using norms using guided classroom discussions and small group activities. Homework assignments work to involve the parents.

Brief Description of programs listed in Table 4.9 – continued

50. Project Toward No Drug Abuse (TND)

This program is a drug abuse prevention program for high school students that includes 12 in-class 40-minute interactive sessions that provide motivation, skills, and decision making targeting drug use.

51. Olweus Bullying Prevention

This is a bullying prevention program which works at three levels: school-wide, classroom level, and individual student. The program consists of weekly twenty to forty-minute classroom meetings. Teachers participate in regular teacher discussion groups. A coordinating committee consists of administrators, teachers, students, parents, and onsite coordinator.

52. Al's Pals: Kids Making Health Choices

This program consists of 46 lessons delivered by a classroom teacher for 10 – 15 minutes, twice a week. Al's Pals provides opportunities for children to acquire and practice social and emotional skills.

53. Caring School Community

This program focuses on building a school community based on caring relationships. It stresses good citizenship and provides broad multi-year coverage. Students learn competencies (social awareness, self management, self awareness, and communication skills) through teacher modeling, rehearsal, and independent application.

54. Child Development Project (CDP)

The CDP includes a reading-decoding program, reading comprehension program, and a four-part community-building program (school-wide activities, cross-grade buddies, class meetings, and family involvement). The program can take up to three years to complete.

55. Families that Care: Guiding Good Choices

This program consists of five, two-hour sessions that are interactive and skill based, and includes the use of videos and workbooks. Parents have the opportunity to practice new skills and receive feedback.

56. Good Behavior Game

Children in first grade are assigned to one of three classroom groups or teams. Teams are penalized for disruptive or noncompliant behavior and rewarded for not exceeding maladaptive behavior standards. This program also includes a group-based reading mastery component. The program continues into the second grade.

57. High/Scope Educational Approach for Pre-school and Primary Grades

This program develops learning environments where young children naturally engage in fifty-eight activities that foster development of important skills and abilities. The program incorporates active learning, adult-child interaction, maintaining daily routine, and assessment into the classroom.

58. Improving Social Awareness – Social Problem Solving (ISA-SPS)

The ISA-SPS program's three phases focus on reducing stressors associated with the transition from elementary to middle school. The Readiness Phase includes 20, 40-minute lessons which promote self-control, group participation, and social awareness. The Instructional Phase includes 20, 40-minute sessions teaching students eight steps for social decision making and problem solving. The Application Phase trains teachers to promote reinforcement of appropriate behavior.

59. Life Skills Training

This project includes fifteen forty-five-minute sessions for middle/junior high students and twenty-four thirty to forty-five-minute sessions for elementary students. Focuses on drug resistance skills, personal self-management skills, and general social skills.

60. Linking the Interests of Families and Teachers (LIFT)

The program is made up of twenty, one-hour sessions over a ten week intervention consisting of parent training; a classroom based social skills program;, a playground behavioral program; and systematic communication between teachers and parents. Parents meet once per week over six weeks for parent training.

61. Lions Quest Skills Series

This program focuses on character education, service learning, and violence and substance abuse prevention. The series provides 103 lessons across grades from K-12 and provides broad coverage of substance abuse prevention, violence prevention and good citizenship.

62. PATHS: Promoting Alternative Thinking Strategies

The PATHS curriculum has six volumes teaching emotional literacy, self-control, social competence, positive peer relations, and interpersonal problem-solving skills. This program continues over five years.

Brief Description of programs listed in Table 4.9 – continued

63. Positive Youth Development Program

This program uses a highly structured school-based curriculum program of twenty sessions during over fifteen weeks. Curriculum covers topics such as stress management, self esteem, problem solving, by using techniques such as didactic instruction, discussion, videos, diaries, and role play.

64. School Transitional Environment Project (STEP)

STEP creates cohorts of students who remain in homeroom together to develop learning communities. Homeroom teachers are trained to become an advisor for these students and act a liaison between students, families, other teachers, and the rest of the school.

65. Seattle Social Development Project

Teachers are trained in proactive classroom management, interactive teaching, and cooperative learning. Parent training is offered and topics vary according to grade of child.

66. Skills, Opportunities, and Recognition (SOAR)

This program is based on an eight-step model for teaching social and emotional skills. All components of this program emphasize teaching students how to conduct themselves responsibly in school and home settings.

67. Social Decision Making and Problem Solving Programs

This program provides twenty-five to forty lessons per year that are designed to help children recognize and use their emotions effectively in solving problems.

68. Suicide Prevention Program I

Twelve weekly, fifty-minute group sessions which follow a three-phase intervention model: educational-conceptual, exercise-training, and implementation-application.

69. Suicide Prevention Program II

This program is a gradual, controlled confrontation program of seven weekly two-hour workshops, aimed at eliciting introspective discussion. Workshops are semi-structured and centered on description of students' actual experiences, working through those experiences, and coping with the external problems or inner emotions.

70. Athletes Training and Learning to Avoid Steroids (ATLAS)

A drug prevention program delivered to older males within a sports context. The curriculum includes nine classroom hours to deliver ten session/lectures of about forty five minutes each. Each student is required to have 100 hours of team contact during sport season.

71. Class Action

This program consists of eight to ten sessions. The curriculum looks at real-world social and legal consequences of under-age drinking. Students participate in mock legal cases. Class Action also includes community speakers and parent involvement in the form of postcards mailed home. This program can be used as a part of Project Northland (#75) or as a stand-alone program.

72. Communities Mobilizing for Change on Alcohol

The community organizer works with civic groups, faith organizations, school, community groups, law enforcement, liquor licensing agencies, and advertising to influence local public policies and practice to limit youth access to alcohol. The program contains no curriculum.

73. Family Matters

Four booklets containing readings and activities regarding tobacco and alcohol use and are mailed home to parents. Follow-up phone calls to parents by a health educator provides additional support.

74. Keep a Clear Mind

In this project, the teacher (or other school staff) sends home four weekly lessons on tobacco, alcohol, marijuana, and saying "no" to drugs. Students who return completed lessons earn rewards. Five parent newsletters are also included.

75. Midwestern Prevention Project (MPP)

MPP is a skills program of 10-13 classroom sessions focused on drug abuse prevention that starts in school and is then reinforced through parents, the media, and community organization components.

76. Project Northland

Project Northland consists of eight, forty-five-minute sessions of teacher and peer-led classroom sessions. The take home part of the program involves providing a forum for students and families to discuss alcohol-related topics.

Brief Description of programs listed in Table 4.9 – continued

77. Project TNT: Towards No Tobacco Use
This tobacco-use prevention program targets middle school students and includes 10 school-based lessons to be presented over a two-week period. Each lesson lasts 50 minutes.

78. Project Venture
Students participate in classroom-based problem solving activities, outdoor experiential activities, adventure camps, treks, and community-oriented service learning.

79. Protecting You / Protecting Me (PYPM)
Developed by Mothers Against Drunk Driving (MADD), PYPM is a five-year alcohol prevention consisting of interactive classroom modules providing forty-two lessons and forty reinforcement activities including role-play, small group and classroom discussion, reading, writing, story telling, surveys, art, and music.

80. Start Taking Alcohol Risks Seriously (STARS) for Families
STARS is a health promotion program aimed at preventing alcohol use. Families receive an annual health consultation (twenty-minutes) with a nurse/other health care professional about alcohol use. Ten key facts about alcohol use postcards are mailed to parents for five to ten weeks. Parents can return the postcard for more information on a particular topic. Four weekly take-home prevention activities for parents and children to complete together are provided.

81. Strengthening Families Program – Parents & Youth (SFP)
SFP uses family systems and cognitive-behavioral approaches to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems. The program lasts for seven weeks and is delivered in group settings. Parents and youth meet in separate groups during first hour, and together for second hour. Videotapes are used. Booster sessions are offered.

82. Too Good for Drugs
Too Good for Drugs includes ten lessons per grade for K–8th grades and twenty-six lessons for high school grades. This program should be implemented each school year. It provides normative education, information on harmful effects of drug use, pro-social skill development, diverse role-play, cooperative learning, and parental involvement.

83. I Can Problem Solve (ICPS): An Interpersonal Cognitive Problems Solving Program for Children
Designed for students in the four to five year age range, this program consists of a twelve-week interpersonal cognitive problem solving program. This program uses games, discussion, and group interaction techniques to teach communication and problem solving. Also includes teacher (or parent) training in 'problem solving dialoging'.

84. Responding in Peaceful and Positive Ways (RIPP)
This curriculum consists of twenty-five sessions taught during a 45-minute class period once a week. Adult role models are used to teach knowledge, attitudes, and skills that emphasize nonviolence and positive communication. It uses small group work, role play, relaxation techniques, repetition and rehearsal, and peer mediation.

85. Safe Dates
This program consists of nine, fifty-minute sessions about relationships, a school play about dating abuse and violence, a poster contest, and parent letters and brochures. The school can also host family education programs.

86. Second Step: A Violence Prevention Program
Thirty, 35-minute lessons are taught once or twice a week and covers anger management, empathy, and impulse control. A video-based parent guide encourages the reinforcement of skills at home.

87. SMART Team: Students Managing Anger and Resolution Together
This program uses an eight-module process including a multi-media program that focuses on anger management, dispute resolution, and perspective taking.

88. Teaching Students to be Peacemakers
Teaching Students to Be Peacemakers consists of twenty, thirty-minute lessons including case studies, role-playing activities, and simulations. After the twenty lessons, peer medication procedures are implemented in the class and school. The program is re-taught each year as students' progress to more complex levels.

89. Too Good for Violence
This curriculum builds sequentially by grade and focuses on conflict resolution, anger management, respect, and communication skills, through role-play, cooperative learning, games, small group activities, and class discussion.

Brief Description of programs listed in Table 4.9 – continued

90. Know Your Body

This program includes a health education curriculum with forty-nine lessons per year covering topics such as exercise, safety, and disease prevention. Know Your Body develops critical thinking skills about health decisions.

91. Creating Lasting Family Connections (CLFC)

Comprehensive family strengthening, substance abuse, and violence prevention make up the CLFC curriculum. There are six modules, three for parents and three for youth. Follow-up case management is provided in this twenty-week program.

92. Positive Action

The Positive Action curriculum is grade-based and focuses on multiple domains related to improving academic achievement and behaviors. The program also works to impact school climate and classroom management skills of educators. Parents receive a related family kit containing lessons and materials.

Appendix E
Sixteen Individual-Level Outcome Evidence Rating Criteria–NREPP (Request for Comments; NREPP, 2005, pp. 50384-50386; Federal Register, 8/26/05)

Individual-Level Outcome Evidence Rating Criteria

1. Theory-Driven Measure Selection

Outcome measures for a study should be selected before data are collected and should be based on a priori theories of hypotheses.

0 = The applicant selected the measure after data collection for the apparent purpose of obtaining more favorable results than would be expected from using the measures originally planned, OR there is no documentation of selection prior to data analysis.

4 = Documentation shows that the applicant selected the measure prior to study implementation, OR the measure was selected after study inception, but before data analysis, and is supported by a peer review panel or literature related to study theories or hypotheses.

2. Reliability

Outcome measures should have acceptable reliability to be interpretable. "Acceptable" here means reliability at a level that is conventionally accepted by experts in the field.

0 = No evidence of measure reliability.

1 = Reliability coefficients indicate that some but not all relevant types of reliability (e.g., test-retest, inter-rater, inter-item) are acceptable.

3 = All relevant types of reliability have been documented to be at acceptable levels in studies by the applicant.

4 = All relevant types of reliability have been documented to be acceptable levels in studies by independent investigators.

3. Validity

Outcome measures should have acceptable validity to be interpretable. "Acceptable" here means validity at a level that is conventionally accepted by experts in the field.

0 = No evidence of measure validity, or some evidence that the measure is not valid.

1 = Measure has face validity.

3 = Studies by applicant show that measure has one or more acceptable forms of criterion-related validity that are correlated with appropriate, validated measures or objective criteria; OR, as an objective measure of response, there are procedural checks to confirm data validity, but they have not been adequately documented.

4 = Studies by independent investigators show that measure has one or more acceptable forms of criterion-related validity that are correlated with appropriate, validated measures or objective criteria; OR, as an objective measure of response, there are adequately documented procedural checks that confirm data validity.

4. Intervention Fidelity

The "experimental" intervention implemented in a study should have fidelity to the intervention proposed by the applicant. Instruments that have tested acceptable psychometric properties (e.g., inter-rater reliability, validity as shown by positive association with outcomes) provides the highest level of evidence.

0 = There is evidence the intervention implemented was substantially different from the one proposed.

1 = There is only narrative evidence that the applicant or provider believes the intervention was implemented with acceptable fidelity.

2 = There is evidence of acceptable fidelity in the form of judgment(s) by experts, based on limited on-site evaluation and data collection.

3 = There is evidence of acceptable fidelity, based on the systematic collection of data on factors such as dosage, time spent in training, adherence to guidelines or a manual, or a fidelity measure with unspecified or unknown psychometric properties.

4 = There is evidence of acceptable fidelity from a tested fidelity instrument shown to have reliability and validity.

5. Comparison Fidelity

A study's comparison condition should be implemented with fidelity to the comparison condition proposed by the applicant. Instruments for measuring fidelity that have tested acceptable psychometric properties (e.g., inter-rater reliability, validity as shown by predicted association with outcomes) provide the highest level of evidence.

0 = There is evidence that the comparison condition implemented was substantially different from one proposed.

Sixteen Individual-Level Outcome Evidence Rating Criteria–NREPP – continued

1 = There is only narrative evidence that the applicant or provider believes the comparison condition was implemented with fidelity.

2 = Researchers report observational or administrative data that the comparison condition was implemented with fidelity.

3 = Documentation confirms that comparison group participants did not receive interventions that were very similar or identical to intervention participants, AND there is documentation of degree of participation in any comparison conditions such as lectures or treatment.

4 = There is evidence from a tested instrument suggesting that the comparison condition was implemented with fidelity.

6. Nature of Comparison Condition

The quality of evidence for an intervention depends in part on the nature of the comparison condition(s), including assessments of their active components and overall effectiveness. Interventions have the potential to cause more harm than good; therefore, an active comparison intervention should be shown to be better than no treatment.

0 = There was no comparison condition.

1 = The comparison condition is an active intervention that has not been proven to better than no treatment.

2 = The comparison condition is no service or wait-list, or an active intervention shown to be as effective as or better than no treatment.

3 = The comparison condition is an attention control.

4 = The comparison condition was shown to be as safe or safer and more effective than an attention control.

7. Assurances to Participants

Study participants should always be assured that their responses will be kept confidential and not affect their care or services. When these procedures are in place, participants are more likely to disclose valid data.

0 = There was no effort to encourage and reassure subjects about privacy and that consent or participation would have no effect on services.

1 = Data collector was the service provider, AND there were documented assurances to participants about privacy and that consent or participation would have no effect on care or services.

2 = Data collector was not the service provider. There were indications, but no documentation, that participants were assured about their privacy and that consent or participation would have no effect on care or services.

4 = Data collector was not the service provider, AND there were documented assurances to participants about privacy and that consent or participation would have no effect on care or services; OR, data were not collected directly from participants.

8. Participant Expectations

Participants can be biased by how an intervention is introduced to them and by an awareness of their study condition. Information used to recruit and inform study participants should be carefully crafted to equalize expectations. Masking treatment conditions during implementation of the study provides the strongest control for participant expectancies.

0 = Investigators did not make adequate attempts to mask study conditions or equalize expectations among participants in the experimental and comparison conditions, or differential participant expectations were measured and found to be too great to control for statistically.

2 = Investigators attempted to mask study conditions or equalize expectations among participants in the experimental and comparison conditions. Some participants appeared likely to have known their study condition assignment (experimental or comparison).

3 = Investigators attempted to mask study conditions or equalize expectations among participants in the experimental and comparison conditions. Some participants appeared likely to have known their study condition assignment (experimental or comparison), but these differential participant expectations were measured and appropriately controlled for statistically.

4 = Investigators adequately masked study conditions. Participants did not appear likely to have known their study condition assignment.

Sixteen Individual-Level Outcome Evidence Rating Criteria—NREPP – continued

9. Standardized Data Collection

All outcome data should be collected in a standardized manner. Data collectors trained and monitored for adherence to standardized protocols provide the highest quality evidence of standardized data collection.

0 = Applicant did not use standardized data collection protocols.

2 = Data was collected using standardized protocol and trained data collectors.

3 = Data was collected using standardized protocol and trained data collectors, with evidence of good initial adherence by data collectors to the standardized protocol.

4 = Data was collected using standardized protocol and trained data collectors, with evidence of good initial adherence to data collectors to the standardized protocol and evidence of data collector retraining when necessary to control for rater "drift."

10. Data Collector Bias

Data collector bias is most strongly controlled when data collectors are not aware of the conditions to which study participants have been assigned. When data collectors are aware of specific study conditions, their expectations should be controlled for through training and/or statistical methods.

0 = Data collectors were not masked to participants' conditions, and nothing was done to control for possible bias, OR collector bias was measured and found to be too great to control for statistically.

2 = Data collectors were not masked to participants' conditions, but data collectors received training to reduce possible bias.

3 = Data collectors were not masked to participants' conditions; possible bias was appropriately controlled for statistically.

4 = Data collectors were masked to participants' conditions.

11. Selection Bias

Concealed random assignment of participants provides the strongest evidence of control for selection bias. When participants are not randomly assigned, covariates and confounding variables should be controlled as indicated by theory and research.

0 = There was no comparison condition, OR participants or providers selected conditions.

3 = Participants were not assigned randomly, but researchers controlled for theoretically relevant confounding variables, OR participants were assigned with non-concealed randomization.

4 = Selection bias was controlled with concealed random assignment.

12. Attrition

Study results can be biased by participant attrition. Statistical methods as supported by theory and research can be employed to control for attrition that would bias results, but studies with no attrition needing adjustment provide the strongest evidence that results are not biased.

0 = Attrition was taken into account inadequately, OR there was too much attrition to control for bias.

1 = No significant differences were found between participants lost to attrition and remaining participants.

2 = Attrition was taken into account by simpler methods that crudely estimate data for missing observations.

3 = Attrition was taken into account by more sophisticated methods that model missing data, observations, or participants.

4 = There was no attrition, OR there was no attrition needing adjustment.

13. Missing Data

Study results can be biased by missing data. Statistical methods as supported by theory and research can be employed to control for missing data that would bias results, but studies with no missing data needing adjustment provide the strongest evidence.

0 = Missing data were an issue and were taken into account inadequately, OR levels of missing data were too high to control for bias.

1= Missing data were an issue and were taken into account, but high quantity makes the control for bias suspect.

NREPP; Sixteen Individual-Level Outcome Evidence Rating Criteria – continued

2= Missing data were an issue and were taken into account by simpler methods (mean replacement, last point carried forward) that simplistically estimate missing data; control for missing data is plausible.

3= Missing data were an issue and were taken into account by more sophisticated methods that model missing data; control for missing data very plausible.

4= Missing data were not an issue.

14. Analysis Meets Data Assumptions

The appropriateness of statistical analyses is a function of the properties of the data being analyzed and the degree to which meet statistical assumptions.

0= Analyses were clearly inappropriate to the data collected; severe violation(s) of assumptions make analysis uninterpretable.

1= Some data were analyzed appropriately, but for other analyses important violation(s) of assumptions cast doubt on interpretation.

2= There were minor violations of assumptions for most or all analyses, making interpretation of results arguable.

3= There were minor violations of assumptions for only a few analyses; results were generally interpretable.

4= There were no violations of assumptions for any analysis.

15. Theory-Driven Selection of Analytic Methods

Analytic methods should be selected for a study based on a priori theories or hypotheses underlying the intervention. Changes to analytic methods after initial data analysis (e.g., to "dredge" for significant results) decrease the confidence that can be placed in the findings.

0= Analysis selected appears inconsistent with the intervention theory or hypotheses; insufficient rational provided by investigator.

1= Analysis selected appears inconsistent with the intervention theory or hypotheses, but applicant provides a potentially viable rationale.

3= Analysis is widely accepted by the field as the most consistent with study theory or hypotheses; no documentation showing methods were selected prior to data analysis.

4= Analysis is widely accepted by the field as the most consistent with study theory or hypotheses; documentation shows that methods were selected prior to data analysis.

16. Anomalous Findings

Findings that contradict the theories and hypotheses underlying an intervention suggest the possibility of confounding causal variables and limit the validity of study findings.

0 = There were anomalous findings suggesting alternate explanations for outcomes reported.

4 = There were no anomalous findings, OR researchers explained anomalous findings in a way that preserves the validity of results reported.

Based upon the independent reviewer assessments, review coordinators will compute average evidence quality ratings for specific outcome measures (based on the 16 evidence quality criteria), and then ask reviewers to determine the overall intervention outcome evidence ratings according to two components: quality of evidence and intervention replications. Average evidence quality ratings scores below 2.0 will be considered "insufficient current evidence" for the effectiveness of a given outcome, and will not be included in the Registry. Evidence quality rating scores of 2.0 to 2.5 will be considered "emerging evidence" for effectiveness, and scores of 2.5 and higher (4.0 is the maximum) will be considered "strong evidence."

Specific rating category labels for effective outcomes remain to be finalized, but might include categories such as: (1) Strong evidence with independent replication(s); (2) Strong evidence with developer replication(s); (3) Strong evidence without replication; (4) Emerging evidence with independent replication(s); (5) Emerging evidence with developer replication(s); and (6) Emerging evidence without replication.

Appendix F
Definitions and Review Criteria for Population-, Policy-, and System-, Level Outcome Ratings for Interventions. (Request for Comments; NREPP, 2005, p. 50387; Federal Register, 8/26/05)

Review Process for Determining Population-, Policy-, and System-Level Outcome Ratings for Interventions

The NREPP Evidence Rating Criteria for Population-, Policy-, and System- Level Outcomes are proposed as the basis for reviewer ratings of outcomes generated by community prevention coalitions and other environmental interventions to promote resiliency and recovery at the community level. SAMHSA's rationale for use of these separate criteria comes through a recognition that some interventions may be designed to affect a community over time, and that the prevailing scientific standards for assessing the effectiveness of these interventions may indeed be different than those for interventions seeking to change individual-level outcomes.

1. **Population-Level Outcomes**—measures the effect of an intervention of an existing, predefined population. Examples of such existing, predefined populations include "all youth residing in a neighborhood," "all female employees of a manufacturing plant," or "all Native Americans receiving social services from a tribal government." "All patients receiving a specific treatment," in contrast, cannot be defined as an existing, predefined population because that population would have come into existence as a direct response to the intervention.
2. **Policy-Level Outcome**—measures the effect of an intervention on enactment, maintenance, or enforcement of policies that are assumed to have a positive aggregate impact on resiliency or recovery. Examples of such outcomes include "the rate of passage of legislation restricting access to alcoholic beverages" or "the percentage of arrests for illicit drug manufacturing that result in convictions."
3. **System-Level Outcome**—measures the effect of an intervention on prevention and treatment capacity, efficiency, or effectiveness in an existing system or community. Examples of such outcomes include "increased capacity of a State government to quantify alcohol or drug-related problems" or "increased effectiveness of a community treatment system to respond to the comprehensive needs of individuals with Axis I mental health diagnoses."

Twelve Review Criteria

To support the transparency of the review process, SAMHSA wants stakeholders to understand clearly the NREPP procedures and decision-making processes. All community coalition interventions included in NREPP will have demonstrated evidence of effectiveness at the population, policy, or system level. The ratings will indicate the strength of the supporting evidence, and may be as follows:

(1) Strong evidence with replication;

(2) Strong evidence without replication;

(3) Emerging evidence with replication; and

(4) Emerging evidence without replication.

All NREPP evidence ratings are defined at the level of specific outcomes. The 12 evidence rating criteria used for population-, policy and system-level outcomes, summarized as an average Evidence Quality Score (EQS) for each outcome, allow independent expert reviewers to score along dimensions of outcome measurement, intervention fidelity, comparison conditions, participant and data collector biases, design and analysis, and anomalous findings. Each of the 12 criteria is assessed by independent reviewers on a 0 to 2 scale, in which a "1" indicates that methodological rigor may have been acceptable and a "2" indicates that adequate methodological rigor was achieved for this type of outcome.

Preliminary discussions of classifications have suggested that "Strong evidence" be defined as an average EQS of 1.75 or above (out of a possible 2.0), and that "Emerging evidence" be defined as an average EQS between 1.50 and 1.74 (out of a possible 2.0).

Outcome Measurement Criteria

1. Logic-Driven Selection of Measures

Outcome measures should be based on a theory or logic model that associates them with the intervention.

0 = The applicant appears to have selected outcome measures for the purpose of identifying favorable results rather than from a logic-based rationale.

1 = There is no explicit description of a guiding logic model or theory for measures, although a rationale for the inclusion of most measures can be inferred.

2 = Measures are supported by a theory or logic model that associates the intervention with the outcome.

Definitions and Review Criteria for Population – continued

2. Reliability

Outcome measures should have acceptable reliability to be interpretable. "Acceptable" here means reliability at a level that is conventionally accepted by experts in the field.

0 = No evidence of reliability of measures is presented.

1 = Relevant reliability measures are in the marginal range.

2 = Relevant reliability measures are in clearly acceptable ranges.

3. Validity

Outcome measures should have acceptable validity to be interpretable.

0 = No evidence of validity of measures is presented or evidence that is presented suggests measures are not valid.

1 = Measures has face validity.

2 = Relevant validity has been documented to be at acceptable levels in independent studies.

4. Intervention Fidelity

The intervention should be well defined and its implementation should be described in sufficient detail to assess whether implementation affected outcomes.

0 = The intervention and/or its implementation are not described in sufficient detail to verify that the intervention was implemented as intended.

1 = The intervention and its implementation are described in adequate detail, including justification for significant variation during implementation.

2 = The intervention and its implementation are described in adequate detail, reflecting variation during implementation with little or no plausible impact on outcomes.

5. Nature of Comparison Condition

The quality of evidence for an intervention depends in part on the nature of the comparison condition(s).

0 = Research design either lacks a comparison condition, or employs a before/after comparison.

1 = Comparison condition was no service or wait-list (including baseline comparison for a multipoint time series), or an active intervention that has not been shown to be safer or more effective than no service.

2 = Comparison condition was an active intervention shown to be as safe as, or safer and more effective than, no service.

6. Standardized Data Collection

All outcome data should be collected in a standardized manner. Data collectors trained and monitored for adherence to standardized protocols provide the highest quality evidence of standardized data collection.

0 = Data collection or archival sources used by the evaluation to assess outcome did not use standardized data collection protocol(s).

1 = All outcome data were collected using standardized protocol(s).

2 = All outcome data were collected using standardized protocol(s) and trained data collectors.

7. Data Collector Bias

Data collector bias is most strongly controlled when data collectors are not aware of the interventions to which populations have been exposed. When data collectors are aware of specific interventions, their expectations should be controlled for through training and/ or statistical analysis methods on resultant data.

0 = Data collectors were not masked to the population's condition, and nothing was done to control for possible bias, OR collector bias was identified and not controlled for statistically.

1 = Data collectors were not masked to the population's condition; possible bias was appropriately controlled for statistically or through training.

2 = Data collectors were masked to the population's condition, or only archival data was employed.

8. Population Studied

0 = A single group pre/posttest design was applied without a comparison group, OR the alleged comparison group is significantly different from the population receiving the intervention.

1 = Population(s) were studied using time trend analysis, multiple baseline design, or a regression-discontinuity design that uses within-group differences as a substitute for comparison groups.

2 = Population matching or similar techniques were used to compare outcomes of population that received the intervention with the outcomes of a valid comparison group.

Definitions and Review Criteria for Population – continued

9. Missing Data

Study results can be biased by missing data. Statistical methods as supported by theory and research can be employed to control for missing data that would bias results, but studies with no missing data needing adjustment provide the strongest evidence.

0 = Missing data were an issue and were taken into account inadequately, OR levels of missing data were too high to control for bias.

1 = Missing data were an issue and were taken into account, but high quality makes the control for bias suspect.

2 = Missing data were not an issue or were taken into account by methods that estimate missing data.

10. Analysis Meets Data Assumptions

The appropriateness of statistical analysis is a function of the properties of the data being analyzed and the degree to which data meet statistical assumptions.

0 = Analyses were clearly inappropriate to the data collected; severe violation(s) of assumptions make analysis uninterpretable.

1 = There were minor violations of assumptions, making interpretation of results arguable.

2 = There were no or only very minor violations of assumptions; result were generally interpretable.

11. Theory-Driven Selection of Analytic Methods

In addition to the properties of the data, analytic methods should be based on a logic model or theory underlying the intervention. Changes to analytic methods after initial data analysis (e.g., to dredge for significant results) decrease the confidence that can be placed in the findings.

0 = Analysis selected appears inconsistent with the intervention theory or hypotheses; insufficient rationale was provided by the investigator.

1 = Analysis selected appears inconsistent with the intervention logic model or hypotheses, but the investigator provides a potentially viable rationale.

2 = Analysis is widely accepted by the field as consistent with the intervention logic model or hypotheses.

12. Anomalous Findings

Findings that contradict the theories and hypotheses underlying an intervention suggest the possibility of confounding causal variables and limit the validity of study findings.

0 = There were anomalous findings suggesting alternate explanations for outcomes reported that were not acknowledged by the applicant.

1 = There were a few anomalous findings, but additional analysis or previous literature cited by the applicant provide a reasonable explanation.

2 = There were no anomalous findings, OR researchers explained anomalous findings in a way that preserves the validity of results reported.

Appendix G
Possible steps in implementing a public health model for school-based mental health services

1 Surveillance at the population/community level

What is the problem?

Use systematic data collection strategies to determine the specific educational and mental health challenges & needs in your community.

Steps to Identify Priority Problems through Surveillance

- Establish a task force that has resources and authority for engaging in decision-making for service planning.
- Use existing data to create a composite picture of the mental health challenges in the community.
- Existing data should be examined for indicators of mental health functioning in youth in your community and will help direct action.
- Examples:

  What is the youth suicide rate in your community?

  What is the rate of involuntary psychiatric hospitalizations in your community?

  What are some indicators of substance abuse problems among the youth in your community?

  Do existing data point to mental health problems of youth in the juvenile justice system?

  What are the rates of suspensions and dropping out of school in your community?

  What are the rates of young children entering school who are not ready to learn?

- Prioritize the problems to be addressed.

2 Identify risk and protective factors

What are the causes?

Use the information collected in and on your community on a regular basis and integrate with the research literature.

Steps to Identify Risk and Protective Factors

- Identify risk and protective factors for each prioritized problem. Risk factors are those conditions that increase the likelihood of a negative outcome for children. Protective factors are conditions that reduce the probability of the negative outcome.
- Examine the empirical literature and condense the information to identify the risk and protective factors associated with the priority problem.
- Examples:

  Depression is a well-documented risk factor for suicide. Possessing adequate coping skills to deal with stress is an effective protective factor against depression and, subsequently, suicide.

  A common risk factor associated with the problems of aggression and substance use is negative peer influence. For both, protective factors are increased social competence and communication skills.

  A common risk factor for early school failure is a lack of pre-school academic skill development. The protective factors include an academic environment that engages in screening and early intervention for students with academic deficits.

- Integrate the community data with the research literature to identify and prioritize risk and protective factors needing to be addressed in your community.

3 Develop and evaluate interventions

What works and for whom?

Review literature on empirically based interventions and apply/adapt to local community needs.

Steps to Implement Evidence-Based Programs and Practices

- Use the research literature to identify evidence-based programs and practices that are appropriate for addressing the prioritized risk and protective factors in your community.
- Communities need to be aware of the need to integrate and balance the implementation of universal, selective, and indicated interventions. After universal interventions have been established, the effectiveness of implementing selective and indicated interventions will be facilitated.
- The Task Force must also investigate the feasibility of implementing the selected evidence-based program for issues such as cost of the program, staff training necessary for implementation, and cultural relevance. Additionally, Task Force members should outline the resources needed to support the implementation of the selected intervention over the life of the program.
- A Task Force that prioritizes depression, aggression and substance abuse for possible action, for example, could examine the feasibility of implementing the following programs:

  For depression - the *Coping with Stress Course* is a selective intervention that involves cognitive behavioral therapy in a group setting.

  For aggression – the PATHS Program (*Promoting Alternative Thinking Strategies*) is a universal prevention program that teaches skills such as self-control, social competence, and interpersonal problem-solving skills. An example of an indicated intervention is the *Anger Coping Program*, which group settings to reduce antisocial behavior.

  For substance use – *the Midwestern Prevention Project* focuses on drug abuse prevention with classroom-based sessions and parent involvement.

4 Implementation monitoring and scaling-up

Is it meeting the intended needs?

Monitor interventions for proper implementation, scale-up interventions and measure impact.

Steps for Implementation, Monitoring, and Scaling-Up

- Create infrastructure to examine and monitor youth and community outcomes to determine the effectiveness of efforts.
- Create quality assurance standards and training opportunities to support the dissemination and wide spread adoption of successful efforts.

> ***"No mass disorder afflicting humankind has been eliminated or brought under control by attempts at treating the affected individual, nor by training large number of individual practitioners."***

George Albee
Past President
American Psychological Association